Professional Identity of the Physician Leader:

A Qualitative Phenomenological Study

by

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Abstract

Physician professional identity remains elusive despite the role of physician leaders becoming more critical in a complex environment of healthcare. An abundance of literature exists relative to professional identity in other medical disciplines, such as nursing, though a gap remains with regards to physician leaders. The purpose of this study was to determine how professional identity of practicing physicians in leadership roles is established. This qualitative phenomenological study utilized authentic leadership theory as the lens through which to view data and results. Participants included eleven physician leaders from varied specialties and administrative time allocations. Data collection included recorded semi-structured interviews, conducted in person. Transcribed narratives were analyzed utilizing guidance from Moustakas and Saldanas, resulting in the emergence of five primary themes: identity formation begins prior to medical school, early leadership experiences form the basis for future roles, desire for greater impact drives physicians into leadership roles, physician leaders experience a duality of roles, and physician leaders are, above all, physicians first. Recommendations include future research of the perspectives of physician leader colleagues, selecting participants with full-time administrative responsibilities, expanding the geographic regions of potential participants, and developing physician-specific leadership courses. The expansive influence and clinical expertise unique to physician leaders can lead to exceptional outcomes for both organizations and patients. Intentional steps should be taken to ensure physicians hold both capability and competency for leadership roles.

Dedication

This dissertation is dedicated to my grandparents, George O. and Kate Spoonamore and Harold and Wanda Owens, who instilled in me the values of hard work, ethics, compassion, resilience, pride, dedication, hope, and patience. To them and to my family, I owe everything. And to the caregivers who give so much of themselves so that others may thrive.

Acknowledgements

I would like to thank my family and friends their unending love, support, and patience throughout the years of this doctoral journey. Many thanks to the amazing leaders who encouraged my development and inspired me to become an authentic leader: Mary Jo Gibson, Becky Burton, Candy Jackson, Dr. Dick Tibbits, Dr. Sandy Swearingen, June Stovall, Carol Anderson, and Heather Fox. My eternal gratitude to the many instructors I've had throughout my educational career, preparing me for this adventure. I will forever be grateful for the patience, guidance, and support of my dissertation chair, Dr. Katrina Schultz, and my dissertation committee member, Dr. William Smith.

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Chapter 1: Introduction

Effective physician training can make the difference between life and death for patients, especially clinical training for resident physicians (Naveh, Katz-Navon, & Stern, 2015). Error rates for novice internal medicine residents ranked higher than experienced internal medicine residents and both novice and experienced surgical residents. Practicing physicians are often found serving as preceptors for newly graduated student physicians, serve as a critical component to training student physicians (Naveh et al., 2015) and have long been formal and informal leaders in healthcare organizations (Angood & Shannon, 2014).

Physicians are placed into leadership roles through varied approaches, some retaining clinical responsibilities and some not, but all physicians take on unique roles and conflicting self-identities (Quinn, 2013; Quinn & Perelli, 2016). The American Association of Physician Leaders reported 8,371 members in 2016 though the report did not specifically identify physicians in leadership roles (Esselman & Angood, 2016). A qualitative phenomenological study was conducted to determine how professional identity is interpreted and to find commonalities in the shared meaning among the participants.

An overview will be provided by discussing the background of the problem, a statement of the problem, the purpose of the study, and the significance of the study. Additional review will be provided of the research questions, theoretical framework, terms, assumptions, scope, delimitations, and limitations. The final elements include a summary and a preview of the next chapter.

Background of the Problem

Delivering healthcare continues to be multifarious with an increasing emphasis on extensive documentation, clinical performance, care quality, and patient experience (Galstian, Hearld, O'Connor, & Borkowski, 2018). To navigate complexities, many institutes are led by career administrators who have business-related degrees and many years of experience and share the belief healthcare administration is the administrators' exclusive domain (Neal, 2019). A growing number of physicians are taking on administrative roles and are capable of providing valuable insight into the clinical impact of operational decisions, performance/process improvement initiatives, and organizational changes (Angood, 2015; Ennis-Cole, Cullum, & Iwundu, 2018).

The significance and elevation of the physician leader role continues to be a critical factor the future landscape of healthcare (Fernandez, Noble, Jensen, & Chapin, 2016; Hudak, Russell, Fung, & Rosenkrans, 2015). Physician leaders are constantly in a dynamic struggle to navigate between operating and clinical foci (Berghout, Fabbricotti, Buljac-Samardzic, & Hilders, 2017; Spehar, Frich, & Kjekshus, 2015). Literature on the development of leadership interventions for clinical leaders exists in abundance (Mianda & Voce, 2018). Unique perspectives provided by physicians are paramount to guiding complex healthcare organizations (Angood, 2015; Styhre, Roth, & Roth, 2016). The need to develop a strong professional identity is a significant concern of the medical community at large (Molleman & Rink, 2015). While the beginning of physician professional identity formation occurs in medical school, professional identity can be further refined as additional training is pursued (Chan, Pratt, Poole, & Sidhu, 2018).

This qualitative phenomenological study was necessary in order to narrow the literature gap between the professional identity of administrative physicians and development programs, and the evolving role of physician leaders in healthcare. Physician professional identity is a critical aspect of physician leader efficacy and developing a better understanding of how physicians view professional identity is crucial (Quinn & Perelli, 2016). While many studies exist on the professional identity of nurses (Choudhry, Armstrong, & Dregan, 2017; Hensel & Laux, 2014), a gap occurs with relation to physicians' professional identity (Andersson, 2015; Naveh et al., 2015).

Statement of the Problem

The problem is administrative physician professional self-identity is unknown. The background of the problem is physicians ascend to executive positions because of clinical abilities, capability to influence other physicians, or political capital all without formal leadership training or development (Quinn, 2013). The importance of the problem is the potential for patient harm (Naveh et al., 2015) as a result of challenged professional identity and strained relationships as a result of role confusion (Vincent et al., 2017).

