PHYSICIAN LEADERSHIP AND SELF-EFFICACY: 
A CASE STUDY USING GROUNDED THEORY 

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Bombarded by constant and rapid change, healthcare organizations feel a sense of urgency to meet their needs for leaders. They rely on physicians to lead at all levels in their healthcare organizations. For them to successfully navigate today’s healthcare environment, they require more than a medical education. To address this need, healthcare organizations are developing in-house physician leadership development programs. In this paper, I conduct a case study of physicians transitioning into leadership and their self-efficacy facilitated through an in-house leadership development program. Documentation, semi-structured interviews, and observations are examined to explore how physicians think about their leadership experiences following their participation in a six-month in-house leadership development program. The study also explores at a high level how these experiences influenced physician’s self-efficacy as a first step in developing a theory of physician leadership and self-efficacy.
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My journey started in Omaha, Nebraska in 1997 when my mom was diagnosed with cancer for the second and last time. My mother lost her battle to cancer with beauty, dignity, and grace. Although I accepted her passing, I didn’t accept the lack of compassion and care she received from her oncologist. The disappointing experience with my mother’s oncologist led me to my work in leadership development with physician leaders. I am very grateful for my journey.

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CHAPTER 1
INTRODUCTION

Introduction to the Problem

Healthcare is no longer recession-proof as suggested by the biggest driver of rising costs, medical progress: new drugs, new tests, new devices and tools, and new ways of using them (Hughes, 1999). These tools are frequently complex, and their effective use requires increasing numbers of personnel trained in narrow fields. Patients with complicated conditions like cancer end up seeing a variety of physicians, who are often spread across several institutions. The result can lead to confusion as the release of knowledge and communication that is distributed within a system might be too fragmented and disorganized for medical personnel to absorb. Ongoing and meaningful coordination, communication, knowledge sharing, and teamwork across disciplines are required if value and outcomes are to improve (Lee, 2010). Healthcare organizations face a tough balancing act between delivering patient-centered care and eliminating redundant care and errors that raise costs and threaten quality.

Today’s challenges for healthcare organizations cannot be met by improving efficiency and effectiveness alone. Striving for growth means that businesses are constantly reevaluating their business models and underlying business processes (Skerlavaj, Stemberger, Skrinjar, & Dimovski, 2007). There is extensive literature on business process change (Burlton, 2001; Davenport, 1993; Hammer & Champy, 1993; Harmon, 2003; McCormack & Johnson, 2001). However, this literature stops short of suggesting that organizations can enhance their overall performance by adopting an organizational culture that supports innovations being implemented and superior performance being achieved (Hammer, 2002).
Organizational culture involves a dominant set of norms that emerge over time and guide the way in which work is accomplished within an organization (Sadri & Lees, 2001). The study of organizational culture began in America during the last two decades due in part to an influential book entitled *Corporate Cultures: The Rites and Rituals of Corporate Life* (Deal & Kennedy, 1982). In the more than three decades since the book introduced the relatively unknown concept of organizational culture, hundreds of books and thousands of articles have recognized its central role in corporate strategy (Sadri & Lees, 2001).

Organizational culture drives better clinical and financial outcomes and makes it possible to improve existing services, invest in new programs, and recruit and retain talented healthcare leaders. The literature is full of a variety of definitions for leaders. For the purpose of this study, leaders are defined as transformational leaders who have demonstrated influence over followers to achieve mutual goals (Bass, 1990a). If mutual goals are met, organizations are able to create an ever-improving environment to care for patients and their families. Not creating a positive organizational culture can have detrimental effects on individual and organizational performance and contribute to burnout in these difficult economic times.

The national issues of healthcare reform, declining quality of patient care, and shortages in healthcare leadership are serious concerns for most American healthcare organizations (Lee, 2010). In order to address these issues, American healthcare organizations are scrambling to recruit and hire, as well as train their leadership (Gawande, 2010). If physicians work in any sort of leadership role, they have probably attended a leadership seminar, consulted with an executive coach, or gone back to school for a master’s degree in business administration (Guthrie, 1999). For the purpose of this study, transformation leadership involves trust and admiration in order to
achieve the ongoing attainment of desired goals and maintain a culture of continuous improvement (Bass, 1990a).

Within physician leadership, a specific style, transformational physician leadership, appears to be most effective (McAlearney, 2006). Transformational physician leadership is important in the delivery of healthcare services, but physicians are rarely employed full-time by healthcare organizations, and are therefore left outside of conventional human resources practices and leadership development initiatives (McAlearney, 2006). Leadership development is a process of personal development that improves a leader’s ability to engage effectively in leadership roles (McCauley, Moxley, & Van Velsor, 2004 p. 3). Furthermore, physicians are required by professional norms and practice standards to continue their clinical education and development, but this education and professional development are rarely linked to the leadership of the healthcare organization (McAlearney, 2006). Consequently, physicians rarely receive managerial and organizational learning in healthcare organizations, and the ability to build and sustain trust and admiration in the past has largely been intuitive rather than being systematically trained and developed (McAlearney, 2006).

One solution healthcare organizations are exploring to address this issue is physician leadership development. Physician leadership development may involve a master’s degree (post-medical school) in medical management, public health administration, or business administration (Schwartz et al., 2000). Additional forms of professional development include certification in a physician executive management education program or a formal or informal internal development program including classes, mentoring, and/or coaching (Zismer & Person, 2008). Leadership programs designed with physicians rather than designed for physicians, incorporation of metrics to know whether/where the programs are succeeding, and approaching physician
leadership development as an ongoing process rather than a series of events are leadership development program features that appeal to physicians (McAlearney, 2006).

The literature reveals that meaningful program activities, in combination with program support structures (e.g., executive leadership involvement, additional support services and tools), facilitate physician engagement and productivity (McAlearney, 2006). Physician leadership development programs are promising programs for producing physician leadership, yet physicians with previous negative relationship/teambuilding and communication experiences are likely to struggle in these programs; fear of failure or other compounding factors may cause physicians to not complete a program successfully. Physician leaders are those whose roles include healthcare administration (day-to-day operations and management) and leadership (influence followers toward mutual goals) to ensure the appropriate patient care regardless of whether they are full-time, part-time, named leaders (e.g. Chief Executive Officer), or unnamed leaders (lack formal leadership position) (Merry, 1999).

The question often arises to how physicians become leaders. In general, there is consensus in the literature that there are some skills for leading that can be taught (Bass, 1990; Hill, 2004; Gregory, 2004). However, some people are undoubtedly more inclined to being able to lead than others (Conger 2004). Day (2001+, Conger & Benjamin (1999), and McCauley et al., (2004) differentiate between leader development and leadership. Their view is that leader development is focused on developing an individual’s capacity to lead and the leadership development is focused on developing the leadership within an organization. Regardless of these differences, leader development and leadership development are often referred to interchangeably. For the purpose of this study, they are referred to interchangeably.
This case study explores how an in-house leadership development program affected physicians’ perceptions of their leadership self-efficacy. Aspects of the research process align with Bandura’s (1977) self-efficacy theory. This framework can also be used to narrow the focus and guide the analysis of this dissertation.

Background of the Study

In 1847, the American Medical Association (AMA) was founded. The AMA’s goal was to uphold physician dominance over healthcare administrators and to maintain autonomy in the healthcare profession (Freidson, 1988). The AMA strived to preserve the elite status of physicians and established a model of individual rather than cooperative practice (Schneck, 2004; Starr, 1982). As a result, physicians have historically had a hard time transitioning from individual practitioners to collaborative team members (Lanier & Rose, 2008; Palatchi, 2003). Many of the skills physicians learn in medical education programs are not readily transferable to the business operations and leadership of a healthcare organization (Guthrie, 1999; Schwartz et al., 2000; Taylor et al., 2008). Furthermore, there are numerous hierarchies of both clinical and administrative professionals in healthcare organizations. This produces unique challenges for directing the organization and coordinating the work and often results in a culture of division between administrators and clinicians (Friedson, 1972; McAlearney, Fisher, Heiser, Robbins, & Kellher, 2005; Shortell, 1992). Even within clinical ranks, there are divisions between physicians and nurses, pharmacists and physicians, and so forth (McAlearney, 2006). Such differences create substantial challenges for leadership as physicians tend to patients and administrators manage the organization (Schultz, Pal, & Swan, 2004; Zaher, 1996).

The rise in power of health insurance companies and regulatory agencies, combined with prepaid health plans and an educated public, have weakened physician dominance. Frustrated
and disappointed about their loss of influence and autonomy, physicians are moving into management ranks (LeTourneau & Curry, 1997; Mertz, 2003). The literature stresses the importance of physician and administrator partnerships so they can deal effectively with the ever-changing healthcare environment (Dye, 2000; O’Neil, 1999; Tomasik, 2008). However, physicians who want to move into the business and leadership of healthcare organizations must first change from thinking as independents to developing a broader systematic and collaborative perspective (Atchison & Bujak, 2001; Tomasik, 2008). According to Birrer (2002), physician leaders must be liaisons who work with hospitals, medical groups, and the community. They serve as influencers, a challenging position requiring strong leadership skills. According to Reardon (1999), healthcare leaders will need breadth and depth of knowledge, as well as excellent interpersonal skills.

Studies show the key to transitioning physicians from clinical practice to leadership rests on their ability to make identity shifts requiring deep changes, and they must understand business and leadership concepts (Lawson, 1994; McAlearney et al., 2005; Mertz, 2003; Schwartz et al., 2000; Vavala, 1995). Identity is defined as the self within every human being that strives to be authentic (Palmer, 2000). A physician’s sense of identity is an important factor in determining how successful he or she will be in leadership (O’Neil, 1999; Tomasik, 2008; Zaher, 1996). This means that self-efficacy and self-perception are important in developing physician leaders.

A physician’s desire for leadership will support his or her learning process, but most physicians indicate they do not see themselves as leaders (Arond-Thomas, 2004). For healthcare organizations to be successful, physician leaders and administrators must also learn to work together (Warden & Woodward, 2008). This is challenging due to their conflicting mindsets and leadership views (McAlearney et al., 2005). Physicians can assist in this process by pursuing
educational opportunities and developing leadership competencies and skills (Schwartz et al., 2000; Tomasik, 2008). For physicians to become effective change agents, they must embrace more formalized business education, such as a master’s degree in medical management, public health administration, or business administration (Schwartz et al., 2000). Physician leaders can also supplement their clinical education with executive management certification programs (Zismer & Person, 2008).

Within physician leadership, a specific skill - namely transformational physician leadership - appears to be most effective (McAlearney, 2006). The transformational leadership skills that must be developed by physicians (Lanier & Rose, 2008; MacNulty & Kennedy, 2008; McAlearney et al., 2005; Xirasagar et al., 2006) include learning self-awareness, listening, and dialoguing (Rice, 2009). Dialoguing is a process of relating to the self through feelings, desires, and interactions with others (Mezirow, 1991). An association exists between transformational leadership behaviors and values on one hand and personal and professional development on the other (Tickle, Brownlee, & Nailon, 2005). Transformational leadership development involves depth and enlightened leadership (Baker, 2006; Lanier & Rose, 2008), and encourages self-awareness, which positively correlates with leadership effectiveness (Sashkin & Sashkin, 2003).

In order to become effective physician leaders, many physicians need to develop an appropriate sense of self and identity through a process involving deep changes in beliefs and behavior (Atchinson & Bujak, 2001; Kuhn, 1996; LeTourneau, & Curry, 1997). Deep change is defined as a process in which an individual mindfully shifts from previous and routine thought patterns. It involves embracing a new pattern, as opposed to staying with the old and familiar pattern (Mezirow, 1991). As mentioned earlier, there is a relationship in the literature between a
physician’s sense of self and how successful he or she will be as a physician leader (O’Neil, 1999; Tomasik, 2008; Zaher, 1997).

As most physicians do not see themselves as leaders (Arond-Thomas, 2004), they could benefit from learning what challenges their assumptions, beliefs, values, and perceptions of themselves (Gray, 2007; Lamsa & Sintonen, 2006). Mezirow (1994) pointed out that when something does not fit comfortably into a person’s learning structure, that person often resists it. However, one can change these structures through reflection and deep learning. According to Darling-Hammond (2008), deep learning is the process of connecting learning to personal experiences. It occurs when individuals take responsibility for their learning and reflect on their work, measure it against a standard, and continuously improve it. Physician participation in a deep learning process appears to be an important adult learning theory promoting the transition from clinical practice to leadership.

The literature on adult learning theory states that adult learners usually bring a degree of work experience and maturity to their learning environment. They are experienced with life’s circumstances and typically know more about themselves and interpersonal communication than their younger counterparts (Moore & Kearsley, 2011). The adult learner also exhibits a high degree of commitment and motivation to learn, which are also characteristic of physicians as shown by their multiple years of medical education and life-time participation in continuing medical education (CME).

Moreover, the literature is limited in associating learning theories as a means of impacting physicians’ beliefs, values, and perceptions (Gray, 2007; Lamsa & Sintonen, 2006) and transitioning them from clinicians to leaders. According to Spinelli (2006), there is a need for new points of view in leadership that assist physicians in the current healthcare environment.
By studying physician leaders who have successfully changed their identity (self) to become physician leaders, this study adds to the body of knowledge on physician leadership development.

Problem Statement

In the past, physicians have not been effective transitioning into leadership positions, and healthcare organizations feel a sense of urgency to meet their leadership needs with effective physician leaders now and in the future (McAlearney et al., 2005; Xirasagar et al., 2006). These effective physician leaders need to be able to collaborate on teams, perform interdisciplinary work, and optimize health system performance (Frich, Brewster, Cherlin, & Bradley, 2014). In order to develop physician leaders who can meet these needs, “experts are calling for leadership development to strengthen practicing physicians’ leadership skills and competencies (Frich et al., 2014, p. 656). Recent research suggests, however, that healthcare organizations are approaching physician leadership development using a wide variation of methodologies (Frich et al., 2014). According to a 2014 review of leadership development programs for physicians, “most physician leadership development programs focus on skills training and technical and conceptual knowledge, while fewer programs focus on personal growth and (self) awareness” (Frich et al., 2014, p. 656). This leaves a gap in the literature for more research on leadership development programs that focus on personal growth and self-awareness. This is important to the study of physician leadership development because physician leaders need to meticulously evaluate their values, beliefs, and perceptions pertaining to self in order to make the deep and difficult changes to become effective physician leaders (LeTourneau & Curry, 1997). For the purpose of this study, the term leadership development incorporates attempts to develop individual leaders as well as to build capacity for leadership within an organization (Frich et al., 2014).
The literature indicates that physician leaders should play an increasingly important role in healthcare leadership (Cunningham, 1999; Frich et al., 2014; Kirschman, 1996; Lanier & Rose, 2008; MacNulty & Kennedy, 2008; McAlearney et al., 2005; Manaker & Bahn, 2008; Schwartz et al., 2000; Tomasik, 2008; Zismer & Person, 2008). However, the literature also suggests there is a shortage of effective physician leaders (McAlearney et al., 2005). There is a relationship in the literature between physicians’ sense of self and their success in leadership (O’Neil, 1999; Tomasik, 2008; Zaher, 1997); I sought to explore how an in-house leadership development program affected physicians’ perceptions of their leadership self-efficacy.

Purpose of the Study

The purpose of this case study is to explore physician leadership behaviors, characteristics, and self-efficacy. As a basis for exploring physician leadership and self-efficacy, the study centers on the experiences and viewpoints of physician leaders who were selected by senior executive leaders for their ability to expand their leadership capability and assume leadership roles within the organization in the next 12 to 15 months. This study is conducted through the lens of self-efficacy (Bandura, 1977, 1994; Conner & Norman, 2005; Luthans & Peterson, 2002; Rodebaugh, 2006; Settlage, Southerland, Smith, & Ceglie, 2009; Usher & Pajeres, 2008; Williams, 2011) as it relates to physician leadership. Hence the motivation for this study is to understand how physicians think about their leadership experiences following their participation in a six-month in-house leadership development program. The study also explores at a high level how these experiences influenced physician’s self-efficacy as a first step in developing a theory of physician leadership and self-efficacy.
This study adds to the body of knowledge on a topic that is under-researched but significant given that healthcare organizations feel a sense of urgency to meet their leadership needs by transitioning physicians into leadership positions.

Research Questions

The following questions framed this case study of how physicians think about their leadership experiences following their participation in a six-month in-house leadership development program. This study addresses a need for further understanding of physician leadership. The literature indicates that a physician must transition from clinician to physician leader in order to be effective in healthcare organizations. The transition from clinician to physician leader comes from making deep changes, changing perceptions, making a paradigm shift (Atchison & Bujak, 2001; LeTourneau & Curry, 1997), gaining business knowledge, and acquiring leadership skills (Xirasagar et al., 2006). Learning is a process used by leaders to examine the self and continually challenge their underlying perceptions, assumptions, beliefs, and values. The reflective process can promote deep change and shifts in one’s worldview (Gary, 2007; Lamsa & Sintonen, 2006). This study explores these relationships in physician leadership and adds to the leadership development knowledge base.

Q1. How do physicians describe their post experiences following a 6-month in-house leadership development program?

Q2. Do these experiences influence physicians’ self-efficacy related to leadership?

Definitions of Key Terms

Adult Learning Theory/Andragogy. The art and science of helping adults learn (Knowles, 1980).
Deep change. A process in which an individual mindfully shifts from previous routine thought patterns. It involves embracing a new pattern, as opposed to staying with the old and familiar pattern (Mezirow, 1991).

Deep learning. The process of connecting learning to personal experiences. It occurs when individuals take responsibility for their learning and reflect on their work, measure it against a standard, and continuously improve it (Darling-Hammond, 2008).

Dialoguing. A process of relating to the self through feelings, desires, and interactions with others (Mezirow, 1991).

Identity. The self within every human being that strives to be authentic (Palmer, 2000).

Leaders. Transformational leaders who have demonstrated influence over followers to achieve mutual goals (Bass, 1990a).

Leadership development. Attempts to develop individual leaders as well as to build capacity for leadership within an organization (Frich et al., 2014).

Learning. A change in human behavior or attitudes maintained over a period of time (Gagne & Driscoll, 1988).

Motivation. The catalyst that encourages employees’ eagerness to work in a formal setting without pressure.

Self-awareness. When a person focuses attention on self and evaluates and compares her current behavior to her internal standards and values (Duval & Wicklund, 1972).

Self-Directed Learning. A process by which individuals take the initiative, without the help of others, to organize, execute, and assess their own learning experiences (Knowles, 1975).
Self-efficacy. A person’s belief in his or her own competence to perform tasks and attain goals (Bandura, 1977).

Transformational leadership. Leadership that raises followers to a higher moral or spiritual level where they are sacrificing for a cause beyond themselves (Bass, 1999).

Transformational Learning. Learning that changes the way individuals think about themselves and their world such that the learning involves a shift of consciousness (King, 2000).

Summary

This introduction discussed today’s challenges for healthcare organizations and their desire for leadership at all levels in the organization. One solution they are exploring to address these challenges is physician leadership. This chapter demonstrated the need to study how physicians transition from clinical practice to leadership positions.
CHAPTER 2
LITERATURE REVIEW

Introduction

This literature review draws from the research on American Physician Leadership and self-efficacy. It further demonstrates the necessity of conducting this study with discussions of the historical transformation of American physician leadership, transformational leadership, self-efficacy, motivation, organizational culture, and adult learning as it relates to physician leadership development.

History of Physician Leadership

According to the literature, strong physician authority and leadership started as far back as the 19th century (Minich, 1999). The general public, fellow clinicians, patients, and healthcare administrators viewed physicians as being altruistic in nature and the sole experts when it came to understanding what patients needed (Stone, 1997). Internal forces of education and licensing, as well as external forces of public image, social status, economic freedom, and political power promoted physician authority (Starr, 1982). This further promoted social distancing between physicians and patients with the elevation of the physician as authority and expert.

On the other hand, the social distancing between physicians and their colleagues was lessening due to the standardization of medical education. The result was a stronger, unified profession of physicians who turned their authority into economic and political power. They gained control of their service markets and influenced the bodies that governed medical practices. They claimed adherence to a higher standard that placed them above commercialism and market influences (Starr, 1982). As a result, they claimed that nonprofessionals were not qualified to judge their behavior (Freidson, 1988; Starr, 1982). This resulted in few external
barriers for physicians in how they maintained and operated their medical practices. Historically, unlike other professions, the physician existed at the top of a hierarchy where they influenced others’ actions and few people influenced their decisions and services (Freidson, 1988). This history influenced physician leadership roles, skills, and styles in a particular way that strongly emphasized physician autonomy.

Another influence on physician leadership skills was the relationship between physicians and the AMA. Physicians and the AMA fought to preserve physician autonomy by advocating for the separation of clinical and financial decisions. Specifically, they worked together to insist that physician and hospital benefits, as well as physician reimbursement, remained separate (Minich, 1999). However, the end of the Depression in the USA brought prepaid health insurance to several states. Eventually, millions of Americans would utilize these plans, and the physician/patient relationship changed, and those changes affected the strong sense of autonomy that physicians traditionally had felt.

