Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration

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FACTORS THAT INFLUENCE PHYSICIANS TO ASSUME LEADERSHIP ROLES: A FOCUS ON CLINICAL INTEGRATION

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Doctor of Education

By
Jennifer Lynne Jackson

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FACTORs THAT INFLUENCE PHYSICIANS TO ASSUME LEADERSHIP ROLES: A FOCUS ON CLINICAL INTEGRATION

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I dedicate this dissertation to my husband Dedrick Jackson because, without his support, my dream of earning a doctorate would have never been possible. I also dedicate this to my sons Kobi and Dylan.
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Completing a doctorate degree is not an individual endeavor. I owe my deepest gratitude to my husband Dedrick Jackson for his constant encouragement and willingness to be my sounding board. At times when I felt stuck and utterly defeated, he put all else aside to support his crazy wife. I can’t thank him enough for taking the lead parent role when I needed time to attend classes and work on my dissertation.

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PREFACE

It is the researcher’s belief that understanding the leadership choices of current physician leaders is instrumental to inspiring, recruiting, and training additional physician leaders to meet clinical integration needs. It also is the researcher’s belief that personal experiences cannot be generalized.

Qualitative research is performed when the topic is of particular interest to the researcher, and having experience in the topic being researched is essential to being able to draw findings that will inform practice. Currently, the researcher for this study is the director of a physician-hospital organization (PHO) and provides leadership for the credentialing department of a hospital-employed medical group. In this position the researcher is acutely aware of the critical need for physician leadership in all three of the populations being studied. Already an insider, this gave the researcher an advantage in making contact with the potential physician leader participants.

As a leader in healthcare who has worked closely with physicians for 16 years, the researcher believes physician leadership is important for patients to receive the highest quality healthcare. As director of a provider network, the researcher’s work responsibilities include building physician networks and recruiting physicians to serve on boards and committees. Additionally, the researcher is frequently involved in educating physicians on the importance of maximizing payer reimbursements, a highly relevant topic in clinical integration.

The researcher also frequently notices that physicians often are reluctant to assume leadership roles due to the additional administrative burdens these roles require. A few physicians have even expressed to the researcher their fear of failure in assuming
additional leadership responsibilities resulting from the fact that they are already overwhelmed with large patient loads. The above combined experiences provide the researcher with an understanding of and personal interest in the need for developing physician leaders.
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The Patient Protection and Affordable Care Act of 2010 (PPACA) drastically altered the healthcare industry in the United States. Along with multiple other directives, the PPACA mandated that physicians and hospitals work together in strategies known as clinical integration. For effective clinical integration to be achieved, interdependence among physicians and hospitals is required to provide the highest quality outcomes for patients at the best possible value. To this end, healthcare leaders have identified that the key to establishing successful clinical integration is the presence and commitment of physician leaders (Penlington & Marshall, 2016).

This study explores factors that influenced a sample of physician leaders to assume leadership roles in clinical integration. The qualitative phenomenology methodology was selected to study the experiences of physician leaders through their own perspectives. The theoretical framework is guided by the concept of meta-leadership, with a focus on the dimensions of leadership in context and trust.

Semi-structured interviews were conducted with 12 purposefully selected physicians holding leadership roles within hospitals, hospital-employed medical groups, and/or physician-hospital associations. Data collected from these in-depth interviews related to four research questions: (1) How do physicians make the decision to transition into leadership roles within health systems?; (2) What leadership skills are required for physician leaders within health systems?; (3) To what extent does healthcare reform
impact physician leadership within health systems?; and (4) What are the perceived benefits and drawbacks of being a physician leader within health systems?

Based on the four research questions, a concept map was developed to code themes and patterns in participant responses. The overall key findings of this study include: (a) encouragement by mentors or friends, (b) career progression into leadership, (c) desire to impact change, (d) lack of prior leadership education or training, (e) the importance of change management, (f) acceptance and management of healthcare reform, (g) need for physician leaders in healthcare, (h) enjoyment in leadership responsibilities, (i) the importance of having influence and a voice in decision making, (j) giving up time devoted to other causes, (k) frustrations with the amount of time needed to impact change, (l) difficulties in work/life balance, and (m) difficulties in leadership/clinical balance.

Recommendations from this empirical investigation provide guidance to health systems seeking physician leaders. Understanding the leadership choices of current physician leaders is instrumental to inspiring, recruiting, and training additional physician leaders to meet clinical integration needs. If healthcare leaders can begin to understand the reason current physicians have accepted leadership roles, they may be better equipped to recruit additional physician leaders.
CHAPTER I: STATEMENT OF THE PROBLEM

Introduction

Since its inception in 2010, the Patient Protection and Affordable Care Act (PPACA) continues to drastically alter the healthcare industry in the United States. As the title suggests, the statute implemented changes to healthcare practices intended to protect patients by increasing healthcare quality and affordability. Along with expansion of Medicaid and the implementation of penalties to the uninsured, the PPACA mandates that physicians and hospitals work together in strategies known as clinical integration for the purpose of improving the wellbeing of patients. Although clinical integration poses many implications, it invariably refers to the coordination of care among caregivers to improve healthcare quality and to share financial risk (Dye & Sokolov, 2013). According to the federal government, caregivers who collaborate on patient care reduce costly duplicate testing and the risk of adverse reactions to non-compatible medications, among other benefits (Patient Protection and Affordable Care Act of 2010). Consequently, clinical integration requires interdependence among physicians and hospitals to provide the highest quality outcomes for patients at the best possible value.

“Although healthcare represents 17% of the United States’ economy, it has traditionally remained the most fragmented industry” (Pizzo, 2013). Healthcare fragmentation results from the tradition of physicians and hospitals working independently with very little communication or coordination regarding a patient’s care (Dye & Sokolov, 2013). With mandates from the PPACA, commonly referred to as healthcare reform, this is no longer plausible. Similar to other industries, healthcare providers and hospitals rely on payment for services rendered to remain solvent and
“money drives everything” (Lee, 2016). Healthcare reform transformed the way physicians and hospitals must work together by altering the manner in which they are paid for treating patients. Traditionally, healthcare provider reimbursements depended upon the quantity of services, a term defined as fee-for-service (Miller, 2009). Under the fee-for-service model, physicians and hospital earned set fees for procedures, and the only way to increase revenue was to see more patients. Fee-for-service payments inadvertently produced healthcare providers and hospitals focused on the volume of patients served, with little accountability for the quality of care provided to those patients.

With PPACA, healthcare reform shifts provider payments to an emphasis on quality over quantity (Burns & Muller, 2008). In 2017, healthcare providers who practice proactive medicine – keeping patients well – will be rewarded. “The transition from a volume to value reimbursement methodology creates an environment where physicians and hospitals must find novel ways of working together to maximize or even maintain current revenue streams” (Patterson, 2015). However, a major obstacle to clinical integration is evidenced by the underlying structure mismatch of physicians and hospitals. Typically, a hospital is comprised of many departments and individuals working together in a corporate environment. Conversely, physicians commonly work independently or within a small group often removed from the corporate world. Bringing these two very different realities together is inherently complicated.

Healthcare leaders have discerned that the key to establishing successful clinical integration is the presence and commitment of physician leaders (Penlington & Marshall, 2016; Burns & Muller, 2008). According to a recent study, only 5% of current healthcare leaders are physicians (American Hospital Association [AHA], 2014). As physicians are
positioned at the front line in patient care, their knowledge and expertise in clinical practice and patient engagement is paramount. For physician-hospital collaboration to be achieved, engaged physician leaders must be present to work with hospital administrators on common patient care goals. For the formerly autonomous physician, assuming a leadership role and making patient care decisions as a team with the hospital is foreign.

Physicians choosing to assume leadership roles face many challenges. Although clinical integration provides them with many new and inspiring leadership opportunities, intense practice demands and the absence of leadership education have created a shortage of physician leaders (Kasti, 2015). By nature of their work, physicians are busy professionals working in high stress environments laden with heavy workloads and under intense scrutiny (Chervenak, McCullough, & Brent, 2013). The required quantity of medical training and continuing education allows for little time to undertake formal leadership development (Burns & Muller, 2008; Tibbits, 1996). Leadership skills such as vision, purpose, cooperation, and drive should be identified and cultivated in both current and potential physician leaders (Babitch & Chinsky, 2005). Effective physician leaders must possess a number of skills including communication, technical, interprofessional collaboration, and problem solving. Also, strong personal ethics, trust, and motivation are necessary. This study investigates the needed skills, education, and training of current physician leaders.

The changing culture of healthcare is progressively challenging to physician leaders (Carney, 2011). The industry has undergone more dramatic reforms in the past decade than since the 1960s. According to Nilsson and Furaker (2012), the best leaders are those who can take what they have learned and apply that knowledge to the most
volatile situations, especially those concerning change in the organization or the field. Understanding and managing healthcare in a rapidly changing environment is critical for a physician leader. With the implementation of the PPACA, the culture has shifted to a more consumer-based approach (Freeman, 2016; Rosenberg, 2012). As consumers of healthcare, patients make decisions on where they choose to seek care. Physician leaders must not only manage the health of their patients, but they must also provide high quality patient outcomes and commendable customer service. While patient safety, risk, and ethics remain crucial, a constant need to cut funding without impacting patient care is increasingly difficult. Physicians who assume leadership roles are expected to educate their colleagues in an understanding and acceptance of healthcare reform by leading the changes that must be made for productive clinical integration. This study’s examination of current physician leaders’ outlook on healthcare reform is valuable to understanding the leadership choices of physicians.

Assuming a leadership role provides physicians with powerful influence while adding the challenge of tremendous responsibility. The life-and-death business of healthcare generates extreme emotions; thus, physician leaders are meticulously scrutinized. Physician leaders of clinical integration must balance the best interests of their patients against financial considerations. They must live by certain codes of professional conduct, including the moral and ethical delivery of medicine and the promotion of healthcare quality. Reform demands that physicians and hospitals work together to treat patients and expects them to make decisions in the best interest of quality healthcare (Mintz & Stoller, 2014). The dual commitment between patient care and leadership can be difficult for physicians in an increasingly bureaucratic environment.
The interviews in this study explore specific benefits and drawbacks experienced by current physician leaders.

**The Problem Defined**

Clinical integration is a federally mandated strategy for physician-hospital collaboration created to increase healthcare quality (HealthLeaders Media Council, 2015). According to the HealthLeaders Media Council *Physician Alignment Survey* in 2015, 58% of respondents indicated their health system is working toward clinical integration strategies with both independent and hospital-employed physicians by 2018. Clinical integration strategies can take many forms, including growth of physicians employed by hospitals and the development of organizations designed specifically to increase physician-hospital collaboration, such as accountable care organizations (ACOs) and clinically integrated networks (CINs) (Penlington & Marshall, 2016; Kasti, 2015). The success of clinical integration initiatives depends upon the presence and effort of engaged physician leaders. Understanding the choice of physicians to assume leadership roles presents valuable knowledge to a healthcare entity seeking a strong physician leader.

Despite the growing need for physician leadership in clinical integration, limited studies exist regarding the way in which physicians make their decisions to assume leadership roles. Although research is available on the leadership practices and development of physicians, few studies have focused on the underlying reasons physicians choose to assume leadership roles (Pregitzer, 2014; Smartt, 2010). When factors such as the absence of leadership skills and uncertainty regarding healthcare reform combine, physicians may feel reluctant to step out as leaders (Chervenak et al.,
Understanding the individual perceptions of current physician leaders is instrumental to attracting and developing additional physician leaders for clinical integration initiatives.

**Purpose of the Study**

The intent of this investigation is to identify and to understand the individual choices of physician leaders through interviews with doctors holding these roles in three clinically integrated healthcare settings. Over a decade before implementation of the PPACA, researchers recognized that changes in healthcare are better received when physicians understand, accept, and help design their structure (Guthrie, 1999). The importance of physician buy-in and commitment continues to resonate as physician leadership drives modern clinical integration efforts. This qualitative phenomenological study is focused on the manner in which current physician leaders made their decisions to lead. Emphasis is placed on leadership training and education, personal views and beliefs on healthcare reform, and the benefits and drawbacks of leading in a highly volatile industry. This study seeks to provide a rich, in-depth, personal understanding into the career choices of current physician leaders.

**Theoretical Perspective**

The theoretical framework for this study is guided by the concept of metaleadership, with a focus on the dimensions of leadership in context and trust. “Meta-leadership is defined as the overarching leadership framework for strategically linking the efforts of different organizations or organizational units” (Dunbar, 2015). For this research, the leadership context under study is clinical integration, a model that requires the linking of physician and hospital efforts to achieve common healthcare delivery.
goals. As with any joint effort, trust is required between physicians and hospitals for effective clinical integration to be achieved. “Trust is the foundation for engaging and partnering with physicians” (Noon, 2016). As such, the concept of trust is discussed throughout this study.

**Research Questions**

While clinical integration requires an abundance of strong physician leaders, limited research is available concerning the motives behind current physician leaders’ role choices. Therefore, this study focuses on factors that influence physicians to assume leadership roles. The following overarching research questions give structure to the research:

1. How do physicians make the decision to transition into leadership roles within health systems?
2. What leadership skills are required for physician leaders within health systems?
3. To what extent does healthcare reform impact physician leadership within health systems?
4. What are the perceived benefits and drawbacks of being a physician leader within health systems?

