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The future of physician leaders: a study of physician leadership practices

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Pepperdine University

Graduate School of Education and Psychology

THE FUTURE OF PHYSICIAN LEADERS: A STUDY OF PHYSICIAN LEADERSHIP

PRACTICES

A dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Education in Organizational Leadership

by

Lynn M. Pregitzer

June, 2014

Ronald D. Stephens, Ed.D. - Dissertation Chairperson

This dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

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DEDICATION

I dedicate this dissertation to my husband, Karl, for his enduring love, support, and patience. It is the richness of his love and constant optimism that made this doctoral journey possible.

I also dedicate this study to my remarkable children, Roger and Jena, who have proven the resilience of the human spirit. Their strength to push through adversity and their confidence to prevail over difficulties is an inspiration.

Finally, I dedicate this study to my father who was a lifelong learner and my mother who taught me to give back to others.

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ABSTRACT

The administration's healthcare reform act of 2010 brings changes that are targeted to increase the quality of care, cut rising healthcare costs, and improve the health of the population, but the principle objectives of the law can only be met with the active involvement of physicians. However, leading in multidisciplinary healthcare organizations is difficult and physicians prepared for leadership are in short supply. Addressing this shortage first requires an understanding of the leadership practices of physicians in order to develop an effective leadership development program. To this end, the primary purpose of this study is to explore the practices of physician leaders.

This study used the qualitative phenomenological method to examine the experiences of physicians in their lives as leaders. The theoretical framework used to guide the research was the five practices of exemplary leaders (Kouzes & Posner, 2012). Interviews were conducted with 8 participants and the data were coded and analyzed using HyperRESEARCH, a qualitative coding software package. The validity and reliability of the study were enhanced by presenting an in-depth, vivid analysis of the data, by conducting a peer review and by clarifying the researcher's bias at the outset of the study.

The study found that all 5 of the practices in Kouzes and Posner's (2012) theoretical framework were present in physician leaders to varying degrees. Overall, the expressions which represented the practices of "enable others to act," "inspire a shared vision," and "challenge the process," were counted more often than "model the way" and "encourage the heart." The study recommends that instructional designers develop a systematic curriculum with advanced leadership concepts. Additional recommendations include executive coaching and change leadership training. Recommendations for future research include increasing the number of

participants, replicating the study using a different theoretical framework, including more

physicians from small practices, expanding the study to collect demographics of the participants,

and using a quantitative method or mixed method to enhance the transferability of the study

results.

Chapter 1. Introduction

The current administration's landmark healthcare reform legislation, the Patient Protection and Affordable Care Act of 2010 (PPACA), introduces a series of reform measures scheduled to roll out between 2010 and 2014 to stabilize escalating medical costs while raising the quality of patient care. Some measures, such as the provision that mandates coverage for children up to 26 years old and the clause that prohibits denial of coverage for preexisting conditions are fairly straightforward. However, one measure in particular is predicted to completely overhaul and change the way healthcare is managed and delivered today. This key provision calls for the creation of accountable care organizations (ACO). According to the Centers for Medicare and Medicaid Services (CMS), ACOs are an association of physicians and hospitals who coordinate the medical care of a patient population ("Centers for Medicare," 2012). The intent of the ACO is to provide care to more than 49 million Americans currently without insurance, to raise the quality of outcomes, and to reduce unnecessary medical services through healthcare teams that coordinate the care of patients (DeNavas-Walt, Proctor, & Smith, 2011; "Centers for Medicare," 2012). Not surprisingly, however, ACOs are having a major impact on both private and small physician groups. This can be is seen by a study conducted by Accenture which estimated that by 2013, only 33% of physicians in the United States (U.S.) will remain in private practice, down from 57% in the year 2000 (Zismer & Person, 2008). In a system that was previously dominated by private and small group physician practices, more and more physicians are leaving small practices for the stability of the large ACOs to escape the onerous task of implementing the new technology required by the PPACA and deciphering and complying with complex government regulations (Zismer & Person, 2008). Although no one knows how the exodus of solo and small group practitioners will impact the future of healthcare,

there is no question that physicians are paramount not only to the success of the ACO, but also to

stemming rising medical costs in the U.S.

While the advent of ACOs presents many leadership opportunities for physicians, there is

a shortage of physician leaders prepared for the roles. The reasons for the shortage are threefold.

First, most physicians are not ready for the special leadership challenges posed by healthcare

organizations. Healthcare institutions consist of multidisciplinary work forces with different

value systems and are often characterized by silos and fiefdoms—informal self-organizing

centers of power (Minvielle, 1997; Weisbord, 1976). To complicate matters, healthcare systems

commonly have dual bureaucracies—organizationally separate administrative and medical

structures (Stoelwinder & Clayton, 1978). These complexities inherent in the structure of

healthcare institutions coupled with the competing interests of the various centers of power can

be a difficult adjustment for physicians who are used to having independence, self-sufficiency,

and autonomy.

In addition to internal forces, external forces also present challenges in managing a

healthcare organization. For example government oversight agencies often change regulations

regarding insurance and medical practice guidelines. Furthermore, technological advances and

changing market conditions also create a constant tension for leaders in the healthcare who must

strike a delicate balance in decisions regarding cost and high quality care (Stoller, 2009). For

these reasons, managing healthcare institutions are a leadership challenge, not only for

physicians, but also for those with years of experience as leaders.

The second reason for the shortage of physician leaders is the notoriously long and

rigorous training requirements imposed upon the profession, making it burdensome and

expensive to add leadership training to the medical school curriculum. To start, the minimum

schooling for a physician consists of four years of undergraduate work plus four years of medical

school. Thereafter, doctors spend an additional three to five years training as residents in

hospitals. As such, adding new courses to the curriculum load and the years of practical training

is deemed both cost prohibitive and burdensome.

Finally, the third reason for the shortage in physician leaders can be explained by the

societal and cultural perception that frowns upon mixing business with medicine. Business and

medicine are generally viewed as two distinctly separate disciplines with separate value systems,

making it difficult to combine the two disciplines together.

In every healthcare institution across the U.S., thousands of physicians accept leadership

positions eager to collaborate in policy-making and to lead in the organization. Most of these

physicians rise to the position based on their proficiency in technical knowledge and skills and

assume that the same qualities are sufficient for their success as leaders. Leadership, however,

requires a different set of skills from those required to be a physician. Effective leadership is

about understanding the needs of others and what moves them. Early leadership theorists wrote

extensively about the one individual who achieved greatness, but the essence of leadership is in

the relationship with the people or person being led (Bennis, 1999). Thus, physicians in

leadership positions must understand that they cannot succeed based solely on technical

competencies and determination. Leadership training is needed to succeed across time.

One of the most significant advances in leadership studies occurred when scholars began

writing about the mediating and moderating role followers play in enhancing the leader's

effectiveness (Burns, 1978; Kellerman, 2007). Kotter (2001) corroborated this assertion through

research that found that followers played a crucial role in creating dramatic and meaningful

results. To this end, Kotter's research essentially defined leadership through activities that

influenced followers by creating a vision, aligning and motivating people and inspiring people to

move beyond the vision of the leader (Kotter, 2001).

Definition of the Problem

Executives, managers, and board of directors are recognizing the growing need for active

physician involvement in ACO's, the government proposed healthcare model. The reasons for

the urgency are twofold. First, the key aims of the ACO's are largely controlled by activities of

the physicians. These aims are the reduction of costs, improvement of outcomes and more

access to care. Second, the technological mandates and the advent of government controlled

healthcare exchanges—marketplaces where consumers choose insurance plans—will

fundamentally alter the way healthcare institutions interact with their customers. Although

exchanges change the way consumers buy insurance, consumers are predicted to make their

choice based on the physician with whom they have a relationship. Therefore, institutions that

do not actively involve physicians in the business will risk losing market share.

Although it has become apparent that physicians' must actively participate for healthcare

reform to succeed, there is a critical shortage of physician leaders. Extant literature confirms a

growing interest in gaining an understanding of the characteristics of physician leaders, the

tactics they use, and the need for physician leaders in the future (Kim, 2012; Shields, Patel,

Manning, & Sacks, 2011; Stoller, 2009; Ziskind, Ficery, & Fu, 2011; Zismer & Person, 2008).

In spite of the growing attention regarding the urgency for physician leadership, research is

lacking on the practices of physician as leaders. Without a comprehensive understanding of the

current state of the leadership practices of physicians and the meaning that physicians ascribe to

leadership, it is difficult for healthcare institutions, government agencies, and educational

organizations to design andragogical instructional tools to most effectively develop physicians as

leaders. The premise of andragogy is that adults as learners have the best outcomes when they have control over their learning and the instructional design takes into account their past experiences when developing a curriculum (Knowles, 2005). This model contrasts with the pedagogical model where learners play a passive role and defer all decision-making to the teacher.

Purpose of Study

The primary purpose of this dissertation is to explore the leadership practices of physician leaders. Examining the leadership practices of physicians is important because the success of healthcare reform is heavily dependent on their leadership. By focusing on the leadership practices, behaviors, and characteristics of physicians, this study will discover significant similarities or differences with non-physician leaders, which may impact the way physicians are trained in leadership.

Guiding Theoretical Framework

This research study will use Kouzes and Posner's (2013) five practices of exemplary leaders framework to guide the research. Through countless interviews and many years of research, Kouzes and Posner discovered that leaders consistently practiced five practices when describing their best leadership experiences. These are (a) model the way; (b) inspire a shared vision; (c) challenge the process; (d) enable others to act; and (e) encourage the heart. In this study, Kouzes and Posner's model guided the planning of the research design and will be used to frame the analysis of this dissertation.

Research Questions

There is little research available that describes how to best educate and develop physicians as leaders and only recently has there been attention given to the urgent need for a

critical mass of physician leaders. Hence, this research study will explore the experience of

leadership from the physician's perspective particularly focusing on their leadership practices.

The central aim of the study is to explore the leadership practices of physician leaders. In order

to gain an in depth understanding of the phenomenon, the below research subquestions will be

explored in this research study.

1. What are the perspectives of physician leaders regarding leadership?

2. How do the meanings that physician leaders ascribe to leadership affect them as
   leaders?

3. How do physician leaders describe their most effective leadership experience?

4. What behaviors benefited physician leader experiences?

5. How do physician leaders prepare for the multifaceted leadership role in healthcare
   organizations?

6. What do physician leaders perceive as concerns for aspiring physician leaders?

Significance of the Research

American workers and retirees face a looming crisis due to rising healthcare costs.

Although the rising healthcare costs have not yet threatened their economic standing, the rising

costs force some to trade off healthcare for everyday necessities. Decades of rising health care

costs have left millions without insurance and struggling to pay medical bills. Government

leaders assert that the rapid pace at which health care expenditures increase outpace the increase

of worker income and could potentially jeopardize the standard of living of workers and retirees

(Schieber et al., 2009). If this phenomenon continues, they claim that the standard of living of

American workers and retirees could be jeopardized (Schieber et al., 2009). According to the

Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health

and Human Services, the outlook for national healthcare expenditure is bleak. In 2011, U.S. healthcare expenditures were $2.7 trillion in 2011, or 17.9% of the U.S. gross domestic product (GDP) and CMS forecasts expenditures to grow to $4.5 trillion in 2020 and represent 20% of the nation's GDP (Centers for Medicare & Medicaid Services, 2011). In order to address this important issue, the current administration's healthcare reform law set forth new guidelines and proposed provisions to address these issues. The guidelines and provisions of healthcare reform are complex and its efficacy remains to be seen. PPACA, the greatest overhaul in healthcare laws since Medicare was introduced in 1965, has three objectives. These are to improve patient care outcomes, to contain rising costs, and to improve the patient experience. However, achieving these objectives in an environment where a variety of different stakeholders interact in emerging spaces that never existed before is extremely difficult. To complicate matters, healthcare and medicine are different from other organized entities as it is inherently non-linear (Gonnering, 2010). The industry operates in an environment where self-selecting individuals organize and interact organically to produce highly sophisticated emergent results. To do so, participants are quick acting, thrive without equilibrium and interact simultaneously within multiple environments. In contrast, administrative systems are linear, inert, and seek predictable results. For the roughly 33% of doctors who currently practice independently and plan to become salaried employs of accountable care organizations, a major cultural adjustment is in store. For this reason, this study explores the characteristics of physician leaders and seeks to understand the perceived importance of perception that physicians ascribe to effective leadership competencies in the new era of healthcare. The study also fills the void in academic literature regarding the long-term implications of developing appropriate instructional models to develop physicians as leaders.

Definition of Terms

For the purposes of this study, the following definitions are used:

1. Accountable care organization (ACO): A consortium of doctors, hospitals and other providers who coordinate the medical care of a group of patients in order to provide high quality care and eliminate unnecessary services (Centers for Medicare & Medicaid Services, 2012).

2. Healthcare: The discipline concerned with the prevention, maintenance and treatment of illnesses and diseases.

3. Healthcare systems: An institution that consists of licensed professionals, hospitals and other services to provide the healthcare services needed to maintain or restore the health of a population.

4. Patient Protection and Affordable Care Act (PPACA): The PPACA, also known as the healthcare reform act, is the landmark legislation passed by the current administration in March 2010 to provide health insurance for the uninsured, contain rising healthcare costs and raise the quality of patient care. The law includes major provisions that were implemented beginning in 2010 and will be phased in by 2014.

5. Physician leader: An experienced physician who is a practicing clinician and occupies a leadership role in an organization that delivers healthcare.

Assumptions of the Study

A number of assumptions underlie this study. First, the researcher assumes that interviewees will be truthful and honest and the discourse during the interview will be an accurate portrayal of their experiences as a physician leader. Furthermore, the researcher assumes that the interviews will provide patterns, trends and themes of the practices of physician

leaders. Therefore, even if unconscious factors may limit the objectivity of the participants'

accounts as leaders, the interpretive value of the data and the veracity of the leaders can be used

to advance knowledge on the topic (Creswell, 2007).

Secondly, the study assumes that the researcher is able to set aside previous experiences

and suspend judgment during the inquiry. Taking an unbiased view and acting as a

nonparticipant observer is important to the study as it ensures that previously held beliefs or

theories do not encumber the research being conducted (Moustakas, 1994). To this end, the

researcher discloses that her background includes 15 years of experience in a finance capacity at

a large health maintenance organization and that the researcher's family includes practicing

physician leaders and aspiring physicians. Despite the researcher's efforts to conduct the study

based on insights exclusively provided by the data, it should be noted that the aforementioned

background might impact the objectivity of the study (Creswell, 2007).

Limitations of the Study

An unbiased and open discussion of the limitations of the study is important to academic

discourse and progress. Presented below is a discussion of how the limitations of this study

could have affected the findings of the study and the interpretations.

Sampling. Three components are discussed in this section. First, the total number of

physicians who participated in the study was limited to eight. It is conceivable that a larger

sample population could find that physician leaders have different perspectives in leadership

from the sample that participated in this study. Second, the study did not collect the

demographic information of the sample population. As such, it can be suggested that there is a

causal relationship between the practices of physician leaders depending on their age, gender,

where they practice, specialty and experience in a leadership role. Third, it is possible that those

who volunteer their time to this research will be more biased towards the significance of the topic.

Interviews. There were several assumptions made regarding the interviews. First, although there are a large number of leadership characteristics and theories available that are available in organizational leadership studies, this research project used the five practices of exemplary leaders by Kouzes and Posner (2002a) to guide the research. It is possible that a different theoretical framework would produce different results. In addition to limiting the study by using the five practices as the underlying framework, the interview protocol, time, and day and the participant's perceptions of what constitutes an effective leadership experience might also have an effect on the responses of the participant.

Chapter Summary

This chapter began by introducing the rationale of the research by discussing the growing need for physician leaders in the 21st century where changes due to healthcare reform is expected to change the healthcare landscape. The next three sections present the purpose of the study, guiding theoretical framework, research questions and the significance of the study. Chapter one then ends with the definition of terms, the assumptions and the limitations of the research.

As discussed in this chapter, physicians will be essential to the success of healthcare reform in this country. Despite the vital role of physicians in the future of healthcare, physician leaders are in short supply. To ensure future success, an adequate pipeline of physician leaders ready to integrate business competencies with medicine is required. To meet this demand, it is important to first understand physician leadership as it exists today and then develop a solid leadership development strategy. Literature on the topic is discussed in the next chapter.

Chapter Two. Literature Review

This study explores the leadership behaviors of physician leaders. To facilitate an

understanding of the topic, this literature review begins with a discussion of leadership theories

as a foundation for understanding the impact effective leadership has on creating frontrunner

organizations. This literature review on leadership theories includes those that are well regarded

and have withstood critical evaluation in the field. The second section analyzes literature

pertaining to Kouzes and Posner's (2012) five practices of exemplary leaders, the theoretical

framework that will guide this research study. The third section inspects literature on physician

leadership and finally, the chapter ends with a summary and the relevance to this research.

Leadership Theories

This section reviews theories that define leadership as a connected relationship between

the leader and follower. To this end, this section includes a discussion of the leader-member

exchange theory, the transactional and transformational leadership theory, servant leadership,

level 5 leadership and ends with a review of emotional intelligence. Before addressing

contemporary leadership theories, however, first a background on traditional leadership theory is

presented.