The extent of the problem is unknown (Andersson, 2015; Quinn, 2013; Quinn & Perelli, 2016; Vincent et al., 2017). Those impacted by the problem are physicians within dual roles of leader and practitioner and ultimately the patient. There is an identified gap in the research and literature of physician leader professional identity. Potential for patient harm and strained relationships between physicians and other care providers may continue if a qualitative phenomenological study is not conducted.

Purpose of the Study

The purpose of this qualitative phenomenological study was to determine how professional identity of practicing physicians in leadership roles is established. This qualitative phenomenological study was designed to examine the professional identity experiences and perceptions of physician leaders in administrative roles and uncover meaning attributed to the perceptions of physician leaders. This study was necessary to create greater awareness and insight into the physician leadership role among physicians, nursing staff, hospital administrators, and patients.

This study contributed to the knowledge base by providing data on actual experiences of physician leaders, and the meanings these leaders provide regarding personal lived experiences. This information adds to the limited research on effective models of development for practicing physicians in leadership roles. As a result of this study, healthcare institutions and physician educators may be able to develop leadership programs to effectively prepare physicians for leadership roles aligned to the actual lived experience of physician leaders. The results of this study may be shared with institutions responsible for educating physicians as well as healthcare organizations where physician leaders practice.

Significance of the Study

A qualitative phenomenological study contributes to the knowledge base by providing data on actual experiences of physician leaders, and the meanings leaders provide regarding personal lived experiences (Quinn & Perelli, 2016). Findings add to the limited research on useful models of development for practicing physicians in leadership roles. Healthcare institutions and physician educators may be able to develop leadership programs to adequately

prepare physicians for leadership roles aligned with the actual lived experience of physician leaders. The results of this qualitative phenomenological study may be shared with institutions responsible for educating physicians as well as healthcare organizations where physician leaders practice.

Research Questions

This qualitative phenomenological study focused on uncovering the lived experiences of practicing physicians in current or previous leadership roles. The goal was to contribute to the furtherance of physician leader development. Qualitative research questions focus and define aspects of the research and are designed to be open-ended and nondirectional (Creswell & Creswell, 2018; Glesne, 2016). The following research questions guided the study:

Research Question One: What are the professional identity experiences of practicing physicians in leadership roles at a hospital in the southeast United States?

Research Question Two: What are the professional identity perceptions of practicing physician leaders at a hospital in the southeast United States?

Theoretical Framework

Creswell and Creswell (2018) describe three main functions of theories used in qualitative research. A theory may be used to explain behavior, to serve as an orienting framework and lens to view data and results, or to be the end point of a study. This qualitative phenomenological study utilized authentic leadership theory (Avolio & Gardner, 2005) as the lens through which to view data and results. The theory's roots can be traced back to the early concept of transformational theory where transformational leadership began to diverge from transactional theories (Bass, 1985). Northouse (2019) states authentic leadership is conceptually

simple but operationally complex. Avolio and Gardner (2005) framed authentic leadership as a root construct differentiated by the exclusion of a concept called visioning. Rodriguez, Green, Sun, and Baggerly-Hinojosa (2017) additionally excluded charisma as a defining characteristic, thereby distinguishing authentic leadership as unique.

Sharing similarities to both transformational and servant leadership, authentic leadership includes an overt element of morality (Northouse, 2019). Authentic leaders recognize and leverage strengths while aligning follower interests for the benefit of all. The underlying principle of authenticity compels leaders to make decisions and lead from a place of righteousness and virtuosity.

Authentic leadership views the role of the leader within four dimensions (Avolio & Gardner, 2005). Behaviors of authentic leaders can be classified as relational transparency, internal moral perspective, balanced processing, and self-awareness (Avolio & Gardner, 2005; Duncan, Green, Gergen, & Ecung, 2017). Leaders who remain faithful to values and consistent with behaviors can build trusting relationships with followers which leads to increased performance (Avolio & Gardner, 2005; Lord, Day, Saccaro, Avolio, & Eagly, 2017).

Authentic leadership theory provides a holistic approach to establishing oneself within the context of others through a focus on first becoming self-aware (Northouse, 2019). Self-awareness is seen as an evolutionary process by which an individual becomes increasingly aware of one's values, cognitions regarding identity, emotions, sense of purpose, and desires (Avolio & Gardner, 2005). Distinct from trait-based theories, authentic leadership is considered a developmental approach due to the ability of a leader to attain or cultivate behaviors lead to success (Avolio & Gardner, 2005).

Definitions of Terms

The terms listed below are used throughout this study. The definitions provided are intended to provide clarity and enhance understanding. Each of the terms are grounded in literature and supported by accompanying references.

Authentic Leadership – A behavior-based leadership theory valuing individual genuineness with the goal of doing what is best for the group and followers. Critical elements of authentic leadership are relational transparency, internal moral perspective, balanced processing, and self-awareness (Avolio & Gardner, 2005).

Clinical Manager – Clinicians (physicians and nurses) in formal administrative roles who may or may not maintain clinical work (Spehar et al., 2015).

Medical Leadership – Collaborative practices led by a member of any medical professional group resulting in influence on followers (Tagawa, 2019; Touati, Rodriguez, Paquette, Maillet, & Denis, 2019)

Physician Leadership – The leadership practices of medical doctors serving in the capacity of strategic leader, social leader, or clinical leader (van de Riet, Berghout, Buljac-Samardzic, van Exel, & Hilders, 2019).

Professional Identity – An iterative construct of personal identification and values, derived from experiences, education, direct feedback, and others' perspectives (Chan et al., 2018).