**Significance of the Study**

The need for physician leaders grows exponentially as collaboration among caregivers increases through clinical integration efforts (Burns & Muller, 2008; Sowers, Newman, & Langdon, 2013). When physicians and hospitals collaborate with the purpose of managing healthcare, patient satisfaction and quality increase while the cost of care
decreases (Miller, 2009). Therefore, the qualitative research approach of this study identifies factors that influenced a sample of physician leaders to assume their leadership roles. Because physicians typically respond favorably to influences from their peers, this research provides valuable knowledge to other physicians considering leadership roles with hospitals (Deschamps, Rinfret, Lagace, & Prive, 2016).

First, a need exists to understand the phenomenon of physician leadership on an individual level. As healthcare evolves and greater collaboration among caregivers is required for clinical integration and quality care, the need for strong physician leadership is critical. As such, understanding personal perceptions of physician leaders who have made this transition is instrumental to attracting and retaining additional physician leaders.

Second, healthcare leaders require a certain skillset; thus, training and education play a role in physician leadership success (Babitch & Chinsky, 2005; Tibbitts, 1996). It is a common but misplaced assumption that, due to a physician’s extensive education and training he or she is well prepared to be an effective leader (Dye & Sokolov, 2013). Although a physician’s education typically is more extensive than other professions, the curriculum consists primarily of biology, clinical training, and practice-focused residencies, leaving little time for business and leadership training. Understanding the experiences and leadership competencies of physician leaders in this study should provide needed insight into the qualifications and skills required and the means to develop them in burgeoning physician leaders.

Third, this study is conducted during one of the most revolutionary decades in healthcare history – only a few years following implementation of the PPACA. In 2017
the PPACA revolutionary reform statute continues to alter clinical practice and reimbursements (Burns & Muller, 2008). This study explores the impact of healthcare reform on physician leadership, including repercussions to both providers and patients.

Finally, making the choice to become a leader provides physicians with additional influence in decision making but forces them to balance patient needs with financial constraints and operational obligations. Through the individual interviews in this study, specific advantages and disadvantages regarding the responsibilities of physician leaders are investigated.

**Limitations of the Study**

Several limitations exist for the current study. First, the sample included physicians holding leadership roles within hospitals, hospital-employed medical groups, and physician-hospital associations. Physicians outside the aforementioned health system affiliations were not included. Thus, the findings may not be generalizable to all physician leaders. Second, the total number of participants was limited to 12. Although the sample is representative of the population being studied, a larger sample could conceivably offer additional perspectives.

Third, the researcher used purposive sampling by equally distributing the number of physician participants in each of the three healthcare settings. Participants were further segmented by their years of experience in a leadership capacity. Although each physician met the criteria for inclusion in the sample, findings may not be transferable to all physician leaders. Fourth, the researcher conducted interviews either in person or by telephone. Although the same semi-structured interview schedule was used for all participants, responses in person may differ from those by telephone.
Fifth, although not a physician, the researcher is a healthcare leader who has worked very closely with physician leaders for many years. The researcher discloses that she has served in the healthcare industry for 16 years, including leadership of a physician-hospital organization. The perception of the physician leader toward the researcher as a colleague should be considered. Finally, qualitative research design is inherently limited by the interpretation of the researcher. Although every effort was made to remain unbiased, it is possible that another researcher may interpret findings in a different manner.

**Definition of Terms**

The terms in this section are directly related to the research that is cited throughout this study. All are commonly used in healthcare.

*Clinical Integration* refers to physicians and hospitals working together to provide quality healthcare to patients at reduced costs (Dye & Sokolov, 2013).

*Electronic Medical Record (EMR)* allows physicians and hospitals to view patient records electronically, providing health information from a variety of providers in one centralized location (Henochowicz & Hetherington, 2006).

*Fee-For-Service (FFS)* refers to payments physicians and hospitals receive for treating patients from private insurance companies, Medicare, and Medicaid (Miller, 2009).

*Healthcare Reform* is legislation requiring that every American have access to affordable quality healthcare (Patient Protection and Affordable Care Act of 2010).

*Physician Leadership* refers to physicians in a position to positively influence other physicians (Kasti, 2015).
Summary

Healthcare reform dictates that physicians and hospitals align in clinical integration strategies for the purpose of increasing quality and reducing expenditures. Effective clinical integration depends upon strong physician leadership for collaboration with hospital administrators in patient care. The need for physician leadership is clear, but very little data exist on physicians’ decisions to undertake leadership roles. Physician leaders may need to build leadership skills through training and continuing education. An understanding of healthcare reform can present challenges to leading in a clinically integrated environment. Devoting time and energy to leadership responsibilities presents physicians with many advantages and disadvantages. By interviewing a sample of physician leaders, this study seeks to investigate the underlying reasons for their choices and the challenges encountered. Literature on these topics is discussed in Chapter II.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

This phenomenological study seeks to examine the underlying reasons physicians choose to assume leadership roles, including the benefits and drawbacks to that choice. Understanding the influences of this decision is crucial to attracting and developing additional physician leaders to direct the clinical integration movement. The literature includes studies on historical physician-hospital relationships, physician leadership skills and how to build them, and current topics in healthcare reform. For the current study, the following search terms were utilized: clinical integration, physician leadership, physician leadership training, healthcare reform, healthcare change management, and physician/hospital relationships.

The remainder of this chapter covers the following primary sections: Historical Physician/Hospital Relationships, Importance of Physician Leadership in Healthcare, Physician Leadership Training, and Healthcare Reform. The chapter concludes with a summary.

Historical Physician/Hospital Relationships

An effort to understand the trend of physicians choosing leadership roles in clinical integration should begin with an historical examination of the relationship between hospitals and physicians. In the 1990s the movement toward clinical integration began. Dynan, Bazzoli, Burns, and Kuramoto, (1998) explored several physician and hospital alignment strategies, including: “management service organizations (MSOs), physician-hospital organizations (PHOs), hospital-affiliated independent practice associations (IPAs), and hospital-sponsored ‘group practices without walls’ (GPWWs)”
To perform their research, Dynan et al. utilized a special survey on physician-hospital arrangements conducted by the American Hospital Association (AHA) in 1995. The recipients were selected from AHA’s annual survey in 1993, which included questions in regard to the presence of physician-hospital associations. AHA distributed the 1995 special survey to the 1,283 hospitals that responded affirmatively to the presence of physician-hospital associations during the 1993 annual survey. In the survey, PHOs were the most prevalent, with 402 of the 1,283 hospitals reporting those organizations in place. Approximately 10% confirmed the presence of GPWWs and IHOs, leaving about one third of the organizations as either MSOs or ISMs. Of the 1,283 hospitals with physician-hospital associations, 665 of the AHA’s special survey on physician-hospital arrangements were returned.

As the researchers chose to focus on physician-hospital arrangements governed by direct associations to the hospitals, 92 respondents with indirect relationships were excluded, leaving a sample of 573 (Dynan et al., 1998). The special AHA survey included 44 questions that the researchers grouped into six categories: “administrative and practice management services, physician financial risk-sharing arrangements, joint ventures to create new services, computer linkages, physician involvement in strategic planning, and salaried physician arrangements” (p. 250). The questions in these categories were assigned factor-based scores in order to determine the degree of integration achieved by each organizational model. By using multivariate analyses, the physician-employment associations were ranked in order of greatest integration score to lowest integration score.
Of the 573 hospital respondents, nearly 67% reported the presence of two or more physician-hospital association models, while 33% reported having at least one. Findings indicate that some models scored higher in certain categories and lower in others. Overall, the IPA was found to be the least integrated physician-hospital organization, while the PHO was second lowest (Dynan et al., 1998). This retained the researchers’ first hypothesis to be true: those models with loose governance structure will have the least integration. Hypothesis 2 also was retained because the MSO by definition has the most centralized ownership structure and was found to provide the highest level of physician-hospital integration.

An inherent limitation to the methods of this study (Dynan et al., 1998) was that the survey included only hospital administration respondents. Further, the researchers reduced the sample size to only those hospitals with one physician-hospital association, thus disregarding those with multiple models. Although the results are meaningful, the limitations provide several opportunities for further research.

**Physician and Hospital Alignment**

As the mere presence of a physician-hospital association does not ensure clinical integration, it is important to analyze underlying social cooperation and consortium between both parties. Zuckerman et al., (1998) examined the importance of physician-hospital alignment and strategic initiatives to encourage this relationship, such as “building trust, placing physicians in management and governance, and developing physician leadership” (p. 3). In their study, the researchers utilized information collected from the Center for Health Management Research (CHMR) from 1993-1996. The data included information from a survey distributed to 105 hospital CEOs, follow-up
telephone surveys with 75 of those CEOs, a separate survey given to 4,200 physicians, and a series of eight physician-hospital alignment case studies. Triangulation was used to compare data derived from each collection method in order to assimilate similarities and variances.

Overwhelmingly, Zuckerman et al. (1998) found that the subject of trust between physicians and hospitals surfaced in both the survey and in case studies. Trust was gauged by the presence of or lack of respect expressed by each party for the other through answers to questions in the surveys and observations in the case studies. The willingness of both the physicians and hospitals to share information with one another further contributed to the measure of trust.

The second leading concept the researchers discovered was the importance of having physicians in management and governance roles. Throughout each data collection method respondents identified the significance of strong physician leadership within the hospital as being crucial to the success of integration. Hospitals require input from physician expertise, and physicians need to view colleagues as having integral roles in the hospital system. Last, investment in the development of physician leaders formed a recurring theme in all of the data. As physicians spend much of their careers immersed in clinical practice, leadership qualities are not always identified (Tibbitts, 1996). Health systems that promote leadership education for their physicians foster a more collaborative environment than those that do not (HealthLeaders Media Council, 2015). This opportunity to have more influence over the hospital’s strategic planning may indicate another reason leadership is attractive to physicians.
The study, as Zuckerman et al. (1998) pointed out, was not free of limitation. The CHMR physician survey was distributed primarily to physicians in primary care practice rather than specialists. Specialty physicians are more challenging to integrate based on their higher salaries and dynamic tension with primary care physicians. Further, the trend of hospitals purchasing physician practices was not examined. Quality outcomes and physician recruitment competition between hospitals and small group practices also were not studied.

**Hospital-Employed Medical Groups**

A recount of the history of physician-hospital relationships must include the recent trend of physician employment by hospitals. According to a recent study, 76% of hospitals and health systems have progressed beyond physician-hospital associations toward creating hospital-employed medical groups (Betbeze, 2011). Over the last three years, hospital-employed physician numbers have grown by 86% (HealthLeaders, 2015). A study by HealthLeaders Media Council (2013) examined hospital leaders regarding their physician employment ventures. The online survey entitled *Physician Alignment in the New Shared Risk Environment* was distributed to select members of the target audience. Of those distributed and returned, 302 were included in the analysis. Respondents included a myriad of health leaders from hospitals, including senior leaders, operation leaders, and clinical leaders. The survey found that 73% of nationwide healthcare leaders agree that physician buy-in is essential to the development of healthcare quality initiatives. In addition, 87% expect physician employment at their hospital to grow over the next three years. Further, 70% anticipate independent physician numbers to decrease in the next three years.
The perceived advantages for physicians who choose hospital employment are numerous. Because physicians are scientifically trained and typically do not study traditional business and finance courses, administrative burdens of independent practice can create time management challenges (Guthrie, 1999). A doctor attempting to juggle the complexities of practice management has less time to practice medicine. In 2017, independent and small group physician practices face the same issues as other small businesses, including constant increases in overhead, rising health insurance premiums, and growing technology costs. Further, modern physicians greatly value a balance in work and personal life, which can be easier to achieve through employment arrangements that offer on-call coverage and vacation time. These are strong influences, as evidenced by a greater number of physicians choosing to become employed by health systems.

Critics of hospital-employed physicians allege that doctors and hospitals that are too closely aligned can negatively impact patient outcomes. A controversial study by Baker, Bundorf, and Kessler (2016) reported that 83% of the time employed physicians refer their patients to the hospital that employs them, regardless of whether that hospital is the highest quality or lowest cost for the patient. The authors cautioned that employing physicians may not directly equate to increased quality and may actually drive up costs. However, this study examined Medicare data from 2009 prior to many hospitals taking significant steps toward improving coordination of care through clinical integration.

**Importance of Physician Leadership in Healthcare**

Because many healthcare reform and clinical integration initiatives require physician involvement, physician leaders are in high demand. These individuals belong to a unique professional society, balancing both clinical and managerial skills. Physicians
are expected to spend considerable time devoted to research on improving procedures and advancing the field of medicine. These expectations, along with demanding practice schedules and family obligations, can make it difficult to stay current with the demands of healthcare leadership. This is further complicated by payment methodologies and a health insurance industry that is convoluted and under flux.

Physicians play dual roles in the field of healthcare as both clinical providers and leaders in their field. Those who choose to practice medicine and to perform leadership roles must possess a high level of commitment to both causes. Hoff and Mandell (2001) examined the dual commitment exhibited by a sample of physician executives using data from a national survey by the American College of Physician Executives in 1996. Findings indicated that physician executives show high levels of commitment in both clinical practice and leadership. As leaders, they are expected to possess presentation and management skills, be able to solve problems, delegate, and foster collaboration. Often, this is a challenging combination of characteristics.