By the late 20th century, the American public, policymakers, and the insurance industry had started to change their opinions about physicians (Freidson, 1988; LeTourneau & Curry, 1997; Mertz, 2003; Schlesinger, 2002; Starr, 1982). These groups experienced a paradigm shift and no longer believed that physicians were self-sacrificing and independent, or that physicians should exercise influence over them (Ritzer & Walczak, 1988). This, combined with an increase in patient education, resulted in patients challenging physicians’ expertise and wanting greater input into their healthcare decisions (Starr, 1982).

Furthermore, Americans no longer believed in the separation of financial decisions and physicians’ clinical judgment (Stone, 1997). It appeared that the advent of managed care had taken its toll on patient trust in physicians and physician freedoms and on the ability to make
choices (Fisher, 1998). Physicians were now employees of the system, with their power and authority diminished (Fisher, 1998).

Physicians’ reaction to their diminished power and authority was negative and defensive (Crosson, Weiland, & Berenson, 2004). They were dissatisfied with the conflicting obligations of continually seeking a balance between being patient advocates and containing costs, while being monitored by a managed care system. Although physicians are accustomed to disrupted personal lives, long workdays, intense working environments, managing legal risks, and dealing with unknown patient outcomes (Haug, 1998), their dissatisfaction with medical practice has grown as their professional autonomy, power, and authority have diminished (Berenson, Hammons, Gans, & Zuckerman, 2008; Cohn, Friedman, & Allyn, 2007; O’Connor & Fiol, 2006).

In a managed care-dominated environment, physician leadership skills were no longer relevant, and administrators assumed leadership roles (Haug, 1988). Thus, a dichotomy and distrust developed between physicians and administrators as each focused on different goals (Beckham, 1995; McAlearney et al., 2005; Priselac & Grayson, 2007; Zaher, 1996). Administrators focused on solving tomorrow’s problems, imagining and predicting future events, delegating, and valuing teamwork (Guthrie, 1999). Meanwhile, physician leaders were often thought of as being arrogant, insensitive, lacking a vision, and having no business or leadership skills (Bauerschmidt, 2008; Reinertsen, 1998; Zaher, 1996). Additionally, physicians found that the skills that supported their clinical decision making, such as autonomy, gratification, and improvement in patients’ reactive behavior, sometimes interfered with the success of healthcare organizations from an administrative and non-clinical perspective (Arond-Thomas, 2004; Guthrie, 1999; Reinertsen, 1998; Zaher, 1996).
The differences between administrators and physicians have produced negative consequences. For example, communication has become less straightforward and clear. Physicians have received unintended messages from administrators; organizational objectives are not equally important to administrators and physicians; many physicians are convinced that few administrators care as much about patients as they do; physicians do not necessarily see the need for changes in the organization that in the past have diminished physician autonomy; and some organizational objectives are in economic conflict with the individual success of physicians (Guthrie, 1999).

With the shift in leadership going from physicians to administrators, physicians are challenged by their lack of understanding and inclusion in business decisions. In order to transition back into leadership roles, physicians will need to make adjustments in the way they think and what they do. Examples of these adjustments include shifting from an independent role to a dependent role, changing from a controlling position to one of influence, changing from collegial relationships with other physicians to one based on authority, and shifting from medical to business competencies (Zaher, 1996).

Currently, physicians are attempting to regain their power and authority by remaking themselves and redefining their roles as leaders in a complex and continually changing healthcare industry (LeTourneau & Curry, 1997; Martin, 2007; Mertz, 2003; Philips, 2005). The problem is that physicians see themselves as leaders when they lead from a position of authority. Although they are in leadership positions, physicians describe their job as a manager and emphasize that they do not see themselves as leaders (Arond-Thomas, 2004; MacNulty & Kennedy, 2008; Verdone, 2008; Zaher, 1996). Unfortunately for them, gone are the command-and-control days of executive managing by decree (Conger, 1998). An employee in an
organization is not only asking “What should I do?” She is also asking “Why should I do it?” (Conger, 1998). In order for physicians to accomplish their goal of becoming leaders, they will need to embrace leadership as part of their identity and not just a part of their job (Lyons & Ford, 1996).

The literature suggests that new mental models and paradigm shifts are necessary requirements for healthcare leaders (Martin, 2007; McKenna & Pugno, 2006; Plsek & Wilson, 2001; Schwartz et al., 2000; Treister, 1995). As healthcare organizations are fragmented and divided, they need a new type of leader to help them come back together and deliver healthcare as a whole. Physician leaders need to become change agents and position their organizations for sustainability (Bujak, 2008). This will not be easy for physicians, as they must develop business and leadership competencies and make identity and perspective shifts.

The literature states that physician leaders will assume the leadership positions of administrators if they have the right skill set due to their twofold perspective (LeTourneau & Curry, 1997; Shannon, 2008a). For this to transpire, physicians must undergo a behavioral change that takes place in a leadership development class (Tremblay, 2001; Williams, 2001). However, many physicians bring attitudes of anger and oppression to leadership development classes (Cunningham, 1999).

Leadership development training and experience are necessary for physician leaders because of (a) the complexity of healthcare organizations and current healthcare climate, (b) physicians’ disinclination toward followership and collaboration, (c) the traditional practice of promoting physicians to leadership positions based upon clinical/academic skills, and (d) inattention to training physicians in leadership competencies (Stoller, 2008). The competencies that should be developed in leadership development programs for physicians include (a) expert
assessments of individual physicians’ challenges, typically in the form of 360-degree feedback and the needs of the healthcare environment, (b) reported failures of existing physician leaders, (c) and surveys of existing and aspiring physician leaders (Stoller, 2008). Additionally, there are six domains of physician leadership that should be included: (a) technical knowledge and skills (operations, finance, information technology, human resources, strategic planning, legal); (b) knowledge of healthcare (reimbursement, legislation/regulation, quality); (c) problem solving; (d) emotional intelligence; (e) communication (in leading change, negotiation, conflict resolution); and (f) commitment to lifelong learning (Stoller, 2008). Furthermore, leadership development programs should be uniform in design, long term, and as rigorous as residency training to develop the caliber of physician leaders needed (Birrer, 2002; Schwartz et al., 2000).

Often physicians attend external programs to learn leadership competencies. Institutions providing certification in physician leadership development include the American College of Healthcare Executives, the Medical Group Management Association Educational Programs, the National Center for Healthcare Leadership, and various seminars and resources (Rice, 2009). However, physicians who attend external programs often lack relevant skills needed to connect effective decision making and ongoing quality improvement because the education does not combine leadership development and training pertaining to context-specific actions, procedures, and policies (Schwartz et al., 2000). Leadership development goals that link learning and action facilitate transformational change; therefore, any knowledge-based learning outside of the organizational context rarely results in long-lasting change (McAlearney et al., 2005). Learning needs should be associated with the context, and in-house leadership development programs can provide these links. Healthcare organizations with internal physician leadership development
programs include Cleveland Clinic, Mayo Clinic, Aucra Health (South Dakota), University of Kentucky, Cone Health, and Medical College of Wisconsin (Stoller, 2008).

Leadership training is most effective when it includes training with ongoing assessment and regular measurement (McCauley et al., 2004). In-house programs allow for short learning sessions related to real world experience and help physicians manage their time more effectively (Rice, 2009). Additionally, research evaluating in-house and external programs suggests that in-house programs increase the collegial climate within organizations (Scott, Tangelos, Blomberg, & Bender, 1997). Collaboration between physicians and administrators can also be increased by appealing to the physician’s need to do the right thing and by eliminating resistance by sharing data (Lee, 2010).

The research indicates that leadership development programs for physicians can be effective; however, they need to facilitate deep changes (LeTourneau & Curry, 1997). Physicians need to change from an identity of autonomy and seeing themselves as the patient’s sole advocate to being part of the system of care (Lee, 2010). Additionally, they need assistance with letting go of the need to be perfect, resistance to being measured, reluctance to criticize colleagues, and resistance to engage in teamwork (Lee, 2010). For physicians to transition from clinicians to physician leaders, “doctors must accept that being all-caring is different from being all-knowing or all-controlling” (Lee, 2010, p.58). This can be a challenge for physicians. Physicians require individualized leadership development because of the unique social and cultural differences among them. Physician leaders face unique obstacles to success in the role of leaders because of their professional selection, socialization, and medical education. Much physician leadership talent goes untapped and underdeveloped, and institutions still have room to improve the quality of their physician leadership development programs (Guthrie, 1999).
The literature indicates that becoming an effective physician leader requires healing and a care process; understanding the mission of medicine; sharing values of fellow physicians; being driven by the need for excellence; understanding that the whole organization must work together with shared goals/vision; being able to see the whole healthcare system; and being drawn to the possibility of helping many people, not just one person at a time (Guthrie, 1999).

When faced with demands on their time, physicians are often resistant to leadership development because they lack a basic understanding of its importance (Lee, 2010). What types of leaders make these changes? According to Guthrie (1999), they are physicians who want to make a difference and are determined to embrace the challenge. Additionally, these physicians are more willing to make individual changes that affect their self-perception and the perceptions of them held by others. The literature indicates that to succeed in these aspirations, physician leaders need to embrace medical, business, and leadership training (Guthrie, 1999; LeTourneau & Curry, 1997; Lloyd & Lyons, 1995; Zaher, 1996) and become effective transformational leaders (Gabriel, 2008).

Transformational Leadership

Although there are several theories on leadership in the literature, in this study the focus is on transformational leadership, as that appears to be the most promising area to pursue with regard to physician leadership given the realities of modern healthcare practice in the USA. The concept of transformational leadership was first introduced in the literature by Burns (1978) in his descriptive research on political leaders. Bass (1985) is credited with extending the theory by developing measures and metrics to determine the effect of transformational leadership on motivation and performance. The theory has been researched hundreds of times by additional
theorists (e.g., Bass & Steidlmeier, 1999; Chen & Silverthorne, 2005; Fanelli & Misangyi, 2006; Judge & Piccolo, 2004).

Transformational leadership is defined as leadership that raises followers to a higher moral or spiritual level where they are sacrificing for a cause beyond themselves (Bass, 1999). Common denominators and similar themes and patterns overlap in the transformational leadership model. Most models recognize leadership characteristics such as charisma (Baker, 2006; Bass, 1990a; Conger & Kanungo, 1987; McLaurin & Al Amri, 2008), communication (Bass, 1990a; Bueno & Tubbs, 2004), confidence (Kouzes & Posner, 2003), trustworthiness (Avolio & Reichard, 2008; Kouzes & Posner, 2007) and vision (Bass & Steidlmeier, 1999; Conger & Kanungo, 1987; Sashkin & Sashkin, 2003) as key characteristics of transformational leadership.

Transformational leadership is the ability to get people to want to change, to improve, and to be led. It involves assessing employees’ motives, satisfying their needs, and valuing them (Northouse, 2001). According to Bass (1999), transformational leaders achieve change by using one or a combination of individualized consideration, intellectual stimulation, inspirational motivation, and idealized influence to motive followers to set aside individual or short-term interests and work together toward a group goal.

Individualized consideration is the caring of a leader (Bass, 1999; Coad & Berry, 1998). It describes managers who act as coaches and advisors to employees. It facilitates personal attention, mentoring, listening, and empowerment. Transformational leadership also involves offering support and encouragement to individual followers. In order to foster supportive relationships, transformational leaders keep lines of communication open so that followers feel
free to share ideas and so that leaders can offer direct recognition of each follower’s unique contributions.

Intellectual stimulation is the thought-provoking mindset of a leader (Bass, 1999). It describes managers who encourage innovation and creativity through challenging the normal beliefs or views of a group. It facilitates critical thinking, rationality, and problem solving. Transformational leaders not only challenge the status quo, they also encourage creativity among followers. The leader encourages followers to explore new ways of doing things and new opportunities to learn.

Inspirational motivation is the inspiration of a leader (Bass, 1999). It describes managers who motivate associates to commit to the vision of the organization. It facilitates commitment to goals, communication, and enthusiasm. Transformational leaders have a clear vision that they are able to articulate to followers. These leaders are also able to help followers experience the same passion and motivation to fulfill these goals. The transformational leader serves as a role model for followers. Because followers trust and respect the leaders, they emulate the leaders and internalize their ideals.

In the literature, there are several advantages of transformational leadership listed, such as improved leadership behavior, greater sense of team, stronger sense of mission, improved individual and group performance, more innovation, and growth as an organization (Bass, 1999). However, the literature lists weaknesses of transformational leadership, including its potential for abusing power (Sashkin & Sashkin, 2003; Yuki, 2006). The use of transformational leadership depends on the individual (Bass, 1999). It is time consuming, and transformational leaders must invest time and energy into building trust and convincing followers to believe in a shared vision (Bass, 1999). In addition, transformational leadership assumes follower motivation to work
together toward a larger goal (Bass, 1999). Transformational approaches are not as effective in situations where followers do not have the skills or experience necessary to complete a task or are not motivated to perform without an immediate and tangible reward.

Self-Efficacy

Bandura’s (1977) theory of self-efficacy refers to a person’s belief in his or her own competence to perform tasks and attain goals. Bandura hypothesized, “expectations of personal efficacy determine whether coping behavior will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences” (p. 191). In essence, the concept of self-efficacy states that an individual’s ability to achieve a goal is directly related to whether or not the individual believes that he or she can achieve the goal (Bandura, 1994). In most cases, the higher the individual’s self-efficacy, the more likely it is that he or she will achieve a goal. Similarly, individuals with low self-efficacy are likely to struggle to attain goals (Bandura, 1977). Self-efficacy beliefs can be used as predictors to determine whether or not an individual will engage in a particular goal and to what degree the individual will persevere and achieve said goal (Bandura, 1977; Luthans & Peterson, 2002).

Bandura (1977) hypothesized that personal efficacy expectations come from four information sources: “performance accomplishments, vicarious experience, verbal persuasion, and physiological states” (p. 191). Performance accomplishment (participant modeling) has the greatest effect on self-efficacy, as repeated successes or failures may raise or lower personal expectations (Bandura, 1977). Vicarious experience refers to personal witness of task attainment by others (modeling), and verbal persuasion refers to attempts by others to influence an individual’s behavior through suggestion (Bandura, 1977). Physiological state refers to the amount of stress, fear, and anxiety that an individual exhibits in the consideration of a particular
task or goal. Fear of failure can create elevated anxiety levels, which may hinder an individual’s ability to accomplish a task (Bandura, 1977; Usher & Pajares, 2008).

The aforementioned sources, in varying combinations and degrees, can influence an individual’s self-efficacy (Bandura, 1977). Individuals will “avoid threatening situations they believe exceed their coping skills [yet will] get involved in activities and behave assuredly when they judge themselves capable of handling situations that would otherwise be intimidating” (Bandura, 1977, p. 194). Researchers have leveraged self-efficacy sources to influence an individual’s performance and goal attainment, particularly in the areas of health behavior (e.g., smoking cessation and dieting) and academic achievement (Conner & Norman, 2005; Usher & Pajares, 2008).

Conflicting self-efficacy research has indicated that individuals with high self-efficacy may overestimate their abilities to attain goals and may experience failure, whereas those with low self-efficacy may feel motivated to achieve tasks or goals and may experience success even when they are not confident in their abilities (Jernigan, 2004; Settlage, Southerland, Smith, & Ceglie, 2009). Other researchers have found that self-efficacy was not an accurate predictor of socially oriented behavior (such as public speaking). There are ongoing debates in the field regarding the relationship between outcome expectancies (what an individual believes will happen as a result of his or her behavior) and self-efficacy (Rodebaugh, 2006; Williams, 2010).

Physicians who avoid perceived threatening relational or communicative situations with others may believe these interactions exceed their coping skills. In the meanwhile, they do not hesitate to engage in life-or-death clinical activities, and they behave assuredly as they judge themselves capable of handling clinical situations that would otherwise be intimidating to the average person. The proposed study of how physicians think about their leadership experiences
following their participation in a leadership development program will shed some light on how to build physician leadership. Also, the proposed research may reveal how a physician’s perception of leadership self-efficacy manifests.

Motivation

Unfortunately, many physicians have a negative opinion of their ability to lead and affect employee motivation (Arond-Thomas, 2004). Gone are the command-and-control days during which they managed by decree (Conger, 1998). An employee in an organization is not only asking, “What should I do?” but also “Why should I do it?” (Conger, 1998). This is where motivation and leadership come into play. Motivation can be used to answer both questions. Motivation is the catalyst that encourages employees’ eagerness to work in a formal setting without pressure. To motivate is to provide employees with a motive to do some tasks. It is to cause or provoke somebody to act either positively or negatively.

Physicians in leadership roles greatly misunderstand and underuse motivation. However, employees’ performance has been directly linked to employees’ motivation and is affected by leaders. It has been established in the literature that employees are not motivated by salaries and wages alone (Pink, 2011).

Furthermore, healthcare organizations can no longer grow with unmotivated, underutilized, and underperforming employees. Healthcare is a constantly changing environment, and the working conditions are increasingly becoming demanding and stressful (Holden et al., 2011). Several studies focusing on healthcare organizations have revealed that employees are exposed to a variety of severe work-related stressors, such as time pressure, low supportive social networks at work, high workloads, uncertainty regarding patient treatment, and a tendency to experience emotional responses due to contact with suffering and dying patients.
(Holden et al., 2011). In turn, this could affect employees’ performance, which has been found to be directly related to employee motivation.

Leaders know that motivated employees are needed to stay competitive. However, leaders also believe that in these difficult economic times, some employees lack motivation. One culprit is low morale due to company layoffs, reorganizations, and increased workloads for the employees who remain. A solution for combating employees’ lack of motivation is job enrichment, which provides the opportunity for employees’ psychological growth (Herzberg, 1987). Job enrichment does not merely make a job structurally bigger (Herzberg, 1987). Job enrichment can be summed up quite simply as follows:

If you have employees on a job, use them. If you can’t use them on the job, get rid of them, either via automation or by selecting someone with lesser ability. If you can’t use them and you can’t get rid of them, you will have a motivation problem (Herzberg, 1987 p. 10).

Employees’ motivation can be increased by getting them to feel more positive about their jobs (Herzberg, 1987). In a controlled study conducted by Herzberg (1987), the group of employees introduced to a motivator became more positive about their jobs, whereas the attitude of the control unit remained about the same.

Factors that affect motivation for one employee or a group of employees may not affect others. For employees to be fully motivated, leaders must be aware that human beings have different needs that motivate them in the workplace. Maslow (1943) said that people work to survive and live through financial compensation, to make new friends, to have job security, for a sense of achievement and to feel important in society, to have a sense of self, and to have job satisfaction. These factors are important because the literature has supported a relationship between job satisfaction and high performance in the workplace.
Motivating employees requires leaders to recognize and understand what needs employees’ desire from the workplace in order for them to be motivated to do their best work. Leaders can adequately motivate employees if they use observations, questioning, and/or direct interaction to uncover their needs and motivations. Motivation to some people means an excellent salary; to others, motivation means working in a neat and comfortable environment; whereas some employees are best motivated by having a sense of belonging and having opportunities for job enrichment. Whatever their motivation, motivated employees add value to the workplace.

Organizational Culture

Recruiting and retaining motivated employees, investing in new programs, and improving existing services are all driven by organizational culture. Organizational culture also drives better clinical and financial outcomes in healthcare organizations. Importantly for physician leaders, not creating a positive organizational culture can have detrimental effects on individual and organizational performance and contribute to burnout in these difficult economic times.

There are many ways to define organizational culture because it is influenced heavily by factors such as the industry in which the company operates, its geographic location, events that have occurred during its history, the personalities of its employees, and their patterns of interaction (Sadri & Lees, 2001). Ott (1989) identified over 70 different words or phrases used to define organizational culture. Jacques (1952) first defined organizational culture as the customary and traditional way of doing things, a way shared to a greater or lesser degree by all members, and a way that the new members must learn and at least partially accept in order to be accepted as members of the organization.
Harrison (1972) focused more on culture itself rather than on its effects. Harrison defined culture as a set of ideologies, beliefs, and deep-set values that occur in all firms and are prescriptions for the ways in which people should work in these organizations. Peters and Waterman (1984) saw culture as a dominant and coherent set of shared values conveyed by symbolic means such as stories, myths, legends, slogans, anecdotes, and fairy tales. Deal and Kennedy (1982) defined organizational culture as the way things get done in a particular organization. Schein (1990) described organizational culture as “a pattern of basic assumptions—invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration” (p. 109). Wiener (1988) claimed that “most researchers of organizational culture agree that shared values are a key element in the definition of culture” (p. 534). Some more recent formal definitions of culture include “a cognitive framework consisting of attitudes, values, behavioral norms, and expectations” (Greenberg & Baron, 1997); “the collective thoughts, habits, attitudes, feelings, and patterns of behavior” (Clemente & Greenspan, 1999); and “the pattern of arrangement, material or behavior which has been adopted by a society (corporation, group, or team) as the accepted way of solving problems” (Ahmed et al., 1999).