Traditional leadership theory. The basic tenant of early leadership studies was that

great leaders were born with leadership qualities, thus destined for leadership from birth. Unlike

more recent research describing leadership as a process or interaction between two people in a

social construct, early researchers argued that great leaders were individuals that possessed

unique personality traits that separated them from the masses (Northouse, 2001). The theories,

categorized as "great man" (Northouse, 2001, p. 15) theories—noting that great leaders of the

time were men—resulted in the isolation of a range of personality traits that were associated with

the popular leaders of the era. This approach implied that an individual achieved leader status purely as a function of his personality. While the studies produced a variety of traits associated with the great leaders of the time, rather than clarifying what makes an effective leader, the inconsistencies in the results created confusion. For example, in a meta-analysis of leadership literature from the 1900s to 1957, Mann (1959) reported that intelligence, extroversion, masculinity, and dominance were characteristics related to high performing people in a group. In contrast, in Stogdill's (1948) earlier survey of 124 trait studies, characteristics such as insight, responsibility, initiative, and persistence surfaced, but again, there were no identifiable traits that separated a leader from a follower. From this study, the author concluded that one could not become a leader solely based on personality traits. Instead, he posited that individuals who became leaders did so because the personality traits matched the situation at hand (Stogdill, 1948).

A follow up study conducted by Stogdill expanded on his previous conclusion that leadership was purely situational and provided an updated analysis of the traits theory.   He reiterated that traits alone do not determine a leader. In his updated theory, however, he asserted that neither does the situation. Rather, it was the combination of the traits and the consequences of the situation at hand that determined who would emerge as a leader (Bass, 1990a).

In contrast to Stogdill's theory, Kirkpatrick and Locke (1991) asserted that the field of leadership could not necessarily ignore trait theorists. The authors assert that while certain traits do not have to necessarily be inborn in a leader, leaders are different from non-leaders. They note that foundationally, leaders have the drive and the desire to lead—two traits that are required to see them through the daily challenges as a leader. They also assert that while

perseverance is a key trait of a leader, equally important are the traits of honesty and integrity, self-confidence, cognitive ability and knowledge of business (Kirkpatrick & Locke, 1991).

While discussion on trait theory continues in the leadership discipline, most agree that the inconsistencies in the results reveal that personality and leadership were two mutually exclusive factors. In the end, although the attempts to identify the common traits of great leaders are left unresolved, Northouse (2001) synthesized that the variety of personality characteristics isolated by trait theorists could serve as an example of traits that aspiring leaders could cultivate in themselves. These traits are intelligence, self-confidence, determination, integrity and sociability.

Leader-member exchange theory. Unlike trait theorists who examined the characteristics of an individual leader, the leadership discipline next examined leadership through the interactions and relationships of leader and follower. In the leader-member exchange (LMX) theory, the follower is referred to as the member. In an effort to understand the dynamics of the leader and follower, researchers conducted empirical studies on the leader-follower dyad (Northouse, 2001).

According to the leader-member exchange (LMX) theory, leaders develop relationships with subordinates to clarify expectations for desired outcomes due to the ambiguity of roles at work. In LMX, leaders develop relationships with followers of a high quality. These individuals are characterized as motivated high performance individuals. In contrast, in LMX, individuals of a low quality do not have a relationship with the leader. Those in the high quality group enjoy a positive and encouraging relationship with their leader, while those in the low quality group are largely ignored. Theoretically, the LMX theory works by concentrating on building a distinctive,

trusting relationship within the leader-member dyad. The dependency people form with each other to complete tasks also characterizes the LMX theory.

The LMX theory is important to leadership studies for three reasons. First, it effectively describes a productive work unit as one where the members have special relationships with others to get more done. Second, rather than focusing on the traits of a leader, or the situational aspects of leadership, LMX is the first to make the leader-member dyad a central point in the leadership model. Third, LMX is notable because it emphasizes the importance of communication, mutual trust, and respect in leadership.

Critics of LMX, however, argue that LMX's narrow focus denies equal treatment and fairness, potentially creating a harmful work environment (Dienesch & Liden, 1986). The concept of high quality "in-group" (Northouse, 2001, p. 112) versus low quality "out-group" (Northouse, 2001, p. 112) contradicts American values that honor equality for all gender, race, creed, or disability. To remedy this flaw in the theory, experts note that guidelines on how to create high quality exchanges should be clearly articulated in LMX (Northouse, 2001).

Although the earlier versions of LMX include perceived prejudices that run counter to the principles of the workplace today, more recently, there's been an emphasis in LMX to palliate the discriminatory features of the theory. In particular, there has been research on "leadership-making" (as cited in Northouse, 2001, p. 115), a feature that notes that leaders should make the effort to create high-quality interactions with all, not only those in the in-group (Northouse, 2001).

Transactional leadership. An alternate view of the way a leader can influence a follower is depicted in the transactional leadership theory. The theory grew out of the leader-member exchange based theories, but the stark difference between the two is that LMX is

relationship based while transactional leadership is task based. Transactional leadership is

predicated on the foundation that something of value is exchanged for objectives met. An

example of this can be demonstrated by the arrangement often seen in the automotive industry

where a commission is paid to the car salesman for each car sold.

James Burns (1978) introduced the concept of transactional leadership in the 1970s. A

well-known author of leadership, Burns introduced transactional leadership in conjunction with

another well-received leadership style known as the transformational leadership style. The

transformational leadership style is discussed in detail in the next section. Burns' (1978) work

brought into the mainstream leadership theories that emphasized the interdependency and links

between the leader and follower. Accordingly, Burns (1978) asserted that transactional

leadership is when a leader engages with others to exchange things of values. He notes that this

style is often seen in politics when a candidate exchanges campaign promises for votes.

Recently, Miller (2011) provided an example of transactional leadership. He wrote that

integrity was essential to successful transactions between student affairs counselors and students.

Unlike Burns' work, which simply identified the framework of transactional leadership, Miller

(2011) spoke to the ethics of the transactional leadership model using the setting of a school. He

suggested that limited resources, social, political, cultural, and technological forces create

situations that force counselors to succumb to pressures that jeopardize the students' interests.

He asserts that these tensions result in choices that could challenge the ethics of the counselor

who must make value judgments in seemingly routine decisions. In situations where value

judgments are the norm, the lack of an ethical framework is problematic. Thiroux and

Krasemann (2009) assert that values are affected by the context or situation and can be either

subjective or objective, depending on the person. To address this dilemma, Miller (2011) offers

a useful set of guiding principles that are meant to preserve the integrity of transactions between counselors and college students. The principles are: clarity, consistency, and fairness in transactions with students.

Bass (1990) posited more downsides to transactional leadership. First he described the limitation from the lens of organizational outcome, stating that the style is clearly leader centric and the notion of reward-for-task limits the bottom line results to a level predetermined by the leader. To describe the second, he delineated two types of transactional leaders: one who is passive and another who is active. The student-counselor transaction described earlier is an active relationship while the automobile dealer-car salesman transaction is characterized as a passive relationship. Of these two types of transactional leaders, the author notes that passive leaders are largely uninvolved with the follower. This can ultimately lead to a negative effect on productivity, as followers feel distanced from their leader. Thus, Bass (1990) purports that the transactional leadership should be actively managed to avoid negative consequences.

In summary, the transactional leadership style can be effectively employed in business. Some have successfully used it as a profit generator by crafting individual customized incentive plans that allow the person to have control over the outcomes and rewards, while others increasingly rely on it as a strategy to quickly gain marketshare in a depressed economy. Although limitations to the style are largely understood and acknowledged, the transactional leadership style, employed with an appropriate framework of principles can be used for positive organizational outcomes.

Transformational leadership. Discussions of leadership through the lens of those being led were the origins for the now popular approach to leadership, the transformational leadership style. While the transactional leadership concept is predicated on the contingent reinforcement

of followers through an exchange of something of value, in contrast, the transformational leadership style motivates followers to take actions that transcend their own self-interest to achieve the vision of the organization. Leaders who use this style create high performing organizations by understanding the values, ethics, and underlying needs of the followers (Northouse, 2001). The style can also be described as a process whereby the leader uplifts others through high-quality emotional connections, charisma, and consideration ultimately leading both the leader and follower to establish a stronger and strengthened set of moral values.

The impact of transformational leadership as an antecedent to positive organizational outcomes has proliferated in leadership studies over the past three decades. Extant literature agrees that the leadership style enhances employee performance (Shannahan, Bush, & Shannahan, 2013), promotes occupational success (Vincent-Höper, Muser, & Janneck, 2012), and a high level of job satisfaction (Deluga, 1988). While enhancing the employees' well being—more particularly inspiring through the alignment of values and morals—is intuitively ideal and draws attention to this concept, the transformational leadership style is growing in popularity because research indicates that it is linked to an organization's ability to meet its objectives (Bass & Avolio, 1994; Hater & Bass, 1988; Hsin-Kuang, Chun-Hsiung, & Dorjgotov, 2012; Willink, 2009).

In a study of 524 research and development professionals from 21 research institutes in Mongolia, researchers showed that transformational leadership was an antecedent to enhancing employee efficiencies and knowledge capacity, consequently having a positive effect on organizational effectiveness (Hsin-Kuang et al., 2012). This study based its findings on the transformational theory construct of idealized attributes and influence, motivation, intellectual stimulation, and individualized consideration (Bass, 1990b). Guided by this framework, the

study found that creativity, productivity, quality and satisfaction was positively influenced, thus

resulting in enhanced organizational effectiveness (Hsin-Kuang et al., 2012). Hater and Bass

(1988) go on to establish the importance of a participative leadership style in a better educated

work force that is increasingly concerned with self-improvement and doing interesting and

fulfilling work. Although this study had a small sample of 54 managers, it replicated previous

findings that transformational leadership was positively correlated to perceived leadership

effectiveness.

Although many proclaim the positive attributes of transformational leadership, some

argue that these leaders can be narcissistic, manipulative and self-centered (Parry & Proctor-

Thomson, 2002; Sankowsky, 1995;). Sankowsky (1995) cautions that people who are

charismatic—a prevailing characteristic of transformational leaders—have a tendency to abuse

their power. His psychoanalytic view of the charismatic leader warns that followers should be

wary of often unintentional and unconscious manipulations of power by leaders at the

subordinate's expense.

The power manipulations and ethics of transformational leadership was also addressed by

Parry and Proctor-Thomsen (2002) who reflected on Bass' (1990b) concept of an authentic

transformational leader in comparison to one that is a pseudo-transformational leader. Pseudo-

transformational leaders possess some characteristics of a transformational leader, but lack

integrity. In the study, the authors surveyed 1,354 business managers in New Zealand to test

whether there was a correlation between the perceived integrity of a leader, as one variable, and

organizational effectiveness or transformational leadership as the second variable. The study

found a significant correlation between perceived integrity and effectiveness. In particular, there

was a strong relationship between leader integrity and organizational effectiveness. The

researchers purport that ethical conduct is no longer optional. Rather, ethical conduct is a

requirement for positive organizational outcomes (Parry & Proctor-Thomson, 2002).

Overall, it can be suggested that transformational leaders who have high-quality,

emotional connections with people, charisma, and exhibit consideration for each individual can

positively impact organizational effectiveness. Nonetheless, the debate continues as to whether

the focus on charisma in this style of leadership creates situations where unethical transgressions

could thrive.

Servant leadership. Of all leadership styles, the servant leadership style, is the most

follower centric and people focused style. Although the servant leadership style philosophy has

existed since 1970, current societal demands for more altruistic leaders and social responsibility

from corporations have created a resurgence of interest in this style of leadership (Patterson,

2003; Russell & Stone, 2002;). Extant literature conceptualizes the servant leadership style as

putting the needs of the follower first and as the end in itself, not a means to meet company

objectives (Ehrhart, 2004). Research refers to leaders in this type of leadership style as assuming

the position of the subordinate and transcending self-interest. Servant leaders then are motivated

to focus on the needs of the constituents (Greenleaf, n.d.). In most leadership styles, the leader

sets forth the vision and directives to achieve the organizational goals, but in the servant

leadership model, the leader is not only responsible for the organization, but also to the

employees, customers, and other stakeholders (Ehrhart, 2004). A central premise to servant

leadership is that the responsibility rests upon the leader who has the power to create an

environment conducive to the population's efficacy (Jaramillo, Grisaffe, Chonko, & Roberts,

2009).

Similar to the formative years of trait theories, servant leadership suffers from a lack of clarity. In addition, literature on the topic is generally incongruent. For example, using the premise of theoretical extension, the premise by which a new theory arises when a former one doesn't fully explain a phenomenon, Patterson (2003) posits that the servant leadership supplements the transformational leadership theory. His study presents a framework of servant leadership with features that overlap the transformational leadership theory: altruism, empowerment, humility, love, service, trust, and vision. On the other hand, Russell and Stone (2002) offered a more robust framework with 20 characteristics that were primarily derived from synthesizing literature on the topic. These were: vision, honesty, integrity, trust, service, modeling, pioneering, appreciation of others, empowerment, communication, credibility, competence, stewardship, visibility, influence, persuasion, listening, encouraging, teaching, and delegation. Because of the disparity of models offered in servant leadership literature and lack of empirical research to support the findings, the current structures available for servant leadership are clearly subject to debate. Van Dierendonck (2011) asserts that the lack of a reliable and validated research instrument to identify the servant leadership behavior makes it difficult to set a comprehensive definition for servant leadership for researchers to use.

Yet the close proximity to transformational leadership and the ties to values of high ethical standards makes servant leadership attractive for settings that require a culture of care such as healthcare, childcare, and education. In particular, Schwartz and Tumblin (2002) declare the need for servant leadership in healthcare in the 21st century. The authors raise the issue of tensions and pressures on present healthcare professionals to elevate levels of performance. They state that these issues have led healthcare organizations to become more political and dysfunctional, leading to a phenomenon described as the "cesspool syndrome," (Schwartz &

Tumblin, 2002, p. 1421) a phenomenon that runs counter to current leadership theories that accentuate principles of positive organizational scholarship. By definition, the "cesspool syndrome" (Schwartz & Tumblin, 2002, p. 1421) uses the metaphor of dreck floating to the top of dysfunctional organizations. It describes the phenomenon where mediocre and insecure executives, threatened by talented subordinates, promote mediocre employees. Bedeian and Armenakis (1998) note that this practice not only leads to the departure of competent employees, but also leaves the least qualified to take on additional functions--conditions they note as a recipe for failure. To avoid the "cesspool syndrome," (Schwartz & Tumblin, 2002, p. 1421) Schwartz and Tumblin advocate using the servant leadership style to transform healthcare institutions, an inherently servant oriented service community.

In summary, the crumbling state of ethical leadership over the past decade has recently brought attention back to servant leadership (van Dierendonck, 2011). Popular media has aptly illustrated the tragedies that arise from the lack of ethics and the inability for leaders to engage in mature ethical discernment. Pressures on leaders to lower costs, enhance efficiencies, and boost effectiveness at a speed never before seen in history has given rise to best business practices which are designed in a quick, haphazard, and uncritical manner. Given the societal outcry for ethical leaders in current difficult economic times, Gabriele (2011) asserts that a return to simple, pure, and ethical values—characteristics generally accepted servant leadership principles—could build organizations of integrity and purpose.

Level 5 leadership. Offering a contemporary perspective on leadership, the level 5 leadership model is predicated on the theory that underlying the success of high performing companies are passionate, yet humble leaders who build organizations with disciplined people, thought, and actions (Collins, 2001b). The level 5 leadership style was an unexpected discovery

of a five-year research study that compared data on 1,435 companies and distinguished 11

companies that met the criteria of a great company. In the study, a great company had rising

cumulative stock returns over 15 years after a period of low performance (Collins, 2005). The

outcome of this empirical research was the discovery that companies with sustained success had

leaders with characteristics unlike those identified in previous leadership research. Sustained

success is defined by the study as cumulative stock returns at least three times market for a

minimum of 15 years after the leader's departure. Similar to transformational leaders, level 5

leaders focus on their relationship with subordinates. They are team players that are visionaries

who inspire others to pursue common goals. Yet, there is a distinct difference between

transformational leaders and level 5 leaders. Level 5 leaders were found to be discreet and

humble people, personality traits that are more closely associated with servant leaders. Before

this study, humility was never before empirically proven to affect organizational efficacy.

Paradoxically, level 5 leaders are modest, quiet, and introverted, characteristics that contrast with

successful transformational leaders who are characterized as charismatic and extroverted. In

fact, when organizational goals were met, level 5 leaders assigned credit for the accomplishment

to other people, external circumstances, and sometimes just simply to good luck. Yet, level 5

leaders have an equally prominent trait—extreme professional will. Level 5 leaders set the

highest standard for building an enduring organization and, in all respects, are intolerant of

anyone who accepts that just good is good enough. The study showed that the unyielding

resolve for excellence and unwillingness to accept mediocrity, was crucial to producing

breakthroughs. Collins (2001a) describes this as the hedgehog concept. He uses the parable of a

clever fox that knows a little about a lot of things as compared to the hedgehog that knows only

one thing. The author found that level 5 leaders also focused on only one thing: what the

company was best at, what economics worked best, or what the people of the organization were most passionate about (Collins, 2005).

People have questioned whether the level 5 leadership style can be learned or achieved through coaching and the issue is noticeably absent in extant leadership literature. Collins (2005) acknowledges that his research did not support developing a credible and replicable method of becoming a level 5 leader.

In conclusion, the author suggests that in light of the ongoing misguided belief of corporation boards who think that the egocentric leader with a large personality is needed to make an organization succeed, the level 5 leadership theory is a powerful and essential idea for leadership (Collins, 2005). It is a paradoxical revelation about companies that grow from an average company to a great one—one that is a high performing company that endures long after the leader's departure. Although there isn't much written in leadership literature on operationalizing the level 5 leadership model, Collins (2005) notes that there is a close association between this and other leadership styles. Therefore, rather than minimizing the concept by providing a simple recipe of becoming a level 5 leader, the author suggests that leading by using other well-regarded leadership styles such as transformational and servant leadership should help move leaders in the right direction. By doing so, he asserts that in the end, those with the core characteristics to get to level 5 will emerge (Collins, 2005).