According to Dye and Sokolov (2013), great physician leadership is critical to the success of clinical integration. Physician leaders present in clinically integrated organizations must work together with the hospital to advocate for the quality delivery of healthcare. A 2009 study of the top 100 U.S. hospitals for cancer, digestive disorders, and heart health found that quality ratings for hospitals by physicians are 25% higher than those by non-medical CEOs (Goodall, 2011). Although physician-run hospitals are rare, Goodall’s (2011) breakthrough research established a clear association between quality and the presence of physician leaders.
The American College of Physician Executives (ACPE) declared that physician leadership is one of nine critical elements necessary to achieve care that is centered on patients (Angood & Birk, 2014). Due to their centrality in patient care, physicians “have extensive knowledge about the ‘core business’ of caring for human beings” (p. 3). Additionally, physicians make ideal healthcare leaders due to their inherent focus on patients, as evidenced by the oath physicians take to “do no harm” and “do what is best for the patient” (Angood & Shannon, 2014, p. 274). These are valuable characteristics a physician leader brings to clinical integration efforts.

**Physicians as Leaders**

Research has indicated that physicians hold the opinion and advice of their peers much higher than that of non-clinical healthcare executives (White & Lindsey, 2015). Henochowicz and Hetherington (2006) suggested that current physician leaders are in the best position to persuade their peers because they are viewed as knowledgeable colleagues. According to Angood and Birk (2014), “A shared history and a common language give physician leaders the credibility among their colleagues and other providers needed to garner critical support for clinical integration” (p. 6). These physicians should be viewed as leaders in clinical integration and adept at influencing their colleagues. They are immensely valuable to healthcare organizations for their ability to influence other physicians.

Researchers at the Mayo Medical School in Rochester, New York, performed a case study analysis in 2016 on physician leadership at the Mayo Clinic (Swensen, Kabcenell, & Shanafelt, 2016). The Mayo Clinic is the oldest and one of the most respected physician-led medical groups in the world. The researchers created the Listen-
Act-Develop model designed to reduce burnout and to engage physicians in leadership. This model was directed at physicians’ needs, including the ability to make choices, the ability to make meaningful connections with other physicians, and the ability to be a part of something greater.

According to the authors, the Listen-Act-Develop model was constructed following decades of research on physicians at the Mayo Clinic (Swensen et. al, 2016). In the “listen” stage, the researchers held focus groups with physicians to listen to their concerns and to identify specific triggers to burnout. The “act” stage included working with physicians one-on-one, helping them address their burnout issues, developing solutions for implementation, recognizing their successes, and communicating results back to the group. Finally, in the “develop” stage the researchers identified specific physician leaders who could serve as coaches and mentors to the others. Following the conclusion of the study, these physician leaders would carry on the skills they had learned, offering resources and support to others who may be struggling with burnout.

Promoting Physician Leaders

An increased number of physicians are choosing to expand their leadership roles to impact change. According to a 2015 benchmark survey by the Advisory Board Survey Solutions on Physician Engagement, 47% of hospital-affiliated physicians agree with the statement, “I am interested in physician leadership opportunities at this organization.” Capitalizing on the commitment of experienced physician leaders can offer a powerful tool to hospitals and other healthcare organizations. Promoting physician leadership serves as an opportunity to reach other doctors who may be reluctant or even afraid to change.
**Identifying physician leaders.** In the late 1990s, published literature materialized on identifying potential physician leaders. Guthrie (1999) suggested that physicians who are interested in leadership roles are attracted by the opportunity to be involved with decision making. Additionally, physicians who crave problem solving and innovation are more geared toward leading. These individuals are characterized by their value of patient care, support of peers, strive for excellence, and desire to reach common goals. Some may even be observed engaging other physicians in the use of technology, data management, etc.

Scott (2015) added that potential physician leaders can be identified by the research publications or continuing education interests listed on their resume. These individuals may have served as chief resident or other similar title during their medical education. Furthermore, physicians who pursue a Master of Business Administration or a Master of Healthcare Administration after earning their medical degree are almost certainly interested in leading.

**Expectations of physician leaders.** In order to become a physician leader, the doctor must first understand what it means to be a leader. Hay/McBer, an independent consulting firm, found that a resilient leader encompasses vision, coaching, democracy, and effective relationships (Arond-Thomas, 2004). These characteristics positively impact an organization’s culture. Arond-Thomas (2004) chose six different leadership styles to examine, to include commanding or authoritative, visionary, affiliative, democratic, pacesetter, and coaching. The commanding or authoritative leader focuses on achievement and self-preservation, often having a negative impact on follower attitudes. The visionary leader strives to accomplish organizational goals and becomes a catalyst
The affiliative leader is the people-pleaser and desires to do that which is best for everyone. The democratic leader encourages collaboration and team leadership; and the pacesetter leadership type is similar to commanding, in that he or she focuses on self-achievement and encourages followers to imitate his or her methods. The coaching leader strives to help others achieve their goals. Naturally, many leaders fall under multiple models at different times, and a truly resilient leader is one who adapts his or her model to the current situation. Physician leaders are more effective when provided with an understanding of these models.

As leaders in healthcare, physicians are expected to be professional executives and to use their leadership authority for ethical and worthy causes (Chervenak & McCullough, 2001). Physician leaders must foster patient trust, follow established standards, pursue continuing education, and participate in constant peer review (Block, 2004). In addition to clinical excellence, they are expected to be self-aware, effective communicators, and compassionate caregivers. Leadership attributes such as ethical values, excellences in care, professionalism, and commitment have a profound impact on the delivery of quality healthcare (Carney, 2011).

Chervenak and McCullough (2001) proclaimed that physician leaders possess immense power in the field of medicine, within the organization, and with their patients. As such, they must practice tremendous moral judgment in decision making. The authors cautioned against allowing self-interest or corruption to impede the physician leader’s judgment. A suggested method to combat this threat is to encourage them to participate in leadership training as a way to improve patient outcomes while developing administrative abilities (Morrissey, 2015).
Physician Leadership Training

Historically, doctors have been expected to practice medicine and to run a business, often with no training in the latter (Guthrie, 1999). This self-sufficiency leads to independence among physicians and a fragmented healthcare industry in which physicians fail to communicate sufficiently with one another or with hospitals in order to manage a patient’s care (Dye & Sokolov, 2013). In the era of healthcare reform and clinical integration, this independence is no longer plausible.

Quality in healthcare can be improved through enhanced leadership training for physicians. Doctors are trained extensively in chemistry, biology, anatomy, and the practice of medicine (Guthrie, 1999). However, they often do not receive formal training in management, relationships, leadership, and people issues. Typically, physicians choose healthcare for the desire to practice medicine and may not immediately recognize the level of leadership skills required by the job (Kasti, 2015). As medical professionals, physicians are expected to exhibit competence in information technology, human resource management, and finance. In addition to clinical skills, those in leadership positions must possess multiple managerial skills. Menzies (2004) analyzed six specific skills needed by physician leaders, including 360-degree communication, support from hospital administration, business ethics, global perspective, team building, and the ability to troubleshoot and to solve problems. Unfortunately, these business areas are not normally part of a physician’s educational training.

As patients are the ultimate stakeholders in healthcare, physicians have paramount responsibility to provide quality care (Block, 2004), although this care does not stop at the patient’s bedside. To fill this gap, Block (2004) advocated for physician leadership
training in these areas. Block also suggested that doctors benefit from training on personal responsibility and accountability in order to achieve true professionalism and to regain control of healthcare delivery, the physician must possess and continually renew these characteristics.

Significant challenges exist to promoting physician leadership, including vast cultural differences, training obstacles, and underdeveloped management talents (Tibbitts, 1996). Physicians value their autonomy; as individual experts, they often are reluctant to delegate (Quinn, 2015). Additionally, physicians typically are quite busy and have been known to suffer from stress. A study conducted by Askin (2008) identified that 62.9% cite stress due to struggles in balancing personal and professional life. Stress makes transitioning to a leadership role much more difficult; therefore, the importance of building resilient physician leaders is fundamental.

Leaders must effectively communicate and listen to superiors, subordinates, and peers (Menzies, 2004). This is especially true for physician leaders, as they often deal with confidential information. Even as a physician, this leadership position comes with superiors who should be respected and involved in decision making. The measure of a leader’s success often can be gauged by the evaluation of his or her superiors and followers.

Business ethics are crucial to any leadership role, particularly in the medical field when dealing with the health and wellbeing of patients (Menzies, 2004). Further, physician leaders must gain the trust of not only their patients, but also other members of the hospital management and leadership team. They typically are quite segmented, focusing narrowly on a specific specialty or research interest. However, as a leader within
an organization, the physician must make decisions that impact the entire organization and their peers in a number of other specialties.

A physician leader must network effectively with other clinicians, members of corporate management, and the community (Menzies, 2004). Networking can be difficult for a physician accustomed to speaking in clinical jargon. Making the transition from quick, clinical decisions to a somewhat slower corporate decision making environment in which multiple processes and approval matrices are in play can be a challenge for the former autonomous doctor. Scott (2015) asserted that all healthcare executives should participate in a needs-based assessment to gauge leadership skills for focused training. Scott stressed that physician leaders are successful only if the healthcare organization invests in formal leadership training for the physician. He further advocated for administrative fellowships, a continuing education opportunity for physicians specifically geared toward leadership training.

According to Scott (2015), leadership training must include mentoring and succession planning to maintain and to increase the number of physician leaders. Seasoned physician leaders are instrumental in identifying and training new recruits. An experienced mentor assists new physician leaders in managing stress and in improving relationships with their patients and followers. Unfortunately, although doctors are experts in healthcare, they are not always interested in leadership obligations due to their lack of managerial training (Marr & Kusy, 1993). Marr and Kusy (1993) performed a case study at Minneapolis Children’s Medical Center, in which physician executives from several service lines were invited to participate. Initially, a needs assessment was
performed revealing that management, leadership, and interpersonal skills were the most important focuses of the group.

The content of the program was then developed around these objectives, including activities in role refinement, organizational culture appreciation, team building, negotiation tactics, and planning initiatives (Marr & Kusy, 1993). The authors then conducted eight training seminars focused on these topics over a two-year period. Trainings incorporated classroom, research, hands-on simulations, and group techniques. Further, Marr and Kusy (1993) constructed one-on-one coaching sessions with each doctor to pay individual attention to his or her specific needs. The physicians also were paired with one another as accountability partners. As a result of the training, the physicians became more involved in the operations of the organization, began to utilize group problem-solving methods, and even assisted in the strategic planning and redevelopment of the organization’s physician appraisal system (Marr & Kusy, 1993). The authors concluded that, by exposing physicians to management practices, their view on management and leadership becomes more favorable. In addition, the authors received feedback from non-participants on the improved attitude and performance of the participants.

**Leadership Training Opportunities**

A number of formal physician leadership training opportunities are available for physicians seeking to enhance their leadership skills. The American College of Healthcare Executives (ACHE) boasts 50 annual seminars focused on enhancing physician leadership. HealthLeaders Media Council offers a beginner course on leadership and business fundamentals for doctors. The Greeley Company conducts
multiple seminar series on physician and hospital leadership and recently held a conference in 2015 specifically geared toward training physicians to lead clinical integration efforts. Harvard Leadership Training offers focused business management training on strategy, operations, financial analysis, and conflict resolution.

In 1975, the American College of Physician Executives (ACPE) was established as a professional association for physicians interested in expanding their leadership skills. In 2014 ACPE was renamed as the American Association for Physician Leadership. Currently, over 11,000 physician leaders belong to the association in 46 countries. Members receive free publication journals on the topic of leadership and have the opportunity to attend leadership conferences at discounted rates. Additionally, education courses and mentoring opportunities are available. For organizations interested in on-site training tailored to fit their specific needs, a Physician Leadership Development Program is available.

In 2015, the American Medical Association (AMA) implemented the first national, grant-funded program centered on physician leadership training (American Medical Association, 2015). Ten physicians were selected to participate, each with a strong history of physician leadership in their respective communities. The program assists physician leaders in becoming advocates for healthy change in their communities. Upon completion, the physician leaders earn the designation of Physicians as Community Health Advocates (PACHA) and are certified to train other physician leaders.

**Leadership Resources**

A number of resources currently are available to physician leaders seeking to enrich their leadership skills. In his book, *The Medical Staff Leader’s Survival Guide,*
Cors (2014) provided physician leaders with assistance in transitioning into their new role and also in identifying the expectations of their position. As these roles typically do not come with detailed rules and responsibilities, this handbook can be helpful for new or even experienced leaders. Cors declared that it is possible to be a good physician leader while continuing to provide excellent patient care, even amidst physician-hospital conflict and distrust.

The Credentialing Resource Center Daily, a free electronic newsletter publication by HCPro, published *The Medical Executive Committee Manual* detailing tips for succeeding as a physician leader. The manual consists of 10 essential guidelines including meeting with seasoned physician leaders, avoidance of negative colleagues, and discussions on additional time commitments with family.