Self-Awareness - An evolutionary process by which an individual becomes increasingly aware of one's values, cognitions regarding identity, emotions, sense of purpose, and desires (Avolio & Gardner, 2005)

Transformational Leadership – An encompassing set of leader behaviors which inspire, motivate, stimulate, and transform people (Northouse, 2019) while seeking to meet the high-order needs of followers (Banks, McCauley, Gardner, & Guler, 2016).

Assumptions

Inherent in qualitative research are assumptions requiring acknowledgment and elucidation (Creswell & Creswell, 2018). Phenomenology is based on an ontological assumption in which reality is subjective and is uniquely experienced by each participant (Glesne, 2016). One assumption within the study was each participant would embody a particular and distinctive experience as a physician leader. An epistemological assumption of qualitative research is to seek close collaboration and to remove distance from participants (Creswell & Creswell, 2018). The epistemological assumption intrinsic to this study was each participant would experience the phenomenon of physician leadership uniquely and be willing to share experiences honestly.

Scope and Delimitations

Clearly defining the scope and identifying the delimitations of a study contributes to the trustworthiness of research by declaring what will be and what will not be studied (Glesne, 2016). While scope refers to the boundaries of the study, delimitations provide the rationale for the set boundaries. The scope of this study was limited to practicing physicians in leadership roles located at a single organization.

The phenomenological study consisted of data collected via semi-structured in-person interviews with eleven physician leaders. This study focused on the experiences of physician leaders in a leadership role, specifically exploring professional identity. Authentic leadership served as the theoretical framework to examine participant responses. The delimitation of the

study was the geographic location of the organization. Wide transferability of results was limited due to the geographic location of participants and the focused scope of participants and respective clinical specialties.

Limitations

This qualitative research was limited to practicing physicians in current or previous leadership roles located in the southeast United States. Quantitative research often requires large populations from which to draw statistically representative samples enabling generalizable results. Conversely, qualitative research often utilizes a smaller, purposive sample from which to derive information-rich data relative to a central phenomenon enabling transferable results (Glesne, 2016).

Trustworthiness is an accepted measure of qualitative research rigor (Glesne, 2016). Multiple strategies can be employed to contribute to the trustworthiness of a study such as rich, thick narrative, member checking, reflexivity, triangulation, peer review, post-study debriefing, and negative case analysis (Glesne, 2016; Patton, 2002). Triangulation through member checks, reflexivity, peer debriefing, and rich/thick narrative was utilized in this study to ensure collected data and subsequent analysis were accurate and trustworthy.

Chapter Summary

Elevating the physician administrative leadership role continues to be a central element in the future healthcare (Fernandez et al., 2016). Developing a greater understanding of the professional identity formation of physician leaders is an important facet in the advancement of training future physicians (Quinn & Perelli, 2016) and is a great concern of the medical community (Molleman & Rink, 2015). An overview was provided by discussing the background

of the problem, a statement of the problem, the purpose of the study, and the significance of the study. Guiding research questions, theoretical framework, terms, assumptions, scope, delimitations, and limitations were presented sequentially. The next chapter includes a literature review strategy, comprehensive literature review and analysis, and guiding theoretical framework.

Chapter 2: Literature Review

The purpose of this qualitative phenomenological study was to determine how professional identity of practicing physicians in leadership roles is established. The problem was administrative physician professional self-identity is unknown (Andersson, 2015; Berghout et al., 2017; Quinn & Perelli, 2016; Vincent et al., 2017). This qualitative phenomenological study was designed to examine the professional identity experiences and perceptions of physician leaders in administrative roles and uncover meaning attributed to the perceptions of physician leaders. This qualitative phenomenological study was necessary to create greater awareness and insight into the physician leadership role among physicians, nursing staff, hospital administrators, and patients.

Physician professional identity is a critical aspect of physician leader efficacy and understanding how physicians view professional identity is critical (Quinn & Perelli, 2016). While many studies exist on the professional identity of nurses (Choudhry et al., 2017; Hensel & Laux, 2014), a gap occurs with relation to physicians' professional identity (Andersson, 2015; Naveh et al., 2015). The problem is administrative physician professional self-identity is unknown. The potential for patient harm and strained relationships between physicians and other care providers may continue if a qualitative phenomenological study is not conducted.

A qualitative phenomenological study contributed to the knowledge base by providing data on actual experiences of physician leaders, and the meanings leaders provide regarding personal lived experiences (Quinn & Perelli, 2016). Findings added to the limited research on useful models of development for practicing physicians in leadership roles. Healthcare institutions and physician educators may be able to develop leadership programs to adequately

prepare physicians for leadership roles aligned with the actual lived experience of physician leaders. The results of this qualitative phenomenological study may be shared with institutions responsible for educating physicians as well as healthcare organizations where physician leaders practice.

Literature Search Strategy

Online databases used for the search were found within the virtual library of American College of Education. Databases provided the electronic sourcing for locating relevant theoretical and empirical articles for the literature review. Multiple databases were employed including, ProQuest, ERIC, and Medline Complete. The focus of the literature search encompassed an exploration of physician leadership through the lens of authentic leadership theory as the theoretical framework (Avolio & Gardner, 2005).

The discovered relevant literature served two purposes. The sources were utilized as primary articles to support this proposed qualitative phenomenological study. The selected articles served as a source for cross-referencing further research, establishing a general to specific topic flow. The process of cross-referencing led to the discovery of gaps within the literature about the unknown perceptions of the professional identity of physician leaders. Due to the general nature of professional identity, extensive searches were conducted to identify cogent resources establishing support for the specific topic of physician identity.