Emotional intelligence. Using emotional intelligence in organizations has become a popular leadership theory that has received recent attention from both practitioners and scholars. As previously illustrated in transformational leadership, servant leadership and level 5 leadership, recent focus on ethics and consideration has heightened the interest in developing leaders with the capacity to critically reflect and ultimately act to advance the good and best in

people. Rather than emphasize the cognitive qualities, academic achievement, and strategic acumen of an individual, emotional intelligence puts a higher value on personal and social competencies such as self-awareness, self-regulation, and social awareness and relationship management (Goleman, Boyatzis, & McKee, 2002).

Emotional intelligence was brought into prominence by the work of Goleman (1998) who explained it from the lens of a lay practitioner and Mayer, Salovey, and Caruso (2004) who shed light on it through a scientific lens. Goleman (1998) popularized emotional intelligence through intuitive principles such as creating resonance with others and empathy to influence relationships and organizational outcomes. On the other hand, Mayer et al. (2004) scientifically placed emotional intelligence in the context of other cognitive intelligences like social, practical, and personal intelligence. They define it specifically as "the capacity to reason about emotions, and of emotions to enhance thinking" (Mayer et al., 2004, p. 197). Although both have advanced the concept of emotional intelligence--one through its practical application in everyday life activities and the other through empirical research--there is a stark difference in opinion on the potency of emotional intelligence. Mayer et al. (2004) strongly argue against Goleman's (1998) claims that emotional intelligence is more powerful than cognitive intelligence or that it is a predictor of success. Their claim is supported through a study of 59 leaders at an international service organization where emotional intelligence was not an antecedent to promotion. In fact, the study found a decline in emotional intelligence in some managers that were promoted (Collins, 2001).

Nevertheless, in spite of the popularity of emotional intelligence in both the practitioner and academic world, to date little empirical research exists on its correlation to organizational effectiveness in specific occupations and industries. This gap in research leads one to believe that until further studies are conducted, Goleman's (2000) claims that imply cause and

consequence will remain controversial in the scientific community (Zeidner, Roberts, &

Matthews, 2008).

Summary of leadership theories. In this section, several well-regarded leadership

theories that emphasize the leader-follower dynamic and its relevance to positive organizational

outcomes were discussed. Before discussing theories based on the leader-follower framework,

however, first, a review of traditional theories was provided. The section followed with a review

of LMX, transactional leadership and transformational leadership, servant leadership, level 5

leadership and ended with a discussion on emotional intelligence.

The next section of this chapter reviews Kouzes and Posner's (2002a) five practices of

exemplary leader model, the underlying framework that guides this research.

Five Practices of Exemplary Leaders and Physician Leaders

House and Aditya (1997) suggest that transformational leadership, level 5 leadership, and

the five practices of exemplary leaders are of a common genre called neocharismatic theories.

The commonalities of these theories were four-fold. First, the theories all attempt to explain how

leaders achieve extraordinary results in the face of overwhelming odds. Second, the theories

explore how leaders evoke high levels of motivation, loyalty, and commitment from their

followership. Third, the theories put special emphasis on emotionally appealing leadership

behaviors, and fourth, the emotional state of the follower is described as high self-esteem,

inspired, satisfied, and positively influenced by the leader's vision (House & Aditya, 1997). In

particular, one outgrowth from neocharismatic theories that has been proven through strong

empirical research and has withstood the intense scrutiny of researchers over the last forty years

is Kouzes and Posner's (2002a) five practices of exemplary leaders. Jim Kouzes and Gary

Posner are award-winning authors of leadership books, developers of a highly acclaimed

leadership measure tool and academics at a major university. They challenged the school of

thought that leadership was a phenomenon for a chosen few people. Rather, as their research

later found, leadership is available to all by learning a distinguishable group of skills and

capabilities.

Kouzes and Posner distinguish themselves from other neocharismatic theorists by asking

leaders to self-report their experiences in one particular instance of excellence. It should be

noted that by doing so, the moderating effect of the context is inherent in the response. This

approach is distinctly different from other neocharismatic theorists that explained leadership only

through the relationship between the leader and those they lead while ignoring the moderating

effect of the culture of the institution, the dynamics of the situation, and other environmental

forces (House & Aditya, 1997).

An evidence-based leadership model, the framework of the five practices constitutes the

following elements: (a) model the way, (b) inspire a shared vision, (c) challenge the process, (d)

enable others to act, and (e) encourage the heart. This conceptual framework emerged from a

qualitative analysis of hundreds of case studies and interviews that were conducted to determine

the behavior of leaders when they were at their "personal best" (Kouzes & Posner, 2012, pg. 24).

The authors define personal best as the experience when the respondent thought they were

functioning at their peak as a leader (Kouzes & Posner, 2002a). The case studies included 38

open-ended questions such as: Who initiated the project? What made you believe you could

accomplish the results you sought? What did you learn most from this experience (Kouzes &

Posner, 2002a)?

From the framework of the five practices, the well-regarded leadership practices

inventory (LPI) survey instrument was developed to evaluate the leadership practices of

individuals. To date, the instrument has been taken by over 1.3 million people and used in over

500 research projects. Moreover, over 3 million people have used the LPI to learn the behaviors

of five practices to develop themselves as leaders and attain their personal best (Kouzes &

Posner, 2002b). To further strengthen the generalizability of the instrument, the LPI scores were

tested and compared between males and females, public and non-profit organizations, and across

functional fields such as customer service, finance, informational technology and marketing.

The five leadership practices of exemplary leaders focuses on the practices people must

exhibit to be an exemplary leader, but it represents only part of the picture. People who lead

must first have a full understanding of the underlying motivations of the constituents. Without

knowing what motivates their followers, they cannot create meaningful connections that appeal

to emotions of those being led (Bass, 1990b; Burns, 1978; Kellerman, 2007; Kouzes and Posner,

2002; Waldman, Bass, & Yammarino, 1988). To this end, the question arises: What do

followers expect from leaders before they choose to follow them? In a survey conducted over 20

years in Africa, North America, South America, Asia, Europe and Australia, Kouzes and Posner

(2002b) found evidence of four characteristics that consistently surface as qualities one must

possess before someone will willingly follow. These are honesty, forward-looking, competent,

and inspiring. Short reviews of these four attributes are provided next.

Honesty is a key characteristic people look for in a leader. Extant literature asserts that

the quality of the leader-follower relationship is a vital component to successful outcomes, but

Hollander (1995) draws attention to the fact that the leader continues to be seen as having

paramount power over others. Clearly, although current leadership philosophy promotes leader

stewardship and service in the leader-follower dyad, the follower is acutely aware that the ability

to inflict pain and suffering is inherent in the leader's positional authority. Because of this

imbalance of power, people willing follow only those they deem are worthy of their trust and

exhibit integrity and good character. In every setting surveyed, respondents consistently require

honesty as the number one characteristic they look for in a leader (Kouzes & Posner, 2002b).

The second most sought after trait in a leader, forward-looking, arises out of desire of

followers to have a clear purpose coupled with a vivid image of what the future brings. The need

to know where one is going and a concern for a map of the future corresponds directly to the

ability of a leader to create a vision. Several contemporary leadership scholars have repeatedly

affirmed the impact of a clear vision and the need for direction (Bass, 1985; Burns, 1978;

Collins, 2001a; Kouzes & Posner, 2002a; Senge 1990). According to Blanchard and Stoner

(2004), being stagnant, static, and keeping things status quo is not leadership. Leadership is

about making change and going somewhere. They assert that vision is important because it

guides people to make smart and informed choices. Kouzes and Posner (1990) cautions that data

on this characteristic must be interpreted with caution because it shows that the criticality of

vision varies based on the position an individual holds in an organization. The authors assert that

their research shows that at least 35% more senior people than front line personnel responded as

needing a long-term view of the future. Hence, this finding suggests that people moving into

strategic roles will benefit from strategic planning and leadership training (Kouzes & Posner,

1990).

To motivate others to join a cause, a leader must show competence in getting to an end

result. Knowing what to do and having the ability to get things done require leadership

competencies (Kouzes & Posner, 2002a). While competence often refers to the technical

capability and skills of a person, a leader's competence is most judged by his or her ability to

mobilize others and enabling others to act. Although popular media has reported extensively on

executive incompetence in recent years, Drucker (1988) suggested it as a real problem for organizations three decades ago. In addition, another study found that at least 50% of the corporate executives in the United States from the 1980s to 1990s failed at their jobs (DeVries, 1992). Accordingly, this unfavorable statistic indicates a great need for improvements in leadership.

The fourth characteristic, inspiring, was identified as a requirement before people willingly follow. In conjunction with being honest, forward-looking, and competent, people want their leaders to communicate their message with enthusiasm and energy and have a positive outlook of the future. Inspiring others is an active and intentional process by which leaders connect with followers, enable them to act, and give them hope (Searle & Hanrahan, 2011). As stated earlier in this review, studies confirm that inspirational leaders have a positive effect on people and have achieved results beyond expectations (Bass, 1985; Burns, 1978). In contrast, although extant literature largely supports the positive impact that inspiring leaders have on others, paradoxically, others have noted their discomfort with the idea (Drucker, 1988; Searle & Hanrahan, 2011). In the end, Kouzes and Posner (2002a) conclude that a leader must exude enthusiasm and excitement in pursuit of a vision. They claim that if the leaders do not have energy and passion for a goal, others will not join the cause.

To summarize, honest, forward-looking, competent, and inspiring are the top four behaviors people look for in a leader. The degree to which these characteristics are ranked may vary over the years, but Kouzes and Posner (2002a) state that these four have consistently been chosen as the top qualities people look for in leaders. The authors synthesize these four characteristics into one concept—credibility in leadership. Three of the characteristics, honest, competent, and inspiring collectively form the basis for what communication experts refers to as

"credibility." These three factors make the person communicating the message believable. By making sure that their actions align with what they say, leaders establish a positive reputation and gain the trust of their constituents. In a culture where prevailing criticism of executives is ever present, it is not surprising that people are more discriminating of whom they choose to follow. For these reasons, it can be concluded that a sensitivity or understanding of the constituents and having credibility as a leader are important to getting people to follow. These elements complement the other part of the equation of exemplary leadership--the five practices of exemplary leaders (Kouzes & Posner, 2002a). These practices are presented in detail in the following order: (a) model the way, (b) inspire a shared vision, (c) challenge the process, (d) enable others to act, and (e) encourage the heart.

Model the way. The first practice of exemplary leaders is about setting an example and simply put: doing what you say you'll do. Drawing on the results from a survey that indicates honesty as the foremost characteristic desired in a leader, model the way confirms to others that the leader's words are in alignment with the leader's behavior. To effectively model the way, leaders must have clear values, express themselves in a genuine manner and serve as a good example for others to follow. There is evidence that clarifying one's moral values and exhibiting the same moral constitution promotes similar moral behavior in others, thereby, enhancing one's leadership capacity (Avolio, Gardner, Walumbwa, Luthans, & May, 2004; Hannah, Walumbwa, & Fry, 2011; Verplanken & Holland, 2002;).

Yet, leadership isn't straightforward. Leaders are constantly faced with controversial issues that challenge their morals and values. Some are not able to self-regulate and succumb, while others rise above the leadership challenge and succeed. Bill George (2007), former chief executive officer and chairman from Medtronic, a large medical technology company, describes

leadership as a journey which begins with the concept of I in the early years, but switches to the

concept of we as the leader matures. He uses the metaphor of a compass needle pointing

northward to guide a leader on the journey to authentic leadership. His model includes, self-

awareness, values, and principles (the needle pointing to the north), integrated life, support team,

and inner and deeper motivations. Another study confirms the benefits of the authentic

leadership style as it creates a positive psychological and ethical climate in an organization

(Walumbwa, Wang, Wang, Schaubroeck, & Avolio, 2010). The climate created by an authentic

leader enhances the capacity of employees to learn self-awareness principles, thus empowering

them to take a better moral perspective of situations.

Inspire a shared vision. The second practice of exemplary leaders states that leaders

must be able to mobilize people by inspiring them to achieve great things. In order to do so,

however, people must first have a purpose. Therefore, it is important for leaders to help others

envision exciting possibilities for alternative futures and inspire them to pursue a shared vision.

Blanchard and Stoner (2004) note that most organizations already have vision statements, but

often, the statement and where the organization goes are two different things. They explain that

the vision statement provides guidance for daily decision-making and must be compelling. If

people understand that the vision has a significant purpose and is grounded in the real business of

the organization, they get a clear picture in their mind of the desired outcomes and know what

they are working towards.

Yet, research indicates that even when people were at their personal best and when they

could envision a future where dreams could be realized, vision alone, was not enough to become

an exemplary leader (Kouzes & Posner, 2013). The authors note that a connection with the

follower by understanding their desires and motivation was critical to effective leadership, but

Kouzes and Posner (2011) add that the courage to stand up and the audacity to believe in great possibilities also capture the attention of people. To support this view, the moderating effect of the dimension of inspiring a vision on the efficacy of a leader has been supported by a wide variety of practitioners and scholars through observational studies, empirical research, and anecdotal experiences in writings by Goleman (2000), Blanchard and Stoner (2004), Kotter (2007), and Senge (1990). In conclusion, as leaders learn how to communicate a compelling vision to the hearts of people with courage and trust, they will enjoy the support of an inspired group of people.

Challenge the process. By anyone's account, leadership is about making significant change, not about prodding along daily routines in maintenance mode. As more and more organizations are pushed to cut costs, improve efficiencies in global markets, and find new ways to innovate, leaders must confront the status quo by taking charge and look for new ways, process, and methods. The leader's role in the organization is to be the change agent who seeks out opportunities to innovate, grow, and improve. As architects of change, leaders do not generate new ideas alone. Instead, their primary role is to listen carefully to their constituents and support good ideas by challenging the ingrained culture to get new ideas adopted. They challenge the process by questioning the way things have always been done. Breaking the long held mental molds is necessary to establish new mindsets that move an organization forward (Senge, 1990).

While leaders themselves must challenge long held norms and beliefs, they also must support those that challenge existing processes. Followers who support change and challenge processes often find themselves in awkward and uncomfortable situations. Accordingly, those

that lead must help people feel safe if mistakes are made and encourage the team by generating

small wins during the change process (Gupta, 2011; Kotter, 2007).

Enable others to act. It is common knowledge that change is inordinately difficult, but

as alluded to earlier, leaders are pioneers and have a positive attitude about change. However,

change does not happen by one person alone. It takes a coordinated effort of the team members.

Therefore, a positive climate where risk taking and experimenting is accepted as part of the

challenge is important to a climate that empowers people. The fifth principle of the five

practices is enabling others to act. The impact of empowering others has been supported as a key

leadership practice since scholars began studying leadership through the relationship with

followers beginning with the LMX theory in the 1970s. Kotter (2001), a well-regarded professor

and expert in leadership and change, also confirms that significant transformations rarely occur

without the assistance of the group.

Similar to the previously discussed principles of the Five Practices, 'enabling others to

act' engages others at a deep emotional level and creates a sense of trust in the relationship.

Leadership is not about having power and directing others to follow. Instead, it is about

empowering others and developing them as leaders (George, 2007).

Encourage the heart. Interest in the practice, encouraging the heart, has snowballed in

recent years. Researchers, business leaders, and community leaders all agree that the demands of

the 21st century require motivated constituents. While structured reward systems—particularly

bonus systems and merit increases—are in place to keep people motivated to do their best work,

it is becoming increasingly clear that the need for recognition and approval is a fundamental

human drive. Extant literature asserts that leaders who foster an environment of trust,

cooperation, and collaboration produce high performing organizations and positive results

(Goleman, 2000; Kouzes & Posner, 2002a).

In the third principle of the five practices, challenge the process, followers take on

ventures that put them at risk. In addition, these ventures have a high possibility of failure.

These endeavors require energy and while in pursuit of the vision, people get exhausted,

frustrated, and disenchanted by the constant pushback from those that seek to preserve the status

quo. Hence, encouraging people through their hearts by showing appreciation and giving people

small wins to celebrate are prescriptive to keeping spirits elevated. Some assert that encourage

the heart is soft and has no place in business. This claim is often heard from leaders who ascribe

to the outdated command and control leadership model. Be that as it may, extant research shows

that encouraging people from the heart should be seriously considered as it directly correlates to

higher performance in organizations (Kouzes & Posner, 2002a).

Surprisingly, unlike other leadership theories, the five practices of exemplary leaders

does not have many critics. Some have tested its validity and reliability in international settings

for comparison, but these studies, although showing slight variations in results, have produced

nothing significant that challenges the validity and reliability of the LPI. For example, in a study

of 155 managers in Hong Kong, Lam (1998) found a three-factor framework--rather than five--

consisting of modeling, empowering and encouraging. Similarly, in a quantitative doctoral

project by Wilberg (2003) studying 147 newspaper employees in Norway and Sweden, again the

three factors were discovered. However, unlike the Hong Kong study, the author of this study

empirically revised the LPI and created three new scales: change and vision, collaboration, and

motivation. In yet another variation on the five practices model, a quantitative study of 1,440

bank employees in Australia found that the LPI produced results similar to the transformational

leadership (Carless, 2001). In its broadest sense, all the studies mentioned in this paragraph may

not have found all five factors of the five practices of exemplary leaders, but the factors found by

the LPI remain viable. Scholars have posited that the differences in factor structure are due to

the international context in which the studies were administered (Sandbakken, 2004).