**Healthcare Reform**

Healthcare is a constantly evolving field. Changes occur as new techniques and medicines are developed, as technology advances, as understanding increases, and as new government regulations are introduced. The PPACA mandated that every American have access to affordable quality healthcare. Meanwhile, Merit-Based Incentive Payment Systems (MIPS), including health insurance mergers, balance billing, prescription drug costs, and health data security, make providing affordable quality healthcare increasingly difficult (Parks, 2016). Healthcare providers must accept these changes and find ways to work together in delivering that care affordably. In response to PPACA and MIPS, physicians and hospitals are exploring models of integration that go beyond caring for the sick to managing patient health.
Impact on Healthcare Providers

Healthcare reform has brought about many changes for physicians and hospitals. These changes can assume multiple forms, and healthcare providers must be prepared to manage them. Reform brings increased costs, confusion, and uncertainty of the future for all healthcare providers. To address these trends, Bowden and Smits (2012) suggested a tighter collaboration of care among caregivers. This requires healthcare administrators and physicians to actively seek input from one another through a team leadership approach. By working together, quality can be improved through increased communication and collaboration.

**Consumerism.** The changes in health insurance and the constant increase of patient deductibles have placed medicine solidly into a business with consumerism (Freeman, 2016). This is evidenced by consumer-demanded convenience of care and pricing transparency. This change to consumer-driven healthcare is new takes many healthcare organizations by surprise if they are unprepared. As consumers of healthcare dollars sustain higher deductibles and health savings accounts, they will shop around for medical care the way they shop for a car. Physician leaders with a consumer focus will undoubtedly fair better in this new environment. “Doctors' training and knowledge of new medical treatments are less important to many patients than their interpersonal skills -- treating patients with respect, listening carefully, being easy to talk to, taking patients' concerns seriously, spending enough time with them, and really caring" (Doctors’, 2004). According to Rosenberg (2012), health leaders must be flexible and have a vision for this new consumer-driven method of delivery. Consumer engagement is the key. Other industries survive based on their ability to attract and to retain customers; in healthcare
this is a new thought process.

**Volume-to-value reimbursements.** Employers and payers, including Medicare, have struggled for decades to control healthcare expenses (Rosenberg, 2012). Provider reimbursements, called fee-for-service (FFS), refer to the payments physicians and hospitals receive from private insurance companies, Medicare, and Medicaid for treating patients (Miller, 2009). The FFS model equates a set fee reimbursement to the service provided. Because FFS focuses on the number of encounters or treatments physicians and hospitals provide, it inadvertently causes them to spend less time with patients in order to see more of them. Additionally, FFS places little emphasis on patient outcomes or the quality of care provided (Leaver, 2013). This emphasis on volume has a definitive cap, as physicians and hospitals can see only a specific number of patients per day.

As the cost of healthcare rapidly increases, the FFS payment schedules are continuously cut to offset employer and patient expenses (Miller, 2009). Physicians and hospitals experience decreases in revenue as FFS declines. Healthcare reform shifts provider reimbursements from FFS in favor of a quality approach (Henochowicz & Hetherington, 2006). Provider reimbursements are evolving beyond FFS and becoming more driven by population health management and quality outcomes (Miller, 2009; Leaver, 2013). As FFS reimbursements continue to decline, and increasing quantity is no longer the solution, physicians and hospitals must seek alternative income solutions. This change can be devastating for doctors who are not financially prepared.

In 2015, The Centers for Medicare and Medicaid Services (CMS) released the final rule of the Medicare Access and CHIP Reauthorization Act (MACRA). With MACRA, providers are paid based on the quality – not quantity – of healthcare services.
MACRA requires that physicians manage the health and wellness of their patients, rather than providing sick care. In order to remain financially sound with MACRA, physicians must perfect a method of patient-centered care. Those who succeed in building relationships with patients prevail.

**Electronic medical records.** The American Recovery and Reinvestment Act of 2009 introduced a major driving force behind healthcare quality known as the Electronic Medical Record (EMR). EMR technology allows physicians and hospitals to view and to share patient records electronically, providing health information from a variety of providers in one centralized location. They must utilize EMR to easily share data on patients. This electronic tool for coordination of care increases patient outcomes and satisfaction by providing patient health information in a single repository that can be accessed by many providers (Leaver, 2013). Further, EMR leads to reduction in duplicate or unnecessary testing because physicians can easily see previous patient test results, even those performed by other healthcare providers.

Using EMR can be difficult for physicians who are inexperienced in technology. CMS requires EMR programs to be used meaningfully to manage patient health data or risk heavy payment penalties (Parks, 2016). Physician leaders can assist their colleagues in using EMR and can help them understand the importance of this new technology. Robert M. Wah, M.D., President of the American Medical Association (AMA), presented the keynote address at the 2015 Annual Healthcare Information and Management Systems Society (HIMSS) Conference Innovation Symposium. In his speech, Dr. Wah proclaimed, “In these rapidly changing times in healthcare, we will need agile technology
to adapt and succeed. To harness these capabilities, physicians are leading new approaches for (that) delivery…”

**Impact on Patients**

Healthcare reform impacts not only healthcare providers, but patients as well. Individuals traditionally seek healthcare when they are sick as a means of getting better. Historically, physicians and hospitals have failed to continue post-visit communication with these patients to ensure they remain in good health (Leaver, 2013). Those who do not understand their prescribed medication or do not follow their treatment plan accordingly may subsequently present back in the doctor’s office or in the hospital (Al-Amin & Makarem, 2016). Repeat encounters are expensive to the patient, to the healthcare provider, and to government health plans of Medicare and Medicaid because they equate to additional testing, a drain on medical resources and, subsequently, slower patient healing. As health plans tighten quality requirements and assessments, healthcare leaders are required to make decisions that impact patient care (Angood & Shannon, 2014). Physician leaders are in a better position than non-clinical healthcare executives to make these tough decisions, as they are closely involved in patient care.

Much focus has been placed recently on improving medicine through technological advancements. However, as healthcare becomes increasingly more technological, some of the personal touch is lost. Unfortunately, innovations such as the EMR cause physicians to spend more time in front of a computer than in front of a patient (Bowden & Smits, 2012). Because healthcare likely will continue the electronic trend, it is important for leaders to learn to manage innovation while continuing to serve the patient.
Patients have access to more information now than ever before through the use of multiple expert medical websites. As such, they can and will be more selective in searching out care and treatment. Historical healthcare plans promoted a lack of transparency in pricing, as patients typically were responsible for only a fraction of their medical costs. New healthcare plans include high deductibles, which require patients to pay a greater portion of initial costs before the health insurance company begins to pay its share. High deductible plans make it crucial that patients have an understanding of costs and quality before seeking treatment. The Leap Frog Group is an organization founded in 2000 to educate patients in choosing the highest quality and most affordable healthcare (The Leap Frog Group, n.d.). By using information from the Leap Frog Group’s website, patients and their families can compare hospitals based on quality ratings, surveys, and pricing data voluntarily provided by hospitals.

Additionally, as the number of patients choosing home health care over hospital admission rises, more individuals learn to care for themselves (Bowden & Smits, 2012). In order to stay connected to these at-home patients, healthcare providers should embrace these changes by assisting patients to be more self-sufficient and offer training on technology. By being proactive, healthcare professionals can change with the culture, rather than fight against it.

**Summary**

Reform has transformed the traditionally fragmented healthcare model, requiring physicians to not only participate in, but also lead clinical integration efforts with hospitals. PPACA altered the healthcare industry in the US more in the past decade than in the last 50 years. Administrative burdens such as electronic medical records (EMR) are
on the rise, while FFS reimbursements are rapidly declining.

Conceivably, the challenges and dynamic tensions that constitute healthcare reform are the reason physicians are increasingly choosing to assume leadership roles. A review of the literature suggested that physician leadership is on the rise and necessary for clinical integration (Rosenberg, 2012; Dye & Sokolov, 2013). Multiple studies have been conducted on physician-hospital collaboration, but very little data are available on the way in which the physician makes the initial decision to assume a leadership role.

Chapter III details the methodology for this study.
CHAPTER III: METHODOLOGY

Introduction

This study examined a sample of physicians who chose to assume leadership roles for clinical integration efforts and the factors that influenced those decisions. Healthcare entities such as hospitals, hospital-employed medical groups, and physician-hospital associations benefit from the experience, knowledge, and influence of effective physician leaders (Penlington & Marshall, 2016; Kasti, 2015). The qualitative phenomenology method was selected to study the experiences of physician leaders through their own perspectives.

This chapter provides a description of the research methods used in this study. The population and sample, research questions, and the instrumentation are explained. Procedures for the pilot study, data collection, and analysis also are included. This chapter concludes with the trustworthiness, validity, and ethical considerations of the study.

Research Design

A qualitative phenomenological approach was chosen for this study, with semi-structured interview questions designed to give insights into choice. Specifically, 12 physician leaders from hospitals, hospital-employed medical groups, and physician-hospital associations were interviewed to collect in-depth thoughts and feelings regarding their decision to assume leadership roles. The qualitative interview approach was chosen to understand the reality of the reason why a physician in an already demanding profession would elect to undertake additional leadership responsibilities.
In this study, the subject of interest was physicians who have chosen to assume leadership roles for the pursuit of clinical integration. By nature of their work, doctors are regarded as leaders to patient followers (Kasti, 2015). However, some choose to escalate their medical leadership roles beyond the typical physician-patient relationship and become leaders of other physicians. The phenomenology of this study sought to gain an understanding of this transition through the point of view of the experiencer. The data on this phenomenon were collected from each physician leader through his or her individual voice.

**Population and Sample**

The population for this study was licensed physicians holding leadership roles within hospitals, hospital-employed medical groups, and physician-hospital associations in a small metropolitan area of Kentucky. The term *physician leader* referred to those having official responsibilities in clinical integration initiatives. For selection purposes, the physician leaders were identified by their title, including chief medical officer, chief of staff, chief patient safety officer, chief medical information officer, chief clinical integration officer, department chief, board member, practice founder, and practice owner. Whether the physicians in this study continued to practice clinically in addition to their leadership role is discussed, but the sample was not subcategorized by this factor.

Purposive sampling based on specific criteria was used to select a small sample of participants, which allowed the researcher an in-depth focus. A list of potential participants was constructed through personal contacts in the healthcare community, the local hospital, and the hospital medical group. Additionally, snowball sampling was used to solicit referrals from the study participants (Creswell, 2013). Fourteen physician
leaders were invited to participate, with 12 accepting. The sample included four to
represent each of the three healthcare settings under investigation. Participants were
selected and categorized based upon years of leadership experience. Of the four in each
setting, two are considered new to the field of physician leadership (0-5 years) and two
were experienced (6+ years). Table 1 depicts the sample.

Table 1

*Purposive Sampling Grid for Physician Leaders*

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<th>Experience</th>
<th>Experience</th>
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<tr>
<td></td>
<td>0-5 Years</td>
<td>6+ Years</td>
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<tr>
<td>Hospital</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Hospital-Employed Medical Group</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Physician-Hospital Association</td>
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<td>2</td>
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</table>

**Research Questions**

This phenomenological study was guided by the central question: What factors
influence physicians to assume leadership roles? The research questions were introduced
in Chapter I and are included in this chapter for the convenience of the reader. The
following four research questions guided the construction of the interview schedule
(Appendix A):

1. How do physicians make the decision to transition into leadership roles within
   health systems?
2. What leadership skills are required for physician leaders within health
   systems?
3. To what extent does healthcare reform impact physician leadership within health systems?

4. What are the perceived benefits and drawbacks of being a physician leader within health systems?

Instrument Development

Qualitative research methods typically consist of interviews, surveys, observations, and a review of documentation pertinent to the study (Thomas, 2006). Instrumentation for this study included a semi-structured interview schedule organized around the research questions. Nine main questions, including five with sub-questions, constituted the format of the interview guide. The schedule was developed based on a review of physician leadership and clinical integration literature and adaptations from questions used in other similar studies.

Expert Review of Research Instrument

To ensure validity of the interview schedule, an expert panel reviewed the questions for accuracy and relevance. The questions were submitted to two content experts, including one qualitative methodologist and one physician leader. Both were sent a letter (Appendix B) briefly describing the purpose of the study and requesting their feedback. Along with the letter, they were furnished a draft of the semi-structured interview questions. Following their review, revisions were made to improve the suitability of the instrument prior to beginning the pilot study.

Pilot Study

A pilot study is a scaled-down version of the major study used to test the validity of the interview questions and procedures (Merriam, 2002; Patton, 2002). A pilot of the
instrument was conducted with two physician leaders meeting the qualifications for participation but not included in this study’s sample. Conducting a pilot study enables the researcher to test the length of the interview format and to ensure questions are clear to the participants (Marshall & Rossman, 2011). Pilot participants were emailed a letter describing the study and requesting their assistance (Appendix C). Upon completion of the pilot interviews, the participants provided feedback to the researcher. No further revisions to the interview schedule were needed subsequent to the pilot study.

Data Collection

Data collection for this study consisted of an individual, semi-structured interview with each participant. Interviews allow the researcher to gather in-depth perceptions and feelings from the participants, offering a richer understanding than surveys (Patton, 2002). During an interview, the researcher is able to ask clarifying questions and to probe deeper into responses without influencing participant answers.

To begin, an introductory email was sent to the selected physician leaders describing the purpose of the study and requesting their participation (Appendix D). Included with the letter was the informed consent document (Appendix F) detailing the purpose, timeline, and confidentiality of the study. The introductory email stressed the voluntary nature of the study and the right to withdraw from participation at any time for any reason without consequence. As physicians maintain tight work schedules and often are solicited by numerous parties, the interview questions were included in the email to allow time to prepare their responses in advance. Several of the physician leaders responded immediately to the introductory email, and the remaining were contacted by either a follow-up email or telephone call to inquire regarding their willingness to
participate. Many expressed genuine interest and excitement to participate and several requested a copy of the final report.