In more practical terms, organizational culture typically encompasses several key elements. First, culture includes a mission statement and corporate vision, which together form a mental picture of the company’s desired future (Qubein, 1999). Second, culture includes a shared pattern of values and beliefs that are consistent with the purpose of the company and align with the personal values of organizational members (Qubein, 1999). Third, organizational culture involves employees who are highly valued at all levels of the organization, and among whom there is extensive employee interaction both within and across functional departments.
(Clemente & Greenspan, 1999). Fourth, an organizational culture is adaptable; adjusting quickly in response to external conditions, and is consistent, treating all employees equally and fairly (Ahmed et al., 1999). Fifth, organizational culture is perpetuated through tangible symbols, slogans, stories, or ceremonies that highlight corporate values (Greenberg & Baron, 1997). The above mentioned characteristics set the expectations that influence and guide the thinking and behaviors of the employees of an organization. The employees of an organization also shape the organizational culture.

Organizational culture has many dimensions and variations (Skerlavaj et al., 2007). In order to provide a basis for further analysis, researchers have sought to place organizational culture into general categories (Sadri & Lees, 2001). According to one such categorization (Goffee & Jones, 1996), organizational culture is determined by levels of sociability (a measure of sincere friendliness among members of a community) and solidarity (a community’s ability to pursue shared objectives quickly and effectively). According to Goffee and Jones (1996), these dimensions combine to form the following categories:

- **Networked** – distinguished by high sociability and low solidarity. Individuals feel like family and socialize often. Promotions are achieved and work is accomplished via informal networks or subcultures within the organization.

- **Mercenary** – characterized by low sociability and high solidarity. Individuals do not interact socially but are united in supporting strategic business objectives. Employees do not tend to exhibit a strong degree of loyalty, staying only as long as their personal needs continue to be met.
- Fragmented – described as having low sociability and low solidarity. People in this type of organization rarely interact. Employees commonly work with their office doors shut or from home.

- Communal – displaying high sociability and high solidarity. Members work closely together for long hours and are likely to socialize together. These employees strongly identify with the organizational culture and have a high sense of fairness, so that rewards are shared equally.

None of these categories are considered better than the others. Each serves as a way for leaders to determine where the culture fits relative to other types of cultures (Goffee & Jones, 1996).

Most researchers have agreed that culture in an organization is a combination of different cultural orientations, although usually one type is more dominant than the others (Skerlavaj et al., 2007). Although there is a consensus that organizational culture is critical in any change initiative, no such consensus exists as to what type of organizational culture best supports business transformation (Skerlavaj et al., 2007). Prajogo and McDermott (2005) presented findings that indicated that an organization can implement different, even opposite, culture types, in harmony. These findings lead to the question of which combination of culture types is most appropriate for business process change in organizations (Skerlavaj et al., 2007).

Theories of Adult Learning

Physician leaders need to learn to become change agents and position their organizations for sustainability (Bujak, 2008). This will not be easy for physicians, as they must develop business and leadership competencies and make identity and perspective shifts. One way that healthcare organizations are attempting to assist physicians in making these shifts is through
leadership development and learning. According to Gagne’s learning theory (Gagne & Driscoll, 1988), learning can be described as a change in human behavior or attitudes maintained over a period of time. Interested parties who seek to understand learning by adults may consider the following three theories of adult learning for review: (a) Knowles’ (1980) adult learning or andragogy, (b) Knowles’ (1975) self-directed learning (SDL), and (c) transformational learning (TL). These three theories are compared and contrasted, and the five characteristics of adult learners, based on Knowles (1980) principle of andragogy, are reviewed as they pertain to physician leadership development.

**Adult Learning Theory (Andragogy)**

To document differences between the ways children and adults learn, Knowles (1980) disseminated the concept of andragogy, which is the art and science of helping adults learn. According to Knowles, five key principles affect the way adults learn:

- **Self-directedness**: As people mature, they develop a need to move from dependency to awareness that they can direct their own learning.
- **Prior experiences**: As people mature, they desire to use their accumulated reservoir of life experiences as a resource for learning.
- **Readiness to learn**: As people mature, they are motivated to learn as they experience needs and interests that learning will satisfy.
- **Problem-centered**: As people mature, their desire to learn is problem-centered and they seek knowledge they can use immediately.
- **Motivated to learn**: As people mature, they are motivated by internal, rather than external, factors.
Knowles (1984) states that Andragogy has the following implications for practitioners and educators who teach adult learners:

- In the classroom, set a cooperative climate.
- Take the time to assess the learner’s specific needs and interests.
- Based on the learner’s needs, interests, and skill levels, develop learning objectives.
- To achieve the objectives, design sequential learning activities.
- Work collaboratively with the learner to select methods, materials, and resources for instruction.
- While assessing needs for further learning, evaluate the quality of the learning experiences and make adjustments as needed.

Self-Directed Learning (SDL)

Cross (1981) indicated that approximately 30 percent of adult learning is not self-directed. According to Knowles (1975), SDL is when individuals initiate, without the help of others, the organization, execution, and assessment of their own learning experiences. In brief, self-directed learning encourages students to engage learning in a deep and meaningful manner outside of the classroom. The student makes the decisions about the content, methods, resources, and evaluation of the learning. However, these decisions are not made in isolation. These learning decisions are made with the assistance of instructors. The challenge for instructors is to work with students to create a shared purpose for learning (Thomas & Harri-Augstein, 1985).

There are several strategies for instructors who are facilitating SDL, including the following:

- Determine appropriate learning objectives by conducting a self-assessment of skill levels and needs.
• Provide guidance for the starting point for a learning project.
• Align resources (books and articles) and the appropriate methods (Internet searches and lectures) with the learning goal.
• Agree on a learning contract that sets learning goals, strategies, and evaluation criteria.
• Develop strategies for decision making and self-evaluation of work.
• Keep a positive and can-do attitude relative to self-directed learning.
• Take time to reflect on what is being learned.

Transformational Learning (TL)

TL is learning that involves a shift of consciousness as learners change the way they think about themselves and their world (King, 2000). How to interpret TL depends on the theorist whose lens is being used.

One such theorist is Freire (2000), who engaged Brazilian workers about working conditions and poor compensation and taught them how to read. At the same time, Freire helped these workers to change their thinking and to strive for social change.

Another theorist, Mezirow (2000), explained TL as a rational process whereby individuals reflected on and discussed their assumptions about the world. As part of this rational process, learners often experienced a shift in their frame of reference or worldview.

Adult learning theory/andragogy, SDL, and TL all indicate frameworks that practitioners and educators may use (a) to provide insights into how adults learn, (b) to be more effective in the classroom, and (c) to be more responsive to the needs of their adult learners. There are inherent similarities and differences in the three theories. In sum, adult learning theory/andragogy is “the art and science of helping adults learn” (Knowles, 1980). SDL is “a process by which individuals take the initiative, without the help of others,” to organize, execute,
and assess their own learning experiences (Knowles, 1975). Finally, TL is often described as learning that changes the way individuals think about themselves and their world such that the learning involves a shift of consciousness (King, 2000).

In regard to how adults want to learn, adult learning theory/andragogy and SDL can both be easily incorporated into adult learners’ daily routines. These forms of learning occur at the learners’ convenience and according to their personal preferences. In addition, both adult learning theory/andragogy and SDL share a similar criticism. Brookfield (2000) referred to adult learning theory/andragogy as “culture blind.” The concept of self-directed learning and the concept of non-threatening relationships between students and teachers may not fit comfortably in all cultures. In some cultures, the teacher is valued as the primary source of knowledge (Brookfield, 2000). Similarly, TL has been criticized for neglecting a learner’s race, class, and gender, as well as the historical context in which the learning occurs (Taylor, 2000).

**Characteristics of Adult Learners**

By their nature, the lives of adult learners are increasingly busy. As such, adult learners seek convenient opportunities to continue their education and development. An adult learner can be characterized as an individual who (a) has been out of school from school more than 4 years; (b) is a member of the U.S. armed forces; (c) is over 23 years of age; or (d) performs multiple roles such as parenting, working, taking care of the home and/or children, studying, and caring for the elderly (Pennsylvania State University, 2005).

Adult learners usually bring a degree of work experience and maturity to their learning environment. They are experienced with life circumstances and typically know more about themselves and interpersonal communication than their younger counterparts (Moore & Kearsley, 2011). The adult learner also exhibits a high degree of commitment and motivation to
learn, which are also characteristic of physicians, as evidenced by their multiple years of medical education and life-time participation in continuing medical education (CME).

Summary

This chapter demonstrated the necessity of conducting this study with discussions of the historical transformation of American physician leadership, transformational leadership, self-efficacy, motivation, organizational culture, and adult learning as they related to physician leadership development. This research informed the methodology of the study.
CHAPTER 3
RESEARCH METHODOLOGY

A qualitative case study was conducted to determine how an in-house leadership development program affected physicians’ perceptions of their leadership self-efficacy. A qualitative approach was selected for the study, as qualitative research “is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem…[It] involves emerging questions and procedures, [and] data analysis inductively build[s] from particulars to general themes” (Creswell, 2009, p. 4). The study was aligned with this definition, as the research focused on the human problem of physicians not transitioning into leadership and of their self-efficacy. A qualitative case study may be able to indicate the meaning individuals attribute to this problem.

A case study is a type of qualitative strategy and can be defined as “an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (Yin, 2009, p. 18). The design of this case study relied on the methodology described by Yin (1994), which is considered the research standard for this exploratory methodological approach. Physician leadership development programs are promising programs for producing physician leaders. However, physicians with previous negative relationship/teambuilding and communication experiences are likely to struggle in these programs. Fear of failure or other compounding factors may cause physicians to be unsuccessful in transitioning from clinicians to leaders.

As the focus of the proposed study was on the contemporary phenomenon of physician leadership and self-efficacy within the real-life context of an in-house leadership development program, a case study approach was appropriate for this research. The literature advocated for a
case-study approach to understanding physician leadership and self-efficacy as facilitated by an in-house leadership development program as cases are often intricately tied to political, social, historical, and personal contexts. An effective case study can capture all the details that make a case unique.

The case study was instrumental in nature, meaning the study was used to understand something else related to the case (Stake, 1995). To this effect, the case study was used to understand how physicians think about their leadership experiences following their participation in a six-month in-house leadership development program. The study also explored at a high level how these experiences influenced physicians’ self-efficacy as a first step in developing a theory of physician leadership and self-efficacy.

The study was constructed as a single-case, holistic design with a single unit of analysis (Yin, 2009). The following rationales justify a single case design: (a) the case was critical in testing a well-formulated theory, which in this study was Bandura’s (1977) theory of self-efficacy; and (b) the environment was unique and an extreme situation (e.g., oncology specialty clinic) (Yin, 2009). The single unit of analysis included physicians who completed leadership development program activities and were promoted to leadership positions at the center for oncology.

Suggested ways to bind the case include (a) by time and place (Creswell, 2009); (b) by time and activity (Stake, 1995); and (c) by definition and context (Miles & Huberman, 1994). To ensure that the study remained reasonable in scope (Yin, 2009; Stake 1995), boundaries were established in several ways, including studying physicians’ experiences in the first six months following a single leadership development program at a center for oncology in south metro Atlanta. The following case study design components were incorporated into the study: study
questions, propositions, unit of analysis, logic linking data to the propositions, and criteria for interpreting findings (Yin, 2009).

Case study design has inherent strengths and weaknesses. Case study research is subject to criticism because methods for collecting and reporting data may not follow a systematic, scientific process, may lack rigor, or may provide little basis for generalization. Additionally, case studies may be presumed to take an extensive amount of time to conduct (Yin, 2009). Case study strengths include the researcher’s ability to investigate complex human phenomena, while retaining “the holistic and meaningful characteristics of real-life events” (Yin, 2009, p. 4). In this study, the focus was on complex human phenomena involving leadership development for physicians with regard to their self-efficacy and transformational leadership behaviors and characteristics.

In order to further elaborate, this chapter contains a brief discussion of qualitative methods in general and how they are contrasted with quantitative methods. Next, there is a discussion of grounded theory and its application in this specific study. Finally, there is a description of the participants and procedures for data collection and data analysis for this study.

Qualitative Methods

Qualitative research may be traditionally associated with interviews and observations; however, there are empirical materials that can be gathered and analyzed using statistical methods. The goal of qualitative research is not associated with prediction and control but rather is used to further illustrate the phenomenon in question. Thus, various methods may be used in qualitative research, such as rich descriptions and the reliance on words of the participants to allow their voice to make meaning of the phenomenon. The researcher is not the only person
making meaning of the data; rather, the participants in the study have a voice, and the end-
consumers make meaning for themselves.

Qualitative research also has inherent strengths and weaknesses. Critics of qualitative research believe that quantitative, experimental research design is the gold standard and the generally preferred research methodology (Trochim & Donnelly, 2008). Critics may regard qualitative research as less rigorous, as conclusions are based on researchers’ interpretations versus more objective data analysis of quantitative research (Cozby, 2009). On the other hand, quantitative research processes are limited in terms of depth of inquiry, whereas qualitative research provides a search for deep understanding that often “involves emerging questions and procedure” (Creswell, 2009, p. 4). These questions and procedures are not easily accommodated by quantitative methods, and they can then provide the basis for follow-up quantitative studies.

Quantitative data do not readily provide rich, detailed descriptions or elaborations on the nuances that provide insight into various situations and phenomena. Often, a quantitative study fails to establish a significant difference, and qualitative data is needed to explain why no significant differences were found. In other cases, a qualitative study is needed in order to understand which factors and variables might be worth studying in a rigorous experimental study, as this is not always known when investigating a new area.

Grounded Theory

Strauss and Corbin (1998) outline techniques and procedures for developing grounded theory, which informed the data collection and analysis of this study. Data were collected through interviews, observations, and document reviews in the field. The procedures are described below.
As conceived by Strauss and Corbin, grounded theory entails gathering data, using various coding procedures to analyze it, developing key concepts, and theorizing, as an iterative process that takes place concurrently. Data are collected using methods familiar to most qualitative researchers. The design of this study relied on the methodology described by Strauss and Corbin (1998), which is considered the research standard for this exploratory methodological approach. A grounded theory approach was appropriate for this research, as the focus of the study was on the contemporary phenomenon of physicians’ perceptions of their leadership self-efficacy following the real-life context of an in-house leadership development program.

According to Strauss and Corbin, at the start of the study, the researcher collects the data through various methods including observations, interviews, program artifacts and documents. Next, the researcher undertakes microanalysis, which is the line-by-line coding of data text in order to generate initial categories and their properties and dimensions, and to suggest the relationships among the categories (p. 57). Categories are phenomena, such as problems, issues, events, or occurrences that are important to participants. This process consists of a combination of two procedures, open coding and axial coding. Open coding is the initial development of categories. Axial coding is the act of relating categories to subcategories along their properties and dimensions. Subcategories answer questions about categories, such as who, what, when, where, why, how, and with what consequences. As the research progresses, one category will emerge that seems to relate to all others. It will occur in most observations, and it will be the integrative category for the research. This will be the central category, which frames the writing and encompasses the other categories that arise from the data.

This study met the four principles that guide grounded theory research: (1) the study captured the inherent complexity of social life by elaborating upon a well-formulated theory,
which in this study was Bandura’s (1977) theory of self-efficacy, to discover and articulate core themes and patterns among them that helped me to understand how physician leaders think about physician leadership and leadership self-efficacy following their participation in an in-house leadership development program; (2) I interacted deeply with the data by carrying out a detailed investigation that included observations, interviews, program artifacts, physician stories, and survey findings that conveyed social action to uncover “what was going on” in the unique environment of the oncology specialty clinic; (3) the research tasks of planning the study, gathering the data, analyzing the data, and writing it up were intertwined in a way that honed insights that could plausibly represent some aspect of social life, were useful in that they articulated dynamics that were previously hidden from view, and had the potential for further elaboration of physicians’ perceptions of their leadership self-efficacy (Strauss, 1987); (4) the study provided a unique insight into organizational life for physicians at an oncology specialty clinic.

Participants (Unit of Analysis)

A grounded theory approach uses a form of purposive sampling, known as theoretical sampling, where participants are selected according to criteria specified by the researcher and based on initial findings. This study included 10 participants who graduated from an in-house physician leadership development program 10 months prior at the Southeast Cancer Center¹, a center for oncology in south suburban Atlanta. Participants’ names were replaced with code numbers to ensure their anonymity. The 10 participants were assigned the numbers P01 – P10. The codes for the same 10 participants of the second-round interviews followed the same system, starting with number P01.

¹ Names of persons and institutions have been changed to preserve anonymity in accordance with the Institutional Review Board requirements for this study.
Participants were 10 autonomous physicians, eight male and two female, who opted to attend a voluntary leadership development program and provided informed consent. A non-technical, jargon-free informed consent form shown in Appendix C was provided to participants and included: the study’s purpose and procedures, information on deception, participation requirements, the names and numbers of research personnel, compensation information, potential risks and benefits of participation, clarifications of anonymity/confidentiality procedures, and information regarding the participant’s right to withdraw from the study (Cozby, 2009).

The proposed study took place with physicians involved in a leadership development program at Southeast Cancer Center. As such, the potential for psychological stress, fear, and anxiety was possible as sensitive issues (personal failures, burnout and compassion fatigue) could have surfaced during the data collection processes. Stress could have been compounded by the presence of research personnel. An elaboration of participant demographics is displayed in Table 1 below.

Table 1

**Participant Demographic Data**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Married</th>
<th>Age</th>
<th>Experience</th>
<th>Management Level</th>
<th>Direct Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>P01</td>
<td>1</td>
<td>Yes</td>
<td>32</td>
<td>7</td>
<td>Director</td>
<td>2</td>
</tr>
<tr>
<td>P02</td>
<td>1</td>
<td>Yes</td>
<td>56</td>
<td>28</td>
<td>Self</td>
<td>0</td>
</tr>
<tr>
<td>P03</td>
<td>1</td>
<td>Yes</td>
<td>62</td>
<td>22</td>
<td>Director</td>
<td>0</td>
</tr>
<tr>
<td>P04</td>
<td>1</td>
<td>Yes</td>
<td>44</td>
<td>17</td>
<td>Chief</td>
<td>12</td>
</tr>
<tr>
<td>P05</td>
<td>1</td>
<td>Yes</td>
<td>61</td>
<td>11</td>
<td>Director</td>
<td>0</td>
</tr>
<tr>
<td>P06</td>
<td>1</td>
<td>Yes</td>
<td>46</td>
<td>6</td>
<td>Director</td>
<td>0</td>
</tr>
<tr>
<td>P07</td>
<td>1</td>
<td>Yes</td>
<td>48</td>
<td>16</td>
<td>Director</td>
<td>0</td>
</tr>
<tr>
<td>P08</td>
<td>1</td>
<td>Yes</td>
<td>49</td>
<td>11</td>
<td>Chief</td>
<td>1</td>
</tr>
<tr>
<td>P09</td>
<td>1</td>
<td>Yes</td>
<td>43</td>
<td>11</td>
<td>Chief</td>
<td>1</td>
</tr>
<tr>
<td>P10</td>
<td>1</td>
<td>Yes</td>
<td>57</td>
<td>25</td>
<td>Director</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>2</td>
<td>154</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To mitigate harm, Yin (2009) explains that qualitative researchers should provide additional, personalized attention to participants. Yin further explains that qualitative methodology is not as structured as other research methods and may involve both direct contact with participants as well as the use of personal records.

The study debriefing included the 10 participants. All parties were reassured that all study data would remain confidential. Participants were informed of withheld information (e.g., the study’s theoretical framework and data collection on physician self-efficacy).

Procedures

The following procedures were used to collect empirical data: interviews, observations, and documents. Data collection and analysis took place over a six-month period and involved multiple sources of evidence in several stages and in alternating sequences. This was an important and beneficial element of using a grounded theory approach. Description of time line, data collection and analysis, method and reflection tool are displayed in Table 2.

Table 2

*Data Collection and Analysis Phases*

<table>
<thead>
<tr>
<th>Time Line</th>
<th>Data Collection</th>
<th>Data Analysis</th>
<th>Method</th>
<th>Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>October and November 2015</td>
<td>Initial Interviews - Conduct and transcribe (10) 1-hour semi-structured physician interviews</td>
<td>Open Codes</td>
<td>Constant Comparison Method Open coding</td>
<td>Memo Writing</td>
</tr>
<tr>
<td></td>
<td>Observation - Observe 10 participants during 2-day leadership retreat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December - March 2016</td>
<td>Follow-up Interviews - Conduct and transcribe (10) 1-hour in-depth physician interviews</td>
<td>Axial Codes</td>
<td>Axial coding</td>
<td>Memo Writing</td>
</tr>
</tbody>
</table>
The Southeast Cancer Center sponsored the physician leadership development program, and course materials were provided by Development Dimensions International and consultants. Contact was made in person with the Assistant Vice-President, Talent, and the Chief Operating Officer of Southeast Cancer Center which provided leadership development programs for high-potentials, front-line managers, managers of managers, and executives, but the physician leadership development program was open to only physicians. A request was made to conduct face-to-face interviews with participants who successfully completed an in-house physician leadership development program in an attempt to understand how physicians think about their leadership experiences and to explore how these experiences influence physicians’ self-efficacy as a first step in developing a theory of physician leadership and self-efficacy.