In this section, the five practices of exemplary leaders, Kouzes and Posner's framework

conceptualized through the leadership practices inventory (LPI), a highly regarded leadership

evaluation device, was discussed in detail. First, the section started with an overview of

neocharismatic theories, the genre of theories addressing charismatic leaders and the function of

emotions in the relationship with the follower. Next, the five practices framework was

introduced along with the theory and evidence behind the LPI. The third part of the section

discussed the top four characteristics people look for when deciding to follow someone. These

were honesty, forward-looking, competent, and inspiring. These four characteristics shape the

follower's perceived impression of the leader's credibility. Finally, the five practices of an

exemplary leader, model the way, inspire a shared vision, challenge the process, enable others to

act, and encourage the heart were reviewed. The next section of this chapter reviews literature

on physician leadership.

Physician Leadership

It is evident that the 2010 healthcare reform legislation, the Patient Protection and

Accountable Care Act (PPACA), has created an urgent need for qualified physician leaders to

guide its implementation. Experts in the field point out that physicians are front and center in the

effective execution of the PPACA because, in practice, they control the quality and the resource

utilization of medical care, both key aims of the new legislation (MacLeod, 2012; McAlearney,

Fisher, Heisner, Robbins, & Kelleher, 2005; Schwartz, Pogge, Gillis, & Holsinger, 2000; Stoller, 2009).

Traditionally, practicing physicians were largely free to concentrate on the practice of clinical medical care, primarily concentrating on diagnosing illnesses, treating injuries, performing surgical procedures, and managing the care of chronic patients. However, a recent study by the Physicians Foundation (2011), a nonprofit organization that advocates for both physicians and patients, noted that within the top issues impacting physicians were the growing administrative demands that take time away from patients. In the study, 63% of the physicians indicated that regulatory paperwork and bureaucratic controls minimized their clinical time with patients and 94% say that the administrative burden has grown between 2008 and 2011 ("Physicians Foundation," 2011). While no one disagrees that the legislative changes has significantly impacted the traditional model of healthcare delivery, more professional associations, medical groups, and healthcare systems have suggested that physicians must not only perform the traditional clinician role, but also actively engage in policy-making and the business processes of healthcare systems (McAlearney et al., 2005). As such, the failure to develop physicians that can balance the dual role of physician and administrator has negative implications for the success of future healthcare systems.

To understand the conflicts faced by individuals in multiple roles, a brief discussion of role theory is warranted. Role theory presumes that people are a member of a social system where others expect a certain behavior pattern from an individual. Assuming that organizations are a social system, an environment where boundaries are often blurred, it is suggested that problems are created when people adapt to changes in position or when the expectations for the position are changed (Biddle, 1986).

Researchers, however, have diverging views on situations involving multiple roles and responsibilities (Goode, 1960; Tamakoshi, Ikeda, Fujino, Tamakoshi, & Iso, 2013). In a recent qualitative study, 76,000 Japanese people were surveyed over 16 years to determine whether multiple roles put people at higher risk for stress and lower mortality. The results of the study were interesting because of its unexpected results. As expected, it was found that multiple roles could overload people. Intriguingly, however, the study found that performing multiple roles also had a positive effect on a person's health (Tamakoshi et al., 2013). In contrast, Goode (1960) asserts that people who try to perform multiple roles are more likely to feel overtaxed and conflicted. He explains that the stress is caused by accepting roles that are beyond an individual's capacity while conflict is caused by taking on two roles with competing statuses. In the case of physicians, conflict is created by the competing missions of a physician as a patient advocate, a role that competes with the physician's role as a policy-maker. At the same time, as noted by the Japanese study, multiple roles can be motivating and stimulating for some.

Clinician and administration cultural conflict. The research on culture indicates that there is general agreement that culture can be defined as the values and behaviors of a group. According to Hofstede, Neuijen, Ohayv, and Sanders (1990), culture is the collective thinking of a group that differentiates them from another group. However, Schein (1990) provides a pragmatic viewpoint that defines culture as a group of values and behaviors that are acquired as people solve issues to live. While various definitions exist to define culture, it is commonly defined as the shared principles, standards of behaviors, beliefs, ethics, tenets, and communications of groups of people.

Most literature on change and merging culture in an organizational context addresses situations in which a single dominant culture prevails, but this is not the case in healthcare

organizations. Medical institutions commonly consist of two equally dominant cultures—

physicians and administrators (Goodall, 2011; House, 1970). As with all cultural conflicts, the

conflict between physicians and administrators is created by the underlying assumptions each

group has of each other. Administrators feel that physicians are unrealistic and uncooperative in

their demands for meeting compliance and management measures while physicians feel that

managers are constantly putting administrative demands on their time.

Cultural differences can be attributed to the distinct differences in the way these

professions are trained. Physicians are ingrained in the culture of care through the lengthy

process of their education and training. The requirements in the United States to become a

practicing physician consists of four years of undergraduate studies, four years in medical

school, followed by three to five years in residency. In addition, physicians are a tight group of

professionals who often band together to support one another in issues that impact their patient.

This solidarity implicitly denies an outsider's intrusion into patient care (MacLeod, 2012).

In contrast, individuals trained in business rarely experience intra-professional support

from peers. Business school training is largely focused on achieving bottom line results and

using tactics that encourage the win at all costs way of thinking. Because of the differences in

training and socialization, physicians and administrators approach issues from decidedly

differing perspectives. Therefore, as can be predicted, these differing backgrounds potentially

create an environment rife with cultural clashes.

Bridging the cultural gap and creating change. Central to the entire discussion of

culture is the concept of cultural competence. In its broadest sense, cultural competence grapples

with the ways in which diverse groups of people come together in a system to enable them to

work together (MacLeod, 2012).   Cultural competence has long been a concept discussed by

academic medicine because it plays an important role in eliminating health disparities due to race in the hopes of equalizing access to health care, treatment and outcomes for minorities. It has, in fact, developed into a vital role in medical education and is linked to accreditation standards at universities (Hester, 2012). For healthcare institutions, a high level of urgency should be placed on strengthening the physician-administrator relationship by reconciling cultural differences and therefore, raising the level of cultural competence of the organization.

Change, however, is difficult to create and sustain. Some have asserted that a combination of cultures that resist change and people who don't know how to productively create it can be lethal (Kotter, 2007). While much has been written about the difficulty of implementing change, scholarly literature asserts that change at the individual level can lead to large-scale change. One particular research study explains how a radical change occurred at a small neglected church with the simple act of serving food to a few homeless people on Sunday mornings. This act inspired doctors, dentists, lawyers and later, city officials to lend support to the church's initiative. The support from the community sparked a continuous strand of changes that resulted in a complete revival and transformation of the church. Based on the framework of the complexity theory, the study establishes that radical change is helped by disruptions to the equilibrium of an environment and actions to initiate small changes in response to the instability can amplify dynamic interactions (Plowman et al., 2007).

A study by Reay, Golden-Biddle, and Germann (2006) also reports that changes can begin at an individual level, but follows a theoretical framework of legitimizing change by institutionalizing or embedding it into the process. This was a four-year investigation of a Canadian healthcare system that embedded nurse practitioners into new areas of hospital processes in response to a physician shortage. Rather than constraining actions, the nurses were

able to take purposeful approaches to change established new work processes. Their intimate

knowledge of the work environment led to efficiencies and higher productivity. The study

concluded that change occurs when the new processes became widely accepted by the workforce

and ingrained into the existing culture. Hence, the practice of embedding cultivated

opportunities for change, fit new roles into old systems and proved the value of the new role.

Berwick and Nolan (1998) don't refute the claim that individuals can be the catalyst for

large-scale change. Like other physicians who have written on the topic of physician leadership,

however, they emphasize, "being a better physician and making a better system are not the same

job" (Berwick & Nolan, 1998, p. 290). The fact remains that the core elements of medical

education concentrate on providing care, not to function as change leaders. This gap in the

education of physicians as leaders and change agents validates the resistance by physicians to

engage in business leadership practices. In addition, the incongruence of the values between the

physician and business activities plays a key role in shaping the physician's response to change.

Extant literature suggests that need for physician leadership competencies has been overlooked

in the past, but with the demands of healthcare reform threatening to change the landscape of

healthcare as we know it today, developing physicians as leaders will be essential for healthcare

to remain a viable enterprise in America (Abdoljavad et al., 2012; Kaplan & Feldman, 2008;

McAlearney et al., 2005; Porter & Olmsted-Teisberg, 2007).

Physician leadership development. The external demands created by new government

laws and regulations, diminishing insurance reimbursements, professional compliance rules, and

technological advances helped make physicians the critical protestors they are today—physicians

who rebel against yet submit to prevailing business and government agencies. Pulled by

opposite forces, doctors are taught to never do harm to an individual patient, yet are now told to

make business decisions for the good of society. Furthermore, doctors are taught that clinical

decisions rest on their shoulders alone, but now must look out for the larger interests of society.

These diverging interests have trapped physicians in a contest of competing values. The

profession satisfies the physician's calling to care for patients while the new demands on the

profession triggers a conflict. In reality, on the one hand, society desires the physicians of the

past—noble and honor bound, yet, on the other hand it demands business-like accountability of

them. Nevertheless, physicians, as leaders of the medical discipline, play a critical role in

ensuring that the new accountability and transparency measures are implemented in alignment

with the ideals of medical professionalism--altruism, morality and virtue (Cruess, Cruess, &

Johnston, 2000).

When it comes to the topic of developing physicians as leaders, most experts readily

agree that it is a critical imperative (Berwick & Nolan, 1998; Kaplan & Feldman, 2008;

Reinertsen, 1998; Stoller, 2009). Moreover, there is general agreement in the striking difference

in the cultural constructs of physicians versus managers. However, those who expect a radical

change by physicians to revolutionize medicine will be disappointed because simply changing

physicians alone cannot solve all problems. Impediments to improving healthcare in the United

States largely lie deep within the culture and structure of the healthcare systems, an area out of

the realm of control of the physicians. Consequently, to bridge the cultural gap, it is necessary to

develop the leadership competencies of not only physicians, but also managers of the healthcare

institutions.

Summary of Literature Review

The extent to which healthcare reform impacts the roles of the physician in the healthcare

industry remains to be seen. It is clear, however, that physicians will have to become more

actively involved and take a high profile role in the implementation of policies to achieve the

best possible results as transformations occurs in the years ahead.

Scholars of leadership indicate that leadership competencies with overriding themes of

empathy, vision, consideration, and social awareness are applicable, not only across all

industries, but also in the specific context of the medical profession and physicians (Kouzes &

Posner, 2002a). The issue of the need for establishing physician leaders in healthcare is gaining

momentum as shown by the growing interest to the topic by healthcare organizations

(McAlearney et al., 2005; Stoller, 2009). Key points on the literature regarding physician

leadership revolve around the dual roles of physicians and competing values of physicians and

managers.

While ample literature on professional and organizational development is available, there

is a gap in literature regarding the perceptions of the physician leadership practices. Because of

the lengthy training period and rigor to become a physician, the question arises as to whether the

physician themselves know the connection between leadership competencies and organizational

effectiveness. If the literature is correct in assuming that there is a need for more physician

leaders for the future success of healthcare in America, it is expected that physicians will have to

adapt for healthcare systems to succeed under the current administration's healthcare act.

Therefore, it is important to examine and understand the practices of physicians today and

develop tools to develop effective physician leaders for the future.

The following chapter explains the methodology for this research.

Chapter 3. Methodology

Introduction

This chapter discusses the design of this research study. It is well known that effective leadership has an impact on positive organizational outcomes (Bass & Avolio, 1993; Goleman, 2000; Maranville, 1995). Therefore, understanding how physicians in leadership positions behave in roles as leaders of healthcare systems was important to the success of healthcare institutions in the wake of revolutionary changes mandated by the current administration's healthcare reform act. The primary purpose of this study was to explore the leadership practices of physicians. The leadership dimensions of Kouzes and Posner's (2012) five practices of exemplary leaders: model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart was used to guide this research. The existing research on leadership behaviors of physician leaders and their attitudes and beliefs regarding leadership training and competencies (Kaiser, 2010; Ramsey, 2012; Smartt, 2010) was not adequate to provide a comprehensive understanding from a phenomenological perspective. Because of the social nature of phenomenological research, it was well suited to understand the lived experiences, attitudes, and beliefs of the physician towards leadership so that healthcare governing bodies and educational institutions could effectively develop physician leaders.

As stated earlier, this study approached the research questions using the phenomenological qualitative method. Using this method, the researcher relied on semi-structured interviews and used open-ended questions to collect data and make sense of the meaning of the physician leadership phenomenon. The objective of the interviews was to discover the practices, behaviors, attitudes and beliefs about leadership derived from the lived experiences of physician leaders. To ensure that the interviews offered information relevant to

the subject matter and appropriate to the underlying theoretical framework, follow-up probing

questions were used. Creswell (2009) states that qualitative research involves flexible questions

and procedures as a method of exploring and understanding what the phenomenon means to

participants. In this study, qualified physician leaders in the United States, including leaders in

group practices of any size and private practice, were invited to participate in the study.

This chapter explains the research methods of this project. It begins with a basic

background on research with an emphasis on phenomenology. Next, the research question is

restated, the sampling method explained, and the steps taken to protect human subjects

identified. Thereafter, a discussion of how the participants for the interviews were chosen is

presented and followed by an overview of the data collection and analysis process. Finally, the

chapter reviews measures taken to ensure the trustworthiness and credibility of the study, the role

of the researcher, and ends with a summary of the chapter.

Qualitative Research

In qualitative research, the researcher strives to attain a detailed understanding of a

challenging issue that cannot be explored through a survey instrument alone. Furthermore, the

qualitative method lets the researcher explore the contexts in which the participants address the

issue being studied. It is an approach to research that allows subjectivity and empowers the

participants to tell their stories from their personal experiences. Through the qualitative research

method, the researcher seeks to explore the meanings physicians ascribe to being a leader.

Creswell (2007) states that qualitative researchers explore the research problem by immersing

themselves into the environment of the setting being researched, by embedding themselves into

the participants' world, or by seeking the participants' perspectives to understand how they make

sense of the situation, event, role, group or interaction being investigated. To this end, the

researcher seeks to understand the rich experiences of physician leaders through semi-structured interviews.

In qualitative research, theory can be employed to explain behavior and attitudes. This study used the five practices of exemplary leaders, a framework that combines theory and method (Kouzes & Posner, 2002a), to guide the research. This methodological approach to leadership provided a foundation for discussion about the data gathered during the interviews. Kouzes and Posner (2002a) posit that effective leaders mobilize others through values and vision and convert challenges into opportunities for success. Using the five practices framework as the underlying foundation gave the research a basis for the analysis of the data. As noted by scholars of qualitative research, data and theory must have a dependent relationship where the data allow propositions to arise out of and generate new propositions without being contained into a bounded framework (Creswell, 2009; Lather, 1986). Thus, the use of an a priori theoretical framework is permitted for use in qualitative research in a way that does not limit the creation of propositions (Lather, 1986).

Creswell (2007) noted five approaches to qualitative research: narrative, grounded theory, ethnography, case study, and phenomenology. Narrative research, rooted in social and humanities disciplines, focuses on one or two individuals, gathers data through their stories, and reports the meaning of those experiences chronologically. Grounded theory research is conducted with the intent to discover a theory that might explain the process being investigated or might provide a framework for future research. In ethnographic research, the researcher is immersed into a single cultural group on a daily basis while observing and interviewing the group to collect data on the meaning of the behavior, language and interaction of the group members. The case study method researches an issue of one or more individuals within a setting

or context. It seeks to understand the factors that impact the individuals in a common setting.

The last strategy of inquiry, phenomenology, was a good fit for this research project because this

type of inquiry seeks to report through vivid language what is common for those that

experienced the phenomenon (Creswell, 2007). The result of this approach was a synthesized

description of the essence of the meaning for all of the individuals—mainly consisting of what

was experienced and how it was experienced (Moustakas, 1994). This strategy was chosen so

that the researcher would garner a rich understanding of physician leadership within the entire

context of the participants' lives at work.

In this study, phenomenology was chosen because the study aimed to understand the

phenomenon of physicians as leaders by exploring the common practices of physician leaders

through their lives at work. It was appropriate for this research because the approach described

the issue being investigated from the essence of the lived phenomenon (Creswell, 2007). The

phenomenological method allowed the researcher to gain insights into the deeper meanings of

leadership to physicians by analyzing data collected through interviews that used a probing open-

ended question format. To this end, participants were asked to elaborate on their thoughts on

their experiences as leaders and how they developed and practiced leadership competences. The

discussions were based on their thoughts and feelings with the goal of collecting richer data.

Overall, all qualitative research originates in the philosophical beliefs about how or what

we can know and what the nature of reality is. These philosophical assumptions consist of

ontology, the stand taken toward the nature of reality and epistemology, how knowledge is

acquired. The roots of phenomenology, one of five qualitative research methodologies discussed

by Creswell, drew on the works of four philosophers Husserl (2012), Heidegger, Sartre, and

Merleau-Ponty (Macann, 1993). Although other philosophers expounded on Husserl's views

over the years, there is still no agreement on one common definition of phenomenology. Today, Creswell (2007) asserts that across all perspectives, there are common factors that underlie the philosophy of phenomenology. These commonalities were that phenomenology is the study of lived experiences of individuals; it is a view that the actions of people are intentional and of pure consciousness (Van Manen, 1990); and that phenomenological research is not an explanation or an analysis, but a description of the essences of people who experienced the phenomenon (Creswell, 2007; Moustakas, 1994).