Prior to beginning each interview, the researcher reviewed the informed consent document with each participant to assure them of confidentiality and anonymity. Two interview formats were utilized: in person and by telephone. Of the 12 physician leaders interviewed, 10 were conducted in person and two were by telephone. Because participant responses typically are more open and descriptive when they feel comfortable in the physical interview location, the interviews occurred at a convenient time and quiet place of each individual’s choosing, primarily in their office or conference room. The researcher audiotaped all interviews for later transcription. Each was asked the same nine open-ended questions and the researcher added spontaneous clarifying questions as needed. This encouraged participants to expand upon their thoughts and feelings, adding to the depth of description. Each interview lasted between 30 minutes to one hour, depending upon the participant’s availability and willingness to share information.

Data Analysis

The collection and interpretation of qualitative data typically occur concurrently in qualitative research (Marshall & Rossman, 2011). In order to aid with this endeavor, the researcher mapped the interview questions to the research questions prior to undertaking the interviews (Appendix G). Marshall and Rossman (2011) recommended the use of a concept map to assist in the identification of themes and patterns in responses to interview questions. Figure 1 details the concept map for the coding of this study. As noted in the map, each research question is centered on physician leadership, with the identified themes and patterns of responses listed. The interview transcripts were read
and reread to create specific category labels mapped to the research questions. Text from the answers was highlighted and assigned to category labels. Any irrelevant or off-topic excerpts were eliminated. All identified themes fit within the aforementioned concept map categories.

**RQ1.** How do physicians make the decision to transition into leadership roles within health systems?

- Mentor
- Situational motivation
- Opportunity to impact change

**RQ2.** What leadership skills are required for physician leaders within health systems?

- Education
- Leadership training
- Change management

**RQ3.** To what extent does healthcare reform impact physician leadership within health systems?

- Ability to manage healthcare reforms
- Necessity of physician leaders

**RQ4.** What are the perceived benefits and drawbacks of being a physician leader within health systems?

- Benefits
  - Excitement & passion
  - Influence, power, & voice

- Drawbacks
  - Opportunity cost
  - Timelines
  - Work/life balance
  - Leadership/clinical balance

*Figure 1.* Concept map of physician leadership themes.
Trustworthiness and Validity

In qualitative studies, the researcher serves as the research instrument (Merriam, 2002). As such, qualitative methodology is contingent upon the researcher’s interpretation of data (Creswell, 2013). To combat this threat to validity, the researcher must establish a sense of trustworthiness with the participant. According to Merriam (2002), the “question of trustworthiness has to do with issues of internal validity, reliability, and external validity or generalizability” (p. 31). Qualitative studies carry an inherent risk of trustworthiness during the researcher’s data collection and analysis. To promote validity and reliability, Merriam suggested eight procedures: (a) triangulation, (b) member checks, (c) peer review/examination, (d) researcher’s position or reflexivity, (e) adequate engagement in data collection, (f) maximum variation, (g) audit trail, and (h) rich, thick descriptions.

Diversity was achieved by purposefully selecting participants representative of the three healthcare settings and years of leadership experience categorized by the groupings in Table 1. The researcher maintained an audit trail by carefully examining the data, detailing the research steps taken, and using a matrix to keep track of answers to interview questions. The study results are provided using rich, thick descriptions allowing transferability to other situations as appropriate.

Anonymity and Confidentiality

It is imperative in research that participants’ have their anonymity and confidentiality be protected to the extent required by law (Marshall & Rossman, 2011). All individuals in this study, including pilot participants, signed a written informed consent document prior to data collection. The data analysis and findings discussed in
this study do not identify anyone by name. Each participant was assigned an alphanumeric code relevant to the subcategory of the sample (see Table 1), and all audiotapes and transcripts were labeled using these codes as identifiers; e.g., the individuals representing 0-5 years of experience in the hospital setting were categorized as AH0 and BH0. The key to this coding assignment was maintained in a secure location. At the conclusion of this study, any identifiable information linking participants to their responses will be protected and secured for five years.

**Summary**

This chapter highlighted the methodological issues surrounding physician leadership role choices for clinical integration. The intent was to provide insight into physician leaders’ experiences by highlighting training and education, challenges and benefits to leadership, and personal views on healthcare reform. The purpose of this study was to examine the thoughts and feelings of physician leaders on these topics from a personal perspective. According to Patton (2002), qualitative data explain a story capturing one’s experience of the world. The phenomenological approach in this study allowed for examination of physician leadership within the context of participants’ lives.

Chapter IV illustrates the results and findings of this study.
CHAPTER IV: RESULTS

Introduction

According to the HealthLeaders Media Council *Physician Alignment Survey* (2015), 58% of health systems are working towards clinical integration strategies with physicians by 2018. To meet this demand, physicians must be willing and able to assume leadership roles. However, physician leaders face a multitude of challenges, including lack of leadership training, struggles in managing the many mandates of healthcare reform, and difficulty balancing leadership roles with other responsibilities. Results of this qualitative phenomenological study are discussed in this chapter. Specific sections include the purpose of the study and guiding research questions, methodological considerations, and a profile of the participants. Findings are then organized by each research question. This chapter concludes with a summary.

Purpose and Research Questions

The purpose of this study was to provide insights into the factors that influenced a sample of physician leaders in assuming their leadership roles. As previously presented in Chapter I, the following research questions were applied:

1. How do physicians make the decision to transition into leadership roles within health systems?
2. What leadership skills are required for physician leaders within health systems?
3. To what extent does healthcare reform impact physician leadership within health systems?
4. What are the perceived benefits and drawbacks of being a physician leader within health systems?

Profile of Participants

Participants for this study were selected using a purposive sampling and snowball process. All met the criteria for inclusion, specifically (a) a licensed physician; (b) holding a leadership role in a hospital, hospital-employed medical group, and/or a physician-hospital association; and (c) categorized as a new leader (0-5 years) or an experienced leader (6+ years). Each participant held at least one of the following physician leadership titles: chief medical officer, chief of staff, chief patient safety officer, chief medical information officer, chief clinical integration officer, department chief, board of director member, practice founder, and practice owner. Eleven represented a small metropolitan area, with one participant from a larger metropolitan area, all in the state of Kentucky.

Methodological Considerations

This research was a qualitative phenomenological study involving the oral account of current physician leaders through semi-structured interviews. This study focused on the central research question, what factors influence physicians to assume leadership roles in clinical integration? The framework was based on physician leadership in the context of clinical integration and the concept of trust between physicians and hospitals. Findings were drawn from the data collected in the individual semi-structured interviews and guided by the four research questions. In the interview, each participant reflected on his or her motivations in assuming a leadership role.
Findings

As detailed in Chapter III, the researcher developed a matrix to code each of the 12 interview transcripts with an individual identification letter, A-L. The matrix for identification also included a letter for the specific healthcare setting H = Hospital, M = Hospital-Employed Medical Group, P = Physician-Hospital Association. The subcategory of leadership experience was identified with a number (0 = 0-5 years of leadership experience, 6 = 6+ years of leadership experience). The complete transcripts of the 12 participants included 122 pages of data. Each response to the nine interview questions and five sub-questions was read and reread to identify themes and patterns following the concept map coding presented in Chapter III.

The findings from the Interview Schedule Guide for Physician Leaders, as well as the researcher’s observations during the interview process, are reported in the following sections. The four questions provided organization and structure for the data. The researcher’s decision to categorize patterns based on the three healthcare settings or length of leadership experience was based on the differential degree of responses. For those responses that expressed strong commonalities among the subgroups, an overall summary of the theme is given.

Research Question 1: How do physicians make the decision to transition into leadership roles within health systems?

The intent of this research question was to uncover underlying “personal” motivations for doctors choosing leadership roles. The physicians in this study chose leadership for a variety of reasons; many stated that a friend or mentor encouraged them
to lead, many discussed situational reasons, and several expressed a desire to impact change.

First Theme: [Several participants discussed that the choice to assume a leadership role was highly influenced by a mentor, sometimes a relative and other times a colleague.] Regarding the individuals who influenced the participants to assume leadership roles, responses varied among the subgroups.

Pattern: [The hospital subgroup acknowledged strong encouragement from hospital administration]. One physician told the story of his initial meeting with hospital administration:

I sat down and had a discussion with (the Vice President) at the time and said, Okay, what do you think? What’s your plan? and I said are you interested in having someone full time trying to do…that kind of (leadership) stuff, and he said are you interested in maybe doing something full time, and I said well, I might. He said well, write up something what you think would be appropriate, and I wrote up my job descriptions and what my needs were, and they said, sounds great to us. And in a month’s time, I left my own practice and started doing this.

Another participant shared, “I was probably encouraged most by administration here at the hospital. They approached me…with the idea of working with them in administration...”

Pattern: [The hospital-owned medical group physician leaders discussed assuming their leadership roles by default.] One physician stated, “My partners made me do it. They kind of looked around and said, you going to do that, or…?” Another conceded, “There was a lot of arm twisting.” One powerfully described the following:

Being a leader is…not just telling people what to do, it’s actually listening to them and actually understanding their concerns not only from a colleague, but from your medical assistant, your receptionist, your patients, even the janitor that helps. I learned that, when you’re respectful to everybody, I think (other leaders) take a good look on that.
Pattern: [The participants from the physician-hospital associations discussed encouragement from other physicians.] One physician commented: “The people in my group, I think actually at the time were real supportive of leadership roles because they felt that having hospital leadership roles really gave you a different seat at the table.”

Another discussed politics: “There were several doctors at state level who encouraged me to become involved. The (Kentucky) Medical Association is a real political animal.”

Second Theme: [Situational reasons varied among the participants, although several disclosed that the natural progression of their career developed into leadership.]

Three physicians discussed backgrounds in the military: “I also spent a whole career in the Navy, so I retired from the Navy Reserves as a captain… and I just think through my exposure, they asked me.” “I was a flight surgeon for the Navy…and military in general, it’s all about being able to be an effective leader. I would say the military helped me out because it’s very structured, you know, there’s a chain of command.” “The military has given me…the position where (as a doctor) I had to take care of our members to make sure that the mission was ready to be accomplished.”

One physician admitted to inadvertently stumbling into leadership:

I never wanted to really…you always have a lot of stuff to do, and it’s just one more thing you have to do but…after a while you’re on one committee then another, next thing you know, they want you to be on a credentials thing, or medical staff officer, or something, you know? Then you kind of figure, well, I guess it’s my turn.

In transitioning from private practice into hospital leadership, one physician exclaimed, “Well damn, I’ve got a job that I can get fired at! I’ve never had a job I could get fired.”

Another commented:

Often times, you assume the leadership mantle because of the people look at the way you function and they think you’d be a good leader; they ask if you’d
consider taking on that role. Which is always a pat on the back and a kick in the ass. You get that pat on the back and then you’re going, Aw man, why did I do this?!

Third Theme: [Several participants revealed a desire to impact change as the primary reason for assuming their leadership role.] One physician, after spending multiple years in private practice before transitioning into leadership, adamantly exclaimed: “Now what? Is this all there is?! Is this what I’m going to be finishing my life about?! Is this it?! And I found myself sort of frustrated…what else can I do? How can I do this better? You know, I just was finished. Darn it!” Another was unwavering: “To affect change. Period. I’m not somebody who will complain and then not try to do something about it.” One discussed that leadership provides an opportunity to positively impact large numbers of patients, many more than a practicing physician can handle:

(I) like that idea of affecting more than one person at a time, I mean you’ve got a very limited number of people you can see daily or weekly or yearly, and this…hopefully will affect the population we serve as opposed to one person at a time.

A participant described the importance of having a physician in leadership to voice concern in decision making:

There’s a lot of physicians out there, and sometimes they feel like they’re lost, but if they have voices of concerns and you hear those voices, and you use your physician (leadership role) as, hey, look, one of your physicians has a concern, and I’m in agreement with that concern and I think these are the changes we should do.

Research Question 2: What leadership skills are required for physician leaders within health systems?

This research question was intended to explore the way in which current physician leaders acquired their leadership skills, including a focus on training and education along with the importance of managing change.
Fourth Theme: [An identified theme among the subgroups was that all but one of the participants admitted they did not seek any formal leadership education before assuming their physician leadership role.] Several physicians discussed the application of their experience into their leadership role. One commented:

…it’s not because I think I’m the most brilliant person on earth, I’ve got all the answers to everything and it’s not because I’ve got some God like complex… I think that I've got enough experience and training and practice experience to know some things about practice I think I bring to a position like this, a lot of practical experience.

Another stated, “I originally didn’t do any formal training. I’ve kind of watched people, learned from watching leaders and how they handle themselves and who was effective and who was not.” One noted: “I was…hired because of my experience with physicians, not because of (a) PhD in health or healthcare administration”

Fifth Theme: [Once in their leadership role, a theme emerged that many of the participants attended formal training to sharpen their leadership skills.]