The request was received favorably, and a subsequent request was made to the University IRB for approval to conduct this study. The approved IRB is shown in Appendix I.

Once approval was granted, 12 face-to-face interviews were scheduled to take place between October and November 2015. Next, the two-day physician leadership retreat outlined in the retreat agenda in Appendix F took place on November 20-21, 2015. Eight out of the 10 participants attended the retreat. The desired outcomes of the retreat were as follows:

- Create shared vision of the most desirable physician leadership team
- Introduce Physician Empowered Performance Program
- Develop greater understanding and appreciation of work styles on the team
- Provide team feedback that results in more effective performance
- Make commitments to reinforce progress

Of the 12 physicians asked to participate in the study, two were not able to participate due to scheduling conflicts involving physician/patient appointments. Semi-structured interviews
were conducted with 10 participants both in person and by telephone, using rigorous ethnographic interview techniques (Spradley, 1979). In both the initial 10 and follow-up 10 interviews, eight participant interviews were face-to-face and two were conducted via telephone to accommodate the physicians’ patient appointments. There was no perceived difference in length, depth, or quality of responses between the face-to-face and phone interviews. At the initial interview with each of the 10 physicians, informed consent was obtained and each person was informed that they could terminate their participation at any time. Interviews lasted between 45 and 90 minutes, with an average duration of one hour, consistent with the methods suggested for in-depth interviews (Legard, Keegan, & Ward, 2003).

The interview questions gave as little guidance as possible to allow the interviewees to talk about what was important to them regarding physician leadership and self-efficacy. Semi-structured lists of questions were used, including questions for probing for more information. During the interviews, each participant was asked about

- his views of himself as a leader,
- his views on how others viewed him as a leader,
- any attempts by others to influence his behavior,
- whether or not he personally witnessed another physician growing as a leader,
- leading a change in business that required him to influence others,
- his perspective on how the physician leadership development program helped to form/reinforce his beliefs that he could be/was a leader,
- his perspective on how the physician leadership development program helped him to grow as a leader,
the significant learning events and performance accomplishments that helped him to grow as a leader in the last six months,

what triggered learning,

strategies from the physician leadership development program that he used during the learning event(s),

learning about himself as a leader during the learning event(s),

any physiological states that he exhibited during the learning event(s), and

any shifts he has made in the last six months to identify himself as a leader.

The last interview question was open-ended and asked if the participant had any additional information to share.

The interviews were conducted in a comfortable environment to ensure participants had a positive reaction to the study’s purpose and ultimately to the study’s results. Each interview’s audio was recorded and professionally transcribed.

During field work, an iPad with voice recognition and transcription software was used as the primary method to capture and transcribe the first four participant conversations verbatim. Also, a digital voice recorder was used as a backup to the iPad to capture any information that the iPad may have missed. The iPad transcriptions were captured as notes on the iPad, copied, and pasted into a Word Document. Unfortunately, the voice recognizer was not able to accurately transcribe all of the words. I then approached the manager of the Health Information Management Department at Southeast Cancer Center about the possibility of having a transcriptionist transcribe the conversations recorded on the digital voice recorder. The manager agreed to allow one of her transcriptionists to transcribe the participant conversations on the digital voice recorder. The audio recordings on the digital voice recorder were used by the
transcriptionist in the Health Information Management Department at Southeast Cancer Center to transcribe the same four participant conversations as were automatically transcribed by the software on the iPad.

However, the transcriptionist was concerned that the transcription process was taking too long. The transcriptionist suggested transcribing the remaining six conversations using their Nuance telephone dictation system, with which it was easier to transcribe with the foot pedal capability. Through trial and error, the transcriptionist and I were able to finalize the dictation process.

In addition, the transcriptionist instructed me to break up the 60 minute interview session into two 30 minute segments; however, the conversations were very engaging, and I always forgot to stop after 30 minutes. I would always conduct the conversations for 60 minutes until the Nuance System would stop recording. I was also instructed to make sure that the telephone volume was up loud so the telephone recording system could pick up the voices. Lastly, I was instructed to complete a test dictation first before I officially started, using the Nuance Telephone Dictation System, so that the transcriptionist could listen to the recordings, know that it was working, and troubleshoot on her end if necessary. Although using the Nuance System worked out better for everyone involved, the voices on the recording were not always clear, and the transcriptionist occasionally found it hard to determine if it was the participant or me talking. As a result, the transcriptionist started using special headphones to block out any additional noises. In the end, the transcriptionist sometimes left lots of blanks in the finished transcriptions as indicated by underlined spaces left in the transcriptions when she could not determine what was recorded. This issue leads to the discussion of transcription interpretation in the next section.
Transcription interpretation is a sensitive topic for qualitative researchers. Proponents of *naturalized transcription* (exact transcription) hold that this method allows for the voice of the participant and incorporates important sociocultural data aspects, whereas proponents of *denaturalized transcription* (interpreted transcription) hold that this method allows for greater focus on informational content and helps avoid reader assumptions (Oliver et al., 2005). Researchers have advised that if transcriptions must be interpreted, great care must be taken to reflect upon alterations to ensure analysis and results are not affected, and that research is respectful to participants (Oliver et al., 2005).

After receiving the transcripts, I organized the study data by question, theme, and pattern (Patton, 2002; Trochim & Donnelly, 2008; Yin, 2009). I created a database of question/answer summaries by placing all 10 participants’ answers to each question into a question summary. There was one question summary for each question, totaling 13 question summaries. I analyzed the data in each question summary by utilizing the constant comparative method of qualitative data analysis (Glaser & Strauss, 1967), along with common techniques to code the data (Constas, 1992; Miles & Huberman, 1994).

Prior to coding the data, I produced ideas about the themes I expected to find based on my initial understanding of the phenomenon. Initial ideas about the themes included the following: selection, vision, passion, collaboration, and integrity. Next, I read the question summaries closely to advance code development inductively. I completed a detailed and thorough line-by-line review of the text contained in the question summaries referring to my initial ideas and allowing for emerging ideas. I coded each line of text with a word that described the open code and helped to open up the text. For example, if the text described the participant’s commitment, I made the notation *commit* in the margin next to the line of the transcribed text.
This process allowed me to interpret the text in new and unfamiliar ways which also helped to test my ideas. After notating open codes in the margins of each line, I created an Excel table including each open code and participants P01-P10. I then noted in the table how many times the open code was referenced by each participant. Next, I consolidated similar and duplicate open codes together. I prioritized the open codes from most to least based on the number of times each one was stated by the participants, and I followed the same procedure for the text in each question summary. Finally, I grouped all the open codes from the 13 question summaries into one table by removing duplications and consolidating similar open codes. I prioritized the open codes again from most to least. This process of open coding permitted me to organize the data into many open codes, to identify broad themes that emerged from the data (Miles & Huberman, 1994), and to record the frequency of their occurrence.

The term “theme” was used to identify a cohesive category of responses, found across participants, that aggregated patterns observed in the data. There were 16 themes that resulted from the open codes. Additionally, periodic discussions throughout this iterative process with the Assistant Vice President, Talent, and on ongoing review of the literature helped validate, compare, and extend the findings, where appropriate (Glaser & Strauss, 1967). Next, comments that were believed to be significant to each broad theme were identified. Data were reviewed several times to make sure I captured all themes and categories. Data were collected until theoretical saturation was reached, in other words, until words in the text appeared 10 or more times and/or no new or relevant data emerged regarding a category and relationships between established categories (Strauss & Corbin, 1998).

Also, eight out of the 10 physician leaders who completed the initial interviews were observed during the physician leadership team retreat held on November 20-21, 2015. The
observation notes from the retreat are shown in Appendix G. Care was taken after observations notes were completed by offering participants an opportunity to validate the accuracy of the field notes to ensure field notes were sufficient to allow for robust description during report write-up. Robust description may help readers to become immersed in described settings and scenarios (Patton, 2002). The analysis of the observation notes was used to informally confirm the 16 open coding categories from the 10 initial interviews.

After the 16 open coding categories were confirmed via observation notes from the retreat, the interview guide was updated with questions intended to help better understand the 16 open codes. These follow-up questions were designed to gain an in-depth knowledge of the open codes uncovered during the initial interviews and observation notes as shown in the Interview Guides in Appendix A and B. The follow-up questions included information pertaining to:

- Physicians’ beliefs/perceptions of their ability to lead as “in progress” and “immature leaders”
- Physicians learning to be leaders through “formal training/education”
- What was helpful in the training that helped them be leaders
- Whether or not the training was successful in increasing physician self-efficacy in leadership
- Being “pushed into uncomfortable situations to learn”
- Physicians sharing integrity, trust, respect for others, transparency, and knowing the bigger picture as the way a physician leader acts/shows up
- “Hybrid physician leaders”
- Perceptions as a “servant leader”
- Becoming leaders through a “heart change”
• Learning events that have helped them grow as physician leaders

Once again, the last question was open ended for the physicians to speak freely about anything on their mind relating to the study. All interview questions were reviewed by the Assistant Vice President, Talent, before being presented to participants.

All data from the follow-up interviews was reviewed and axil coding was utilized to relate the 16 open coding categories to subcategories along their properties and dimensions. I created a database of question/answer summaries by placing all 10 participants’ answers to each question into a question summary. There was one question summary for each question, totaling 11 question summaries. I analyzed the data in each question summary by utilizing the constant comparative method of qualitative data analysis (Glaser & Strauss, 1967), along with common techniques to code the data (Constas, 1992; Miles & Huberman, 1994).

A notation system was used to label data in the margins of each line of data (Patton, 2002). For example, if the main point in the line of text was maturity, I wrote maturity in the margin. The notations were utilized to keep track of the comparison grouping in which it occurred. To this procedure, I compared the notation with the previous notations in the same and different groups that were coded in the same category. For example, as I coded a line of text in which a participant responded maturity of physician leaders, I also compared this notation, before further coding, with others previously coded in the same category, like confidence.

Continuing with the constant comparison of the notations, I started to generate theoretical properties of the categories. I started to think in terms of who, what, when, where, why, and how of each category. For example, what were its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relation to other categories, and its other properties? After coding for a category approximately three or four times, I found myself
conflicted and confused over the notations, trying to compare them to the next notation and trying to determine the alternate ways by which they should be coded and compared. At this point, I stopped coding and wrote memos which were used to facilitate and document my thinking about the data being collected as well as a way for me to process an “internal dialogue” as described in the next section.

**Memos**

Memos are the theorizing write-ups of ideas about codes and their relationships (Glaser & Strauss, 1967). Although data collection, analysis, and recording memos are ongoing and overlap, the literature suggests stopping coding and recording a memo to tap into the researcher’s theoretical notions while they are still fresh in one’s mind (Glaser & Strauss, 1967). I found it necessary to record memos when I developed conflicting ideas about a category after axil coding for a category several times. The memos helped me to organize my ideas. Likewise, I often stopped coding and started memoing to capture and reflect upon the themes as well as note their frequency (Glaser & Strauss, 1967). I wrote a total of 16 memos during the entire process of collecting and analyzing data, as this facilitated reflection on the collected data. I recorded the memos as the thoughts came to mind with no concern about spelling or grammar. I later revisited my memos and edited the text as more ideas were discovered about the topic. The memoing shown in Appendix H morphed into the write-up of the eight axil coding categories that emerged from the data and the analysis. As I continued to code, the memos changed from the comparing of notations with notations to comparing notations with properties of the category that resulted from initial comparisons of notations. Finally, the memos changed as I began to integrate one category with other categories and a central category emerged. The next section discusses how this qualitative case study addresses validity and reliability.
Validity and Reliability

While conducting a case study, internal study validity concerns may arise due to inaccurate inferences. Yin (2009) recommends that case study researchers utilize the following analytic tactics to address internal validity: (a) pattern matching (compare an empirically based pattern with a predicted one, define patterns prior to data collection), (b) addressing rival explanations, monitor for bias, and (c) using logic models (match empirically observed events to theoretically predicted events). Case study construct validity can be challenging to address as researchers are often criticized for failing to develop “a sufficiently operational set of measures and (using) ‘subjective’ judgments to collect data” (Yin, 2009, p. 41). To mitigate criticism, Yin suggests that researchers define constructs in terms of specific concepts and then relate the constructs to study objectives. Researchers can then identify the “operational measures that match the concepts” and cite “published studies that make the same matches” (Yin, 2009, p. 42). Yin also recommends the following tactics to improve construct validity: use multiple sources of evidence, establish a chain of evidence, and have the draft case study reviewed by key informants.

It is critical for case study researchers to establish and maintain a chain of evidence (Yin, 2009). Comparable to the evidence collected by criminologists, case study evidence (the case study report) should be able to stand up in court (should be irrefutable by the research community; Yin, 2009). To establish a reliable chain of evidence, the case study report should have sufficient citations from the case study database; the database in turn should contain the actual evidence collected; the collected evidence needs to be based on the procedures and questions outlined in the study protocol; and the protocol needs to link back to the original study.
questions (Yin, 2009). External observers should be able to trace the case study steps from conclusion back to the initial research questions, and vice versa (Yin, 2009).

To address internal validity in this study, rival theories were identified prior to data collection in order to investigate potential alternatives. Rival theories included unacceptable threats to validity, investigator bias, and “super rivals (where) a force larger than, but including the intervention, accounts for the results” (Yin, 2009, p. 135). One such rival theory was that physician participant selection bias was responsible for physicians’ success in leadership development programs. Furthermore, linking data to Bandura’s (1977) self-efficacy theoretical propositions through pattern matching techniques (Trochim & Donnelly, 2008; Yin, 2009) was utilized to address internal validity. Examples of observed self-efficacy included (a) the facilitation and promotion of performance accomplishments that helped build a physician’s sense of personal mastery, (b) the facilitation and promotion of vicarious experiences that allowed physicians to see tasks modeled and achieved by others, (c) verbal persuasion, such as positive reinforcement and praise, and (d) demonstrated understanding and mitigation of a physician’s physiological state in regards to fear of failure (Bandura, 1977).

Rigor

Yin (2009) states that in order to enhance the rigor of a case study, it is critical for researchers to establish and maintain a chain of evidence. In order to enhance the rigor of this study, I created a reliable chain of evidence including multiple citations from the case study database (Yin, 2009). In turn, the database contained the actual evidence collected which was based on the procedures and questions outlined in the study protocol (Yin, 2009). The protocol linked back to the original study questions (Yin, 2009).
Ethical Assurances

The University of North Texas Institutional Review Board (IRB) requires human subject approval prior to data collection. This approval demonstrates study integrity and adherence to ethical principles. The proposed study was aligned with the Belmont Report which outlines basic ethical principles for behavioral research with human subjects including: respect for persons (acknowledge autonomy, protect those with diminished autonomy, ensure subjects participate willingly and with adequate information), beneficence (maximize benefits, minimize possible harm), and justice (ensure for equal distribution of study burdens and benefits on study subjects) (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

Summary

Today’s physician leadership development programs provide physicians with business survival skills not taught in medical school, residency, and fellowship, including process skills such as communication, win-win negotiation, and conflict resolution. It is clear that medical schools and residency programs do not perceive the need for physician leadership to be a part of their educational offerings (Frank, 1997). Meaningful curriculum in a leadership development program, effective facilitation, and consistent program support can lead to physician success. Physicians with previous negative relationship/team building and communication experiences may struggle with curriculum, and fear of failure may cause physicians to not complete the program. A case study using grounded theory, guided by a self-efficacy framework, may increase the understanding of how physicians think about their leadership experiences following their participation in a leadership development program. The resulting data may be utilized as a first step in developing a theory of physician leadership and self-efficacy.
CHAPTER 4
FINDINGS
Overview

The purpose of this case study is to understand how physicians think about their leadership experiences following their participation in a six-month in-house leadership development program. The study also explored at a high level how these experiences influenced physicians’ self-efficacy as a first step in developing a theory of physician leadership and self-efficacy.

The focus of this chapter is to present the findings of the data collection as well as to discuss those findings in light of the relevant research literature. Accordingly, this chapter is structured into three sections: the first section is a description of the Southeast Cancer Center and the physician leadership development program; the second section focuses on the findings with the relevant academic literature that relate to research question one; and the third section focuses on the findings in light of the relevant academic literature that relates to research question two.

Grounded theory codes, memoing, and visual demonstrations of ideas provide insights into how the final grounded theory categories were developed. The methodology for this study, which was discussed and explained in the previous chapter, has guided the data collection. The significant findings, the limitations of findings, and suggestions for further research are covered in Chapter 5. The next section will elaborate on the demographics and characteristics of the participants.

Participants in the Study

Southeast Cancer Center gave permission for me to interview 10 diverse participants: two males of Middle Eastern descent, two Caucasian Females, one African American Male, one Latin American Male, and four Caucasian Males. The diverse participants were in different
stages of their careers and averaged 15.4 years of experience. In addition, they varied in terms of supervision with a range of 1-12 direct reports. The participants were selected based on their positions as Director and/or Chief or their demonstrated ability to be lead and influence others and their willingness/availability to talk with me. In regards to the participants’ ages, one participant was 30+, five of the participants were 40+, two were 50+, and two were 60+.

One of the participants had completed a Master of Business Administration prior to enrollment in the in-house leadership development program. Two other participants had attended external and/or internal physician leadership development training programs.

Company and Program Background

The physician leadership development program aligned with the Southeast Cancer Center’s strategic goal to positively impact the performance of the physician/manager of others and improve the percentage of highly engaged employees. The physician leadership development program was created as a means to “condense the universe of leadership materials” and provide physicians with a pathway to becoming engaged leaders. The Assistant Vice President, Talent, expressed that every employee in at the Southeast Cancer Center viewed the physicians as leaders and virtual leaders. Physician leaders are physicians who are involved in healthcare administration (day-to-day operations and management) and leadership (influencing followers toward mutual goals) to ensure the appropriate patient care regardless of whether they are full-time, part-time, named leaders (e.g., Chief Executive Officer, Chief), or unnamed leaders (lack formal leadership position) (Merry, 1999).

In addition, the executive team’s goal in creating the program was to improve the leadership quality of physician/managers of others, which is the leadership level that is a key driver of stakeholder (employee) engagement influencing/supervising 80% of employees at the
Southeast Cancer Center. The program was also intended to enhance a physician’s ability to lead followers through influence. Only 16% of physician participants had direct reports at the start of the program. The overwhelming majority of physicians were leaders through influence not authority. Several of the physicians had even expressed a level of tension or challenge because of the lack of physicians in clear management roles at the Cancer Center.

The six-month Physician Leadership Development Program was held onsite at the Southeast Cancer Center in south suburban Atlanta between April and October 2014. The Center is the newest of five hospitals that opened its doors in August 2012. It is recognized as one of the top healthcare providers of cancer care in the southeast region, receiving numerous awards such as AJC Top Workplaces. Its clinical and financial successes have allowed it to double in square footage from 226,000 square feet to 455,000 square feet and to grow its stakeholders (employees) to over 1100+ in three years, surpassing the 500 employees it projected in its first five years of operation. The Center offers care in more than 18 treatment options, with more than 200 physicians across a variety of specialties.

Along with the Center’s success come several leadership challenges that have to do with working through growth and start-up challenges associated with taking on new services and a growing number of new patients. There is a consistent challenge with acculturating new employees and physicians into the “patient-centered” approach to oncology care.

Six months after opening, other challenges included an expected employee turnover rate of 20 percent and stakeholder (employee) complaints about the number of physicians/managers (11 percent). The Executive Team realized early on that they would need the physicians to be fully engaged in the patient-centered approach to oncology care and to think in terms of the
Below is a description of the physician leadership development program. The program’s orientation presentation, shown in Appendix E, documented that the program was divided into three components: pre-program, program, and post-program. Each component is described in detail in the following paragraphs.

**Pre-program Activities**

The pre-program activities were the nomination/selection process, the 360-degree assessment, the Insight Profile, and the Pre-Program Interviews. To begin, the program selection/nomination process was orchestrated by the physicians’ Executive Team Leaders comprised of the Chief Operating Officer, Chief Financial Officer, and Assistant Vice-President of Oncology Patient Services. Each one of these individuals was asked to nominate/select physicians on their teams that demonstrated the ability to expand their leadership capability and assume leadership roles within the organization in the next 12 to 15 months. No minimums or maximums were placed on the number of physicians that an executive could nominate for the program. The nomination process took three weeks from start to finish. There were 26 physicians selected and invited to participate in the leadership development program; however, only 25 agreed to participate in the program. One physician declined the invitation to participate due to a busy schedule.

The physicians who accepted the invitation to join the program received two self-assessments. Each physician received an in-house 360-degree Assessment and an Insights Profile. Stoller (2008) states that expert assessments of individual physicians’ challenges, typically in the form of 360-degree Assessments, is one of the competencies that should be
developed in leadership development programs for physicians. The 360-degree Assessment process is one of the most accurate and powerful ways of obtaining feedback on personal performance due to the 360-degree nature of the assessment design. The program participants were instructed to select the following people as raters for their 360-degree Assessment: themselves, Executive Team Leader, Manager, direct reports, peers, and other stakeholders (employees). Table 3 on page 62 elaborates on the list of possible raters and provides selection tips that were given to the physicians to assist with selecting their raters.