Key Words

To generate a comprehensive cross-section of relevant results, a search of critical topics was conducted, followed by an in-depth search of words taken from the literature. A search of

individual words as well as combinations was performed. Primary key words are listed and defined below.

Authentic Leadership – A behavior-based leadership theory valuing individual genuineness with the goal of doing what is best for the group and followers. Critical elements of authentic leadership are relational transparency, internal moral perspective, balanced processing, and self-awareness (Avolio & Gardner, 2005).

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Theoretical Framework

Theories used in qualitative research serve three main functions (Creswell & Creswell, 2018). A theory may be used to explain behavior, to be the end point of a study, or to serve as an orienting framework and lens to view data and results. This qualitative phenomenological utilized authentic leadership theory (Avolio & Gardner, 2005) as the lens through which to view data and results. The theory's roots can be traced back to the early concept of transformational theory where transformational leadership began to diverge from transactional theories (Bass, 1985). Northouse (2019) states authentic leadership is conceptually simple but operationally complex. Avolio and Gardner (2005) framed authentic leadership as a root construct differentiated by the exclusion of a concept called visioning. Rodriguez et al. (2017) additionally excluded charisma as a defining characteristic, thereby distinguishing authentic leadership as unique.

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build trusting relationships with followers which leads to increased performance (Avolio & Gardner, 2005; Lord et al., 2017).

Authentic leadership theory provides a holistic approach to establishing oneself within the context of others through a focus on first becoming self-aware (Northouse, 2019). Self-awareness is seen as an evolutionary process by which an individual becomes increasingly aware of one's values, cognitions regarding identity, emotions, sense of purpose, and desires (Avolio & Gardner, 2005). Distinct from trait-based theories, authentic leadership is considered a developmental approach due to the ability of a leader to attain or cultivate behaviors that lead to success (Avolio & Gardner, 2005).

Trait Theory

One view of leadership is to believe leaders are born with specific, definable, and intrinsic traits can enable great leadership (Shafique & Beh, 2017; Stogdill, 1948). Over time, several seminal studies attempted to define leadership success through a lens of defined traits (Northouse, 2019). Stogdill (1948) suggested leaders exhibited eight specific traits. Stogdill's traits are intelligence, alertness, insight, responsibility, initiative, persistence, self-confidence, and sociability. The wide variation demonstrated across time demonstrates the difficulty to definitively isolate critical traits enable leadership success (Northouse, 2016).

Developmental Perspective

The foundational premise behind authentic leadership as a theory is an acceptance in which leaders can foster and nurture behaviors rather than accepting individuals have fixed innate traits (Duncan et al., 2017; Lord et al., 2017; Northouse, 2016). Identification of specific behaviors and skills in only one element of a developmental perspective (Duncan et al., 2017).

Hammond, Clapp-Smith, and Palanski (2017) found the environment where leaders develop skills is often as important as how the skills are developed. Hammond et al. (2017) surmise leaders develop across multiple domains such as community, family, friends, or work. While a leader may develop within a single domain, a synergistic effect takes place at the intersection of two or more, creating a cross-domain approach. The components Avolio and Gardner (2005) identified as representative of authentic leaders are relational transparency, internal moral perspective, balanced processing, and self-awareness. Behaviors represented in each of the components are grounded in a positive psychological mindset (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008) and are learned over a lifetime (Northouse, 2016).

Relational Transparency

Liu, Fuller, Hester, Bennett, and Dickerson (2018) describe relational transparency as presenting one's real and genuine self to others. Petersen and Youssef-Morgan (2018) explain relational transparency as a requirement for leaders to share thoughts and feelings while concurrently displaying appropriate emotions. Relational transparency as a component of authentic leadership is particularly relevant to the ability to develop trust with followers (Petersen & Youssef-Morgan, 2018). Candidness is necessary to foster trust between leader and follower.

Internal Moral Perspective

The trust-building nature of relational transparency is the concept of internal moral perspective (Takos, Murray, & O'Boyle, 2018). Authentic leaders are transparent in behaviors, but transparency alone does not make an individual authentic (Avolio & Gardner, 2005). Central to guiding behaviors are a set of internalized principles, core values, and high ethical standards

(Avolio & Gardner, 2005; Petersen & Youssef-Morgan, 2018; Semedo, Coelho, & Ribeiro, 2016). The central core of the moral perspective is directly correlated to a robust leader-follower relationship and performance output (Semedo et al., 2016).

Balanced Processing

Avolio and Gardner (2005) found the concept of balanced processing is intentionally exclusive of an unbiased view. An authentic leader can recognize and consider multiple aspects of an issue and varied perspectives when making decisions or drawing conclusions. Being self-aware enables a leader to identify potential biases, label the biases, and to place biases in balance with other perspectives (Takos et al., 2018).

Self-Awareness

Perhaps one of the most important facets of authentic leadership is self-awareness (Rodriguez et al., 2017). Dishon, Oldmeadow, and Kaufman (2018) conceptualize self-awareness as a combination of self-insight, self-knowledge, and self-understanding. (Avolio & Gardner, 2005) posit self-awareness to be a process of continual emergence where one becomes increasingly aware of individual strengths, talents, beliefs, core values, and desires. Self-awareness is not only a key element of authentic leadership, but a cornerstone to self-identity formation (Takos et al., 2018).

Research Literature Review

The literature review section is divided into six main topics related to leadership and the experience of practicing physician leaders, clinical versus non-clinical leadership, physician leadership, and physician identity. A review of formal education is followed by an analysis of clinical leadership versus non-clinical leadership. Physician leadership is then presented through

an examination of leader characteristics and skills, followed by an exploration of the dual nature of physician leader roles, and a survey of clinical leadership development interventions. The remaining topics include physician leadership development and professional identity formation and concluding with physician identity. The last element of the literature review includes a summary of related literature and reiterates the need for this qualitative phenomenological study.