Phenomenology has two approaches: hermeneutic phenomenology and transcendental phenomenology (Creswell, 2007). The hermeneutical approach describes the experiences of people by analyzing the "texts" (Van Manen, 1990, p. 4) of life. This approach does not have a rigid set of rules or methods, but purports that the researcher is an essential element of the research, and thus maintains a strong relationship to the topic and mediates within the different views to develop an interpretation of the meaning of the nature of the lived experience of the participant (Creswell, 2007).

Unlike hermeneutical phenomenology, transcendental phenomenology concentrates more on the description of the participants' experiences and less on the interpretation of the researcher (Moustakas, 1994). This descriptive approach to phenomenology was first posited by Husserl (2012) to attempt to bring scientific rigor into the research of individual behavioral phenomena. Expanding on the original work of Husserl, Moustakas (1994) proposed the heuristic approach to phenomenology, one that emphasizes the researcher's role in self-reflection with an intense awareness and insight into the phenomenon being studied. For this study, the researcher uses Moustakas' (1994) heuristic approach and studies the phenomenon of physician leadership with awareness and self-reflection.

Moustakas (1994) also expounded on Husserl's (2012) concept of epoche, also referred to as bracketing, a practice in which researcher's past experiences, biases, and opinions are put away or distanced, to report a clean, fresh, and new perspective toward the phenomenon being studied. Husserl's transcendental phenomenology theory is based on the premise that the researcher withholds past assumptions in order to be open to discover the essence of the "thing" (Husserl, 2012, p. 74) being researched. Husserl (2012) defines "thing" (Husserl, 2012, p. 74) as the perception of the world of objects individuals live in and the experience as interactions with the world through the inner self, physical body, and interactions with others. Thus, the term transcendental refers to that which is perceived new, as if never encountered or experienced before. The transcendental approach was used in this study. Creswell (2007) notes that although it is difficult to perfectly set aside one's past, researchers often begin first by describing their own experiences with the phenomenon being investigated and bracketing out their own views. In preparation for this study, the researcher bracketed personal assumptions and understandings in this chapter in the section role of the researcher.

Restatement of the Research Questions

This study explores the phenomenon of physician leaders using the underlying framework of the five practices of exemplary leaders (Kouzes & Posner, 2002a) to guide the study. Therefore, the study aimed to answer the question: What are the leadership practices of physician leaders? The following subquestions were posed to attain a deeper understanding of the central question:

1. What are the perspectives of physician leaders regarding leadership?

2. How do the meanings that physician leaders ascribe to leadership affect them as leaders?

3. How do physician leaders describe their most effective leadership experience?

4. What behaviors benefited physician leader experiences?

5. How do physician leaders prepare for the multifaceted leadership role in healthcare organizations?

6. What do physician leaders perceive are concerns for aspiring physician leaders?

Sampling Strategy

To conduct the research, the researcher used purposive sampling, a method used when explicit criterion is identified for the selection of participants. In this study, the participants were licensed practicing physicians in the United States; functioned in a decision-making capacity in a large, medium, small, or private practice with a title of chief executive officer, president, medical director, associate medical director, chief, owner, or other title placing the person in the senior echelon of the practice. The participants had at least three years of experience in the capacity. As demonstrated by the criteria, the individuals that participated were important to their organization's practice and provided direction towards their organization's core business strategies. The researcher began identifying participants for this project by listing qualified physician leaders employed at the medical group contracted with the researcher's former employer and through referrals from the researcher's fellow classmates and family members. Then, from the list of referrals, the researcher contacted participants for the study through an introductory email or letter explaining the purpose of the study, timelines, confidentiality measures, and other pertinent information of interest to the recruit.

In addition to purposive sampling, the snowball or chain technique was used to identify additional participants (Creswell, 2007). This procedure identifies future potential participants through referrals from current study participants. The technique accumulates referrals by

generating other qualified referrals through established participants—a process described as snowballing. In keeping with this proposed snowballing technique, the researcher asked each established participant to refer knowledgeable and interested participants who may be amicable to participating in this study, but none were provided.

On the topic of sufficiency of data in qualitative research, extant literature exhibits differing opinions (Bowen, 2008; O'Reilly & Parker, 2012). In contrast to quantitative research, which predetermines the quantity of data, qualitative research is focused on the richness of information. Therefore, some argue that the researcher should be pragmatic and flexible in sampling and when the depth as well as the breadth of information is achieved, data gathered are deemed adequate (Bowen, 2008). On the other hand, others are more pragmatic and recommend that phenomenological studies should consist of five to twenty-five interviews (Polkinghorne, 1989). Using the pragmatic approach, the researcher chose fourteen physician leaders to participate with eight accepting the invitation. The participants were chosen with the intent of ensuring a broad representation of medical practices sizes from various areas of the country. To satisfy the breadth of information required for this study, the researcher collected vivid personal accounts of leadership experiences of each participant through a semi-structured interview format and probed as needed with follow-up questions.

Protection of Human Subjects

This phenomenological research used interviews for data collection making it important to protect the rights, welfare, dignity, and well being of the participants. As required by Pepperdine University, the researcher prepared and submitted an expedited application to the Pepperdine University Institutional Review Board (IRB) before recruiting subjects and beginning research.

The Pepperdine University policies are in compliance with all pertinent federal, state, and local laws and regulations in addition to emphasizing that all research under its auspices adheres to all relevant ethical guidelines that have a bearing on the research. The Pepperdine University policies follow the appurtenant ethical principles regarding research with human subjects of the Belmont Report (U.S. Department of Health & Human Services, 1979). Three basic tenets are prescribed by the Belmont Report: respect for the individual, beneficence—making efforts to secure their well-being—acts that go beyond kindness or charity, and justice.

Furthermore, Pepperdine University's IRB policies stipulate that researchers comply with U.S. Code of Federal Regulation sections entitled Protection of Human Subjects and Standards for Privacy of Individually Identifiable Health Information and the California Protection of Human Subjects in Medical Experimentation Act. To this end, the Pepperdine University IRB mandates that researchers seek written approval before initiating research projects. In keeping with Pepperdine University policy, the researcher awaited approval from the IRB before commencing research. After commencing research, the researcher was in compliance with all University IRB rules that protected the participants, created trust, and guarded against unethical behavior, negligence, or impropriety that might have potentially reflected on the participant or their organization.

In addition to the U.S. Code of Federal Regulation sections, the IRB requires researchers to meet the following stipulations. First, risks to participants must be minimal and reasonable in relation to the predicted benefits of the research. The research process must employ valid research design components that do not unnecessarily put participants at risk. Second, the selection of participants must be unprejudiced and objective based on the purpose of the research. Third, informed consent will be sought and consistently documented. Fourth, the

research design must incorporate data monitoring measures to guard the safety of the

participants. Fifth, the research must include measures that safeguard participants' privacy and

ensure confidentiality. Lastly, the sixth requirement of the IRB states that additional safeguards

must be included in the research design in the event participants could be subject to duress or

unwarranted pressure ("Pepperdine University," 2013). The IRB application included

information on the six requirements as detailed above and the researcher complied with the six

stipulations discussed above and foremost consideration was given to the participants' well being

and dignity.

       Participant confidentiality. To ensure the confidentiality of the participants, Creswell

(2009) asserts that names not be divulged in the research. For this reason, the eight participants

in the study were assigned an alias as a substitute for his or her name. The protocol for the alias

consisted of a code with an alphabetic character and a four-digit number that represented the

month and day of the interview. For example, the first interview was assigned the letter A, B for

the second, and C for the third. As an example, the individual interviewed on October 3 and was

the first in the sequence of interviews was assigned the code identifier A1003. The key to the

code was only known to the researcher and kept in a secure location along with any other

confidential demographic information to ensure all ethical considerations were respectfully met.

In addition, both hard and digital copies of data were equally secured to protect the

confidentiality and integrity of the research. According to Pepperdine University IRB directions,

these confidential documents are to be destroyed no sooner than three years after the conclusion

of this research project. In addition, all responses in the study were and will remain confidential

and anonymous and the final report did not link the responses to any individual or organization.

Moreover, because the interviews were recorded, the application included a description of the measures included in the research design to minimize the risks to the participants. Prior to submission of the application, the researcher completed the National Institutes of Health Office of Extramural Research training course Protecting Human Research Participants. The certificate of completion is attached as Appendix A.

Informed consent. After permission to commence research was granted by the Pepperdine University IRB, each participant received a letter of inquiry by email or by United States mail seeking participation. The letter of inquiry is attached as Appendix B. After receiving verbal or written agreement, the participant was emailed a written letter of introduction (see Appendix C) and an informed consent form (see Appendix D) to document participant permission. The consent form articulated the nature and purpose of the study, an explanation of the risks, and the confidentiality guidelines. In addition, the form advised the participant of their right to withdraw from the research without prejudice at any time. A self-addressed stamped envelope was provided with each informed consent form.

Data Collection

In this study, one-on-one semi-structured interviews with open-ended questions were used to collect data. Although the open-ended questions guided the interviews, whenever necessary, the researcher used spontaneous probing questions in order to gain a better understanding of the respondent's meaning. According to Polkinghorne (1989), during semi-structured interviews, the researcher is allowed to ask for clarification with the aim to gain an in depth meaning of the subject being discussed. This process allowed participants to expound on their thoughts and feelings regarding leadership resulting in insights that would not have been forthcoming.

Creswell (2007) notes that interviews are one of the most popular data collection methods used in all qualitative research approaches. Interviews in qualitative research are useful because it provides a deeper understanding into the experiences, knowledge, opinions, attitudes, and behaviors of the participant. With the aim of learning about the rich experiences of the participants during the interviews, the researcher contacted prospective participants first through an introductory email. The participants who agreed to participate in the study received a warm and welcoming follow up email that emphasized the voluntary nature of their participation. Furthermore, to mitigate any anxiety related to the interview, the interview questions were included to empower the respondent to prepare their answers in advance. Creswell (2007) asserts that a friendly and warm environment coupled with a healthy rapport encourages genuine responses to the questions during the interview. Hence, in addition to the friendly emails and providing material in advance of the interview, the researcher also scheduled the interviews at a place and time convenient to the participant. As noted by Creswell, these measures proved effective in building a healthy relationship with each participant. Indeed, several participants expressed excitement and interest in the study and requested a final version of the study.

Subsequent to building rapport with the participants, the interviews commenced using two modalities: face-to-face and telephone. Two participants were interviewed face-to-face and six were interviewed over the telephone. Extant literature states that participants tend to provide less detailed responses in telephone interviews than in a face-to-face interview (Sturges & Hanrahan, 2004), but others assert that, it is better to get some data from participants than no data at all (Harvey, 2011). Contrary to the assertions of extant literature, due to the healthy rapport with the participants, the researcher found that there was no significant difference in the data collected through the face-to-face interviews as compared to the telephone interviews. The two

modalities used in this research, face-to-face and telephone, were effective for data collection

and resulted in rich data.

Recording and transcription. In this study, the researcher used a digital recording

device and a microphone sensitive to the acoustics of the environment and manually transcribed

the interview (Creswell, 2007). Moreover, in case of a problem, the interviewer documented key

points through handwritten notes on an interview protocol (see Appendix C), a form designed to

record information during the interview and a notebook. Creswell (2007) advocates the use of an

interview protocol as it aids the researcher in organizing items such as headings, data on

interview start and end times, concluding propositions and at the end of the interview, serves as a

placeholder for closing comments.

Data Analysis

Generally, data analysis consists of three steps in qualitative research: assembling and

arranging data for analysis, collating the data into themes, and lastly, reporting the data using

illustrations, models, narratives, or discussions. As Creswell (2007) described, the data

collection, analysis, and report writing follows a spiraling process that consists of three steps. In

the first step, data management, the data was organized into file folders and computer files. The

folders and files were assigned a code identifier as previously described in chapter 3 to protect

the respondent's identity and confidentiality.

In the second step, the research moves to the analysis phase where a deeper

understanding of the details is gained while simultaneously getting a sense of the whole

interview. To do so, the researcher began by applying Moustakas' (1994) method of

horizontalization to analyze the data. Horizontalization is the process of listing statements

relevant to the phenomenon being examined and clustering them into themes. Moustakas (1994)

and Creswell (2007) assert that the process of reducing the data into themes raises consciousness

to attain an understanding of the inner meaning of the phenomenon through the interviewees'

expressions. For purposes of this research, HyperRESEARCH, a popular qualitative analysis

data software was used to perform the reduction and to clump the expressions into thematic

categories. First, the interview computer files were loaded into the software. Features in the

software package enabled the researcher to easily highlight important statements and assign

codes. The process continued until all answers to the interview questions were reviewed and

either coded or eliminated. According to Merriam (2009), in a phenomenological study, it is

important to give every statement equal value and continually process the data until the core

essence or meaning of the experience can be described. Therefore, after the first pass, the

statements were read and re-read to capture the essential meanings. As a final measure, the

imaginative variation was applied to the data. By using *imaginative variation*, the researcher

viewed the data from various perspectives with an open mind and produced descriptions that are

optimized to indicate all dimensions of the information (Merriam, 2009).

      While it is important to optimize the coding through several iterations, Creswell (2007)

asserts that a short list of pre-existing or a priori codes is useful to begin the coding process. He

notes that as an end result, elaborate coding schemes are unwieldy and in the end, only five or six

themes are needed for most publications (Creswell, 2009). Following Creswell's advice, in this

study, the theoretical framework of Kouzes and Posner's (2002a) five practices of exemplary

leaders was used to guide the coding or categorizing process. Creswell (2007) warns that using

predetermined categories can constrain the data analysis and says that the researcher should be

flexible and add new codes as they emerge. Hence, as suggested by Creswell (2007), the

researcher looked for expressions that described information to develop emerging themes, but all

expressions in this research fit within the five a priori categories provided by the five practices of exemplary leaders (Kouzes & Posner, 2012).

Validity and Reliability

There is no universal opinion on a standard of validation for qualitative studies. Lincoln and Guba (1985) posit that the issue of the trustworthiness and credibility of a qualitative inquiry can be addressed by internal validity, external validity, reliability, and objectivity. In another view, Polkinghorne (1989) posits that a study is valid if an idea has solid grounding and is well supported by the descriptive prose in the study. Creswell (2007) acknowledges that standards widely differ, but using at least two validation strategies in the research design enhances the study's trustworthiness and credibility.

As such, the researcher established validation in this study using three techniques. First, thorough, vivid, rich, and in-depth descriptions of the significant statements are provided in the study to ensure that others can perform comparisons (Creswell, 2007; Merriam 2009; Polkinghorne 1989;). Extant literature confirms that providing a detailed description increases the reader's ability to prescribe the information to other settings and determine whether the results are transferable.

Second, a peer review was performed to validate the researcher's data reduction, coding and categorizations. Lincoln and Guba (1985) believe that the peer provides the researcher an opportunity to refine the analysis by challenging the researcher's interpretations, processes, and methods. This systematic review of the researcher's work serves as an external test that increases the level of confidence in the interpretation of the data and ultimately results in a high quality research study. For this study, an individual with a doctoral degree in Organizational Leadership from the Pepperdine University Graduate School of Education and Psychology

performed the peer review. The individual was qualified to perform the review as she was an experienced researcher with an understanding of qualitative phenomenological studies and has a certificate for the protection of human subjects through the National Institute of Health. After the peer reviewer's independent review was concluded, the researcher and the reviewer held a debriefing session to discuss the results. The researcher answered questions to help clarify any vague phrases. In addition, when there were questions regarding the context of the expressions, the researcher provided further information regarding the spirit and intentions in which the comments were made. While assessing the coded material, the peer reviewer also made recommendations for missed, added, or rejected codes. These recommendations were collaboratively discussed, documented, and accepted or rejected during the debriefing session (Creswell, 2007). Accordingly, after concluding the debriefing, the researcher made the agreed upon edits to the codes in the HyperRESEARCH software.

The third and last procedure used to enhance the validity and credibility of the study was to clarify the researcher's bias at the beginning of the study (Creswell, 2007). Merriam (2009) posits that the disclosure of information regarding the researcher's background before commencing the study helps the reader to understand the researcher's position. The idea of bracketing or setting aside one's reality and suspend judgment while observing the phenomena from a pure perspective was established by Husserl (2012). Husserl refers to this process as epoche. He defines it as withholding one's judgment to view the phenomena in the purely by the life experience and intent of the participant. Respecting the philosophy of Husserl (2012), the researcher explicated past experiences and beliefs regarding physician leadership in the next section.

Role of the Researcher

As outlined by Husserl (2012) and recommended by Creswell (2007), this section brackets the researcher's past experience and previous knowledge of the phenomena being studied, physician leadership. The researcher was a manager at a major healthcare organization for fifteen years and was involved with business functions and decisions that placed physicians in administrative roles. In addition, the researcher's job required her to have in depth knowledge of the Patient Protection and Accountable Care Act (PPACA). While some of the researcher's biases were shaped through work experiences, other assumptions and beliefs are derived through discussions with the researcher's spouse who is a physician leader that is actively involved in policy and decision-making activities at a large medical group. These past experiences has led the researcher to believe that physicians always put their patients first and being a leader is inherent in their training. However, the researcher believes that physician leadership presents a unique leadership challenge. Although physicians are trained to be leaders, when taking on administrative roles they are challenged with balancing a culture of independent decision-making to a culture where decisions are collaboratively managed. As such, managing the apparent tension of the situation is a key leadership issue for physicians.

While practicing epoche, the researcher found that past life experiences raised her consciousness and sensitivity on issues regarding physician leaders. However, both Moustakas (1994) and Creswell (2007) confirm that achieving perfect epoche can be difficult. Despite the challenge, however, Moustakas (1994) posits that the special attention, energy, and effort involved in epoche reduce the influence of biases on research. Although perfect epoche may be not reached, the researcher approached the process of epoche with respect and determination to open her mind to the expressions of the participant. As a final measure to prevent biases from

affecting the findings of the study, the researcher noted that the interview questions were designed to look only at the leadership practices of physician leaders and not make any value judgments.