Another key component of the 360-degree Assessment process was confidentiality of assessments. By design, all information (with the exception of manager ratings) was reported back to the physicians in the form of averages. This allowed the raters to provide honest and open feedback on the skills being assessed. The process to select the raters took two weeks. The in-house 360-degree Assessment was created in Survey Monkey and administered via email. Individual reports were generated approximately two weeks after the online survey had closed. During the week of the program orientation, the reports and a learning goals template were emailed to the physicians with a copy sent to their Executive Team Leader. The Executive Team Leader was instructed to work with each physician to schedule a face-to-face meeting to review the 360° Assessment report and develop learning goals for each month of the program. The physician and Executive Team Leader were instructed to meet and complete the learning goals document within the first month of the program.

Table 3 below elaborates on the list of possible raters and provides selection tips that were given to the physicians to assist with selecting their raters.
Table 3

360-Degree Assessment Evaluator

<table>
<thead>
<tr>
<th>Rater</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Team</td>
<td>Medical group leadership, Hospital Chief Operating Officer or C-suite member, division chief</td>
</tr>
<tr>
<td>Leader</td>
<td>Head of your practice group, service line or division chief, hospital/medical group leadership, a “senior” physician, perhaps someone who’s mentored you</td>
</tr>
<tr>
<td>Manager</td>
<td>Practice Partner(s), other physicians, executive administrator, surgeon, anyone you could say is a professional colleague</td>
</tr>
<tr>
<td>Peer</td>
<td>Nurses, assistants, technicians, practice/office staff, executives or team members from whom you would like feedback</td>
</tr>
<tr>
<td>Direct Reports</td>
<td>Former work colleagues, peers or superiors, spouse, close friends, adult children - perhaps use this as a separate category for all those who don’t fit into the previous categories but from who you would like feedback</td>
</tr>
</tbody>
</table>

Rater Selection Tips:
- Choose AT LEAST 3 PEERS and 3 DIRECT REPORTS, plus at least one Manager and /or one Superior (*Other is an optional category)
- Do not choose current or past patients
- Raters should have frequent work-related interactions with you.
- Raters should understand the nature of your role and job duties.
- Select raters with whom you work well, as well as those with whom they have not worked well so that you get a balanced perspective.
- The better your raters know you, the good and the bad, the better picture you’ll gain of yourself.

According to Insights website, the Insights Profile is a 25 frame word-pair evaluation created to capture the respondents’ perceptions of their work preferences. The Insights Profile assessment was sent to physicians via an email link and administered online to the program participants. The evaluator asked the physicians to read each statement carefully and choose the one statement that most described them in their work environment and select M (most). From the remaining three statements, they were instructed to choose the statement that least described them in their work environment and select L (least). For each of the remaining two statements,
the physicians were instructed to select a weighting from 1 (not likely to describe me) to 5 (very likely to describe me). After the physicians completed all 25 frames, their responses were electronically sent to Insights. Insights then generated an individual profile for each physician, which they received via email a week following the completion of the evaluation. A third-party certified Insights Coach reviewed the profiles with the physicians via a three hour virtually facilitated session one week prior to the program orientation session.

One month prior to the program orientation session, the Assistant Vice President, Talent, conducted 60-minute interviews with each physician participant. The purpose of this Pre-Program Interview was to get to know the physicians better, to provide an overview of the program to the participants, and to help the physicians make the most of the program. All 25 of the physicians were interviewed. The findings from the interviews were applied to directionally guide the program toward an emphasis on communication and interpersonal skills. It was during this time that the decision was made to provide pre-program training for the Executive Team Leaders.

The Executive Team Leaders were invited to attend the Reinforcing Leadership Development session for managers of the participants in the physician leadership development program. The session was facilitated by a third-party vendor, The Center for Learning, to equip the executives with coaching skills and program resources to support the development efforts of the physicians in the program. However, none of the Executive Team Leaders attended the session due to scheduling conflicts. In lieu of attending the four-hour training session, the Executive Team Leaders met bi-weekly for 30 minutes with the Program Manager to review program curriculum and coaching skills. This bi-weekly meeting ran through the fourth month of
the program when it disbanded due to scheduling conflicts. The next section will describe the program activities in detail.

Program Activities

For the Executive Team, the desired outcome of the physician leadership program was to strengthen the succession pipeline to increase the number of candidates who were ready for leadership roles and to increase physician engagement. Stoller (2008) states that one of the competencies that should be developed in leadership development programs for physicians is an awareness of the needs of the healthcare environment. According to the program syllabus shown in Appendix D, the program was a six month leadership development program dedicated to physicians. The program objective was to develop physicians to influence and lead high performing teams and achieve results. The target audience was physicians who had been in their roles for six months, who were deemed by their Executive Team Leader to be a capable leader with the aspiration to assume administrative roles and/or responsibilities. According to the Assistant Vice President, Talent, the Executive Team’s goal was to apply leadership skills to the physicians’ already strong base of technical skills. She went on to comment that they believed that physician leadership development had the power to enhance their organizational culture, patient outcomes, and even the future of medicine.

There were four components to the program activities, the Orientation, the six months of program delivery, monthly meetings with an Executive Team Leader, and session monitoring/evaluation. Each of these components is described in more detail in the subsequent paragraphs.

An analysis of the Program Orientation Deck, shown in Appendix E, revealed that the program was built around national benchmarks, such as the Advisory Board Physician
Leadership Academy, the American College of Physician Executives, the Association of Talent Development, and the Society of Human Resource Management. In addition, it was stated in the Program Orientation Deck (Appendix E) that the physician leadership development program was modeled and enhanced after the success of the Southeast Cancer Center’s previously launched Manager of Others Program. Lastly, the program delivery was conducted by external consultants including a national physician speaker, DDI Facilitators, Center Executives, and a leadership development specialist and mentor with a career spanning decades between children’s healthcare and Fortune 500 Companies.

Review of the program syllabus, shown in Appendix D, revealed that there was a different topic for each month based on Southeast Cancer Center’s Performance Standards for Managers of Others, including Communication, Relationship and Team Building, Management and Planning, Development and Learning, Innovation and Change, and Patient Centricity. Stoller (2008) states that there are six domains of physician leadership that should be included in physician leadership development: (a) technical knowledge and skills (operations, finance, information technology, human resources, strategic planning, legal); (b) knowledge of healthcare (reimbursement, legislation/regulation, quality); (c) problem solving; (d) emotional intelligence; (e) communication (in leading change, negotiation, conflict resolution); and (f) commitment to lifelong learning.

Table 4 on page 66 provides a visual depiction of the alignment between Performance Standards and Learning Objectives. The Assistant Vice President, Talent, stated that “The program aligning to Performance Standards was a benefit in that they aligned the dialogue and language so that the conversation was consistent and participants could get traction”. Rice (2009) states that learning needs should be associated with context and in-house leadership development.
programs provide the links from theory to application. In-house programs allow for short learning sessions related to real world experience and help physicians manage their time more effectively (Rice, 2009).

Leadership development programs should be uniform in design, long term, and as rigorous as residency training to develop the caliber of physician leaders needed (Birrer, 2002; Schwartz et al., 2000). The program was held two times a month for six consecutive months, which was a total of 24 classroom hours over six months, as opposed to three days. The frequency and duration of the classroom sessions was in line with Adult Learning Methodology. Knowles (1980) states that the most effective learning for adults takes place in small groups where knowledge can be immediately applied, analyzed, and discussed through the prism of the adult participants’ life experiences.

Table 4 on below provides a visual depiction of the alignment between Performance Standards and Learning Objectives.

Table 4

*Alignment of Performance Standards and Learning Objectives*

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Learning Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship &amp; Teambuilding</td>
<td>How to enhance team performance.</td>
</tr>
<tr>
<td>Communication</td>
<td>How to provide positive feedback that recognizes and motivates individuals and teams as well as developmental feedback that helps others get back on track.</td>
</tr>
<tr>
<td>Patient Centricity</td>
<td>How to handle patient experience issues with compassion.</td>
</tr>
<tr>
<td>Management &amp; Planning</td>
<td>How to determine goals and measurement methods that will help track and demonstrate the results of effective leadership.</td>
</tr>
<tr>
<td>Innovation &amp; Change</td>
<td>How to encourage team members to find solutions to problems and change opportunities.</td>
</tr>
<tr>
<td>Development &amp; Learning</td>
<td>How to treat all stakeholders equitably and fairly.</td>
</tr>
</tbody>
</table>
The Assistant Vice President, Talent, stated that the program’s leadership methodology was based on the psychology of Servant Leadership, which at its core is the idea that leadership should not be hierarchical or dictatorial, but it should instead be the forming of a community that involves others in decision making (Greenleaf, 2002). She also stated that the program’s framework was based on the principles outlined in the Leadership Pipeline (Charan, Drotter, & Noel, 2010) an internal strategy to grow leaders. Table 5 below provides a visual depiction of the relationship between Servant Leadership, Leadership Pipeline, and the Performance Standards.

Table 5

<table>
<thead>
<tr>
<th>Servant Leadership (Leadership Psychology)</th>
<th>Leadership Pipeline (Leadership Framework)</th>
<th>Performance Standards (Competencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
<td>Manager of Self</td>
<td>Relationship &amp; Teambuilding</td>
</tr>
<tr>
<td>Empathy</td>
<td>Manager of Others</td>
<td>Communication</td>
</tr>
<tr>
<td>Healing</td>
<td>Manager of Managers</td>
<td>Patient Centricity</td>
</tr>
<tr>
<td>Awareness</td>
<td>Manager of Function</td>
<td>Mgmt &amp; Planning</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Manager of Business Unit</td>
<td>Innovation &amp; Change</td>
</tr>
<tr>
<td>Conceptualization</td>
<td></td>
<td>Development &amp; Learning</td>
</tr>
<tr>
<td>Foresight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stewardship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building Community</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The program was designed in a cohort structure to allow each participant to bring their unique characteristics and viewpoints to the program. In-house programs increase the collegial climate within organizations (Scott, Tangelos, Blomberg, & Bender, 1997). The Assistant Vice President, Talent, commented on the collegial climate by stating:
We love to hear the participants’ feedback and input as they share their war stories with us—the victories and losses. This is their waterhole. We encourage them to lean on each other for support and we hope they learn to view the class sessions as somewhere to replenish their cups.

The program had real-time tracking provided by the participants using an online evaluation tool called Metrics That Matter (MTM). The MTM Class Summary provided feedback from each class session on instructor effectiveness, courseware, learning effectiveness, job impact, support tools, and return on investment. Leadership training is most effective when it includes training with ongoing assessment and regular measurement (McCauley et al., 2004).

According to MTM, for Healthcare Instructor-led courses, the average Net Promoter Score (NPS) score was 57 percent for the 75th percentile of corporate universities in the healthcare industry for 2014. Southeast Cancer Center’s class sessions averaged an NPS of 86 percent. NPS for the top courses included:

- Development and Learning, Part 1 & 2: 100%
- Innovation and Change, Part 1: 100%
- Development Dimensional International Communicating for Leadership Success: 94%

I attended all 12 instructor-led classes and observed the support, full engagement, and participation of Executive Leadership including the Chief Executive Officer, Chief Operating Officer, Chief of Medical Staff, and the Assistant Vice President, Talent. The monthly support included executive coaching and continuous feedback by each physician’s Executive Team Leader, and this support encouraged the participants to set and monitor their learning goals and progress. Also, the program utilized a blended learning approach, including instructor-led classes, assigned book readings, and self-directed learning via a binder used as a resource guide full of resources, materials, and case studies. McAlearney (2006) indicates that meaningful
program activities, in combination with program support structures (e.g., executive leadership involvement, additional support services, and tools) facilitate physician engagement and productivity. Specifically, one session per month where the first session was designed to be theoretical with instructor-led content provided by Development Dimensions International and the second session was designed as an application session led by an Inspirational Executive Speaker. The next paragraph describes in detail the post-program activities.

Post-program Activities

The post-program activities included a graduation and post-program evaluation. The graduation ceremony was held on-site, after hours. It was catered, and each graduating physician was presented a certificate and journal by the Chief Executive Officer, Chief Operating Officer, and Assistant Vice President, Talent. There was a 75 percent attendance rate required to graduate. The attendance rate for the Center’s program was 86 percent, and the graduation rate was 96 percent. Following the graduation, a post-program evaluation was administered via Survey Monkey. Stoller (2008) states that one of the competencies that should be developed in leadership development programs for physicians is the ability to create surveys of existing and aspiring physician leaders. The response rate was a 66.7 percent. The key results can be summarized as follows:

- Overall self-reported ratings on impact of leadership development program on Performance Standards, with pre-program compared to post-program, was 94 percent overall improvement on the 360-degree Assessment.

- 3.9 out of 4 rating by participants who agreed that “The sessions led by learning and development mentor and coach were effective in teaching Innovation/Change and Development/Learning Skills.”

- 3.6 out of 4 rating by participants who agreed that “The program has provided learning and tools I have applied immediately making a positive impact on the way I lead.”
3.6 out of 4 rating by participants who agreed that “The 360-degree Assessment and Insights Profile were a valuable use of my time.”

3.3 out of 4 rating by participants who agreed that “I feel that program components have fulfilled my learning and development needs.”

On the post-program evaluation survey, participants were asked to share what component of the program provided the least value. Participants were very reluctant to answer this question and really did not have a definitive answer. The difficulty of physicians evaluating the leadership development program was highlighted by survey responses showing substantial variability in answers and by limited information provided by participants regarding overall suggested improvements for future programs. Participants’ lack of answers repeatedly emphasized the difficulty physicians have with program evaluation and, in particular, the need to move beyond tracking program participation to tracking learning. The findings for research question one are detailed below.

Research Question 1

How do physicians describe their post experiences following a six-month in-house leadership development program?

This section begins with a diagram of the core categories - the boxed phrases on the category diagram in Figure 1 on the following page - that describe the physicians’ post experiences following a six-month in-house leadership development program. Following the diagram, this paper examines the physician quotes and literature for each core category that relate to the research question.
Figure 1. Physician Descriptions of Their Post Experiences Following a Six Month In-house Leadership Development Program

Clinician

The general public, fellow clinicians, patients, and healthcare administrators view physicians as being experts when it comes to understanding what patients need (Stone, 1997).

Findings about the belief of physicians that they must be all-knowing about patient needs appears to support the existing literature, which reports that for physicians to transition from clinicians to physician leaders, “doctors must accept that being all-caring is different from being all-knowing
or all-controlling” (Lee, 2010, p. 58). Attending an in-house leadership development program helped the participants learn how to help their teams reach higher levels of performance more quickly and boost the team’s impact on the organization’s business results. Thus, they felt freed from feeling like they have to be all-knowing about the patient because they had a team to help them. P04 stated:

I’ve learned that there are some people that are very good at what they do and I need to value that. If I want to be great, I must surround myself with people who are better and don’t be intimidated by the fact that they may be better at something than I am, that’s why I’ve got them. It can be intimidating at times and it can be tough, but that is what is going to make the organization great and that is what is going to make me even better because I learn from them.

Manager

Findings about the physicians’ views on physician leadership appear to contradict existing literature, which reports that physicians describe their job as a manager and emphasize that they do not see themselves as leaders (Arond-Thomas, 2004; MacNulty & Kennedy, 2008; Verdone, 2008; Zaher, 1996). Through participation in the in-house leadership development program, participants enhanced their ability to provide meaningful, supportive feedback that motivated team members and helped individuals improve their performance. P05 stated:

I have been tapped by my colleagues for leadership roles that I don’t have (the official position). That to me is an amazing compliment. There is a dichotomy or a difference sometimes in what administration thinks of us as leaders and what our colleagues think of us as leaders.

The yardstick to measure physician leaders is an administrative yardstick chosen by administration that is not always in line with the yardstick that physicians would use to select their leaders.

Life Experiences

The secret to transitioning physicians to physician leaders is not simply a matter of teaching them skill development as part of a physician leadership development program.
Findings found that the inclusion of physician life experiences (e.g., previous non-clinical work experiences and/or education) are in support to the existing literature, which reports that “most physician leadership development programs focus on skills training and technical and conceptual knowledge, while fewer programs focus on personal growth and (self) awareness” (Frich et al., 2014 p. 656).

Findings support that it is not the skills that physicians learn by participating in an in-house physician leadership development programs but who they are as a person facilitated by their life’s experiences and a supportive environment that allows them to become effective physician leaders. P07 stated:

I think it’s more the feedback from having done things, that at the time you didn’t even realize, that there were options or alternatives, you just went into motion and you did it and afterwards you got very positive feedback and you realized that maybe not everyone would have handled it that way, but then it reinforces continuing to behave that way with others in future situations.

**Skill Development/Transferable Skills**

Seven out of 10 participants agreed that physicians do not need to look at leadership development as simply learning the tools to solve problems. Findings about the ability of physicians to transfer their existing skills to leadership roles contradicts exiting literature that reports that many of the skills physicians learn in medical education programs are not readily transferable to the business operations and leadership of a healthcare organization (Guthrie, 1999; Schwartz et al., 2000; Taylor et al., 2008). Participants interviewed believed that physicians already have many of the skills they need to be effective leaders; they just need to use the skills that they have already developed to effectively treat patients. Participating in the leadership development program provided the participants a safe environment to practice applying their new and transferable skills. Following are two participant comments:
[P08] Yeah, I mean ironically physicians have developed amazing abilities to elicit trust. I can get patients to trust me in a 15 minute conversation and now they are telling me about every intimate detail of their medical past and history. However, physicians either don’t see a need or sometimes just don’t, because it is not natural for them to use these skills outside of the clinic. One of the best pieces of advice that I ever got was that I’ve got these soft skills. The way that I am in the clinic with patients is the same way I should be in a meeting.

[P09] There is definitely some kind of transference of skills because you can’t build skills fast enough to build nine physician leaders, most of them being very successful in their roles, you can’t build those fields fast enough but you can retrain and shift those skills fast enough.

Learning

Knowles (1980) states that the most effective learning for adults takes place in small groups where knowledge can be immediately applied, analyzed, and discussed through the prism of the adult participants’ life experiences. Participating in an in-house leadership development program provided the participants with an opportunity to take stock of what they have learned and put it into practice. The following comments represent the participants’ perceptions on learning:

[P05] So, I don’t know everything there is about medicine, I learn every day. I believe that if I say one day that I know everything, it’s the day that I make my first mistake. So I’m fallible and as a leader it’s the same thing.

[P02] I think I am a leader in progress. I think I will be a leader in progress all my life because I’m learning and I’m working. I think as a leader you have to be, and one of the things I did in one of the leadership classes that was striking to me is a servant leader.

Thus the findings support the literature that states that Transformational Learning (TL) is learning that involves a shift of consciousness as learners change the way they think about themselves and their world (King, 2000).

Problem Solving

All participants interviewed shared that their medical training stressed being able to problem solve. They were clinically trained to look for the problem, find the tool that delivered
the best solution, and solve it. Therefore, it was natural for them to approach leadership in the same manner: identify the issue, find the tools they needed to carry out the solution, and solve the problem. Stoller (2008) states that one of the six domains of physician leadership that should be included in physician leadership development is problem solving. The participants saw the leadership development program as an effective and efficient way to learn the tools (i.e., use specific tools to engage the right people in the right way throughout the change process) that they needed to become better problem solvers and effective leaders. Upon having the tools, the physicians felt that they could now be effective leaders. When asked to describe any verbal persuasion (attempts by others to influence your behavior) that they had experienced and its impact, P07 stated:

There again I was the one that people came to, to solve problems. I can even remember the residency director coming to me at one point, so angry he was shaking about a situation that someone else had not handled well. I just grabbed him by the arm and said okay, we can take care of it, because I take care of things. I don’t know where that came from.

Collaboration

Findings regarding physician leadership and collaboration seem to support the literature that states that physicians who want to move into the business and leadership of healthcare organizations must first change from thinking as independents to developing a broader systematic, collaborative perspective (Atchison & Bujak, 2001; Tomasik, 2008). Five out of 10 participants stated that the leadership development program enhanced their ability to plan for successful interactions with a team member. P07 stated, “You are interacting with the rest of the physician leaders and developing relationships with them so that it becomes easier to approach them when there are difficult things that have to be addressed.”
Shared Vision

The findings support the literature that states that transformational leaders must invest time and energy into building trust and convincing followers to believe in a shared vision (Bass, 1999). All participants agreed that the leadership development program enhanced their ability to achieve results through others by enrolling stakeholders (employees) into a shared team vision. Participant P11 commented, “you must have a vision when you are a leader in order to actually provide a model for what you deserve or to be the best for your program, as well as it actually gives a baseline of what tools we have set for our department and that way we can measure our accomplishments over time.”