Pattern: [In particular, the physician leaders from the hospital subgroup attended multiple leadership trainings.] One affirmed, “When you’re a chief of the department you go to a Horty Springer (leadership conference) each term.” Another stated, “The hospital has been very good about sending me to conferences I want to go to or need to go to. CMO (Chief Medical Officer) Academy, I’ve been to that twice…HPI (Healthcare Performance Improvement) conferences, IHI (Institute for Healthcare Improvement) conferences.”

Sixth Theme: [An identified theme among several of the participants involved the importance of managing change in the highly volatile field of healthcare.] One physician discussed the significance of teamwork:
My generation of physicians was not taught teamwork. You get into a groove and that’s the way you practice. You’d like to add new things on as you go, and doctors do. (But) the innovations that really count, the teamwork, communication. (They ask), why do I have to mess with this? (A physician leader’s job is) engaging them in that change and in leading that change.

Another participant recounted the difficult role of physician leaders in implementing changes that impact their colleagues:

There were some doctors that didn’t want to change…and you could…hear them like in the Alcatraz beating the cups on the table to get the meeting started and we were the four of us out here still negotiating on certain words. Gosh! We had the old kind (of doctors). We got in there and had a vote and finally got it changed. The lawyers told us we were the last medical staff in the United States to come around to (a) modern type of bylaws.

One physician described change management as the most rewarding aspect of physician leadership:

I enjoy making changes that…turn out to be a lot more productive and beneficial and positive than what was thought it was going to be. You introduce changes and some changes are just like everyone thought it was going to be, including me. It’s government led, it’s government forced and then it’s not productive. But there are times you’ll introduce a change that is much much more positive than what, I won’t say everyone, but a majority of the physicians wanted.

Research Question 3: To what extent does healthcare reform impact physician leadership within health systems?

The intent of this question was to gauge the level of interest and passion exhibited by current physician leaders toward healthcare reform and clinical integration.

Seventh Theme: [A common theme recognized among the subgroups entailed acceptance of the PPACA and finding ways to manage the numerous mandates.] According to one physician, “You have to adapt, it’s as simple as that.” Another admitted, “A lot of this reform is pushed down on the hospitals and the doctors
and…(we) have to be pretty flexible in order to stay in business because…changes pays
the bills.” One physician surmised:

I think with all the rules and regulations of a value based care you have to have
physician leadership. One of the problems with healthcare is you have
physicians…doing their own thing in their own world…and then you’ve got the
reality of the world and resources are not unlimited and doctors like to practice
the way they like to practice. If you’re the patient and it costs 10 trillion dollars to
get you well, I’m going to spend ten trillion dollars. Well society can’t do that,
and if you’re having to do it for one patient, you can’t do it for every patient.

Eighth Theme: [Common among the subgroups was discussion of the need for
physician leaders in healthcare.] One physician explained:

It’s become much more complicated, and I think that physician leaders in
administration are becoming more and more important…and I can still tell that
from meetings that I go to with finance and…different things that are brought up
that they don’t have the clinical…their statements are not accurate. What they
think is not right, so I do think that a lot of benefit of me doing what I’m
doing…but it’s going to get a lot more complicated than what I’m doing. I mean,
they’re going to have to actually get into the finances and say, Well, this needs to
be changed, that needs to be changed.

Another pointed to the research: “The research really shows us that organizations (that)
are heavily physician involved and/or lead tend to function the best, have the highest
quality of care, and overall are the most profitable.” One adamantly voiced that physician
leadership is critical to maintain some control, “You want some control over things that
the…institution is going to force on you.”

Research Question 4: What are the perceived benefits and drawbacks of being a
physician leader within health systems?

This question was intended to understand the positive and negative ramifications
experienced by current physician leaders in their roles. Many told stories to articulate
their positions on the benefits of leadership.
Ninth Theme: [The researcher observed that several of the participants enjoyed the opportunity to share insight into physician leadership.]

Pattern: [An identified pattern among the physician leaders from the 0-5 year category was excitement for their role.] One physician who transitioned from private practice into hospital leadership exclaimed, “I’m in the ideal job. And I’ve had two perfect careers! Who gets to say that?! Who gets that opportunity?!” A participant from the 0-5 year category described that leadership “was bigger better broader, it was a new challenge. It was something I felt like I could actually make a difference in and had a passion for…and allowed me then to expand what I wanted to do in my life and do something better.”

A physician from the hospital-employed medical group subcategory, a newer setting in the field of healthcare, passionately described:

I’m a builder and that’s even true in my personal life. I like seeing how systems work and how we can improve them…how do we work with one another, we’ve taken groups in the community and people outside of this area, we’ve put them all together, and they’ve brought their own individual culture with them. The thing I find most enjoyable is building that process, allowing physicians to work in getting the extraneous stuff out of their way, and then building this (medical group).

Pattern: [Several of the physicians from the experienced category also expressed passion in the power of their role.] A seasoned physician leader in the hospital subgroup described:

I consider over 40 years as being here has really been on vacation. I remember rolling barrels down at the distillery during teenage years, and that was sort of like work but this is different. It’s not physical work or manual work. It’s get up and go, be called and all that stuff. I’ve enjoyed the whole 42 years I’ve been here.

Another experienced leader stated, “What you enjoy most is to get a project, take it under your belt, and make some change for the good.”
Tenth Theme: [Among the subgroups, a common theme was expressed regarding the importance of having influence and a voice in decision-making.] One physician described:

I think those are rewarding times when you were able…to make a difference in your colleagues concerns because maybe they wouldn't have been able to get that done because they…maybe they felt like their voice wasn't heard, so kind of being an advocate for them, I think that’s rewarding…you’re able to see the strengths of your colleagues, strengths of even your staff, and let other people know about those strengths, and…reward them for those strengths.

A major mandate from the PPACA impacting physicians involved the implementation of electronic patient medical records. In regard to leading the transition from paper to electronic medical records, one physician proudly narrated:

I was able to garner enough support, enough vision, enough wind, enough tools, enough education and buy-in, to have physicians…go live with a brand new electronic system. Overnight they went from a piece of paper to putting every single order in an electronic digital format.

Regarding drawbacks to leadership, the responses from all three subgroups involved common themes of high opportunity costs, time management frustrations, and difficulties in balancing work and life.

Eleventh Theme: [Assuming a leadership role often means giving up time devoted to other causes.] One physician described the opportunity costs of giving up part of clinical practice to allow time for leadership responsibilities: “The obstetrical lifestyle is very difficult. It’s not time-able, it’s not really do-able in this (leadership) situation so you kind of have to go all or none with it, and so that’s a struggle to give up.” Another experienced physician leader grumbled:

I think they need more stooges to carry out their bidding…they’ve got a lot of the extraneous organizations set up and they have to have an MD in place to head this stuff up, it looks to me like there’s a lot of busy work for not a lot of good coming out of it.
Twelfth Theme: [Several of the physician leaders in this study discussed frustrations with the amount of time needed to impact change.] In describing the biggest hurdle to leadership in healthcare, one physician sighed, “The frustration with not being able to make change quickly. Culture change is difficult.” A physician from the experienced leadership category, in describing frustrations with investing time in leadership, complained, “Anything that I do getting into leadership is not going to affect change and so I choose to protect my mental health by not beating my head against a wall, because that’s how leadership has become.”

Thirteenth Theme: [Physician leadership creates difficulties in work/life balance.] One physician discussed the toll leadership takes on a physician’s family and patients:

You’ve got personal life, then you’ve got practice, and you’ve got leadership roles. And each one of those is almost a full time job. So the first one that gets sacrificed…is your family. And to some extent, it is your patients because patients do demand that you are loyal to them…and want to know their doctor’s always available to them.

Another asserted, “If you’re going to be a leader, you’ve got to give up something somewhere. Usually it’s the family that pays…because you can’t work less.”

To combat the challenge of balancing work and life, one participant suggested:

I think to be an effective leader, you also have to find a way to have a balance in regards to enjoy things outside of work too…making sure that you have some alone time with yourself and work doesn’t consume you because I think that work consumes you…you may not be as an effective leader if your mind is not in the proper place

Fourteenth Theme: [Physician leadership creates difficulties in leadership/clinical balance.] A physician who made the decision to maintain both clinical practice and leadership described the struggle of balancing both:
It was very hard for me to take time off, there was nobody to take my place, so…on my days off, I was traveling somewhere either to committee meetings or to meet with KMA (Kentucky Medical Association) or something like that, and so my vacation time was always scheduled to go to meetings which may or may not have been fun times for my wife and I together. I would travel and schedule hospital meetings at noon. My patients I think accepted that because I was there at least four days a week, so I was there for them.

Another who was balancing clinical practice and leadership explained:

When I work with administrators, administrators have their own schedule, and they just think oh we have to have this meeting Friday, so let’s set this meeting up at 10:00 in the morning and then I get this email that says we have a meeting at 10:00 on Friday, it’s like, well that’s great, but I’m doing procedures and those patients are already scheduled, and would you like me to call you and cancel your procedure days beforehand? I don’t think so. So I find that I have to jockey a lot of those things.

Summary

Each of the 12 purposefully selected physician leaders in this study participated in a semi-structured interview. They shared their experiences and feelings on their decisions to assume leadership roles in clinical integration within a health system. The rich descriptions of this group provided details related to an initial motivation for leading, the development of leadership skills, and a passion for healthcare reform. They also shared some of the benefits and the challenges they have experienced in their leadership positions. The descriptions of their concerns and accomplishments were profound.

The interview data were organized across the four research questions. For each question, themes and patterns in the participants’ responses were identified and analyzed. Overall, individuals were open to sharing their thoughts and feelings on each question posed by the researcher during the interview. At times, stories were shared to further expand upon responses to certain questions, enriching the data. While most of the themes...
and patterns were consistent with the literature on physician leadership, some presented new thoughts and ideas on the subject.

Chapter V presents the conclusion of this study, including a discussion on the findings from Chapter IV and with recommendations for future research and practice.
CHAPTER V: DISCUSSION AND CONCLUSION

The Study in Brief

As providers of healthcare collaborate to fulfill the clinical integration mandates of the PPACA of 2010, physician leadership is critical (Dye & Sokolov, 2013). This qualitative study was designed to explore factors that influence physicians to assume leadership roles in clinical integration. The study focused on an examination of the experiences of physicians through their own voice. In an effort to understand the underlying reasons physicians choose to assume leadership roles, an interview schedule was constructed from the research questions.

The target population for this study included licensed physicians currently holding leadership roles in hospitals, hospital-employed medical groups, and/or physician-hospital associations. Through purposive sampling, four individuals from each health system setting were selected to participate in a semi-structured interview and were segmented by years of leadership experience: new leaders (0-5 years) and experienced leaders (6+ years). A sampling matrix was developed to ensure leadership experience was equally represented among the three health system settings.

Interview questions were derived from the literature on physician leadership and adaptations from questions in similar studies. An expert panel, consisting of one physician leader and one qualitative methodologist, reviewed the instrument and provided feedback for validity. A pilot study of the instrument also was performed with two physician leaders to further safeguard validity prior to beginning the research.

The study began with an email enlisting the participation of 15 selected physician leaders, detailing the purpose of the study and providing the informed consent document.
Twelve physicians agreed to participate and were contacted by the researcher to arrange a convenient interview time. Each session lasted between 30 minutes to one hour. All interviews were audio recorded and later transcribed. The interview data analyzed by the researcher provided needed insight into factors that influence physicians to assume leadership roles in clinical integration.

The remainder of this chapter includes a discussion of the findings organized by each research question, recommendations for further research and practice, and conclusions.

**Discussion of Findings**

The literature review for this study revealed that the evolution of healthcare requires effective collaboration between hospitals and physicians to provide quality care to patients. Many researchers have agreed that the presence and effort of engaged physician leaders is necessary for clinical integration (Goodall, 2011; Penlington & Marshall, 2016). Noticeably absent from the research were qualitative inquiries into the individual reasons of current physician leaders in assuming their leadership roles. The purpose of this study was to provide insight into the factors that influenced a sample of physician leaders to assume their leadership roles in clinical integration.

The discussion of findings in this section is organized by the four research questions as previously stated in Chapter V. For each question, the findings from the Interview Schedule for Physician Leaders are discussed in terms of the literature and implications for the field. Based on the results presented in Chapter IV, the following represent significant themes and patterns identified in physician leadership for clinical integration.
Research Question 1: How do physicians make the decision to transition into leadership roles within health systems?

First Theme: [Several participants discussed that the choice to assume a leadership role was highly influenced by a mentor, sometimes a relative and other times a colleague.] The majority of participants did not immediately identify a mentor as the reason for transitioning into leadership until the sub-question was posed directly by the researcher. The findings are consistent with previous research by Swensen et al. (2016) that mentoring among physicians promotes engagement in leadership. Although all participants acknowledged the shortage of physician leaders, it was interesting to note that none were currently mentoring a physician to assume a leadership role. However, several were intrigued by the question and indicated a desire to do so subsequent to this research interview.

Pattern: [The hospital subgroup acknowledged strong encouragement from hospital administration.] The pattern of physician leaders from the hospital subgroup receiving encouragement to enter leadership from hospital administration is not surprising. Similar to many other professions, the progression toward leadership frequently develops as other leaders take notice of one’s passion and ability to influence others. Several of the physician leaders from the hospital setting told stories that they were practicing in specialties which frequently required them to work closely with the hospital and were subsequently approached by leaders in the hospital offering them administrative roles.