Chapter Summary

This chapter provided an in depth discussion of the research design. The researcher used purposive sampling and invited fourteen subjects to participate, of whom eight accepted. Before approaching the subjects, however, the researcher sought approval from the Pepperdine University IRB. The researcher interviewed the participants using semi-structured open-ended interview questions to gain an understanding of the life experiences of physician leaders. Next, HyperRESEARCH, a qualitative software package, was used to prepare and code the data. Thereafter, a peer reviewed the coding as a measure to increase the reliability of the study. Finally, the chapter ends with an explication of the researcher's background, another practice that enhances the study's validity.

The next chapter of this paper discusses the results of the interviews and key findings of the study.

Chapter 4. Data Analysis and Findings

Introduction

This chapter discusses the findings of this phenomenological research study. Fourteen physician leaders were invited to participate in the study of which eight accepted and participated. In this chapter, the expressions of the eight physician leaders as they see leadership are analyzed and presented in the following sequence. The chapter begins with a restatement of the primary purpose of the study and a restatement of the research questions. Next, a profile of participants is detailed. In the next section, the findings of the research are presented in detail. Finally, the chapter ends with a summary of the findings.

Restatement of the Purpose and Research Questions

The purpose of the study was to examine the leadership practices of physician leaders using the qualitative transcendental phenomenological approach. Unlike leading in a business setting where collaboration and compromise are commonplace, physicians work in an environment where autonomy and independence are expected. The differences between the two environments are distinct and therefore present challenges for physicians who take on administrative roles. To ameliorate the situation, it is important to develop a standard training curriculum to develop well-prepared physician leaders who are ready to balance the tension between the two environments. According to Knowles, Holton, and Swanson (2005) who developed the principles of andragogy, however, one must understand the needs of the learner to develop an effective educational tool. To this end, the following research questions were posed in this study to explore the practices of physician leaders.

1. What are the perspectives of physician leaders regarding leadership?

2. How do the meanings that physician leaders ascribe to leadership affect them as

    leaders?

3. How do physician leaders describe their most effective leadership experience?

4. What behaviors benefited physician leader experiences?

5. How do physician leaders prepare for the multifaceted leadership role in healthcare

    organizations?

6. What do physician leaders perceive as concerns for aspiring physician leaders?

Profiles of Participants

This section describes the profile of the subjects who agreed to participate in this research

study. The participants were recruited from multiple sources including the researcher's former

employer, a healthcare organization, referrals from classmates and family members. Fourteen

physician leaders, two women and 12 men, were invited to participate in the study, of whom two

women and six men accepted.

The participants were selected using the purposive sampling and snowball technique.

The purposive sampling technique calls for the researcher to focus and reduce variants to choose

people who can inform an understanding of the phenomenon being studied (Creswell, 2007).

With this in mind, this study required the subjects to be limited to licensed physicians in the

United States who functioned in a decision-making capacity in a medical organization for a

minimum of three years. As such, only physicians with titles at a high level were chosen to

participate. For recruiting purposes, required professional titles included chief executive officer,

president, medical director, associate medical director, physician owner, or chief. While the

study distinctly called for participants to have the aforementioned titles, it is interesting to note

that the physician leaders that actually participated in the study had, not only one of the required

titles, but the majority had at least two titles, with some even having three. Moreover, many of

the participants were currently a board member of their organization or were on the board in the

past.

The functional capacity of the participant and years in service were instrumental in the

design to ensure that the participants had enough lived experience in the role to share. While the

criteria were crucial to ensuring a homogeneous sample, the researcher sought to diversify the

geographical location of the participants and the size of the medical practice. Consequently,

subjects were recruited from various areas of the country and from different sized medical

groups. In the pool of participants that accepted the invitation to participate, two were located in

the western region of the country, two were from the southern region, one was from the

Midwest, one was from the eastern region and two were from Hawaii. One participant was from

a small private practice, while two were from a medium sized medical group and the remaining

were associated with large medical groups.

In summary, all the participants of the study met the criteria as established in chapter

three and as approved by the Pepperdine University Institutional Review Board. The participants

represented different areas of the country and different sized medical practices. The findings of

the study from data collected through the interviews are presented in the next section.

Findings

Although qualitative research is not about analyzing the numbers in a quantitative

manner, the below table provides an indication of the number of times, in aggregate, each of the

five practices of exemplary leaders (Kouzes & Posner, 2012) were expressed. As shown in

Table 1, this study finds that most of the subjects of this study exhibited all five practices to

varying degrees. The percentages in the table represent the total number of expressions for each

leadership practice as compared to the total number of significant statement coded for the study.

Table 1

Percentage of Five Practices of Exemplary Leaders Exhibited by Participants

Practice	Percentage
Model the Way	19%
Inspire a Shared Vision	22%
Challenge the Process	20%
Enable Others to Act	26%
Encourage the Heart	13%

Note: The table shows an aggregate percentage of the number of
expressions attributed to each practice. The percentages may not
represent the emphasis on which each practice was expressed. Total
number of statements = 221.

The table indicates that "enable others to act" was the most expressed in the interviews at 26%.

Following the dimension of "enable others to act" was "inspire a shared vision" at 22% and

"challenge the process" at 20%. The practices of "modeling the way" and "encouraging the

heart" were not expressed as much as the other practices, but represented at 19% and 13%,

respectively. The detailed findings of the study are presented in the following sections for each

of the research questions in a narrative format. The findings of this study are discussed

sequentially in the order of the research questions.

Response to research question 1. *What are the perspectives of physician leaders*

regarding leadership? This research question was intended to uncover the underlying

significance that the participants have regarding the leadership role. All five practices,

"modeling the way," "inspiring a shared vision," "challenge the process," "enable others to act," and "encouraging the heart" were present in the participants' responses. Although the environment in which physicians operate is dramatically different from leaders in other industries, their perspective of leaders as people who are forward thinking, set good examples and are supportive of others is essentially the same as leaders in other contexts. "Modeling the way" was expressed by participants as "the leader sets the tone," "engage people to move them in the right direction," "you can't just tell people to do things," and "act as a bridge builder." The sense of 'inspiring a shared vision' was expressed as "goal oriented," "communicate my vision," "know where you're going," and "be ahead, to be scanning the horizon." The act of "challenge the process" was described as "change that process if it isn't effective," and "advocate for new tools." The dimensions of "enabling others to act" and "encouraging the heart" were described as "lots of input from constituents," "help my team get a good understanding," and "I always thanked them."

Physician leaders showed a striking similarity with other leaders regarding how they viewed leadership. However, an inherent difference exists in where they root the purpose of leadership. Unlike business administrators who commonly define vision as an ideology for the company, physician leaders cited that their leadership existed for the good of the patient. This was indicated through expressions such as "in my preparation as a position leader, I pay attention to not only what the administrative and financial aspect is but always have in the forefront how to benefit the patient," or "my main goal is to try to make it so that the group as a whole and the physicians do what in the long run is best for the patients." All participants echoed these comments indicating that their final goal was to benefit the welfare of the patient.

As discussed in the preceding paragraph, the physician's purpose of leadership to do good for the patient can be attributed to the long years of training physicians receive in medical school and the philosophical grounding of the culture of the medical profession. Unlike business and political leaders whose primary aim is commonly bottom line profitability, this principle guides the actions of the physician leader without compromise. Although some participants acknowledge that the adherence to putting the patient first may compete with business interests, they also recognize that they need to work collaboratively with business leaders to ensure the viability of the organization. One participant alluded to this in his comment as the need to "realize how folks in other industries think from the business point of view and then translate what we need to do in population health in ways that make sense to people with a primarily business background." Further, he explains the process of negotiating these discussions as "translating one set of principles—strong population health and individual health—and translate it into a business proposition." The spirit of collaboration was emphasized by this participant's comments.

It is interesting to note that the three themes were strikingly similar to the qualities admired in the participants' role models. One participant described her role model as "having passion and engaging people to move them in the right direction." Likewise, when speaking about leadership she commented, "You need to understand your audience or your constituents and understand what motivates them because it isn't always a plea to logic." Another interviewee described his role model as "being able to see 15 to 20 moves ahead on the chess board and adept at master strategy."

Response to research question 2. *How do the meanings that physician leaders ascribe to leadership affect them as leaders?* This question seeks to understand how their underlying

belief of leadership influenced their role as leaders. Based on the participants' responses in the interviews, physicians were committed to their role as patient advocate, therefore attempted to influence patient outcomes by the dimensions of "inspire a shared vision," and "model the way." In addition, their belief in supporting others through the process surfaced through the dimensions of "enable others to act," and "encourage the heart."

It can be suggested that the dimensions of "inspire a shared vision," and "model the way," come from the fact that physicians emphasize patient care as a priority in their jobs. They employ these practices to get the best results in the clinical setting. The ideology of protecting the patient at all costs is a phenomenon so powerful that it becomes the end goal in itself, thus influencing how they lead. One interviewee confirmed, "When you go to medical school, they definitely indoctrinate you in that this is a calling—in their vision, they want people of high value. That's why physicians will do extraordinary things for people—at times even at their own risk." Another physician noted that the willingness to steadfastly stick to this standard was not developed randomly or complied with because of social expectations or political gains. As such, the potent and powerful underlying force to act in the patient's best interest has a strong grip in the physicians' leadership principles.

How physician leaders inculcate this firmly entrenched value as patient advocate into their role as an administrator is varied and complicated. However, most participants said that they led in service of others. This is illustrated by the following comments that support the themes of "encouraging the heart" and "enabling others to act." Below are comments from the interviews:

- "In order to get people to actually want to make sure that the objectives are reached, they have to have active participation and feel that they are part of the solution."

- "I think the primary objective of a leader is to motivate and coordinate people in an effort to achieve a common goal. It involves education, bridge building, team building, being able to recognize their strengths and weaknesses and to be able to put those strengths and weaknesses to use as the group attempts to achieve the goal."

- "What I'd like to see as a leader is to have the constituents using their strengths and weaknesses to accomplish the common goal. And as part of that, they should educate themselves, be active learners so that they are active participants in their job. They should seek opportunities to do better, not only in their own position, but in the sense of the whole."

Analogous to Burns' (1978) theory of transformational leadership where leaders satisfy a followers higher needs to achieve a vision, the personal development of physicians through family, college and clinical practices conditions them and gives them the natural proclivity towards satisfying their followers needs, engaging the person to participate holistically, and thus increasing the chance for success. While it can be generalized that physician leader's behaviors towards followers are congruent to leaders in other industries, they can be distinguished by their ironclad commitment to a purpose beyond financial goals.

Response to research question 3. *How do physician leaders describe their most effective leadership experience?* Clearly, the roots of giving service to others lie deep in physicians who accepted leadership responsibilities. At the same time, physician leaders

consistently describe the need for a more rational and efficient mechanism to improve healthcare. For this reason, physician leaders said they felt most effective at times when they created change--the dimension of "challenge the process." Challenging the process for one participant meant standing at the front to lead her staff, bargaining with others to shape policy and mediating conflict. Another participant said, "I think at some point, you've got to be willing to say the thing in the room that nobody else will say or is even thinking about. That's tough because groupthink is one of the most powerful forces, as you know, in the work you're doing." In a third example, a participant improved a physician scheduling process that created tension and conflict because people could not plan their personal time in advance. To ameliorate the problem, the participant developed and implemented a new scheduling process that gave people the freedom to control their own schedule well in advance and fairly distributed time off. These examples of physician leaders making change are representative of the majority. All in all, the findings show that the beliefs of physician leaders that leaders should have a vision and catalyze others to also compelled them to initiate change and challenge static processes.

Response to research question 4. *What behaviors benefitted physician leadership experiences?* It is not surprising that physician leaders felt that the behaviors that could be put into the categories of the five practices were beneficial to their leadership experiences. As shown in Figure 1, the behaviors that suggested the categories of "model the way," "enable others to act," and "encourage the heart" were mentioned more often as beneficial to physician leaders than the dimensions of "inspire a shared vision" and "challenge the process."
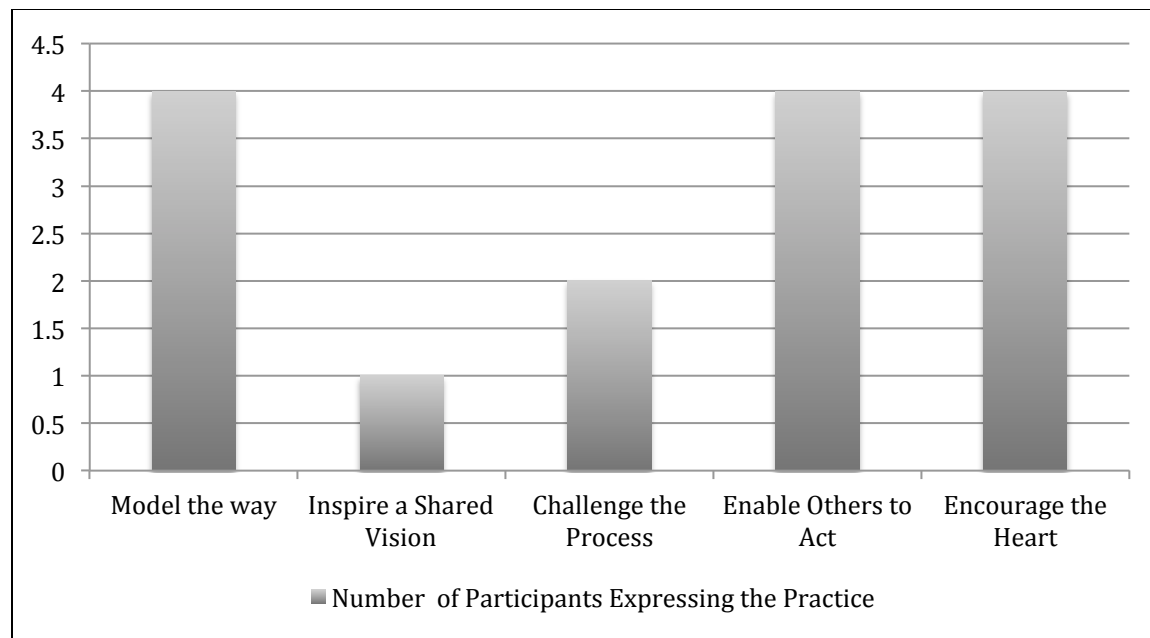
Figure 1. Number of participants expressing each beneficial leadership practice

By far the most critical finding of this research question is that the practices mentioned more often as beneficial to the participants' leadership experience all relate to perspectives that others have of them. These are "model the way," "enable others to act," and "encourage the heart." First, they feel that they must be a good role model for others and align their words to their actions. Second, they feel they benefit when others are empowered to take action towards the mission and third, they feel that recognizing others for their good work is important to succeed. For example, one participant described the importance of recognizing her constituents as:

> I think really focusing on what they were doing that was right, what they were doing that was helpful, and not ignoring things that weren't going right or weren't being done correctly but really not emphasizing those as much as emphasizing here's what I want to see, you did a great job on that, yes I'd like to see more of that. Catch people doing something right and acknowledge it, and celebrate it.

Given that working in a positive manner with others was important, it follows that leaders say communication is crucial to leadership. This is seen by two examples. In the first example, the participant used communication to give people encouragement and to empower them to act. She framed this by stating, "I think that some of my family practice training has really been helpful here because we are taught to listen and reflect. You don't always take everything at the word until you understand what the person is saying. In other words, know that you communicated." In the second example, a physician leader at a large hospital understood that his subordinates dealt not only with the daily technical difficulties of surgeries, but also faced administrative and political challenges. He says:

> If I can communicate my vision and why I'm steering the ship a certain way, that's when I'm most successful. If you give someone a big enough why, they'll get it. My job is to describe why and hope people can help me come through with the how. So it really is communicating. Just laying it all out there. I don't think you ought to lie to anyone. These are the real issues and this is what we really have to do.

Finally, although the dimensions of "inspire a shared vision" and "challenge the process" were not mentioned as frequently as those discussed in the previous paragraph, there were a few participants that mentioned these as beneficial to being a leader. These factors were represented through expressions such as "being able to work with other people and understand what their goals are and what their interests are," "you've got to be able to say what others aren't willing to say," and "being authoritative, but know your weaknesses and get help there."

Response to research question 5. *How do physician leaders prepare for the multifaceted leadership role in healthcare organizations?* The intent of this question was to understand how physician leaders learned leadership practices. The primary finding of this

question was that a standard leadership development path was not available for physician

leaders. Therefore, there was considerable variation in the quality and type of training

physicians used. The most common training modalities mentioned were seminars, executive

leadership programs, employer designed leadership development programs, employer sponsored

off-site workshops, participation in medical societies and community boards, and on the job

training. Without a commonly accepted and standardized educational path to develop physician

leaders, it is not surprising at the miscellaneous choices made by physicians.

While discussing the topic of formal leadership education for physicians, it was

interesting to note what was not said. In general, when people feel they need training to elevate

skills, they usually express their desire to pursue some type of training to master the skill.

However, during the interviews, most of the participants did not directly address the issue of a

lack of a formalized training program to develop physician leaders. It can be suggested that

awareness is lacking regarding the need for a structured program with a logical progression to

develop physicians into effective leaders. While most of the participants did not expressly state

that such a program is necessary, two interviewees did explicitly state the importance of

developing physician expertise to participate in shaping healthcare in the future. One said, "I

think it's a great idea to be studying the explicit and implicit ways that physician develop

leadership skills because I do think we have an important role to play for our patients and for

healthcare in this country." The other participant opined, "There's a lot of changes coming down

the pipe. It's a tough time for physicians. It's time to brace for it, time to educate and brace."