Committed/Engaged

Participants were asked to describe how others view them as leaders and their belief in their competences to perform as leaders following the leadership development program. Across interviews, physicians stated that they felt others viewed them as committed and engaged leaders. The findings support the current literature that indicates that meaningful program activities, in combination with program support structures (e.g., executive leadership involvement, additional support services and tools), facilitate physician engagement and productivity (McAlearney, 2006). Participant P08 commented:

What the cancer center is doing is not usual. I got an annual compensation letter that the company sends. I took the letter to Human Resources and I said you’re missing something here, it doesn’t have advanced education on here, it doesn’t have physician leadership on here, you’re missing $15,000, $25000, or $35,000 of investments that you guys have made in me that I should be grateful for and of course you can be grateful for my efforts too. But I need to be appreciative of that opportunity because otherwise, why here, what’s so special about here. So I told her that she should include it in the letter. The fact that I don’t have to be at the cancer center and I can get another job so quickly, is in some aspects negative. But, I can also use it to say that you can trust that I’m engaged, that I want to be here, that I am going to take this class seriously. I’m going to take this opportunity seriously because if what I wanted was just to continue to get paid well and have everybody say yes doctor when I said something, I can go down the street. I can do
that in any city I want. But these opportunities (leadership development) are rare and I think it is important to foster an appreciation in the physicians that this is not usual.

_Determined_

Five out of 10 participants interviewed admitted that they seek challenges to overcome. Through participation in the leadership development program, the participants gained insights into their current behaviors and implemented individual strategies for change. Findings support Guthrie (1999) who states that physician leaders want to make a difference and are determined to embrace the challenge. P05 commented, “So becoming a leader and learning how to become a leader is out of our comfort zone but you have to do it to make it a comfort zone.”

_Maturity_

The average age of participants in this study was 50. Many had previous work experience outside of medicine in fields such as construction and nuclear engineering. The literature states that adult learners usually bring a degree of work experience and maturity to their learning environment. They were experienced with life circumstances and typically know more about themselves and interpersonal communication than their younger counterparts (Moore & Kearsley, 2011). Following are two comments from participants on their stage in life and their willingness to develop their skills and knowledge in leadership development:

[P08] I just decided that if I could spend those years in medical school developing certain skills and knowledge base well then I could do the same thing here. And it had a lot to do with where I was in my career, I’m 10 years out. No specialty is easy, but I don’t have to stop and have smoke pour out of my ears to handle a tough case these days, I know how to practice my specialty, I know what I’m doing, so that leaves a lot of creative and professional growth effort that could be turned to other things.

[P03] The program probably came at a good time for me, just to help integrate me into the physician group better as well as to give me some tools that I needed and ways of thinking about things that I needed, not just for work but for my personal life. I kind of feel like I’m back to myself, I recognize myself again, there for a while... Who are you? But I think the combination of where you are in your life’s journey and programs happening at a certain time can kind of just generate a good symbiotic situation...
Confidence

Kouzes, Posner, & Biech (2010) state that leaders develop cooperative relationships, treat others with dignity and respect, and trust people to do what they say they will to build individuals’ self-confidence and capacity to accomplish the team’s work. Through participation in the leadership development program, participants learned how to develop stakeholders (employees) on teams. Participants agreed that they were able to build confidence in others by modeling confidence with the treatments of patients. Participant P03 stated, “You have to have the confidence, you can’t be facing life-or-death decisions with patients and say oh but I was third from the bottom of my class, I’m not going to be able to do this.”

Communication

Bueno and Tubbs (2004) state that effective leaders are able to communicate and motivate others. Through the leadership development program, participants learned to communicate in a way that built engagement, inspiration, and ownership. All of the participants agreed that communication was a top priority for them as physician leaders. Following are a few of the participants’ comments on physician leadership and communication:

[P08] I’m not suggesting that all physicians already have strong communication and teambuilding skills, but look at physicians with a high treatment rate. Look at physicians with high patient satisfaction. Patient satisfaction is the same thing as family satisfaction, so if patient satisfaction is high and family satisfaction is high, that’s the same thing as saying that the physician is a good small group leader. Physicians get 4 or 5 people (patient and caregivers) in a room and this is life and death stuff. So to get buy-in from 20 people on a project, it should be something that physicians can adapt to.

[P06] Since the training, I have improved on communicating effectively because I finally realized that it is important that I understand that it might sound beautiful in my head, but it didn’t translate to you. I wasn’t communicating effectively. I think the communication skills training that I was exposed to during the six-month physician leadership development program including the self-learning from the books helped me to improve my communication skills. But I also became more aware of the simple things -- I realized that before the training I may have had a false sense of reality of how I was showing up to others—the formal training helped me to see how I was really showing up to others.
[P07] I am working on being a better communicator that is one of the things I think I haven’t always been the best at. I got the most out of the crucial conversations training, because that is something I struggle with. I realized that I can deal with it and that everyone has to deal with it and I learned to just do it kind of thing. And you can do it in a kind way; you don’t have to do it in a destructive way.

Coaching

Throughout medical school, physicians have grown up on feedback. Most of the physicians interviewed characterized their medical education as structured, regimented, strict and punitive (right/wrong). Participant P06 stated:

I showed up late one day for rounds at six in the morning and my punishment was going to the ICU and counting urine cc by cc for 24 hours. After you have this experience when you are late, then you will never be late again. It was effective; it was nothing like oh my God this is so bad.

However, the physicians interviewed stated that no one provided training or coaching on leadership skills in medical school. According to Brown (2010), physicians spend 40,000 hours learning how to be a physician. Participant P06 commented:

Nobody teaches you how to be a leader in medical training. I didn’t read any leadership books during all of my career. If I would have read one, it was because of self-interest, not because somebody said hey here’s something that you need to learn about being a leader.

Once on the job, physicians traditionally do not receive much coaching from their colleagues and Executives about their leadership skills. Participant P10 commented, “That’s probably the biggest problem with physicians is we don’t get much coaching/feedback, to the extent that I’ve literally asked for feedback from my superiors.” Before working at the cancer center, the majority of participants interviewed said that their experience with feedback from the administration at hospitals where they had worked was negative or non-existent. Furthermore, due to the physician’s high compensation packages, most are not motivated to remain at a hospital or in a position when they receive negative feedback. They feel like they do not need their jobs, they only need their careers. Participant 08 commented,
For me, feedback has to be about encouragement. I don’t respond well to negativity there can be criticism in there, but it has to be, you can do better than this, we expect more from you than this. You’ve got a lot more to give us. It can’t be we can’t see this behavior or we don’t appreciate this. If you give me the we can’t tolerate this, then I’m gone. Where are my car keys? I don’t care what you can tolerate, tolerate with the next guy. Tolerate it with a six month search trying to replace me. Enjoy that integrated $3 million loss or whatever it is.

Physicians would prefer to receive structured feedback. However, they do not typically participate in the performance management process led by Human Resources. Therefore, they do not receive structured feedback. Participant P11 commented, “Feedback in the hospital setting is usually given voluntarily, but I would prefer that it is given in a more structured format.” Participation in a leadership development program is one way for physicians to receive structured feedback through assessments, role plays, coaching, and mentoring. Additional forms of education include certification in a physician executive management education program or a formal or informal internal development program, including classes, mentoring, and/or coaching (Zismer & Person, 2008).

Culture/Environment

Zaher (1996) notes that there is an interaction between leaders and their environment (culture). According to the descriptions of the categories created by Goffee & Jones (1996), the culture at Southeast Cancer Centers would fall into the Communal category displaying high sociability and high solidarity. The following sentiments are shared by several participants:

[P11] The fact that the cancer center is a specialty clinic lends itself to bringing all of these specialty physicians together in order to be the best that shared interest just doesn’t exist in the general hospital.

In this comment, he suggested that the specialty cancer clinic, centered around patient-centered care teams, focuses the physicians to adopt a shared broader collaborative culture.
Findings related to a deep change in order to grow into leaders support the current literature that states that physicians must make a paradigm shift and challenge their perceptions to experience a deep change process (Atchinson & Bujak, 2001; Kuhn, 1996; LeTourneau & Curry, 1997). The deep process change allows for individualized consideration to occur as part of the caring of a leader (Bass, 1999; Coad & Berry, 1998). It describes leaders who act as coaches and advisors to employees. It facilitates personal attention, mentoring, listening, and empowerment. Physician participation in a deep learning process appears to be an important adult learning theory promoting the transition from clinical practices to leadership. According to Darling-Hammond (2008), deep learning is the process of connecting learning to personal experiences. The following comment speaks to the heart change that participants experienced following their participation in the leadership development program:

[P06] After the training, I started looking more into the simplicity of life, what is relevant for me, what is relevant for my family, what I really care about, what I am grateful for every day. Did I make any impact today in my life or in your life? I tell you, I ask myself these questions every day, but I try to think about it and when I start realizing that you know what, I don’t have to be right, I don’t have to speak ugly on anything, I don’t have to try to make sure that if we are in a meeting I have all the answers.

The findings for research question two connecting the experiences above to self-efficacy are detailed below.

Research Question 2

Do these experiences influence physicians’ self-efficacy related to leadership?

To facilitate discussion of each category/experience, factors used by Bandura’s (1977) self-efficacy theory were used to identify self-efficacy in participant interviews. Factors were used to search for self-efficacy indicators. Four factors of observed self-efficacy included:

- Experience: The facilitation and promotion of performance accomplishments/experiences that helped to build a person’s sense of personal
mastery; the experience of mastery is the most important factor determining a person's self-efficacy. Success raises self-efficacy, while failure lowers it.

- **Modeling/Vicarious Experiences:** The facilitation and promotion of modeling/vicarious experiences that allow us to see tasks modeled and achieved by others. Modeling is experienced as, "If they can do it, I can do it as well." When we see someone succeeding, our own self-efficacy increases; where we see people failing, our self-efficacy decreases. This process is most effectual when we see ourselves as similar to the model. Although not as influential as direct experience, modeling is particularly useful for people who are particularly unsure of themselves.

- **Social Persuasion:** Verbal persuasion, such as positive reinforcement and praise, generally manifests as direct encouragement or discouragement from another person. Discouragement is generally more effective at decreasing a person's self-efficacy than encouragement is at increasing it.

- **Physiological Factors:** Demonstrated understanding and mitigation of a person's physiological state in regards to fear of failure. In stressful situations, people commonly exhibit signs of distress: shakes, aches and pains, fatigue, fear, nausea, etc. Perceptions of these responses in oneself can markedly alter self-efficacy. Getting nervous before public speaking will be interpreted by someone with low self-efficacy as a sign of inability, thus decreasing self-efficacy further, where high self-efficacy would lead to interpreting such physiological signs as normal and unrelated to ability. It is one's belief in the implications of physiological response that alters self-efficacy, rather than the physiological response itself.

Evidence of physician demonstrations of self-efficacy were collected, assessed, and connected to categories. Finally, those self-efficacy factors were counted per participant. From the compiled notations, a determination was made as to whether the use of these traits constituted a minimal, moderate, or strong occurrence by considering the consistent use of self-efficacy characteristics.

Final value averages were determined by applying a scale rating that considered the self-efficacy factor observed in each category. This scale rating system was arbitrarily determined as follows: Physiological, 0 to .9; Persuasion, 1 to 1.9; Modeling, 2 to 2.9; or Experience, 3-4. For example, when a participant demonstrated Experience, or Enactive Attainment, the notation was *experience*; when a participant demonstrated Modeling, or Vicarious Experience, the notation was *modeling*; when a participant talked about Social Persuasion, *persuasion* was written beside
that information. When it was obvious that a participant was struggling with self-efficacy and talked about Physiological Factors (i.e., signs of distress, such as shakes, aches and pains, fatigue, fear, nausea, and so on), physiological was noted. By each of the word notations, 0 to .9 was noted for low self-efficacy, 1 to 1.9 for moderate, 2 to 2.9 for medium, and 3-4 for strong self-efficacy. These numbers were recorded in a table and averaged to achieve a composite rating of overall use of self-efficacy factors by Bandura (1977), as displayed in Table 6 on page 84.

Summary

Across interviews, examples of observed physician self-efficacy included (a) signs of distress: fatigue and fear, (b) positive attitudes toward tasks, (c) demonstrations of coping mechanisms, (d) demonstrations of effort expended and maintained despite obstacles and task aversion, (e) reductions in defensive behavior, and (f) demonstrations of self-motivation techniques and mastery. The categories with the highest ratings of self-efficacy were Problem Solving, Shared Vision, and Culture. On the other hand, the categories with the lowest ratings of self-efficacy were Clinician, Communication, and Coaching.

The Factors affecting self-efficacy that participants experienced were as follows:

- Experience, or "Enactive Attainment" (3-4)
- Modeling, or "Vicarious Experience" (2-2.9)
- Social Persuasion (1-1.9)
- Physiological Factors (0 - .9)
- The composite rating of overall use of self-efficacy factors by participants was Experience at 3.41 as displayed in Table 6 below
Table 6

Demonstrations of Self-Efficacy Factors in Physician Leadership

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Summary of Findings

This case study research generated nearly 300 pages of data from 10 individuals. The findings support that the leadership development program encouraged participants to have a deep learning experience that increased their leadership self-efficacy. Context provided by nature of an in-house leadership development program and fully engaged participation by Executive Team Leaders was appreciated by the participants and encouraged them to actively commit to and engage in the program. This was in part due to the social persuasion of the Executive Team.

Each participant came to the program with certain leadership skills and left with increased knowledge about leadership but also with increased self-efficacy for mastering and self-motivating themselves. Across participants, they reported that their leadership experiences following the in-house leadership development program helped to build their sense of personal mastery. The experience of mastery of leadership skills in a safe environment where the participants would not be embarrassed for being a leader in progress was one of the most important factors determining their increase in self-efficacy.

Their success in the program mastering leadership skills raised their self-efficacy. Participants completed the course with more confidence in their leadership ability. Participants indicated unanimously that previous life experiences, maturity, and transferable skills helped them in being promoted to Director and Chief Positions 12-15 months following the program, which would indicate that an increased knowledge was necessary but that the experimental learning and context application of the leadership program facilitated applying that knowledge to the leadership context.

My observations, in tandem with interview information and documents, helped to clarify descriptions and to make interpretations. This involved not commonplace description, but thick
This research took a relativistic viewpoint in gathering data and interpreting meaning. I contributed uniquely to this case study and each reader derives her own unique meanings.

**In-house leadership development programs**

The experience of the study participants would suggest that this in-house leadership development programs was effective for developing effective physician leaders and high leadership self-efficacy. Approaching the leadership training through the lens of transformational leadership seemed to increase the participants’ interest and desire to learn the subject, while providing a framework served to enhance students’ knowledge and their application of knowledge. Participants read books, examined case studies, completed action learning, and questioned national physician speakers, executive leadership, and Learning and Development Executive Speakers. Participants in this grounded study explicitly communicated that this course changed their perception of their ability to be effective leaders and that in the future they would be more conscious about only viewing the world through their problem-solving paradigm.

The adult learning theory employed in this program required participants to take responsibility for their own learning. Findings indicated that participants realized that valuing the opinions of others is deeper than being right, and that openness to others’ opinions increased their knowledge and leadership skills. Interest in differing opinions provided opportunities for participants to expand their own viewpoints and inquiry skills. This process is part of self-efficacy as described by Bandura (1997).

The environment of the course challenged and encouraged participants to think from different points of view but with a shared vision. Instructor and peer collaboration supported and
encouraged collaboration that was intended to move all participants in the program beyond their initial viewpoints and knowledge base to incorporate new knowledge.

The design and adult learning theory used in this program focused on adult learning strategies of facilitation, collaborative interaction, and action based learning. In addition, the essence of a deep learning process required participants to construct a unique solution through the application of course information that required additional self-awareness and understanding of the Southeastern Cancer Center’s culture. Successful resolution of this problem required application of deep learning and self-awareness.

Findings from this case study indicated that participants perceived that their physician leadership and self-efficacy skills had increased as they progressed through the course content and coaching sessions with their Executive Team Leaders. In this program, participants questioned and discussed options and possibilities for leadership development both individually and with others; made comparisons; found logical and clear answers; and identified inferences, assumptions, and implications—all qualities that exhibit transformation leadership skills and strong self-efficacy.

Bandura (1977) states that self-efficacy is the belief in one’s capabilities to organize and execute the courses of action required to manage prospective situations. A person’s belief in her ability to succeed sets the stage for how she thinks, behaves, and feels. The participants demonstrated a strong self-efficacy in clinical situations; for example, they viewed challenges as mere tasks that must be overcome and were not easily discouraged by setbacks. Furthermore, they were aware of their flaws and abilities and chose to utilize these qualities to the best of their ability. If, at times, physicians do not see themselves as leaders, they may possess a weak sense of self-efficacy as demonstrated by evading challenges and quickly feeling discouraged by
setbacks. At these times, they may not be aware of these negative reactions, and therefore, do not always change their attitude.

Research Question 1

How do physicians describe their post experiences following a six month in-house leadership development program?

Physicians are clinically trained to be able to find the problem, solve it, or fix it. In practice, they work alone and are not encouraged to rely on others (Cunningham, 1999). Participants agreed that they are “all caring” about patients because “they are ultimately responsible for patients’ care”. However, at Southeast Cancer Center, they are at a center with other specialists who are highly dedicated to patient care. The participants felt that having highly skilled stakeholders (employees) that were also all caring about the patient allowed them the opportunity “to relax”. They reported feeling like a burden was lifted off of their shoulders and they were free to transition to managers.

According to the Leadership Pipeline, which is the leadership framework of the leadership development program at Southeast Cancer Centers, Level One leadership is positional leadership. Participants reported that they saw their leadership role “as managing people, planning, organizing not developing the people”. The participants reported that because of their “high self-efficacy in clinical care”, they believed that administration expected them to be “excellent at everything” when they were not excellent at everything (e.g., managing others). They felt like they were being judged at a skill level higher than they had because of the administrations’ unrealistic perceptions that they should have been excellent at everything. Historically, when the participants did not meet the expectations of others, they were labeled bad leaders. The findings show that the participants did not feel like bad leaders but “leaders in
“progress” exhibiting the same characteristics that other managers at the first level of leadership exhibit. As with other leaders at this management level, their leadership skills were limited, but they were growing and improving with time and experience. The problem arose because of the participants’ need for the acceptance of others. One participant stated, “When I get negative feedback, I avoid the situation.”

Like most new managers, they eventually started to apply their life experiences to their current situation. Findings revealed that all of the participants who had previous positions inside and/or outside of the medical field had a wealth of transferable skills and knowledge that they could apply and did apply to their new leadership positions. This new finding appears to be in contradiction to the current literature found in Chapter Two that states that physicians’ medical skills and training do not transfer well to managerial and leadership roles. It is not that physicians cannot be good leaders of others; it is that they have not been given the opportunity through their medical training, and the administration often has low leadership expectations of physicians. Thus, resulting in physicians being underutilized in leadership roles.

Although it was not part of the formal curriculum in medical training and residency, all of the participants started to develop team-building skills, the ability to get buy-in, image control, and building others’ trust prior to starting the physician leadership development program. On the job, the participants reported exhibiting these skills every day in the clinic with patients.

Participant 09 stated:

Physicians have a genuine desire to build trust with patients. It’s not phony but you change your style and you change your words and your mannerisms and your body language based on the reaction you are getting. Physicians are phenomenal at this. We coax out the trust and we build this relationship (with patients) fast. Unfortunately those same physicians don’t always have self-awareness of what their body language and tone of voice does at the nurse’s station.
Through coaching and learning, this same participant realized that in order for him to be an effective leader, he needed to be deliberate about using these same skills 24/7 and in transferring them outside of the clinic to use with nurses and administration.

Physicians are natural born learners as well, and their excitement for learning fuels their passion for leading. Participant 08 commented:

The lesson that physicians have to learn outside of the clinic room is that perception matters as much as actions. In the clinic room, that is not true (actions are more important) and physicians are phenomenal at it (managing actions and perceptions). They absolutely understand perception. That’s why I think when done correctly physicians have similar skills to the ones that executives have taken years to develop; they’re just not focused correctly. And that’s why I think our physician leadership program worked so well.

Also, new findings revealed that the Southeast Cancer Center’s leadership development was effective in focusing physicians’ problem solving skills, which Stoller (2008) states is important in leadership development programs.

Following the leadership development program, nine out of the 10 participants graduated from the program and moved into new or enhanced leadership positions. Participants reported that their capacity for collaboration increased and their new leadership skills were utilized in their new leadership roles. Because the culture/environment at the cancer center was highly collaborative, findings suggest that hiring physicians who fit the collaborative environment was critical to the success of the leadership development program. Participants reported, “the behaviors they learned as part of the leadership program were reinforced and modeled in the culture, which was not the case at other hospitals”.

All of the participants stated that “conforming mindsets” were also exhibited as part of the culture. They explained this as everyone having a shared vision for the Center built into the organization’s mission, values, and beliefs. Across interviews, the participants stated that they believed that everyone at the Center was tied together by the shared vision. Participant 06 stated,
“I just observed behaviors from my mentors and I said, you know what I like this, I don’t like that, and I changed my style based on that”.

All of the participants agreed that their engagement was positively impacted by their involvement in the leadership development program. Findings revealed that the participants’ leadership self-efficacy was connected to their increased commitment and engagement at the Center. Across interviews, the participants stated that they felt their involvement in the leadership development program was an investment by the Center in their personal development and growth. To them, the investment meant that the Center believed in them. This is important to physicians because they do not like to stay in the wrong or be unappreciated. Physician P08 commented:

I’m going to stick around to see what it is like for people to invest in me other than clinical productivity and revenue. I’m staying as long as I’m feeling that investment. I’m going to be very loyal and very engaged and I have been because there is a continuous investment.