Medical Education

Physician education in the United States is a multi-year, multi-step process beginning with pre-medical school undergraduate studies. Upon successful completion of pre-requisite coursework, often the student completes a standardized assessment, the Medical College Admission Test, and completes the application for medical school admissions (Bills, VanHouten, Grundy, Chalkley, & Dermody, 2016). Aside from the regional accrediting bodies commissioned by the United States Department of Education, two primary accrediting bodies are each responsible for specific elements of medical education (Accreditation Council for Graduate Medical Education, 2019; Liaison Committee on Medical Education, 2019).

Recognized by the United States Department of Education, the Liaison Committee on Medical Education is an extension of the American Medical Association (Fong et al., 2015). The Committee is charged with determining the accreditation standards and criteria for institutions granting the medical doctor degree. The Accreditation Council for Graduate Medical Education is charged with developing the standards and criteria for graduate medical education, known as residency and fellowship programs (Johnson, John, Lang, & Shelton, 2017).

Liaison Committee on Medical Education (2019) has developed twelve standards covering topics ranging from the organization's mission through curriculum and financial aid

services. Highlighting the importance, three of the standards cover various components of the curriculum and evaluation (Fong et al., 2015). The Liaison Committee on Medical Education standards includes provisions for leadership, faculty preparation, academic and learning environments, clinical teaching, patient safety, and medical student support services.

Medical schools have autonomy to establish admission requirements for potential students, but adopted requirements are mandated to be published (Fong et al., 2015). The standards encourage a broad education which includes study in natural sciences, social sciences, and humanities. Students admitted are to possess high levels of integrity, intelligence, and personal characteristics enabling students to become capable physicians. Once admitted as an accredited medical school, Liaison Committee on Medical Education (2019) standards stipulate eight broad topics be incorporated, including communication skills and interprofessional collaborative skills. The program is to be delivered over 130 weeks as opposed to a set number of semesters or years (Fong et al., 2015). Though students graduate medical school upon completion of program requirements, the American Medical Association requires students to complete graduate medical education before gaining autonomy (Johnson et al., 2017).

Graduate medical education consists of advanced training through residency and fellowship programs (Johnson et al., 2017). In the 2017-2018 academic year, the Accreditation Council for Graduate Medical Education reported 830 accredited institutions sponsoring over 11,000 residency and fellowship programs in recognized 180 specialties and subspecialties (Accreditation Council for Graduate Medical Education, 2019). Accreditation is often required by state licensure entities for physician licensing. The first step toward autonomy is the residency.

Students select a specialty and apply to individual residency programs where both the sponsoring organization and the student select one another in a highly competitive process called matching (Accreditation Council for Graduate Medical Education, 2019). Each residency program length varies by specialty. Selection of the specialty is the beginning of professional identity formation (Chan et al., 2018). Though not required, some students opt for a subspecialty fellowship to further focus on an area of medicine (Accreditation Council for Graduate Medical Education, 2019). Many fellowships require successful completion of an associated residency. To become a gastroenterologist, one completes a residency in internal medicine then complete a fellowship in gastroenterology.

Clinical versus Non-Clinical Leadership

von Knorring, Alexanderson, and Eliasson (2016) conducted 38 interviews of healthcare chief executive officers and clinical department managers to explore how managers view professional roles relative to the medical profession. Interviewees were comprised of leaders with business education and experience, leaders with clinical education and experience, and leaders with medical education and experience. Results from the study showed physicians struggle with leading other physicians due to clinical specialty identity. One interviewed physician leader felt any attempt to influence clinical care in a different specialty would be viewed as non-credible while any attempt to influence clinical care in the same specialty would be unwelcomed. The perceived lack of credibility is found in collaborative clinical settings where the reliance on multiple specialty-level expertise is critical (Molleman & Rink, 2015).

Galstian et al. (2018) conducted a study to understand the relationship between chief executive officer (CEO) characteristics and organizational outcomes. The three characteristics

considered were education, employment term in the organization, and gender (Galstian et al., 2018). In the context of CEO education, Galstian et al. (2018) summarized multiple studies showing more advanced education resulted in better organizational performance.

Earning a terminal degree (Doctor of Philosophy, Doctor of Health Science, Doctor of Nursing Practice) exposes leaders to theories of leadership and specific skills to employ evidence-based decision making (Galstian et al., 2018). In terms of prevalence of advanced degrees in hospital leadership, a survey of fifty hospital top executives found 42% held a doctoral degree and an additional 56% held a master's degree (Rappleye, 2015). Fields of study were varied and included business administration, health administration, humanities, and physical chemistry. One leader lacking an advanced degree held a Bachelor of Accounting and was credentialed as a certified public accountant.

Physician Leadership

Delivering healthcare continues to be complicated with an ever-increasing focus on extensive documentation, clinical outcomes, care quality, and patient experience (Galstian et al., 2018). To navigate complexities, many institutions are led by career administrators who have business-related degrees, many years of experience, and share the belief healthcare administration is the administrator's exclusive domain (Neal, 2019). In some organizations such as Mayo Clinic and Cleveland Clinic, physicians serve the dual role of chief executive officer and medical leader (Fibuch & Ahmed, 2018). A growing number of physicians are taking on administrative roles (Ennis-Cole et al., 2018) and are capable of providing valuable insight into the clinical impact of operational decisions, performance/process improvement initiatives, and organizational changes (Angood, 2015).