Response to research question 6. *What do physician leaders perceive as concerns for*

aspiring physician leaders? According to the respondents, challenging times are ahead. The

following expressions confirm that the overall view of the interviewees were that aspiring

physicians must be willing to 'challenge the process' to shape the future of healthcare. One

respondent expressed this clearly when she talked about the need for developing leadership skills

for physicians. She drew on her experience with a respected mentor who coached her to have

passion for doing the right thing in a way that engages people to move in the right direction. She

said, "I'm a little worried that doctors who come out now just want a job and this is not just a

job. Anything we can do to make sure that physicians don't think of this as just a job and that

they have a professional responsibility to lead us in the right direction, the better off we'll be."

Another interviewee noted that, "There is not an exclusive job of being a physician. I don't care

where you are--it has to be managed. If you hand it over to someone else, then you lose your

opportunity to make a positive change."

Although responses to this question indicated that challenging processes was important for

future leaders, one interviewee added the following advice for aspiring physician leaders: "You

should choose something that you enjoy doing. Don't choose something based on other things,

such as how much money you'll make. I want the people working with me or around me to

enjoy doing what they're doing."

Recap of Findings

The overall finding of the study is that physician leaders do practice all five dimensions

of the guiding framework to varying degrees. The list below presents the findings of the study in

the sequence of the research questions:

- R1. All dimensions of the five practices of exemplary leaders (Kouzes & Posner,

  2012) were present in the expressions of physician leaders. They said leaders

  should be forward thinking, set good examples and are supportive of others.

  Their ultimate goal, however, was different from business leaders because they

frequently expressed that their ultimate goal was to benefit the patient, not to maximize profits.

- R2. Participant expressions showed that they were committed to their role as patient advocate, demonstrating the dimensions of "inspire a shared vision" and "model the way." Although how physicians inculcated this role of patient advocate into their administrative role was varied, most said they led in service of others. This demonstrated the values of "encourage the heart" and "enable others to act."

- R3. Participants said they were most effective when they created change, thus demonstrating the dimension of "challenge the process." While this finding doesn't seem to be directly related to acting for the benefit of others as surfaced in R1 and R2, the researcher suggests that the participants created change to make a difference for others.

- R4. Physician leaders strongly favored the dimensions of "model the way," "enable others to act," and "encourage the heart" as behaviors that benefitted their leadership experiences.

- R5. There was considerable variation in the quality and type of training physicians used. There was no logical pathway, structure, or framework. On the job training and trial and error were most commonly mentioned.

- R6. Participants said that physicians have a responsibility to lead and make a positive impact on the future. Their expressions indicated that "challenge the process" was a key dimension critical for future physician leaders.

Chapter Summary

The key finding presented in chapter 4 was that physician leaders practiced all five practices in the guiding framework of this study, Kouzes and Posner's (2012) five practices of exemplary leaders to varying degrees. The chapter began with a restatement of the purpose of the study and the research questions followed by a profile of the eight physician leaders who participated in the study. The research used the purposive sampling technique to select leaders who were in decision-making capacities for a minimum of three years and were licensed physicians in the United States. Furthermore, to enhance the trustworthiness of the study, the participants represented various geographic regions of the country. After discussing the profile of the participants, the primary findings of the study were presented sequentially in the order of the research questions. Within each discussion of the research question, the intent of the question was stated, and the findings were discussed based on the framework of the five practices of exemplary leaders (Kouzes & Posner, 2012). In summary, the study finds that the themes "challenge the process," "enable others to act," and "inspire a shared vision," were more frequently mentioned in the interviews with the dimensions of "model the way," and "encourage the heart" following.

Chapter 5 presents a discussion of the findings in chapter 4, conclusions and implications, the recommendations for future research and research questions. Next, the chapter discusses the recommendations for policy and practitioners and finally ends with a summary.

Chapter 5 – Discussion, Conclusions, and Recommendations

Introduction

It has become increasingly evident that physician participation is needed to shape the future of healthcare. Yet there is critical shortage of physician leaders in the nation. The purpose of this research study was to explore the leadership practices of physician leaders. The researcher used the qualitative phenomenological approach and collected interview data from eight physician leader participants who were in the senior echelon of their organization for at least three years. An analysis of the interview data revealed that physician leaders exhibited all five practices of the Kouzes and Posner's (2012) five practices of exemplary leaders, the theoretical framework that guided the research. The study finds that the themes "challenge the process," "enable others to act," and "inspire a shared vision," were more frequently mentioned in the interviews with the dimensions of "model the way," and "encourage the heart" following.

The following research questions were posed to explore the practices of physician leaders.

1. What are the perspectives of physician leaders regarding leadership?

2. How do the meanings that physician leaders ascribe to leadership affect them as leaders?

3. How do physician leaders describe their most effective leadership experience?

4. What behaviors benefited physician leader experiences?

5. How do physician leaders prepare for the multifaceted leadership role in healthcare organizations?

6. What do physician leaders perceive as concerns for aspiring physician leaders?

This study was not intended to prove a causal relationship between physician leader practices and leadership effectiveness. Rather, the study focuses on examining the lived experiences of physician's in their leadership role. Chapter 5 includes a discussion of the findings presented according to the sequence of the research question, conclusion, implications for action, best practices for current outcomes, and recommendations for policy and practitioner, and recommendations for future research.

Discussion of Findings

Research question 1. *What are the perspectives of physician leaders regarding leadership?* The findings indicated that physician leaders display to varying degrees all the practices of the theoretical construct for this study, the five practices of exemplary leaders (Kouzes & Posner, 2012). This finding suggests that physician leaders are in good company with millions of global leaders. As physician leaders described how they perceived leaders, they did not refer tangible business outcomes. Most used expressions which highlighted events when they motivated and worked through people.

Kouzes and Posner (2012) confirm that leaders who exhibit these characteristics are more effective than those who do not. Over the years, Kouzes and Posner (2002b) interviewed millions of leaders from different industries, professions, and demographics and asked them describe their "personal best" (Kouzes & Posner, 2012, p. 15) leadership experience. Their responses indicated that every person interviewed had a leadership story to share and within the stories were the elements of the five practices. The findings of this research study reflect the same elements when physician leaders described their personal best experience. In summary, the in-depth exploration of perspectives of physician leaders found that they exhibited the five practices regularly, thereby suggesting their apparent ability to be effective leaders.

It is commonly accepted that having vision is indispensable to getting people on board with the mission. Similarly, participants of this study confirm the same during the interviews. Accordingly, extant literature agrees that effective leaders must have a vision (Bass, 1990; Collins, 2001; Northouse, 2001; Russell & Stone, 2002). In contrast, however, literature exists on a leadership style that does not emphasize vision. To illustrate, Burns (1978) described the transactional leadership style as a leadership style that places an emphasis on exchanging something of value for an objective met. Notably, because the style is advantageous for short-term results, it does not foster a long-term commitment to the leader-follower relationship. This study showed that physicians were not transactional leaders. It was evident in this study that physician leaders focus on making a lasting difference rather than attaining short-term goals. To do so, they make a long-term commitment to build a positive relationship with those they lead and get followers to share in their vision of the future.

Finally, this study found that physician leaders engage the spirit of others by empathizing with them, communicating with enthusiasm, and knowing what motivates them. These actions are found with in the dimensions of "inspire a shared vision," "enable others to act," and "encourage the heart." This leadership style was consistent with the techniques of transformational leaders (Bass & Avolio, 1993; Burns, 1978). Transformational leaders achieve positive organizational outcomes by uplifting the spirit of people through quality emotional connections and individualized consideration to achieve results that transcend self-interest and encourage people to go beyond preset boundaries and act in ways that transcend self-interest. Further, as mentioned by one participant who described situations where physicians put their own life at risk for the patient, it can be concluded that at times physicians are, in fact, servant leaders. In servant leadership, those who lead use the followers' goals as an end goal in itself

rather than directing others to follow their vision (Greenleaf, 2007; Greenleaf, n.d.). Granted, like others in leadership roles, physician leaders also adjust their leadership style based on the circumstances, setting, and people. However, the majority of the expressions in this study were notably related to mentoring, coaching and sponsoring rather than controlling and directing people. Although physician leaders did not specifically point out that they changed their leadership style based on the situation, the researcher suggests that they adjusted themselves depending on the environmental, political, and social forces at play.

In quantitative, qualitative, or mixed methods research, differences in the methodological construct of the research study could possibly lead to different interpretations. As such, because the methodology of this study differs from others, it could be interpreted that physician leader practices as found by this study cannot be compared to other study results. However, the data clearly support the findings. The stories told in the interviews, show that the physicians' personal best stories were often about leadership to the benefit of their constituents. Similarly, the research of Kouzes and Posner (2002b) found the same. Frequently standing at critical touchpoints in the lives of patients, physician leaders are used to leading in the lives of others. Cutting through cultural, political, and emotional barriers, physician leaders motivate others on their team to work towards positive patient outcomes. Although the methodology of this study differed from other research on leadership, the data confirms that vision, empowering the constituent, encouraging others, being a good role model, and initiating new process and innovating, all widely accepted as perspectives of effective leaders, are present in the participants of this research study.

Research question 2. *How do the meanings that physician leaders ascribe to leadership affect them as leaders?* The findings illustrate that "inspire a shared vision," and "model the

way," are featured prominently in physician leaders. To start, physicians had to have a

commitment to a personal vision in order to complete the long and rigorous years in training.

Thereafter, in their job as a doctor, they needed to work closely with patients towards a positive

future result and act as an ideal example for patients to follow. In most cases, they needed to

understand details of the patients; their past habits, family history, and other medical conditions.

The researcher suggests that physicians inculcate the value of vision and modeling so well

because they are exposed to it during years of medical education and extend it into their work.

While the level 5 leadership style (Collins, 2001) does not specifically mention examples of

physicians as leaders in their theory, this researcher suggests that physician leaders can be

included in this category. According to Collins (2001), level 5 leaders are not like other leaders

who are well known, charismatic, and have larger than life personalities. Instead, this type of

leader is humble, passionate and possesses a fierce resolve. What sets these people apart from

other leaders is that they created organizations that were incredibly successful long after they

left. This researcher posits that physician leaders have attributes that make them level 5 leaders.

Physicians are highly trained and learned professionals. They are of a limited group of people

who consist of about 1% of the nation ("Henry J. Kaiser Family Foundation," 2014). Given this

background, physicians could easily feel entitled and contemptuous, but in fact, they are humble,

passionate and like level 5 leaders, have a ironclad resolve to adhere to the mission.

Equally significant, this study finds combining the role of clinician and administrator

causes internal conflicts for physician leaders. They find that the cynicism present in business

can be a challenge to assimilate into their worldview. Physician's perceive their patient-centered

philosophy as noble, honorable and benevolent, and thus, view their leadership in administration

as integral to the common good as well. However, business goals are likely driven by tangible

bottom line goals rather than vague ideologies. Addressing the issues of people in multiple roles,

extant literature notes diverging views. One view posits that people are likely to have stress and

overload due to blurred boundaries in a social system that expects a certain pattern of behavior

(Biddle, 1986; Goode, 1960). In contrast, a longitudinal study of 76,000 Japanese agreed that

performing multiple roles was stressful, but it also found that felt people were stimulated and

motivated while balancing several roles (Tamakoshi et al., 2013). As a result, the authors

asserted that performing multiple roles could have a positive effect on health. In short, the

participant's multiple references to the stresses of balancing a dual role could be construed as

negative, but as indicated by the Japanese researchers, there could be a positive benefit to

performing the two roles.

Research question 3. *How do physician leaders describe their most effective leadership*

experience? Findings for research question 3 indicate that physician leaders felt most effective

when they were able to create change. Indeed, participants were proud and excited when they

cited incidents of innovations, fought to implement new initiatives, and when they sought out

new opportunities. Some of the participants, however, described challenging the process through

instances where they supported team members to make a change. They did so by using words of

encouragement and active positive reinforcement. According to Goleman et al. (2002), effective

leaders resonate and empathize with others. Some even assert that emotional intelligence is

more suitable to predicting success than cognitive capabilities (Goleman, 2000). In contrast,

others argue that emotional intelligence is not scientifically proven to lead to success (Mayer,

Salovey, & Caruso, 2004). Nevertheless, it can be suggested that physician leaders regularly

employ the principles of emotional intelligence. Although training in medicine did not explicitly

expose physicians to the concepts of emotional intelligence, they showed this competence

through words such as "give positive feedback," "engage people to move them in the right direction," and "help others be a high performing individual." As this study revealed, "challenging the process" can take various forms and some of the participants did it directly or through others. The challenge, then, for physicians is effectively create change while balancing the needs of their dual role.

      Research question 4. *What behaviors benefited physician leader experiences?* All participants of the study identified social intelligence skills as behaviors that benefited them as leaders. These were skills such as acknowledging, recognizing, being patient, encouraging, not controlling, understanding goals of others and communicating. In the stories of the participants, all five dimensions of the five practices, "model the way," "inspire a shared vision," "challenge the process," "enable others to act," and "encourage the heart," (Kouzes & Posner, 2012) were represented in the stories told by the participants about behaviors that benefited them. The finding of this research question is consistent with research question 1 which asked about the perspectives that physician leaders had regarding leadership.

      As discussed in the preceding paragraph, there was often evidence of reflective thinking present in the participants. This was represented by a comment by one physician who described why she felt it was necessary to develop a fair scheduling process, "…and the other thing that really affected me as a leader was that of my conscience. I wanted to make sure that I was doing the best for patients, the best for myself, and the best for my staff. And so whatever I wanted to have done, I would make sure that it will have a positive impact on all groups." Similarly, in another story, a participant shared the reflection process as, "You don't always take everything at the word until you understand what the person is saying. In other words, that you communicated. I feel like the part of listening and reflecting back is very helpful. Sometimes

changes aren't as pleasant as we would like, and being able to see that in employees and respond

to that is something that I try to do." These comments show that the participants used reflective

thinking to view situations as they could be, not as they seemed to be. Digging deeper into the

invisible elements that are present in an interaction with other people showed that physician

leaders were adept at emotional intelligence (Goleman, 2000; Goleman, 2011).

To apply these findings to the leadership literature, it can be suggested that physician

leaders parallel behaviors of transformational leaders (Bass & Avolio, 1993; Burns, 1978),

servant leaders (Greenleaf, 2007), level 5 leaders (Collins, 2001), and understand the key

principles of emotional intelligence (Goleman, 2000). Although this study did not explicitly

investigate emotional intelligence in physicians, the researcher observed that the factors of

emotional intelligence were interwoven throughout the interview scripts. The participants

alluded to these while searching for opportunities, motivating people, and tackling ambiguous

issues.

Research question 5. *How do physician leaders prepare for the multifaceted leadership*

role in healthcare organizations? Findings for research question 5 reveal that the participants

did not prepare for leadership in a formalized and structured manner. Rather, leadership training

was obtained as such opportunities arose and, in most cases, was done after they were promoted

into a leadership position. In other cases, participants obtained a Master of Public Health degree

and/or a certificate from a university based leadership program. While the Master of Public

Health is not necessarily geared towards leadership, these participants noted that having an

understanding from the view of population health was helpful to their administrative activities.

Perceptions of whether a structured program was necessary to be a leader was varied

within the group. Some participants were of the opinion that they already had the basic

foundational skills to be a leader while others felt that current learning strategies could be improved. The researcher comes to this conclusion through observations of tones and what was not said during the interviews. While discussing learning strategies, most participants did not explicitly mention that they self-directed themselves to attain leadership training. They often mentioned obtaining the training as incidental to their activity in the organization or serving on community boards. When the interviewer probed deeper with one participant and asked whether he would prepare for his leadership role any differently, the respondent answered quickly and definitively with a negative response. It can be suggested that in order to be a physician, one must be intellectual, analytical, and rational. Therefore, they are quick learners and have the ability to draw upon medical training and practice to lead. However, medical training does not incorporate training regarding the corporate culture, negotiation, and change management. Duberman, Bloom, Conard, and Fromer (2013) corroborate the suggestion that training is needed for physician to learn the right tools for leadership. The authors assert one type of training will not be applicable for all, but a leadership curriculum tailored for physicians should be developed for the nation to have the best healthcare system. In summary, without further research, it is difficult to know to what degree physicians are able to draw upon previous education and experience in order to be effective leaders. The variations in learning strategies, however, suggest that there are also variations in the knowledge regarding leadership skills.

Research question 6. *What do physician leaders perceive as concerns for aspiring physician leaders?* The findings for research question 6 indicate that challenging times are ahead for aspiring physician leaders. Expanding on this finding, it follows that future leaders should be ready to challenge processes. Although the expressions can be clustered into the dimension of "challenge the process," the advice given showed that challenging the status quo

was defined differently from person to person. A participant who ran her own practice said, "There's not an exclusive job of being a physician. It has to be managed. If you hand it over to someone else, then you lose your opportunity to make positive change." In contrast, another expressed the need to choose what you like first and then reach for a goal. She stated, "As a strategy for success, have passion for what you are reaching for. Look to see if something has been tried out and, if not, try to reach that goal." As a last example, a participant in large medical group expressed the importance being curious, innovative, and doing things to influence policy. It can be posited from these comments that these leaders felt that innovation, having the courage to question current processes, and breaking old mindsets will be necessary for those following in their footsteps.