Pattern: [The hospital-owned medical group physician leaders discussed assuming their leadership roles by default.] Several of the physician leaders in the
hospital-owned medical group category described a rotation of responsibilities. Some even conceded that they did not initially desire leadership responsibilities but felt compelled to assume the role in the absence of other willing volunteers.

Pattern: [The participants from the physician-hospital associations discussed encouragement from other physicians.] Unlike the hospital and hospital-employed medical group subcategories, leadership in physician-hospital associations often is a voluntary, unpaid role. Leadership roles from this category generally include membership in a board of directors, typically comprised of both physician and non-physician directors. Most organizations have bylaws mandating the length of term directors can serve on a board. Consequently, physicians nearing the end of their term often identify and recruit their replacements.

Second Theme: [Situational reasons varied among the participants, although several disclosed that the natural progression of their career developed into leadership.] Several participants shared backgrounds in the military, which is a very hierarchal organization. This theme indicated that promotion could be achieved through experience and demonstrated successful leadership.

Third Theme: [Several participants revealed a desire to impact change as the primary reason for assuming their leadership role.] Across the groups, the physicians discussed a desire to be a part of the changes in healthcare. This theme supported Menzies’ (2004) research that physician leaders must make decisions that impact their entire organization and other physicians. Several participants recounted that their original reason for entering medicine was to help patients, and assuming a leadership role allowed them to impact profoundly more patients than they could personally treat.
Research Question 2: What leadership skills are required for physician leaders within health systems?

Fourth Theme: [An identified theme among the subgroups was that all but one of the participants admitted they did not seek any formal leadership education before assuming their physician leadership role.] This finding supports past research (Burns & Muller, 2008), in that physicians must undertake many years of professional training, and have little time left for formal business and leadership courses. Many of the participants pointed to “real-life” experiences that prepared them for leadership. This is consistent with Angood and Shannon’s (2014) research that doctors make good leaders because, throughout their medical training, they are sworn to always do what is best for the patient.

Fifth Theme: [Once in their leadership role, a theme emerged that many of the participants attended formal training to sharpen their leadership skills.] This is consistent with research by Kasti (2015), who found that physicians often do not grasp the depth of leadership knowledge required for their role until they are engrossed in the responsibilities. Findings also support earlier research by Babitch and Chinsky (2005) that physician leaders should participate in training and education to enhance their leadership skills. While several of the participants disclosed that they had been provided some formal physician leadership training, virtually all stated this training occurred after they assumed a leadership role. In fact, nearly all participants revealed that their initial leadership skills were acquired through practice and “real-world” experience, rather than through formal coursework style training.
Pattern: [In particular, the physician leaders from the hospital subgroup attended multiple leadership trainings.] The pattern of physicians in the hospital category attending more leadership training opportunities than the other subcategories is not startling. This finding supports Scott’s (2015) research showing healthcare organizations that invest in training for physician leaders are successful. All of the participants in this subcategory work alongside other non-clinical leaders within the hospital. Continuing education, training, and workshops typically are budgeted annual expenses for the leaders in hospitals. For physician leaders in the hospital, this also was true.

Sixth Theme: [An identified theme among several of the participants involved the importance of managing change in the highly volatile field of healthcare.] Several of the participants discussed the importance of teamwork among physicians. These findings are consistent with past research by Deschamps et al. (2016), who found that when implementing changes, physicians are most influenced by their peers. The results also reflect the work of Angood and Birk (2014), who declared that, because physicians have credibility among their peers, they are most adept at leading changes that influence other physicians.

Research Question 3: To what extent does healthcare reform impact physician leadership within health systems?

Seventh Theme: [A common theme recognized among the subgroups entailed acceptance of the PPACA and finding ways to manage the numerous mandates.] Participants recounted stories of triumph or failure when implementing healthcare reform initiatives. Several pointed out the struggle to control finances while providing consumer-driven healthcare, which supports the research of Rosenberg (2012). The findings from
this study imply that physician leaders, although they may not agree with changes in healthcare, must lead the way in implementing reforms to ensure mutual benefits to other physicians, organizations, and patients.

Eighth Theme: [Common among the subgroups was discussion of the need for physician leaders in healthcare.] The results of this study mirror the wider literature that physician leaders are necessary for effective clinical integration. Several participants discussed the priority differences among physicians and health system administrators. This is similar to the research of Penlington and Marshall (2016) indicating that input from physicians on the frontline of delivery is critical to quality healthcare. Interestingly, one participant objected to the term “physician leader,” stating that he felt “leader” was more appropriate and less likely to limit his future career opportunities.

Research Question 4: What are the perceived benefits and drawbacks of being a physician leader within health systems?

Ninth Theme: [The researcher observed several of the participants enjoyed the opportunity to share insight into physician leadership.] Nearly all participants disclosed that they had participated in other similar interviews but enjoyed the opportunity of the confidential and anonymous format of this study to provide open and honest answers. The researcher observed that the physicians were excited to share both their positive and negative feelings toward clinical integration and leadership.

Pattern: [An identified pattern among the physician leaders from the 0-5 year category was excitement for their role.] The pattern of new physician leaders expressing excitement for their role was refreshing. The researcher observed that the newer
physician leaders are eager to wield their newfound power. One individual even announced that he was seeking larger leadership opportunities.

Pattern: [Several of the physicians from the experienced category also expressed passion in the power of their role.] Although the term “power” arose in several of the interviews, the experienced leader participants were quick to explain that they strive to use their leadership power for the good of healthcare quality. This follows closely with the work of Chervenak and McCullough (2001), who discussed that because physician leaders possess immense power, they must rely on high morals to promote the ethical delivery of medicine by doing what is best for the patient.

Tenth Theme: [Among the subgroups, a common theme was expressed regarding the importance of having influence and a voice in decision making.] When asked to share a story of when they felt most effective in their leadership role, participants were proud to recount policy changes and initiatives they had led to improve the quality of healthcare. Several also discussed working with other physicians and non-clinical leaders in teams to make needed changes. As part of their role, they were responsible for guiding other physicians to make changes and often were met with resistance. The needed ability for physician leaders to manage conflict in decision making is similar to the work of Nilsson and Furaker (2012).

Eleventh Theme: [Assuming a leadership role often means having to give up time devoted to other causes.] A major theme among participants regarding drawbacks to leadership involved time demands. Although the physicians conceded that they expected leadership to come with increased time demands, several expressed frustrations in having to give up other activities.
Twelfth Theme: [Several of the physician leaders in this study discussed frustrations with the amount of time needed to impact change.] The participants recounted their previous ability to make changes quickly and unilaterally. Before assuming their current leadership roles, many spent their days diagnosing and treating patients in quick patient encounters. Now in leadership positions, most of the physicians find this method is no longer feasible, as the input of many stakeholders is needed to make changes. This is akin to Quinn’s (2015) research that the change from autonomy to group efforts can be an adjustment to physician leaders.

Thirteenth Theme: [Physician leadership creates difficulties in work/life balance.] Many of the doctors commented that their added leadership responsibilities would not be possible without support from family. This is a common theme among professionals of all types. Interestingly, several of the participants indicated their leadership roles actually provided more time for family than their clinical practice. This is due likely to the more routine work hours of administrative professionals when compared to physicians who are on-call for patient emergencies.

Fourteenth Theme: [Physician leadership creates difficulties in leadership/clinical balance.] Among the subgroups, the physician leaders expressed difficulties combining the responsibilities of clinician and administration. Overwhelmingly, this study found the participants are struggling to feel comfortable balancing patient needs against financial constraints. Earlier research by Hoff and Mandell (2001) revealed that physician leaders who choose to balance clinical practice with leadership responsibilities must possess high levels of commitment to both causes. Several physicians discussed that assuming a leadership role allows them the opportunity to be involved in financial decision making.
They are able to bring their first-hand knowledge of patient needs to financial discussions.

Although the sample was not selected based on current clinical practice, it is interesting to note that of the 12 physician leaders, six continue to practice clinically and six do not. Of the six balancing clinical practice and leadership responsibilities, four were from the hospital-employed medical group subcategory and two are from the physician-hospital association subcategory. All four from the hospital leadership setting had given up their clinical practice, as had two of the physicians from physician-hospital association leadership roles.

**Recommendations for Further Research**

This study examined the factors that influenced physicians to assume leadership roles in clinical integration through a qualitative phenomenological approach. By way of interviews, the study provides insights into the thoughts and feelings of current physician leaders in a small metropolitan area of Kentucky. As with any focused study, this research involved limitations that provide opportunities for further research. First, the population of focus for this study included physician leaders in hospitals, hospital-employed medical groups, and physician-hospital associations. Research is recommended to study the leadership factors in physicians holding leadership roles in other healthcare settings, particularly from private practice. This may provide a comparison basis between independent physicians and hospital-affiliated physicians.

Second, this study was limited to 12 individuals from a small metropolitan area in Kentucky. The research could be replicated in another geographical location with a larger sample using the same research questions, sampling procedures, and interview schedule.
Third, the requirement for physicians and hospitals to work together in clinical integration strategies was mandated by the PPACA of 2010. The 2017 shift in political party may alter healthcare reform in an entirely new direction. Performing similar research in a future time period may warrant different areas of focus in both the research questions and the interview schedule.

Fourth, participants in this study were segmented by years in physician leadership categorized by new leaders (0-5 years) and experienced leaders (6+ years). Another option of categorization could include separating the physician leaders by those continuing to practice clinically while balancing leadership responsibilities and those physicians who have retired from clinical practice to focus solely on leadership. Finally, this study was limited by the use of one qualitative research instrument. The addition of a quantitative survey could transform this research into a mixed-methods study, thereby eliciting information from additional physicians and allowing the researcher to triangulate results.

**Recommendations for Practice**

If healthcare leaders can begin to understand the reason why current physicians accept leadership roles, they may be better equipped to recruit additional physician leaders. With the personal insights into physician leadership choice provided by this study, health system administrators can experience an advantage in partnering with doctors to lead clinical integration efforts. The data from this study yielded three opportunities for shaping the future of physician leadership in clinical integration. First, although highly trained professionals, doctors choosing to transition into leadership roles benefit from formal training in business and leadership courses. Colleges and
universities, professional societies, and academic health centers should expand leadership training provided to physicians, thereby adding to the network of skilled physician leaders. Coursework should focus on inspiring vision, understanding different leadership styles, and influencing colleagues.

Second, physician leaders of clinical integration movements should be provided with continuing education specific to healthcare reform in order to effectively manage change and to influence their peers. As healthcare is a constantly evolving industry, it is imperative that physician leaders are at the forefront of understanding and are well versed in topics that impact the collaboration of doctors and hospitals for delivering quality and affordable healthcare. Finally, current physician leaders in clinical integration should support and advise other aspiring physician leaders. Because physicians choosing to enter into leadership positions are presented with many benefits and drawbacks, a mentor should be cognizant of the message sent to aspiring leaders regarding the opportunities and challenges they will encounter.

Conclusions

The clinical integration of physicians and hospitals is one of numerous mandates included in the PPACA of 2010. To succeed in clinical integration, doctors and hospitals must work together to improve the quality of healthcare. For this collaboration to be effective, physician leaders must be present to work with hospital administrators on common goals. The purpose of this qualitative study was to identify and to understand the perceptions of current physician leaders regarding their reasons for assuming leadership roles in clinical integration. The 12 physicians in this study held leadership roles within hospitals, hospital-employed medical groups, and/or physician-hospital
associations. Each participated in an individual, semi-structured interview. Through audio recorded responses to open-ended questions, they shared their beliefs on physician leadership and told stories of their personal achievements and hurdles.

Study results provide insights into the individual thoughts and feelings of current physician leaders. This study relied on the experiences of physicians currently serving in leadership roles focused on clinical integration efforts with hospitals. By allowing participants an opportunity to reflect on their beliefs and aspirations for the future, this study expanded upon previous research in physician leadership. By using the interview format, the researcher was able to glean an in-depth perception of each physician’s underlying reasons for assuming a leadership role.

Overall, the key factors that influenced their decisions to assume leadership roles were encouragement from mentors, a desire to participate in decision making, an opportunity to assist other physicians, and pride in the ability to positively impact healthcare delivery. Results indicate that current physician leaders are passionate about clinical integration, interested in further developing their leadership skills, and encourage other physicians to enter leadership roles.

The data provided findings that can be used to shape both current and aspiring physician leaders on an individual level and to influence the culture of leadership in clinical integration. Although the 12 physician leaders were diverse in relation to their years of experience in leadership and their current healthcare setting, responses to interview questions often were similar and provided a rich description of their personal experiences.
Finally, this study stimulates additional opportunities for research and understanding into the field of physician leadership as it relates to the context of clinical integration. The challenge of encouraging physicians to assume leadership roles remains critical to the success of healthcare reform. With progress on developing and training physicians for leadership, the potential for clinical integration to improve healthcare delivery is greater.
REFERENCES


Lee, P. (2016, October). *Key national issues facing healthcare*. Lecture conducted at Owensboro Health Regional Hospital, Owensboro, KY.


Noon, M. (2016, November). *The essential element to employee engagement: Rounding*. Lecture conducted at Owensboro Health Regional Hospital, Owensboro, KY.


Patterson, P. (2015, April). *Healthy exchange 2015. Owensboro Health 2015* (Employee Town Hall Forums). Lecture conducted at Owensboro Health Regional Hospital, Owensboro, KY.