The physician leader's effectiveness is tied to the belief physicians may only listen to physicians (Byrnes, 2016). Others believe as physicians assume more administrative responsibilities for areas such as population health, the impact of physician leadership may grow exponentially (Scott, 2015). At all levels throughout the organization physician leaders bring a unique set of skills and expertise (Ennis-Cole et al., 2018; Fibuch & Ahmed, 2018; Quinn & Perelli, 2016) as well as foster mutual respect among peers and administrators alike (Neal, 2019). In more generalized leadership roles, specific skills necessary to perform tasks can be acquired, in the case of physician leadership, medical expertise can only be acquired through medical training (Neal, 2019).

Traditional views of physician leadership resulted in roles such as chief medical officer, unit medical director, transformational medical director, and vice president of medical affairs (Oostra, 2016). Leaders lacked allocated resources and decision-making authority while serving in a trusted advisor capacity. In other cases, the physicians selected for leadership roles were in the latter portion of the physician's careers. While the rank-and-file physicians developed a view, the new leader had given up professional identity as a practicing physician and could no longer relate to clinical concerns (Hemker & Soloman, 2016).

Berghout et al. (2017) conducted a metanalysis of published journal articles to codify physicians participating in clinical and non-clinical leadership roles. Results from the analysis found two main categories of physician leaders. Type 1 physician leaders participated in formal administrative roles, both full-time and part-time, working in either managerial medical directors or in executive positions. Type 2 physician leaders participated in informal roles, such as performance improvement projects. Duties associated with each type of leadership role varied

widely, dependent on the institution for whom the leader worked. Navigating between the worlds of administration and medicine requiring a demonstration of credibility, skills, attitude, and knowledge. The categorization of physician leadership types serves to further isolate the role of physician leadership from general administrative leadership. The implication is physician leaders find utilizing non-clinical leadership skills to influence change.

Characteristics and skills. The significance and elevation of the physician leader role continues to be a critical factor in an ever-changing landscape of healthcare (Fernandez et al., 2016; Hudak et al., 2015). Wide variation and debate exist in determining what characteristics and skills are necessary for the physician leader despite an abundance of research (Hozni, Hakkak, Vahdati, & Nazarpouri, 2019). Some disciplines have developed or adopted sets of competencies form the basis of development curricula (Comber, Crawford, & Wilson, 2018; Comber, Wilson, & Crawford, 2016). Fernandez et al. (2016) reported the American College of Obstetrics and Gynecologists has adopted ten competency areas used in development programs.

Each of the competencies have accompanying definitions and form the basis for a 3.5-day training program. The American College of Obstetrics and Gynecologists competencies are:

- creating collaborative organizational cultures;
- leading others and empowering success;
- selling a change message;
- leading change successfully;
- motivating others at work;
- applying advocacy skills using a science-based approach;
- managing media communications;

- negotiation skills;
- women's health policy and high-level leadership; and
- maximizing personal leadership success while avoiding derailment (Fernandez et al., 2016).

Creating collaborative organization cultures represents an ability to comprehend the intent of others and to effectively communicate with other members of the team (Fernandez et al., 2016). The goal is to promote diversity of thoughts and create an environment receptive to various perspectives, styles, and collaboration. Leading others and empowering success embody the skills of listening, questioning, and peer coaching. The goal is to empower others to independently solve issues without relying on the formal management structures. Selling a change message is the ability to recognize individual's change preferences and to leverage different styles to effectively communicate messages of change.

Leading change successfully refers to the ability to leverage factors enabling change (Fernandez et al., 2016). Similarly, motivating others at work is the integration and utilization of workplace motivational elements to gain alignment, commitment, and engagement from team members. Advocating for women's health issues encourages the use of a broad range of approaches and incorporating epidemiological studies to demonstrate evidence in support of action. The American College of Obstetrics and Gynecologists asserts competent physician leaders prepare for media interviews and successfully translate research for the lay audience while avoiding interviewing errors. Negotiation skills refer to the ability of a leader to discern between persuasion and negotiation while positioning key messages for influencing others. The

remaining competencies related to the advocacy of women's health issues, acting based on maximizing personal leadership capabilities in furtherance of women's health policy.

The Foundational Health Leadership Self-Assessment, based on the five domains of accountability, collaboration, communication, team management, and self-management is a second example of a skills and competencies model (Van Hala et al., 2018). The validation study of the assessment used a sample population of family medicine residents, though competencies could have applicability across disciplines. Grimm, Watanabe-Galloway, Britigan, and Schumaker (2015) conducted a study to define leadership characteristics of effective public health leaders. Using six models or frameworks, the results condensed 161 different definitions, skills, traits, or characteristics into six domains. The resulting domains are community/organizational responsiveness, ability to inspire, results focused, social intellect, authenticity, and composure and balance.

While the United States lacks a comprehensive and integrated approach to physician leadership competency, a collaboration of multiple Canadian organizations have developed such a model recognized by the acronym LEADS (Comber et al., 2018). Developed over several years, the LEADS acronym represents the five areas of lead self, engage others, achieve results, develop coalitions, and systems transformation. Supporting each of the five domains are four capabilities, which are an amalgamation of lower-level skills (Comber et al., 2018).

Physicians receive significant clinical education to become experts in the field of medicine while only tangentially receiving formal education in the areas of business administration or healthcare leadership (Liaison Committee on Medical Education, 2019). A lack of formal leadership education results in physician leaders learning leadership skills on the job

(Accreditation Council for Graduate Medical Education, 2019). Many physicians report receiving minimal or inadequate preparation prior to assuming a leadership role (Snell, Dickson, Wirtzfeld, & Van Aerde, 2016). When asked about maintaining clinical skills, physician leaders described varied perceptions based on lived experiences (Snell et al., 2016). One grouping found maintaining clinical skills necessary to maintain clinical competence in order to maintain credibility while another group reported no negative impact from abandoning clinical responsibilities. In all situations, leveraging distinctive clinical expertise to positively influence operational outcomes creates dualities unique to physician leaders.