Summarizing the findings, I found that the participants had come to a point where there was no place higher for them to ascend in their clinical careers. They were mature, had various life experiences, had been a part of a collaborative environment where they did not have to shoulder all the responsibility of patient care, were now leaders of others, and had successfully completed a leadership development program, which demonstrated to them that they were leaders, and others recognized and appreciated their leadership abilities enough to invest in them. They found new skills and reapplied old ones in new ways with new people. They did not have to solely rely on their problem solving skills to resolve challenges, and they were self-aware and able to step outside of themselves and really examine their lives, who they were, and what they wanted to be, and to build up their self-efficacy in leadership.
They were now ready to mentor and grow other physicians. In order to accomplish this goal, they needed good communication skills to engage, inspire, and enroll other physicians into their legacy. All participants shared that communication was the number one skill they wanted to and did improve upon in the leadership development program.

For many participants, the leadership development program was supplemented with coaching from their Executive Team Leader. Participants shared that it was very important to their development as physician leaders that they received consistent feedback and course corrections from their Executive Team Leaders. Those participants that received consistent coaching seemed to recover faster from mistakes and made fewer mistakes in their new leadership roles.

Lastly, the participants’ shared common denominators that led them to the cancer center. There was a similarity in what they already believed and wanted to exhibit in a place where they would actually be able to carry those things out. They were all at a place of understanding that as a physician they now believed that “I can’t do it all”, and they felt that it was “a different environment” than any of them had practiced in prior to coming to the cancer center. Like many of the patients they served, they came to the cancer center from other hospitals where physicians were at the top of the food chain: They did it all, they could have it all, and it began and stopped with them. At the cancer center; however, the participants talked about it being all about “we” and “the group”.

Research Question 2

Do these experiences influence physicians’ self-efficacy related to leadership?

The findings support that the participants’ leadership experiences following their participation in an in-house leadership development program influenced their self-efficacy. I was
able to observe and summarize in Table 6 on page 84 from the participant interviews that the participants’ self-efficacy in leadership was improved due in part to their ability to be able to experience and master the categories/experiences. The participants’ stories revealed that because they could practice and experience leadership building activities in a safe environment (the leadership development program), they were able to improve their self-efficacy. Furthermore, the participants received consistent coaching and feedback from their Executive Team Leaders and were in an environment that encouraged and modeled the leadership behaviors that were desired for the physicians to exhibit. The culture provided the framework for the participants to consistently perform their new and/or adapted leadership skills that were learned in the leadership development program. The leadership development program provided a safe environment for the participants to master their leadership skills.
CHAPTER 5

SIGNIFICANCE OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this case study is to explore how physicians describe their experiences following a six-month in-house leadership development program. The study also explores how these experiences influence physician self-efficacy related to leadership.

The research conducted for this study and the literature regarding physician leadership and self-efficacy together suggest that the nine promotions of study participants to Director and Chief positions indicate that the in-house leadership development course they had taken increased their leadership self-efficacy.

Significance of Findings

The findings revealed that both physicians and administrators need to have compassion or a heart change for the other. Another significance of the findings is that physicians are very prone to experience self-doubt. Participant P03 spoke of being depressed, “my outward confidence didn’t match the self-doubt that I felt inside”. Since the high expectations of others for physicians to perform in leadership roles may not match the physicians’ confidence to perform the task, physicians maybe prone to self-doubt, which then would have a negative impact on self-efficacy. In addition, being a physician appears to sometimes be a lonely position where others expect you to perform their best all the time. Physicians may feel that no one understands them and that they have no one to discuss their doubts with, which could also have a negative impact on self-efficacy. Lastly, the participants mentioned, “we rarely get feedback and if we do it is typically negative”.

Furthermore, external coaching at the Center is not made available until employees reach a much higher level of leadership. This is significant because participants in the program felt like
they were expected to perform in leadership roles on the same level as the Executives. However, the majority of them were new to their leadership positions. Throughout my 10-plus years of experience in leadership and development, I have found that when performance was not as expected, the reflexive reaction by management was that it was a performance issue that could be improved through training. Due to my experience, I believe that it may not be a leadership development/training issue but perhaps an issue of hiring for capabilities or fit. There needs to be detailed needs analysis completed prior to initiating any leadership development/training initiative, and this type of analysis was completed prior to the leadership development program at the Southeast Cancer Center.

Significance of findings included a prevalence of physicians’ self-doubt and insecurities, a need to continue to prove themselves, a need for outside stimulus to push them along, a need for acceptance among their peers, and a feeling that they were occasionally being exploited by the administration.

Findings suggest that the fact that participants do not feel like leaders is not because they do not have the skill set or because medical training has not prepared them, as the literature states in Chapter Two. The participants shared that they often do not feel like they are leaders because they do not feel their opinions outside of the clinical arena are respected by administration.

The findings point to one reason for the center’s program’s success: the full engagement of the Executive team in the program, which involved them wanting/valuing the physicians’ input and encouraging them to be in the program. The participants shared that they cared about their involvement in the leadership program because the Executives cared about them participating in the program.
The findings suggest that physicians may not do well in leadership development programs because they do not see the value – the outcome has not been clearly articulated to them. The participants asked themselves questions like, “Why am I doing this?” The findings reveal that the participants do not like doing things that they do not see the value/results in. They are clinically-trained problem solvers that want to resolve a problem/have an outcome.

Limitations of the Study

Although several methodologies were mentioned in the literature review, only interviews and observations were included as a methodology or approach in the study. This is a limitation of the study’s trustworthiness because there was no compensation for the individual limitations of both interviews and observations (Guba, 1981). Also, data from the documents and observations was collected and analyzed informally, and theoretical saturation was determined informally, all of which are limitations of the study.

Since the study was conducted at a small, specialty clinic with only 10 participants, the findings are limited in their ability to generalize the findings to the larger population of physicians. Also, all studies are influenced by the paradigms, perceptions, beliefs, and values of the researcher. To qualify as trustworthy research, those frameworks and assumptions must be made explicit by the researcher (Creswell, 2007). This study was informed by my work with physician leaders in the healthcare industry over a period of three years. A risk of biased subjectivity, where the researcher only notices evidence that supports her own experiences, is another limitation of the study.

Lastly, the coding and scaling utilized to answer Research Question 2 was informal and limited in scope, which is a further limitation of the study.
Conclusions

The findings suggest that leadership development programs should integrate physicians with other non-clinical leaders in leadership development programs and stop isolating them. This change in the structure of leadership development best practices for physicians may encourage more collaboration between physicians and administration. It could also assist in breaking down the work silos and create space for both physicians and administration to work together outside of the healthcare environment which tends to have a hierarchical organizational structure.

Furthermore, physician leadership self-efficacy could be enhanced by a change in administrators’ behavior. The majority of participants agreed that physicians do have transferable leadership skills that they felt were not valued by administrators. These same participants spoke about others’ expectations that because they have high self-efficacy in clinical roles, they should also have high self-efficacy in leadership roles. If this expectation is not met, participants agreed that administrators treat them like they were not good leaders.

The basis of the Center’s leadership framework is the Leadership Pipeline that states that there are various levels of leadership. The participants in the Center’s program were at level one at the start of their leadership development program. Similar to non-physician leaders at level one, physicians may believe that they are not leaders but managers, planners, and organizers of stakeholders (employees).

The findings revealed that just because physicians have already achieved high self-efficacy as clinicians, that does not mean that they can or will skip leadership level one. As physicians, they do possess transferable skills that they can adapt to leadership. The participants agreed that they had transferable skills, but they needed assistance in focusing them toward stakeholders (employees) and not just patients.
One conclusion from the study was that physicians with low leadership self-efficacy may have been impacted by the Center’s leadership training. The leadership training was built on the 70-20-10 development framework, where 70 percent is on-the-job development, 20 percent is coaching, and 10 percent is classroom development. Participant 05 commented, “Physicians have been placed in leadership positions to perform as leaders but have not been given the resources and left to feel like they did not do a good job.” This development design may not be particularly beneficial to increasing physician leadership self-efficacy because the participants reported that physicians avoid situations where they do not feel like they can be successful.

Another conclusion from the study was that the leadership performance issues of physicians reported in the current literature may not always pertain to the physicians not performing because of low skills, knowledge, or abilities any more than it would pertain to non-clinical managers. Findings from this study suggest that leadership performance issues for physicians may be due to the lack of resources that physicians receive when placed in leadership roles. It was not uncommon for participants in the study to have no administrators to assist with their new management duties. I observed at the Center that the Chief of Staff did not have a dedicated Executive Administrator for approximately a year. There was no other Executive at the Center, at the same management level, that did not have a dedicated administrator. This study found that resources and support do not come naturally to physicians when they are promoted to leadership positions. Therefore, physicians’ workloads increase without the resources to assist them in their new role, and this could be contributing to their leadership performance issues.

Another conclusion drawn from the study was that leadership development programs should not be developed to turn our physicians into administrators. The findings suggested that if leadership development programs solely focus on the administrative aspects of leadership, they
will miss a great opportunity to capitalize on the physicians’ unique backgrounds. As a scholar-practitioner, I believe that we would want to have a physician leader bring his unique perspective to our leadership teams.

Moreover, the study concluded that vicariously seeing/hearing others succeed was important to the participants transitioning to leaders. Other physicians’ stories of overcoming failures and how they did it seemed important to increasing self-efficacy in physicians because physicians have a fear of failure and will avoid it at all cost.

Furthermore, the findings indicate that self-efficacy does not seem to be an issue until physicians have to outwardly demonstrate a behavior/skill in front of others – if their outward demonstration is less than they feel about themselves, it causes them to start thinking less about themselves, and then they avoid the experience (forever). The participants agreed that they do not seem to have that little voice inside that says “that’s not right” or “that is right”. Many of the participants relied on outward validation, looking for experiences that validated that they were okay. They wanted to avoid embarrassment, and leadership development classes provided a safe environment/lab for physicians to practice and increase their self-efficacy before demonstrating new behaviors in front of others. Participants shared that they were uncomfortable when others have an expectation of them that they cannot meet. Self-efficacy and outward actions were proved to be related, based on the findings. Physicians need the ability to practice leadership skills/behaviors in a safe environment because if they try it in front of others and fail, they may avoid the experience again (forever).

Lastly, the findings from this case study reveal that in the current administrative environment, the participants believe they need to give up their clinical responsibilities at a certain level of administration. All of the physicians stated that they would not want to be 100
percent administration. The findings indicate that many of them want to be physician leaders, true hybrids between physicians and administrators. In order to accomplish being a true hybrid, they need “leadership enrichment” and the resources to make it happen.

Implications for Practitioners

Findings suggest that practitioners who teach physicians leadership development would benefit from a paradigm shift away from the idea that physicians do not have interpersonal, communication, and trust building skills, and toward the idea that physicians need to learn how to use their interpersonal, trust-building, and communication skills 24/7 and transfer the use of these skills outside of the clinic to use with nurses, support staff, and administration.

Findings show that a key to effective physician leadership development was reminding physicians that they use effective interpersonal and communication skills with patients every day, and they could benefit from adapting and exhibiting these skills when they were interacting with nurses, support staff, and administration.

Being a scholar practitioner, I recalled my days as a performance consultant. I started to wonder about the other possible reasons why physicians may not be successful in leadership, as the existing literature reports in Chapter Two that physicians have not been effective leaders. Could there be other reasons besides physicians not having the skill set or the desire? I was able to brainstorm the following list of possible causes for a perceived lack of leadership from physicians:

- Lack of resources and support
- Lack of planning for their position
- Lack of a career path
- Lack of clear goals
- Lack of role models
- Lack of a support system for new physician leaders

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Thinking about the other reasons why physicians could not perform well in leadership brought me to the conclusion that many healthcare organizations could be placing the cart before the horse by developing physician leadership development programs for physicians before they have developed the foundation or structure to support their success in the program and sustained success as physician leaders. Could this be why they have failed in the past?

One participant also suggested that administration and physicians have a difference of opinion on what physicians want in their leaders. Therefore, I wondered, if physicians could have failed in leadership because of the measurement that is being used by administration to determine their success. The mindset of an administrator is very different than that of a physician. A conclusion I drew from this was that perhaps physicians were being measured against incompatible measures of success. Administrators with a business background may filter the physicians’ leadership behaviors and characteristics through a business lenses, as opposed to creating a new lens that is a combination of business and clinician experiences.

Healthcare organizations that want to have a successful physician leadership program need to have a path to physician leadership; have some idea of where the leaders will go after the program and/or have role models in physicians leaders who have already been successful; and have a high up, hands-on Executive sponsor who values leadership development.

Furthermore, healthcare organizations need to make room at the table for physician leaders because there is no career path that details where the leadership development training is going to lead the physicians.

Lastly, healthcare organizations need to engage Human Resources with the development of career paths, engaging physicians in performance management and having them go through
the entire selection, hiring, onboarding, and training systems just like the other stakeholders (employees).

Recommendations for Further Study

The understanding that physicians do not want to give up their clinical practice sheds light on a need for research on the description, roles, and responsibilities of hybrid physician leaders who are both administration and clinical. There also needs to be a new measurement of physician leadership. Another recommendation for further research is conducting an empirical study to test if there truly is a difference in the level of management skills of physician managers compared to non-clinical employees.

Moreover, future research should include triangulation involving the use of different methods, especially observation, focus groups, and individual interviews, which form the major data collection strategies for much qualitative research. Although observations and documents were informally used in the study, more detailed observations that are analyzed and coded in should be included in future studies. Lastly, theoretical saturation was determined informally, and a more rigorous method of determining saturation should be used in future studies.

Additionally, further research could be conducted on determining what the differences are between what physicians would like to see in their physician leaders and what administration would like to see in physician leaders. The findings support the literature that states that the goals of these two groups (physicians and administrators) may be different, their objectives may be different, and sometimes they do not quite match. I think physician leaders in the administrative world are still fairly new and require additional qualitative and quantitative research on role definition.
Lastly, the findings for Research Question Two were uncovered at a high level due to informal coding and scaling. A more rigorous method of coding and scaling should be used in future studies. Furthermore, the findings in this case study were consistent with much of the research literature in Chapter Two, and therefore, provide a clear argument for using this case study and its findings as a first step toward a theory of physician leadership and self-efficacy to be developed using grounded theory.
APPENDIX A

INITIAL INTERVIEW GUIDE A
1. Describe how you view yourself as a leader and your belief in your competence to perform as a leader.

2. Describe how others view you as a leader and their belief in your competence to perform as a leader.

3. Describe any verbal persuasion (attempts by others to influence your behavior through suggestion) that you have experienced and describe how this experience impacted you.

4. Have you personally witnessed another physician growing as a leader? Please describe how this experience impacted you.

5. Have you led and championed a change in business that required you to influence others? Please describe how you ensured the implementation of the change in the face of obstacles.

6. Please describe how the Physician Leadership Development Program helped form/reinforced your beliefs that you can be/are a leader?

7. Please describe how the Physician Leadership Development Program helped you to grow as a leader?

8. In the last 6 months, what are the significant events and performance accomplishments that have helped you to grow as a leader?

9. If you considered the events that you described, please describe one or two events that specifically impacted your development as a leader?

10. Describe how you learned during the event(s). What triggered the learning? What strategies from the Physician Leadership Development Program did you use during the event(s)?

11. What did you learn about yourself as a leader during the event(s)? Please describe any physiological states (amount of stress, fear, and anxiety) that you exhibited during the event(s).
12. Describe any shifts you have made in the last 6 months to identify yourself as a leader?

13. Is there anything else you would like to share about how you have learned to be the leader that you are?
APPENDIX B

INTERVIEW GUIDE B
1. One of the beliefs/perceptions that physicians have about their ability to lead is that “it is in progress” and “immature leaders”. Will you please elaborate and/or provide examples of what this looks like?

2. One of the ways physicians learn to be leaders is through “formal training/education”. Will you please describe how attending formal training prepares you to be a leader? How is it helpful/successful or not in increasing physician self-efficacy in leadership.

3. “Push myself into situations that are not in my comfort zone.”—Do you have to be pushed, given no way not to do it?

4. Physicians list integrity, trust, respect for others, transparency, and knowing the bigger as how a physician leader act/show up. Can you provide a recent example of a time when you have exhibited these traits?

5. Some of the physicians mentioned a hybrid physician leader someone who is not 100% an administrative leader or a clinical leader. How would you describe this role? What would be the roles and responsibilities of this new leader?

6. Please describe what would be the training/preparations for this type of leader?

7. Please describe how you perceive yourself as a servant leader? How was this perception formed?

8. Some of the physicians described becoming leaders through a “heart change”. Does this concept resonate with you? Why or why not?

9. Please describe how your belief in yourself has grown as a physician leader? Please describe what activities, learning events etc. have increased your belief that you are a leader?
10. Describe how you learned during the event(s). What triggered the learning? What strategies from the Physician Leadership Development Program did you use during the event(s)?

11. Is there anything else you would like to share about how you have learned to be the leader that you are?
APPENDIX C

UNIVERSITY OF NORTH TEXAS INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT FORM
UNIVERSITY OF NORTH TEXAS INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT FORM

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** Physician Leadership and Self-Efficacy: A Case Study Using Grounded Theory

**Student Investigator:** Princess Cullum, University of North Texas (UNT) Department of Learning Technologies. **Supervising Investigator:** Dr. Michael Spector.

**Purpose of the Study:** You are being asked to participate in a research study which involves using a grounded theory approach to determine how voluntary leadership development impacts physicians' beliefs with regard to their leadership self-efficacy. This exploratory research intends to address some of the gaps in the literature on self-efficacy and physician leadership development. The research questions are Q1) How do physicians describe their outcome experiences (what they believe will happen as a result of their behavior) following the completion of a 6-month transformational leadership development program. Q2) Do these experiences influence physicians' self-efficacy related to leadership.

**Study Procedures:** You will be asked to attend two key informant interview at Cancer Treatment Centers of America that will take about 60 minutes of your time.

**Foreseeable Risks:** No foreseeable risks are involved in this study.

**Benefits to the Subjects or Others:** This study is not expected to be of any direct benefit to you, but we hope to learn more about physician leadership development practical applications for healthcare organizations and trainers of physicians. This study could also provide additional information regarding how to train other professions e.g. university and college professors who are asked or required to transition to leadership roles.

**Compensation for Participants:** None

**Procedures for Maintaining Confidentiality of Research Records:** The audio files will be transcribed by the investigators and then deleted. The transcript records will not have real names of the participants and will be only accessible to the researcher of this project. Thus, there is no personally identifiable information on the transcript records (no addresses or telephone numbers and very minimal risks are involved for the participants. Additionally, the confidentiality of your individual information will be maintained in any publications or presentations regarding this study.
Questions about the Study: If you have any questions about the study, you may contact Princess Cullum at 404-908-2251 or Dr. Michael Spector at 940-565-4194.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-4643 with any questions regarding the rights of research subjects.