Pizzo, J. (2013, October). *The new era of healthcare*. Owensboro Health 2013 (Health Policy Leadership Briefing). Lecture conducted at Owensboro Health Regional Hospital, Owensboro, KY.


APPENDIX A

Interview Schedule Guide for Physician Leaders

IS1. What was your personal motivation for assuming this leadership role?
   a. Were you encouraged to assume your leadership role by a friend or mentor?

IS2. When did you start thinking about becoming a physician leader?
   a. Can you remember a particularly important moment in that decision that made you want to be a leader in order to effect change?

IS3. Did you seek any further training or education for this position either before or after assuming your leadership role?

IS4. How has the need for physician leadership changed since healthcare reform?
   a. What have been the most obvious changes?

IS5. What do you enjoy most about being a physician leader?
   a. Can you think of a particularly enjoyable project, event, or time period?

IS6. Think of a time when you felt your leadership was highly effective. Would you tell that story?

IS7. Did you struggle with work/life or leadership/clinical balance after assuming this leadership role?
   a. Describe how you dealt with those struggles.

IS8. What do you like the least about your current leadership role?

IS9. Think of a time when you felt you could have been a more effective leader. Would you tell that story?
APPENDIX B

Letter to Expert Panel Members

Researcher’s Address

Expert Panel Member’s address

Dear Expert Panel Member,

I am a student in the Educational Leadership Doctoral Program at Western Kentucky University. I am completing a research project for my dissertation under the direction of Dr. Randy Capps, Organizational Leadership, Department of Educational Administration, Leadership, and Research at Western Kentucky University.

My qualitative phenomenological research project is titled “Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration.” By studying physician leaders’ responses and opinions concerning their decision to lead, I hope to obtain information that may impact the development and retention of additional physician leaders. I believe that the quality of healthcare delivery can be improved as more physicians assume leadership roles.

The purposeful sample will come from physician leaders in three different healthcare settings: hospital, medical group, and health insurance. The physician leaders will each participate in separate semi-structured interview. I have attached the Interview Schedule as mapped to the research questions.

I would appreciate your expert review of these questions. Please provide feedback directly on the instrument and help me improve the questions. If there are nuances implied that will make the questions difficult to answer, please indicate them. Also, if some wording appears unclear or ambiguous, please identify that as well. I welcome any and all suggestions.

I think this project is important to understanding a critical aspect of healthcare reform, the need for physician leaders. Your feedback will help me improve the clarity and concision of the questions, encouraging the most information from my subjects. Additionally, your participation in this part of my research allows you to receive a copy of the completed research.

Thank you for your time. Please contact me by phone (270-313-5352) or email (jennifer.jackson117@topper.wku.edu) if you have questions or if you are unable to participate. Thank you so much for your assistance.

Sincerely,

Jenny Jackson, MBA
Dear Pilot Study Member,

I am a student in the Educational Leadership Doctoral Program at Western Kentucky University. I am completing a research project for my dissertation under the direction of Dr. Randy Capps, Organizational Leadership, Department of Educational Administration, Leadership, and Research at Western Kentucky University.

My qualitative phenomenological research project is titled “Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration.” By studying physician leaders’ responses and opinions concerning their decision to lead, I hope to obtain information that may impact the development and retention of additional physician leaders. I believe that the quality of healthcare delivery can be improved as more physicians assume leadership roles.

The purposeful sample will come from physician leaders in three different healthcare settings: hospital, medical group, and health insurance. The physician leaders will each participate in separate semi-structured interviews.

I would like feedback from the participant’s point of view regarding my interview protocol. After completing the interview, I will ask for your feedback regarding the wording, format, and content of the questions.

I think this project is important to understanding a critical aspect of healthcare reform, the need for physician leaders. Your feedback will help me improve the clarity and concision of the questions, encouraging the most information from my subjects. Additionally, your participation in this part of my research allows you to receive a copy of the completed research.

Thank you for your time. Please contact me by phone (270-313-5352) or email (jennifer.jackson17@topper.wku.edu) if you have questions or if you are unable to participate. Thank you so much for your assistance.

Sincerely,

Jenny Jackson, MBA
APPENDIX D

Letter to Study Participants

Researcher’s Address

Participant’s address

Dear Participant,

I am a student in the Educational Leadership Doctoral Program at Western Kentucky University. I am completing a research project for my dissertation under the direction of Dr. Randy Capps, Organizational Leadership, Department of Educational Administration, Leadership, and Research at Western Kentucky University.

You are being invited to participate in a qualitative phenomenological research project titled “Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration.” By studying physician leaders’ responses and opinions concerning their decision to lead, I hope to obtain information that may impact the development and retention of additional physician leaders. I believe that the quality of healthcare delivery will continue to improve as more physicians assume leadership roles.

This study is designed to collect semi-structured interview data from 12 physician leaders in three different healthcare settings: hospital, medical group, and health insurance organizations. Prior to participation in the interview, you will be required to complete a consent form. The individual interview, lasting no more than one hour in length will be conducted face-to-face or by telephone based on your preference. Interview data will be confidential and you will receive a transcribed copy to review for accuracy.

The benefits gained from your participation will provide information that is important to understanding a critical aspect of healthcare reform and clinical integration, the need for physician leaders. Additionally, your participation allows you to receive a copy of the completed research.

Please contact me by phone (270-313-5352) or email (jennifer.jackson117@topper.wku.edu) if you have questions. Thank you so much for your participation.

Sincerely,

Jenny Jackson, MBA
APPENDIX E

IRB Approval Letter

DATE: December 4, 2015
TO: Jennifer Jackson, MBA
FROM: Western Kentucky University (WKU) IRB
PROJECT TITLE: [838435-1] Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration
REFERENCE #: IRB 16-217
SUBMISSION TYPE: New Project
ACTION: APPROVED
APPROVAL DATE: December 4, 2015
EXPIRATION DATE: December 4, 2016
REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of December 4, 2016.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Paul Mooney at (270) 745-2129 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.
WESTERN KENTUCKY UNIVERSITY

Institutional Review Board
Continuing Review Report

If this is your third year for your Continuing Review Request, please complete a new application. Otherwise, DO NOT include the complete application in describing modifications and requests for additional time to collect data.

Name of Project: **Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration**  
Name of Researcher: **Jennifer Jackson**  
Department: **Educational Leadership Doctoral Program**

How many total subjects have participated in the study since its inception? **#14**

How many subjects have participated in the project since the last review? **#14**

Is your data collection with human subjects complete?  

- [x] Yes  
- [ ] No

1. Has there been any change in the level of risks to human subjects? (If “Yes”, please explain changes on a separate page).  
- [ ] Yes  
- [x] X  
- [ ] No

2. Have informed consent procedures changed so as to put subjects above minimal risk? (If “Yes”, please describe on a separate page).  
- [ ] Yes  
- [x] X  
- [ ] No

3. Have any subjects withdrawn from the research due to adverse events or any unanticipated risks/problems? (If “Yes”, please describe on a separate page).  
- [ ] Yes  
- [x] X  
- [ ] No

4. Have there been any changes to the source(s) of subjects and the Selection criteria? (If “Yes”, please describe on a separate page).  
- [ ] Yes  
- [x] X  
- [ ] No

5. Have there been any changes to your research design that were not specified in your application, including the frequency, duration and location of each procedure. (If “Yes”, please describe on a separate page).  
- [ ] Yes  
- [x] X  
- [ ] No

6. Has there been any change to the way in which confidentiality of the Data is maintained? (If “Yes”, please describe on a separate page).  
- [ ] Yes  
- [x] X  
- [ ] No

7. Is there desire to extend the time line of the project?  
- [x] Yes  
- [ ] No

On what date do you anticipate data collection with human subjects to be completed? **May 2017**

---

WKU IRB# 16-217  
Approval - 10/10/2016  
End Date - 5/1/2017  
Expedited  
Original - 12/4/2015

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APPENDIX F

Informed Consent

INFORMED CONSENT DOCUMENT

Project Title: Factors that Influence Physicians to Assume Leadership Roles: A Focus on Clinical Integration

Investigator: Jennifer Jackson, Educational Leadership Doctoral Program, 270-313-3352

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign this form in the presence of the person who explained the project to you. You should be given a copy of this form to keep.

1. Nature and Purpose of the Project:
   The intent of this research is to understand physician leadership role choices on a personal level through interviews with doctors holding these roles within healthcare settings. This qualitative, phenomenological study focuses on how physician leaders made their decision to lead. The central research question of this study is: "What factors influence physicians to assume leadership roles?" The following questions give structure to the research: How do physicians make the decision to transition into leadership roles? To what extent is a passion for healthcare reform and continuing education significant to this decision? And, what are the perceived benefits/drawbacks of being a physician leader? This research will add to the field of study on physician leadership and clinical integration.

2. Explanation of Procedures:
   You are being asked to participate in a semi-structured interview focusing on your personal reasons for assuming a physician leadership role. The interviews will take place in a comfortable location of your choosing, at a time convenient to you and will last no longer than one hour.

3. Discomfort and Risks:
   The researcher does not believe there will be any risks involved with participating in this study; however, this study may include risks which are unknown to the researcher at this time.

4. Benefits:
   There are no direct benefits to participants in taking part in this research. I hope the results of this research will enlarge the current literature on physician leadership choices.

WKU IRB# 16-217
Approval - 10/10/2016
End Date - 5/1/2017
Expedited
Original - 12/4/2015
5. **Confidentiality:**

Participants’ confidentiality will be protected in this study. Your name will not be used in any report that is published. Regulators, sponsors, or Institutional Review Board Members that oversee research may review research records to ensure the researcher followed regulatory requirements. The use of an audio recorder will only provide the researcher with a reminder of participants’ answers. All research data will be secured and the audio tapes destroyed at the conclusion of the study.

6. **Refusal/Withdrawal:**

Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in any experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

________________________________________  __________________________
Signature of Participant                      Date

________________________________________  __________________________
Witness                                      Date

- I agree to the audio/video recording of the research. 

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Paul Mooney, Human Protections Administrator
TELEPHONE: (270) 745-2129

WKU IRB# 16-217
Approval - 10/10/2016
End Date - 5/11/2017
Original - 12/4/2015
### APPENDIX G

**Interview Schedule Mapped to Research Questions**

<table>
<thead>
<tr>
<th>RQ1</th>
<th>RQ2</th>
<th>RQ3</th>
<th>RQ4</th>
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</thead>
<tbody>
<tr>
<td>How do physicians make the decision to transition into leadership roles within health systems?</td>
<td>What leadership skills are required for physician leaders within health systems?</td>
<td>To what extent does healthcare reform impact physician leadership within health systems?</td>
<td>What are the perceived benefits and drawbacks of being a physician leader within health systems?</td>
</tr>
<tr>
<td>IS1</td>
<td>IS2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was your personal motivation for assuming this leadership role?</td>
<td>When did you start thinking about becoming a physician leader?</td>
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<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Were you encouraged to assume your leadership role by a friend or mentor?</td>
<td>Can you remember a particularly important moment in that decision that made you want to be a leader in order to effect change?</td>
<td></td>
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<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>IS3</td>
<td>Did you seek any further training or education for this position either before or after assuming your leadership role?</td>
<td>X</td>
<td>X</td>
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<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>IS4</td>
<td>How has the need for physician leadership changed since healthcare reform?</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>a</td>
<td>What have been the most obvious changes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS5</td>
<td>What do you enjoy most about being a physician leader?</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>a</td>
<td>Can you think of a particularly enjoyable project, event, or time period?</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>IS6</td>
<td>Think of a time when you felt your leadership was highly effective. Would you tell that story?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS7</td>
<td>Did you struggle with work/life or leadership/clinical balance after assuming this leadership role?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>Describe how you dealt with those</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
What do you like the least about your current leadership role?

Think of a time when you felt you could have been a more effective leader. Would you tell that story?
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
</tr>
<tr>
<td>ACHE</td>
<td>American College of Healthcare Executives</td>
</tr>
<tr>
<td>ACPE</td>
<td>American College of Physician Executives</td>
</tr>
<tr>
<td>AHA</td>
<td>American Hospital Association</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHMR</td>
<td>Center for Health Management Research</td>
</tr>
<tr>
<td>CIN</td>
<td>Clinically Integrated Network</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CMS</td>
<td>The Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-For-Service</td>
</tr>
<tr>
<td>GPWW</td>
<td>Group Practice Without Walls</td>
</tr>
<tr>
<td>HIMSS</td>
<td>Healthcare Information and Management Systems Society</td>
</tr>
<tr>
<td>HPI</td>
<td>Healthcare Performance Improvement</td>
</tr>
<tr>
<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
</tr>
<tr>
<td>IPA</td>
<td>Independent Practice Association</td>
</tr>
<tr>
<td>KMA</td>
<td>Kentucky Medical Association</td>
</tr>
<tr>
<td>MACRA</td>
<td>Medicare Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>MIPS</td>
<td>Merit-Based Incentive Payment Systems</td>
</tr>
<tr>
<td>MSO</td>
<td>Management Services Organization</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>PACHA</td>
<td>Physicians as Community Health Advocates</td>
</tr>
<tr>
<td>PHO</td>
<td>Physician Hospital Organization</td>
</tr>
<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
</tbody>
</table>