Duality. Physician leaders are in a constant state of choreography between operating and clinical foci to uphold both quality and efficiency of care (Berghout et al., 2017; Spehar et al., 2015). Dichotomous situations frequently occur in administrative roles, but circumstances become increasingly nuanced when the leader is a physician (Berghout et al., 2017). Saxena, Walker, and Kraines (2015) found several dichotomies originating at both the system level and the personal level. The first scenario involves the distinction between management and leadership. Though the role of physician leader varies relative to the organization, the function of the physician leader often involves a mixture of managerial tasks and leadership activities (Angood, 2015).

The industrial age of American society brought about the study of management, but the roots of leadership scholarship can be traced back to the time of Aristotle (Newstead, Dawkins, Macklin, & Martin, 2019; Northouse, 2019). Aristotle sought to distinguish human behavior in the context of ethics, introduced the world to the concept of virtue, and the practice of doing the right thing at the right time (Newstead et al., 2019). Similar to the developmental approach of

authentic leadership (Duncan et al., 2017), Aristotle believed virtue is acquired in early childhood and is continually refined throughout life (Newstead et al., 2019). Taken from the need for standardization, managerial tasks are often associated with reducing chaos and increasing efficiency, while leadership activities are often associated with change and movement (Berghout et al., 2017). For physicians, navigating duality poses unique challenges when considering the leader is asked to influence operational outcomes and ensure quality care while maintaining a clinical perspective.

Another scenario is a dichotomy of shouldering responsibility versus preserving clinical legitimacy (Saxena et al., 2015). In a dichotomous situation, physician leaders assumed management responsibilities while maneuvering to maintain respect among physician peers (Berghout et al., 2017). Physician leaders often maintain an allocated portion of time to clinical patient care while performing managerial functions with the balance of time (Hemker & Soloman, 2016; Oostra, 2016).

Maintaining patient care work enables the physician to lead from a position of credibility by remaining a stakeholder in the decisions being made (Oostra, 2016). Clinical practice poses a challenge of neutrality for physician leaders who are directly impacted by self-made management choices. The situation creates another duality of clinical practice versus administrative work (Saxena et al., 2015). Promoting clinical quality and influencing organizational direction is enabled by the unique perspective of a physician leader (Hopkins, O'Neil, & Stoller, 2015; van de Riet et al., 2019). Saxena et al. Saxena et al. (2015) posit clinical practice is a key element of professional identity and reconciling dualities requires both self-awareness and intentional efforts.

Clinical leadership interventions. Literature on the development of leadership interventions for clinical leaders exists in abundance (Mianda & Voce, 2018). By filtering a literature search of articles published between 2004 and 2017, Mianda and Voce (2018) identified 24 papers meeting the inclusion criteria and were the basis for establishing a model of clinical leadership interventions. Included papers target multidisciplinary audiences encompassed graduate physicians, nurse leaders, student physicians, and allied health professionals.

Interventions employed both asynchronous web-based training as well as in-person instructor-led training (Mianda & Voce, 2018). Integrating a range of learning techniques, most interventions used action or experiential learning. The time allocation for each intervention varied by program as did the method of evaluation, but each study found an increase in management skills and leadership abilities.

Mianda and Voce (2018) incorporated a widely inclusive target audience and multidiscipline approach to clinical leadership interventions. (van de Riet et al., 2019) focused on the specific development of physician leaders. By synthesizing the perceptions of physician leaders, nurses, management, and allied health professionals, three views of physician leaders began to emerge. The research on interventions provides important direction for improving physician leadership development programs (Mianda & Voce, 2018).

Physician Leadership Development

With increased pressures of consumerism, third-party payer influences, decreased reimbursement, and increasing costs, physician leadership is needed (Ennis-Cole et al., 2018). Unique perspectives provided by physicians is paramount to guiding complex healthcare

organizations (Angood, 2015; Styhre et al., 2016). The need for leadership goes beyond traditional physician identity and the integration of clinical expertise with administrative logic, which only physicians can provide (Byrnes, 2016). The multifaceted scenario poses an identity crisis for physicians as the organization requires the physician to maintain the perspective of a clinician and yet adapt to the role of administrator where the skill set required is substantially different (Andersson, 2015).

Hozni et al. (2019) conducted an extensive literature review on the topic of physician leadership development and found medical curricula lacking incorporation of leadership skills. Inclusion of business management, strategic planning, operational resourcing, human resources, crisis management, and business finances could be effective in improving healthcare organizational performance. Hozni et al. (2019) postulated undergraduate medical schools and graduate medical education programs could integrate management workshops or leadership development projects into curricula with positive organizational outcomes. The positive impact of physician leadership development is not lost on physicians (Claes, Storms, & Brabanders, 2018). A 2013 study of family medicine residents found physicians-in-training desire leadership instruction in the areas of system transformation, team collaboration, and administration (Gallagher, Moore, & Schabort, 2017).

Well-known and researched physician competency models exist, but the models fail to capture the psychological impact of attempting to bridge two sometimes opposing roles (Andersson, 2015). One example of a model included four physician competencies, empathy, initiative, emotional self-awareness, and organizational awareness. Getting buy-in from

colleagues, focusing on the organizational mission, communicating deliberately, and showing respect for others were found to be essential practices (Hopkins et al., 2015).

Despite the presence of accepted competency models, the literature on physician leadership development programs is considered scarce at best (Hozni et al., 2019; Steinhilber & Estrada, 2015). A review of physician leadership programs found only 35 focused on physicians (Frich, Brewster, Cherlin, & Bradley, 2015). Within the 35 programs, the minority developed personal growth and awareness, and only six of the studies demonstrated positive organizational outcomes. Three characteristics make physicians unique in the work of administration (Angood, 2015). The Hippocratic Oath principle of doing no harm provides the foundational commitment of physicians to resolve in all clinical practice, the patient's wellbeing is first (Heubel, 2015). A second characteristic is a pledge to make decisions on evidence-based medicine and a third characteristic is a natural proclivity to focus on the patient and do what's best for the patient (Angood, 2015).