Research Participants’ Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Princess Cullum has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

__________________________________________
Printed Name of Participant

__________________________________________  ____________
Signature of Participant  Date

For the Student Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

__________________________________________  ____________
Signature of Student Investigator  Date
APPENDIX D

LEADERSHIP PROGRAM SYLLABUS
### April 2014

**Physician Leadership Development**

**Kick-Off Activities**

<table>
<thead>
<tr>
<th>Monthly/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014 Kick-Off Activities</td>
<td></td>
<td>Participant Welcome Communication</td>
<td>60 minutes</td>
<td>4/11-4/28</td>
<td>Main Conf Room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Pre-Program 360-Degree Performance Standards Assessment</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>o Insights Assessment (select participants)</td>
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<td></td>
<td></td>
<td>o Pre-Program Individual Interviews</td>
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<tr>
<td></td>
<td></td>
<td>Opening Ceremony Introduction of Program, Distribution of Books, Learning Journey, Leadership Program Binder and Executive Speakers – Dr. Daneker, David Kent, and Anna Simelane</td>
<td>2 hours</td>
<td>4/28</td>
<td>Boardroom</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insights Debrief Session (select participants) Facilitator: Susan Nind</td>
<td></td>
<td>4/25</td>
<td></td>
</tr>
</tbody>
</table>
## May 2014
### Communication

<table>
<thead>
<tr>
<th>Month/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
</table>
| May 2014                    | The proactive delivery of clear information that supports the CTCA quest for insights, transparency and wisdom. | **Classroom:**  
- DDI Communicating for Leadership Success  
  Bob Pearson  
- Executive Speaker and Book Club  
  Dr. Kenneth Cohn  
**Book Club:**  
*Crucial Conversations* - K. Patterson, J. Grenny, R. McMillian & A. Switzler  
**Homework** – Reading, Journaling, and Self-Coaching | 2 hours | 5/9 & 5/12 | Main Conf Room |
|                            |                |                           | 60 minutes | 5/23      |                |

## June 2014
### Development and Learning

<table>
<thead>
<tr>
<th>Month/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
</table>
| June 2014                  | Recognize and reward goal achievement  
Give stakeholder specific performance feedback  
Set agreed upon career development goals  
Coach and develop team members | **Classroom:**  
- Development and Learning  
  Larry Mohl  
- Executive Speaker & Book Club  
  Larry Mohl  
**Book Club:**  
*The Leadership Pipeline: How to Build the Leadership Powered Company* – Ram Charan, Stephen Drotter, James Noel  
**Homework** – Reading, Journaling, and Self-Coaching | 2 hours | 6/13 & 6/16 | Main Conf Rom |
|                            |                |                           | 90 minutes | 6/27      |                |

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### July 2014
Management and Planning

<table>
<thead>
<tr>
<th>Month/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>July 2014 Management and Planning</strong></td>
<td><strong>CTCA Behaviors</strong>&lt;br&gt;- Delegate tasks to stakeholders&lt;br&gt;- Make informed decisions that impact strategies&lt;br&gt;- Help each stakeholder on team develop SMART goals</td>
<td><strong>CLASSROOM:</strong>&lt;br&gt;- DDI Coaching for Peak Performance&lt;br&gt;Bob Pearson&lt;br&gt;- Executive Speaker &amp; Book Club&lt;br&gt;Anne Meisner, Chief Executive Officer&lt;br&gt;&lt;br&gt;<strong>Book Club:</strong>&lt;br&gt;<em>1-Minute Manager</em> – Ken Blanchard &amp; Spencer Johnson&lt;br&gt;&lt;br&gt;<strong>Homework</strong> – Reading, Journaling, and Self-Coaching</td>
<td>2 hours</td>
<td>7/11 &amp; 7/14</td>
<td>Main Conf Rom</td>
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</table>

<table>
<thead>
<tr>
<th>Duration</th>
<th>90minutes</th>
<th>7/25</th>
<th>Main Conf Room</th>
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</table>

### August 2014
Relationship and Team Building

<table>
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<tr>
<th>Month/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>August 2014 Relationship and Team Building</strong></td>
<td><strong>CTCA Behaviors</strong>&lt;br&gt;- Build strong collaborative relationships with others&lt;br&gt;- Hold self and team accountable</td>
<td><strong>Classroom</strong>&lt;br&gt;- DDI Working as a High Performance Team&lt;br&gt;Bob Pearson&lt;br&gt;- Executive Speaker &amp; Book Club&lt;br&gt;Dr. Kenneth Cohn&lt;br&gt;&lt;br&gt;<strong>Book Club:</strong>&lt;br&gt;<em>Managing Teams for Dummies</em> - Marty Brounstein&lt;br&gt;&lt;br&gt;<strong>Homework</strong> – Reading, Journaling, and Self-Coaching</td>
<td>2 hours</td>
<td>8/8 &amp; 8/11</td>
<td>Main Conf Rom</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
<th>90 minutes</th>
<th>8/22</th>
<th>Main Conf Room</th>
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</table>

116
### September 2014
#### Innovation and Change

<table>
<thead>
<tr>
<th>Month/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2014</td>
<td>CTCA Behaviors</td>
<td>CLASSROOM:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Listen to stakeholder and patient feedback</td>
<td>• Innovation and Change [Larry Mohl]</td>
<td>2 hours</td>
<td>9/5 &amp; 9/8</td>
<td>Main Conf Room</td>
</tr>
<tr>
<td></td>
<td>• Acknowledge stakeholder’s efforts</td>
<td>• Executive Speaker and Book Club [Larry Mohl]</td>
<td></td>
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<tr>
<td></td>
<td>• Recognize when new or modified approaches are necessary</td>
<td><strong>Book Club:</strong> [The Leadership Challenge: How to Make Extraordinary Things Happen in Organizations, 5th Edition] – James M. Kouzes &amp; Barry Z Posner</td>
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<td></td>
<td></td>
<td><strong>Homework</strong> – Reading, Journaling, and Self-Coaching</td>
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### October 2014
#### Patient Centricity

<table>
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<tr>
<th>Month/Performance Standard</th>
<th>CTCA Behaviors</th>
<th>Activities and Curriculum</th>
<th>Duration</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2014</td>
<td>CTCA Behaviors</td>
<td>Classroom:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prioritize activities</td>
<td>• Prescription for Change: Mindfulness for the Mind and Body [Elaine Smith and Diane Schaab]</td>
<td>2 hours</td>
<td>10/3 &amp; 10/6</td>
<td>Main Conf Room</td>
</tr>
<tr>
<td></td>
<td>• Set realistic and achievable expectations</td>
<td>• Executive Speaker and Book Club [Patient Impact Statement]</td>
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<td></td>
<td></td>
<td><strong>Book Club:</strong> [Servant Leadership: A Journey Into the Nature of Legitimate Power and Greatness] – Robert K. Greenleaf</td>
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<tr>
<td></td>
<td></td>
<td><strong>Homework</strong> – Reading, Journaling, and Self-Coaching</td>
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The program will include a one-hour graduation in November 2014 and final program assessments including:

- Physician Post-Program Survey
- Physician Focus Groups and Individual Interviews
- Coaching Sessions: Held with each physician and a member of Sr. Executive Team

A Post-Program 360-Degree Performance Standards Assessment will be conducted in January 2015 to determine the 30-day post event impact of the program.
APPENDIX E

PHYSICIAN LEADERSHIP DEVELOPMENT

PROGRAM ORIENTATION DECK
SERMC Physician Leadership Development Program

Opening Ceremony

Welcome
Purpose of Program

Program Strategic Alignment: FY15 Enterprise Strategic Initiatives

- Enterprise Stakeholder Engagement Goal
  51% to 55%
- FY14 SERMC Stakeholder Engagement 93%
  Goal to maintain

Built on Best Practices

- National Benchmarks
  - The Advisory Board Physician Leadership Academy
  - American College of Physician Executives
  - American Society of Training and Development
  - Society of Human Resource Management
- SERMC Manager of Others Program enhanced following SWOT analysis
  - 88% of participants stated that the Leadership Development Program greatly influenced their behavior as leaders
  - Reduced Stakeholder Complaint about Manager from 13% to <1%
  - Turnover rate from 11% to 7%
  - Consistently high engagement scores
Engagement over Time

![Bar chart showing engagement over time with data points for Oct '12 BPW, Mar '13 HIM, Aug '13 Eng., Sept '13 HIM, Dec '13 BPW, and Feb '14 HIM. The chart indicates turnover rate incl. and US Best.]
Elements of a Successful Program

- Fully engaged participation by Senior Leadership Team
- Program curriculum anchored in performance standards and engagement behavior
- Continuous coaching and feedback by Executive Team Leader
- Blended Learning
- 24 classroom training hours
- Cohort structure that provides an avenue for peer collaboration and coaching
- Real-time tracking and reporting of program for continuous improvement

Program Objectives

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Do’s</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to apply each Team Success Factor to enhance team performance.</td>
<td>Relationship &amp; Teambuilding</td>
<td>Program Metrics:</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td>Learning relevance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning effectiveness</td>
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<tr>
<td></td>
<td></td>
<td>On-the-job Application</td>
</tr>
<tr>
<td>How to provide positive feedback that recognizes and motivates individuals and teams as well as developmental feedback that helps others get back on track.</td>
<td>Patient Centricity</td>
<td>Individual Metrics:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Behavior change – performance standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year-end review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engagement results – manager specific</td>
</tr>
<tr>
<td></td>
<td></td>
<td>questions</td>
</tr>
<tr>
<td>How to handle patient experience issues with compassion.</td>
<td>Mgmt &amp; Planning</td>
<td>Site Metrics:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engagement results (by dept)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Turnover rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vacancy rate (by dept)</td>
</tr>
<tr>
<td>How to determine goals and measurement methods that will help track and demonstrate the results of effective leadership.</td>
<td>Innovation &amp; Change</td>
<td>Stakeholder relations complaints (by dept.)</td>
</tr>
<tr>
<td>How to encourage my team to find solutions to problems and change opportunities.</td>
<td>Development &amp; Learning</td>
<td></td>
</tr>
</tbody>
</table>
Program Structure

- Pre - Program
  - Cohort selected
  - 360-degree Assessment
  - Individual Interviews
  - Reinforcing Leadership Development workshop for Executive Team Leaders

- Program
  - Kickoff
  - Complete course requirements for 6 month curriculum
  - Monthly Meetings with Executive Team Leader
  - Monitor progress and level of performance support

- Post - Program
  - Graduation
  - Evaluation of results
  - Post-program Assessment
  - After-action review
  - Provide resources to reinforce behavior change
  - Enroll in continuous learning

Program Curriculum

- 6 month curriculum: May 2014 – October 2014
- Built on Performance Standards
- Bi-Weekly learning events
- Duplicate Monday and Friday classes available
- Friday Inspirational Speaker
- Avg. 2hrs./bi-weekly
- 75% Attendance Requirement for Graduation
- Graduation Ceremony – November 2014
Next Steps

- Pre-Program 360-degree Assessment
- Learning goals discussion with Executive Team Leader by May 31, 2014
- Physician Leadership Development Program (May-October 2014)
- Post-Program 360-degree Assessment
APPENDIX F

PHYSICIAN LEADERSHIP TEAM RETREAT AGENDA
Physician Leadership Team Retreat

Chateau Élan

November 20-21, 2015

**Desired Outcomes**
- Create shared vision of the most desired physician leadership team
- Introduce Physician Empowered Performance Program
- Develop greater understanding and appreciation of work styles on the team
- Provide team feedback that results in more effective performance
- Make commitments to reinforce progress

**Saturday Nice Banquet Room**

**Business Casual**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td>Continental Breakfast</td>
</tr>
<tr>
<td>7:50 – 8:00 am</td>
<td>Opening</td>
</tr>
<tr>
<td>8:00 – 8:10 am</td>
<td>Ice Breaker – Setting the Stage in Change</td>
</tr>
<tr>
<td>8:10 – 8:25 am</td>
<td>Introduction to <em>Appreciative Inquiry</em></td>
</tr>
<tr>
<td>8:25 – 9:20 am</td>
<td>Discovery Interviews</td>
</tr>
<tr>
<td>9:20 – 9:35 am</td>
<td>BREAK</td>
</tr>
<tr>
<td>9:35 – 10:15 am</td>
<td>The Positive Core</td>
</tr>
<tr>
<td>10:15 – 11:00 am</td>
<td>Theme Development and Agreement</td>
</tr>
<tr>
<td>11:00 – 12:00 am</td>
<td>Dream – Imagine What Might Be</td>
</tr>
<tr>
<td>12:00 – 12:30 pm</td>
<td>LUNCH</td>
</tr>
<tr>
<td>12:30 – 1:15 pm</td>
<td>Physician Corporation of Georgia Financial Analysis Performance</td>
</tr>
<tr>
<td>1:15 – 2:00 pm</td>
<td>Physician Empowered Performance Program</td>
</tr>
<tr>
<td>2:00 – 3:00 pm</td>
<td>Physician Empowered Performance Program continued</td>
</tr>
<tr>
<td>3:00 – 3:15 pm</td>
<td>BREAK</td>
</tr>
<tr>
<td>3:15 – 4:30 pm</td>
<td><em>Insights 2.0</em></td>
</tr>
<tr>
<td>4:30 – 4:50 pm</td>
<td>Commitments</td>
</tr>
<tr>
<td>4:50 – 5:00 pm</td>
<td>Closing Remarks</td>
</tr>
</tbody>
</table>
APPENDIX G

PHYSICIAN LEADERSHIP TEAM RETREAT OBSERVATION NOTES
• Setting: the setting was an upscale, five-star resort in the northern suburbs of Atlanta. The meetings and catered meals were held in a large meeting space with floor to ceiling windows with a view of trees and grass. The room set-up was a U-shaped table and chairs.

• Organization: the meeting was professionally facilitated by one internal and one external facilitator.

• Attendees: eight participants – missing P07 and P08, the Chief Operation Officer and the Assistant Vice President, Talent. The mood of the attendees appeared to be light hearted and relaxed. Dress was business casual.

• Participant Leadership Strengths: participants’ self-descriptions of their leadership strengths
  o P05: Resilience, Empathy
  o P01: Complionate, Leadership
  o P04: Questioning, Leadership
  o P09: Confidence, Improved Interactions
  o P02: Resilience, Strong Family Unit
  o P03: Inner Strengths
  o P10: Business Minded, Communication
  o P06: Patience, Decision-Making Process, Self-Aware

• Participants’ Positive Core: participants shared their leadership stories with one another and uncovered the common denominator for all participants and the strengths that exist when they feel that they are at their best.
  o Culture
  o Shared Vision
  o Strong Relationships (internal and external)

• Participants’ Vision: participants brainstormed in small groups of three the vision for the physician leadership team and came to a consensus on “The premier physician leadership team delivering exceptional, patient-centric, cancer care, in a collaborative environment”.

• Participants’ Commitment: behaviors observed indicated a high level of commitment by participants including the following:
  o Time: participants’ willingness to give up a two day weekend prior to a Thanksgiving holiday
  o Structure and Stability: participant discussions were orderly and attention was paid to allowing everyone an opportunity to weigh in on topic discussed
  o Relationship and Trust Building: environment was collegial with very little interrupting of one another during discussions and many compliments to one another when one perceived that a good suggestion was spoken by another participant (to assess direction of the departments). Participants offered to assist one another with the following:
- Recognition
- Research
- Commitment to Quality
- Engage Patients
- Share Messaging from Retreat with Colleagues and Stakeholders
- Create shared messaging
- Experience
- Assistance with Recruitment
- Quality – Identifying Meaningful Metrics

- Develop Strategic Plan and Accountability: participants showed thought leadership and shared ideas that spoke to issue at the system not the patient level. Participants suggested that they needed the following to move their leadership team forward:
  - Script/talking points summarizing physician leadership journey
  - Medical Staff Newsletter
  - Administration support to organize group and make sure they move forward (for leadership group)
  - Understand governance structure
  - Talk and communicate with one another
  - Create a physician leadership distribution list
  - Accountability for one another’s success
  - Be solution driven

- Sustainability – participants spoke of desires to build the physician leadership bench and to mentor other physicians.
APPENDIX H

DISTRIBUTED MEMOS
• Physicians prefer a collegial approach. They have not found themselves thinking more as individuals here but more as reaching a goal that their entire center has had since they arrived. They are surrounded by people who are of a similar mindset in a place where the goal of the center is beyond their individual goals so that is also an important thing. Is this the first time they have felt this way?

• Physicians like to be developed and have a history of being successful developed. Like the role of life-long learner. They find leadership development fascinating because it is a whole new world that is different and challenging for them to learn. Like to be challenged. Could it be that they are no longer challenged/reached the top with their medical careers and looking for a new challenge.

• What’s changed, for the physicians is not the tool but the natural growth that occurs in over one’s life’s journey. It appears to happen sometimes when they are going through a very difficult personal thing, and can impact their self-esteem and they may lose some grounding. How is this different from anyone else’s journey to leadership?

• They realize at some point that there is no way as an individual they could come up with the multifaceted treatment that the center’s patients’ need. They simply must acquiesce what they cannot do as well as other over to them. They just don’t know it all. They have to let people do what they do best. When and why does this happen?

• Some of the participants actually have a lot of self-doubt. A few have needed to be convinced that they are good leaders. They are not totally comfortable with this term. This is surprising and I think significant.
• As physician leaders, they need to be able to see themselves in more than one role wearing different caps like clinical leader, team leader, and administrative leader, and know how to blend and work those roles when needed and not work them when they are not needed. How do they learn how to do this?

• Some of the physicians have the type of personality that needs to be pushed into situations that are out of their comfort zone. Why is this? Need to probe more. This seems significant.

• Physicians mentioned how their definitions of leadership have changed from medical school, to residency to their first medical role. They have learned to adapt to their surroundings.

• Realizing that the one size of leadership doesn’t fit all seems to be significant because their medical training reinforces that there is one way to fix a problem and it is their way. They have learned through trial-and-error that perhaps they do need to change their leadership styles for some people, which appears to be very difficult for them. They like to be fair and consistent.

• They have learned that they can be fair and consistent even when delivering messages in different ways.

• They have been tapped on their shoulders for leadership roles their entire lives e.g. sports, student councils etc. They think back and reconcile that they have been leaders most of their lives even if they didn’t recognize it. They have found very little room for “I cannot do this,” and have realized that everybody doesn’t think the same way.

• They like being leaders even though it sometimes competes with their other priorities. So even though they like that, they also learned that perhaps they cannot lead everybody and they
cannot obtain the same results in everybody even if they try different styles. This I think is hard for them because they are used to getting consistent clinical results. When I do this, I should get that.

- They have found the leadership training to be helpful in their personal and work lives e.g. communication skills.

- Physicians I think do believe that they are different; they are the ones that are expected to fix the problem. They are the ones who know what the issue is and how to fix it. Compromising is hard for many of them to do. The problem that many physicians have is communication problems. Why? Because they want to do it their way. How do they change this perception of all knowing?

- Being involved in a leadership program boosts their self-confidence. But what comes first? Are they already self-confident and it is noticed and they are placed in leadership roles. Or are they placed in leadership roles and that is what makes their self-confidence grow? If they are around others that they deem as self-confident do they therefore conclude that they too must be self-confident?

- Self-confidence also shows up because they are in a specialty (oncology) that’s in high demand. They believe they can behave badly and if fired, they will have another job before noon. There is not incentive to act mature. So why do they stay at the Center where there pressure to behave in a certain way? Why the Center?

- Physicians are definitely motivated by money but other than monetary gains, what else matters? How/why do relationships matter?
• Some physicians perceive there to be a value in being able to elicit trust in patients but don’t see that same need outside of the patient/physician relationship? Why? Actually, I don’t believe this is what they are saying. Perhaps, I am making a point out of this, but they are not trying to suggest that they don’t see the value in employee relationships. I need to understand this better. Perhaps, it is just not natural for physicians in general to see that. They need to convince their patients to trust them or they can’t do their jobs, whether they’re talking about getting the case, financial benefit, or just allowing them to help, altruistic benefit.

• There is something about the physicians’ life experiences, age, and previous training that have assisted them in transitioning to leadership. Need to dig deeper.

• Collaboration and now vision are starting to emerge more from the physician interviews as shaping their journey to leadership. Need to better understand why they believe they are important experiences.

• The physicians’ stories about challenges seem to sound to me like those are all things that maybe even led them to the center, because maybe there was a similarity in what the physicians’ already believed, wanted to exhibit in a place where they would actually be able to carry those things out, could that be true?

• The physicians say that it is all about the patient, they say it is similarity and developing different goals. I need to hear more examples of how that actually looks or plays itself out at the center.
The physicians speak with lots of “we” and not many “I”. They speak about the group a lot. So as a leader, what is their specific roles in the collaborative/group environment they keep referring to as being different from other hospitals?

I’m hearing some more of what I’m getting to about physician leadership. The physicians seem to have bought into this concept/vision at the center. They are saying that as a physician, they can’t do it all and this notion is different from their previous environments (hospital). The center is this grandiose idea, different from previous perceptions/beliefs that physicians were at the top, they did it all, they could do it all, it began and stopped with them. This notion stopped when they came to the center. Why?
APPENDIX I

IRB
University of North Texas Institutional Review Board

Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Self-Efficacy in Physician Leadership Development


Purpose of the Study: You are being asked to participate in a research study which involves using a grounded theory approach to determine how voluntary leadership development impacts physicians’ beliefs with regard to their leadership self-efficacy. This exploratory research intends to address some of the gaps in the literature on self-efficacy and physician leadership development.

Study Procedures: You will be asked to attend two key informant interview at Cancer Treatment Centers of America that will take about 60 minutes of your time.

Foreseeable Risks: No foreseeable risks are involved in this study.

Benefits to the Subjects or Others: This study is not expected to be of any direct benefit to you, but we hope to learn more about physician leadership development practical applications for healthcare organizations and trainers of physicians. This study could also provide additional information regarding how to train other professions e.g. university and college professors who are asked or required to transition to leadership roles.

Compensation for Participants: None

Procedures for Maintaining Confidentiality of Research Records: The student investigator will record the participants’ answers using Enhanced Dictation on her Apple device. The student investigator and the participants will use an external microphone connected to her Apple device. The Enhanced Dictation function on her Apple device will allow the spoken words to appear in the text box on her device. The transcribed documents will be manually edited to remove any real names of the participants. Also, the transcribed documents will only be accessible to the researchers of this project. Thus there is no personally identifiable information on the transcribed records (no names, addresses or phone numbers) and very minimal risks are involved for the participants.

Office of Research Integrity & Compliance
University of North Texas
Last Updated: July 11, 2011

APPROVED BY THE UNT IRB
FROM 9/4/15 TO 9/3/16

Page 1 of 2
Questions about the Study: If you have any questions about the study, you may contact Princess Cullum at 404-908-2251 or Dr. Michael Spector at 940-565-4194.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-4643 with any questions regarding the rights of research subjects.

Research Participants' Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Princess Cullum has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

______________
Printed Name of Participant

__________________________
Signature of Participant       Date

For the Student Investigator:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

__________________________
Signature of Student Investigator       Date
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