It follows from the classic structure of change management theories that having a vision and inspiring others to buy in is the only way to make meaningful change (Kotter, 2007). Change, however, can be risky and disruptive to people who have long held mental models (Senge, 1990). Therefore, it is particularly rewarding when a change initiative is successful. This was observed during the interviews, as participants of the study were enthusiastic when sharing examples of innovation and change.

Although goals varied widely from participant to participant, the dominant opinion of physician leaders was that new physician leaders should look for change opportunities in the collective interest. Blanchard and Stoner (2004) confirm that leadership is about making change and going somewhere, not about keeping things stagnant. In summary, the advice provided by the participants to aspiring physician leaders confirm that leadership was largely viewed as an activity to make change.

Conclusions

This study set out to examine the leadership practices of physician leaders using Kouzes and Posner's (2012) five practices of exemplary leaders as a guiding framework. At the same time, the researcher endeavored to determine how physicians learned leadership skills and their recommendations for aspiring physician leaders. The study results found that physician leaders exhibited all key dimensions of the five practices with "inspire a shared vision," "challenge the process," and "encourage the heart," mentioned more often than "model the way," and "enablele others to act." As a result of this research, it was found that incorporating theoretical constructs of change management along with tactical change training would benefit physician leader development programs.

The following conclusions were reached based on the findings of this research study:

1. Physician leaders drew upon the knowledge and skills from years in medical school, residency, and fellowship to guide them in leadership roles. Therefore, in their decision-making processes in their dual role as physician adminsitrator, the philosophical ideology of putting patients first was apparent.

2. A logically structured education curriculum is needed for effective physician leadership development. A formalized structure would save time and resources by eliminating overlapping content and standardize the quality of the training. Leadership was primarily learned through trial and error on the job. Other training modalities used were: seminars, employer designed leadership programs, community sponsored classes and miscellaneous workshops through professional organizations.

3. Training on business culture is needed to ease the transition into a dual role. Given their past experience and training, the participants showed emotional and social

intelligence capabilities. While the participants cited that the leadership-follower relationship was important, they also reflected on the cultural differences in their dual roles.

4. The ability to pursue a personal vision was evident due to a physician's long years in training. While it may seem that achieving this vision was a personal endeavor, completion was predicated on their ability to successfully work with professors, mentors, preceptors, fellow students, and attending physicians. This capacity to manage relationships was evident in their focus on building a shared vision in the workplace.

5. A mentor, role model, or supportive boss was important in the participant's leadership. Although positive role models play a key role for the participants, these role models did not have to be physicians. Participants often cited community leaders, church leaders, coworkers, and family members. Participants modeled the respected behavior of these mentors.

6. Training on leading through change is needed to manage the innovations made and process changes proposed by the physician leaders. The training should be tactical as physicians are aware of the psychological aspects of change.

Implications for Action

As the study concluded, physician leaders exhibited the key components necessary to be an effective leader. However, it was difficult to discern to what degree each participant had inculcated the dimensions of the five practices. Therefore, the below are implications for actions that are recommended:

1. Provide training regarding how to change a personal vision into a shared vision. Achieving a personal vision is different from leading through a shared vision. Training on this topic will give those that don't have a natural inclination to lead confidence to do so.

2. Develop physician leaders into effective change agents to be able to negotiate with the business community. Challenging processes are uncomfortable and risky. Change management tools will ensure minimal derailment of viable innovations.

3. Develop a systematic and organized leadership program tailored for physicians' needs. Doing so will prevent overlap and eliminate the variance in knowledge.

Limitations and Recommendations for Future Research

This study examined the leadership practices of physician leaders using Kouzes and Posner's (2012) five practices of exemplary leaders. Through this examination, it was found that all five practices were present in the interview data in varying degrees depending on the situation being described. Still, like any other focused study, there are limitations to this research that suggest the need for future research. Therefore, the following recommendations are provided:

- This study was limited to eight participants, which may limit the generalizability of the findings. Therefore, the study could be duplicated with an increased number of participants. The same purposive sampling technique, interview instrument and guiding framework could be used. Expanding the study may result in more experiences where physician leaders innovated and initiated meaningful change.

- Kouzes and Posner's (2012) five practices of exemplary leaders was used as the guiding framework for the study. Research could be expanded using a different

theoretical framework such as emotional intelligence or transformational and

transactional leadership. Doing so could produce different results.

- Research is recommended on more physicians from smaller private practices.

    Expanding this demographic could provide a comparison of leadership practices in

    different settings.

- This study could be replicated to include demographic information such as age,

    gender, geographic location, specialty, and years in leadership roles. The additional

    data could inform researchers on any causal relationships between leadership

    practices exhibited and the demographic components. It may also reveal whether

    those with a longer tenure in leadership have a stronger propensity towards the Five

    Practices.

- This study was limited to using an interview instrument. Research could be expanded

    using a quantitative method and a mixed method. A survey tool such as the

    Leadership Practices Inventory (Kouzes & Posner, 2012) or Multifactor Leadership

    Questionnaire (Bass & Avolio, n.d.) could provide more information on physician

    leadership practices. In the case of a mixed methods study, triangulating interview

    results with survey results could improve the transferability of the results.

Practitioner Recommendations

The findings of this study have implications for those who are responsible for overseeing,

designing and providing leadership development for physicians. The study ultimately found that

physician leaders had a solid foundation for the basic leadership skills and showed the desire to

make change. However, the lack of an organized and logical structure in the learning strategies

of physician leaders makes it difficult to know where their leadership strengths and weaknesses

lie. Therefore, this study can be used as a starting block to improve existing physician leadership

training programs by informing stakeholders of physicians' leadership practices. Organizational

leadership trainers will find it useful to tailor training content to eliminate basic leadership

concepts and underscore the research-based applications of transformational leadership, Level 5

leadership and emotional intelligence. The study also found that physician leaders were

champions of new initiatives and had a strong desire to improve the inefficient systems.

Healthcare organizations that wish to improve organizational effectiveness can use this

information to develop physicians as change agents. Change management models have been

proven to work effectively to create change. Using proven models instead of learning by trial

and error will enhance the chances of success.

The results of this study can also be used to advise key stakeholders on how to improve

leadership training for physician leaders. It provides useful information that allows

organizations to design training for physician leaders based on individualized needs. It was

evident from the expressions that physician leaders are aware of the basic psychological needs of

their constituents and understand value-based and ethical leadership principles. Therefore, the

findings of this study can be used to tailor future learning strategies to consider an advanced

level curriculum.

Finally, stakeholders should also consider using 360-degree feedback tools could enhance

the self-efficacy of the physician leader. Given the unmethodical manner in which physicians

acquire leadership experience, individualized coaching is recommended.

Final Summary

There is a growing need for physicians to actively participate to affect positive change in

the new era of healthcare. If physicians take an active role in shaping the healthcare industry,

new systems and initiatives will be designed to efficiently meet the key aims of the government

regulations. However, there is a critical shortage of physician leaders. The purpose of this study

was to explore the practices of physician leaders to understand their leadership practices. The

results aim to enhance the efficacy of physician leadership development tools and practices.

Effective leaders are often described as empathetic, visionary, considerate and socially

aware (Bass & Avolio, 1994; Blanchard & Stoner, 2004; Burns, 1978; Kouzes & Posner, 2012).

These characteristics are applicable across all types of professions, including the medical

profession (Kouzes & Posner, 2002a). Physicians, however, present a unique leadership

challenge. They balance a clinical role that is independent and autonomous with an

administrative role that requires collaboration and compromise. Notwithstanding, one leadership

model, Kouzes and Posner's (2012) five practices of exemplary leaders assert that effective

leaders, no matter the background or culture, consistently exhibit these five behaviors: (a) model

the way, (b) inspire a shared vision, (c) challenge the process, (d) enable others to act, and (e)

encourage the heart. Likewise, the transformational leadership style, the servant leadership style

and the level 5 leadership style incorporate similar themes.

This study used the qualitative phenomenological method to take a detailed look at the

leadership practices of physician leaders and used the five practices to guide the research. After

receiving approval from Pepperdine University's Institutional Review Board, semi-structured

interviews with eight physician leaders were conducted to collect data. The data was analyzed

using HyperRESEARCH coding software.

The study found that the physician leaders resembled other effective leaders and

practiced all five of the practices of physician leaders. It also found that physicians were rooted

in the principle of leading for the benefit of others and therefore, often challenged processes to

make improvements and were aware of the importance working through others to accomplish their goals. Further findings showed that there was no consistency in the way leadership training was acquired by the participants.

As such, the study recommends that using the principles of andragogy (Knowles et al., 2005), leadership trainers must tailor physician development programs at an advanced level. In addition, the findings suggest that stakeholders of physician development incorporate change management models and executive coaching to provide physician leaders with tools for making change.

Finally, the study concludes that physician leaders drew upon past medical and clinical experience in their dual roles as physician leaders. It also concludes that role models were important in molding their value systems. It can be suggested that change leadership training will be beneficial for maneuvering the future challenges that lie ahead for physicians.

In summary, this study found that physician leaders have the foundational components to be effective leaders based on the framework of Kouzes and Posner's (2012) five practices of exemplary leaders. These leadership dimensions will serve them well as they navigate the tumult caused by the new healthcare reform law of 2010. However, a concerted effort to develop aspiring physicians into leaders is needed to meet the shortage of physician leaders in the U.S. Developing a sufficient number of effective physician leaders is important because good medicine leads to good business and good business leads to good medicine. In the end, a balanced and unified effort between business and medicine will ensure the future viability of healthcare in the country.

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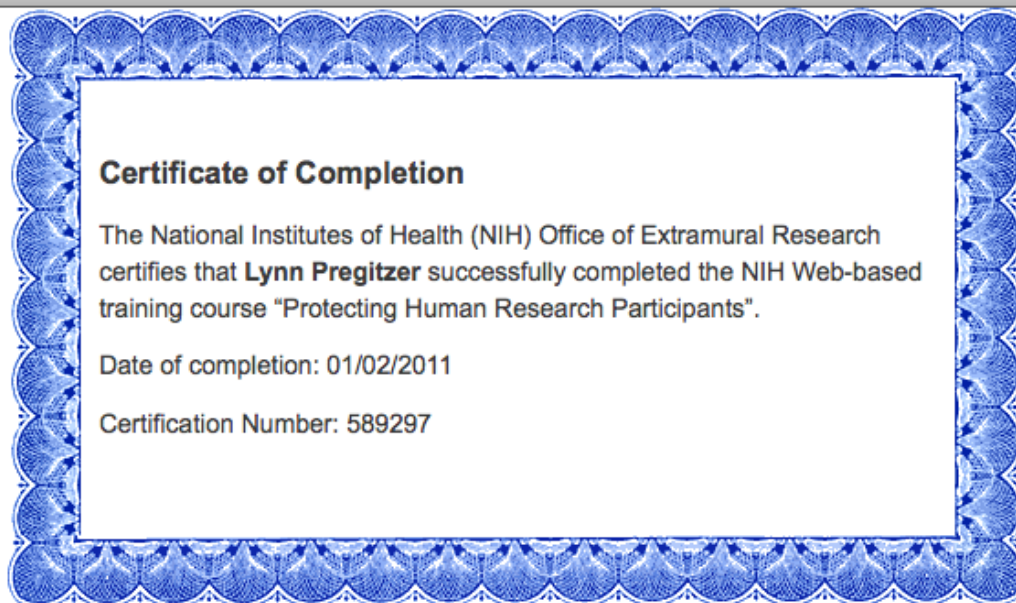172. doi: 10.1377/hlthaff.2010.0824

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APPENDIX A

Certificate of Completion of National Institutes of Health Training

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Lynn Pregitzer** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 01/02/2011

Certification Number: 589297

APPENDIX B

Participant Letter

_____, 2013

Dear Dr. _____:

I am a doctoral candidate in the field of leadership at the Pepperdine University studying organizational leadership. The title of my dissertation is <u>The Future of Physician Leaders: A Study of Physician Leadership Practices</u>. I appreciate your willingness to participate in my study that seeks to explore the practices of physician leaders. In addition, because of the prevailing opinion that the new healthcare reform act is predicted to require a critical mass of physician leaders, this dissertation will explore the meaning physician leaders ascribe to their leadership role as it changes to adjust to the accountable care act.

In my study, I am seeking to understand the leadership practices of physician leaders.
To obtain this information, I am interviewing licensed physicians in all sizes of medical groups who participate in decision and policy-making capacities in their organizations.

The importance of this study will be to ensure that private, government, non-profit and other governing bodies of healthcare understand the specific competencies of physicians as leaders in order to develop physician appropriate leadership programs. To date, physician leaders are educated in leadership in a haphazard, unorganized, and generic manner. This study will help organizations as they strategize on how best to develop physicians as leaders.

Please find attached, a list of interview questions for your review. The aim is to allow you to answer the questions using your own experiences. Also, please be assured that all responses will be kept confidential and you may terminate the interview at any time.

Thank you very much for your consideration and taking time out to contribute to this important phase of my study.

Sincerely,
Lynn Pregitzer

APPENDIX C

Interview Protocol Form

Project description	Research: Physician leadership practices
Date	
Place	
Interviewee	
Interviewee sequence letter	A B C D E F G H

Questions:

1. How did you prepare for the dual role as a physician leader?

2. What are your main clinical responsibilities? What were your main administrative responsibilities?

3. What do you think should be the primary objective of a leader?

4. How do you think leaders should achieve these objectives?

5. What role do you think the constituents of the leader play in the organization?

6. What, if anything, affected you as a leader? Why?

7. Who do you regard as a role model? Why?

8. What strategies have you used to attain success?

9. Could you describe your leadership experience when you felt you were most effective?

10. What behaviors do you think benefited you most in the previously described experience?

11. Please describe the adjustments you had to make in your dual role as a clinician and administrator?

12. Do you have any comments to add?

(Thank the individual for participating in this interview. Assure him or her of confidentiality of responses and potential future interviews.)

APPENDIX D

Informed Consent Form

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Participant: _____
Principal Investigator: Lynn Pregitzer
Title of Project: The Future of Physician Leaders: A Study of Physician Leadership
                                     Practices

I, _____, agree to participate in the research study being conducted by Lynn Pregitzer under the direction of Dr. Ronald Stephens, professor in the Graduate School of Education and Psychology at Pepperdine University. I understand that the primary purpose of the research is to explore the leadership practices of physician leaders. The leadership practices of physicians are important to understand because the success of healthcare reform is heavily dependent on their leadership.

I understand that my participation will involve one interview meeting of no more than 45 minutes to 1 hour. In addition after the meeting, should I desire, I will be given the opportunity to review the transcript of the interview. I have been asked to participate in this study because I attest to being a physician leader. Further, I understand that I will be asked to answer questions to describe my experiences as a physician leader.

I understand that if the interview is conducted in person, the study will be conducted at a location agreed upon by all parties. Further, I understand that if it is not possible to meet in person, the interview will be conducted over the telephone or the Internet. If I decide to participate in this study, the interview will be audio recorded. The recording will be used for research purposes only. The recordings will be stored in a locked file cabinet, maintained by the researcher, and will be destroyed no sooner than three years after the conclusion of the study.

I understand that I have no direct benefit, monetary or otherwise, from participating in this study. However, the social science benefit(s) to the academic community may include knowledge and information about the practices of physicians in leadership positions. This new information will add to the currently limited body of knowledge on this topic.

I understand that there are certain risks and discomforts that might be associated with this research. These risks include my time lost for participating in the study, fatigue, and boredom. In the event that I do experience these conditions, I am free to end the interview at any time or take a rest break. Further, I understand that I will incur no costs associated with my participation in this study.

I understand that my participation in this study is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue in the project or activity at any time without penalty or loss of benefits to which I am otherwise entitled. I also have the right to refuse to answer any question I choose not to answer. I also understand that there may be occasions where the investigator may find it necessary to end my study participation.

I understand that the investigator will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project. I further understand my confidentiality will be maintained by use of non-personal identifiers and that the data gathered will be stored in a locked file cabinet and password protected for electronic files to which only

the investigator will have access. The raw data will be maintained in a secure manner and destroyed no sooner than three years after the conclusion of the study.

If I have any questions, I understand that I can contact Lynn Pregitzer at ███████████. If I have any further questions or concerns about this research, I can also contact Dr. Ronald Stephens at ███████████████████████. If I have questions about my rights as a research participant, I understand that I can contact Dr. Thema Bryant-Davis, Chair of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, at █████████.

I understand that I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness of continue in the study.

I understand that in the event of physical injury resulting from the research procedures in which I am to participate, no form of compensation is available. Medical treatment may be provided at my own expense or at the expense of my health care insurer that may or may not provide coverage. If I have questions, I should contact my insurer.

I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form, which I have read and understood. I hereby consent to participate in the research described above.

_____   _____
Participant's Signature   Date

I have explained and defined in detail the research procedure in which the subject has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

_____   _____
Principal Investigator   Date

APPENDIX E

Pepperdine University Institutional Review Board Exempt Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

September 23, 2013

Lynn M. Pregitzer
~~1325A Moanalualani Place~~
~~Honolulu, HI 96819~~

Protocol #: E0814D03
Project Title: The Future of Physician Leadership: A Study of Physician Leadership Practices

Dear Ms. Pregitzer:

Thank you for submitting your application, *The Future of Physician Leadership: A Study of Physician Leadership Practices*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Ronal Stephens, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.nihtraining.com/ohsrsite/guidelines/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

6100 Center Drive, Los Angeles, California 90045 ▪ 310-568-5600

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact the GPS IRB office at gpsirb@peppderdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
        Ms. Alexandra Roosa, Director Research and Sponsored Programs
        Dr. Ronal Stephens, Graduate School of Education and Psychology