Professional Identity Formation

Professional identity formation is a concept not unique to physicians, but professional identity is widely found across all professions, including other clinical disciplines such as nursing (Choudhry et al., 2017). The process of developing a professional identity occurs over time through individual experiences, feedback from mentors, observing respected colleagues, and from formal education (Chan et al., 2018; Cruess, Cruess, Boudreau, Snell, & Steinert, 2015; Quinn & Perelli, 2016). The need to develop a strong professional identity is driven by the medical community at large but is driven by personal needs for a predictable environment, a sense of belonging, and a desire for a positive self-perception (Molleman & Rink, 2015). When

asked about the experience as first-year medical students, participants share a lingering sentiment of being an imposter lasting well beyond the first year of education (Sharpless et al., 2015). Many students reported a desire to fully appreciate the lack of knowledge as motivation for learning, while others reported a sense of pride when the students were mistaken for autonomous members of the medical team by hospital staff.

Relationships with peers and with mentors are additional supporting mechanisms for developing professional identity (Sharpless et al., 2015; Tagawa, 2019). Medical students view mentors and role models as the desirous professionals of a coveted society (Sharpless et al., 2015). Emulating the appearance and actions of members of the profession allows students to move toward a sense of belonging and further the formation of professional identity (Cruess et al., 2015).

Activities such as conscious reflection, unconscious acquisition, self-assessment, formal teaching, and treatment by other healthcare providers all contribute to professional identity formation (Cruess et al., 2015). Conscious reflection of past experiences and current situations allows students to begin identifying the thoughts, actions, and behaviors of physicians with the goal of becoming like the role models (Sharpless et al., 2015). Unconscious acquisition refers to the behaviors of mentors and role models observed and, over time, become assimilated into the behavior patterns of students (Cruess et al., 2015). One fourth-year medical student reported observing behaviors of physicians viewed as competent resulted in a desire to emulate the behavior while observing physicians who took shortcuts and cared little about patients resulted in an acute awareness of behaviors to avoid (Sharpless et al., 2015).

Formal education. One approach to aid in the formation of a professional identity is to develop an assessment to test for the presence of defined characteristics or traits. Tagawa (2019) advanced the model of professional identity formation through the development of a 15-item questionnaire measuring the beliefs, behaviors, experiences, and attitudes. To determine validity and reliability, Tagawa (2019) collected data from 318 participants comprised of clinical instructors and medical students in the second, fourth, and sixth years of education. As predicted, the group scoring highest on the assessment was comprised of clinical instructors, while the lowest ratings were found among the participants in the earliest phases of medical education.

While the beginning of physician professional identity formation occurs in medical school, professional identity can be further refined as additional training is pursued (Chan et al., 2018). Formal education begins in medical school but extends well beyond graduation as student physicians progress through a required residency and optional fellowship (Accreditation Council for Graduate Medical Education, 2019). Professional identity forms as a result of experiences throughout medical school and experiences as a student physician honing the skills required of practicing physicians (Chan et al., 2018). Many factors contribute to the effectiveness of professional identity formation, including training setting, physician language, practice privileges, and sub-specialization (Chan et al., 2018; de Lasson, Just, Stegeager, & Malling, 2016).

An affirming indicator of perceived professional identity is being acknowledged by other physicians as a peer or as an expert but can be limited by advanced training in the same institution (Chan et al., 2018). Due to the various steps required for advanced training, student physicians may choose to train in multiple settings. As such, a noted benefit is achieved when a

physician trains away from the home organization. Upon return to the home organization from training, one interviewee reported being viewed as a peer and treated as an equal, no longer a student or trainee. Conversely, student physicians who completed all training in the same organization reported an extended transition from trainee to peer, primarily driven by senior staff continuing to view the new physician as a trainee. Senior staff maintained an instructor mindset while continuing to treat the new institution as a learning environment and the new physician a student.

Language plays a critical role in the formation of physician professional identity (Chan et al., 2018; Tagawa, 2019; Touati et al., 2019). One item on the assessment developed by Tagawa (2019) specifically targets the respondent's perceptions of others as a result of being a physician. When interacting with physician colleagues, the titles used to describe the new physician, the credentials earned by the new physician, and the ways in which senior physicians and colleagues approach the new physician all serve to reinforce a developing professional identity (Chan et al., 2018). Despite remaining in student physician status, the completion of a fellowship is optional, and the physician-in-training could be fully credentialed, licensed, and practice as an autonomous physician (Johnson et al., 2017).

Being afforded the privileges and responsibilities typically reserved for attending physicians endows new physicians with a higher level of confidence and expertise, further solidifying a professional identity (Chan et al., 2018). Having a sense of belonging and presenting as a physician to colleagues and peers impacts collaboration among medical professionals (Touati et al., 2019). When asked to respond to a question regarding self-perceptions about the level of difficulty experienced when adjusting and acting consistent with

the values and behaviors of physicians, clinical instructors scored the item highest with fourth-year medical students rating the item lowest of the groupings (Tagawa, 2019). The conclusion drawn from the results indicated a varied sense of professional identity and a willingness to acquiesce to socially accepted behaviors associated with becoming a physician.

Advanced medical training. Following medical school, newly graduated physicians are required to complete a residency within a chosen field of medicine such as general surgery, pediatrics, internal medicine (Johnson et al., 2017). The physician's choice of specialty triggers a series of events including a possible move to another state or a move to another medical facility (Accreditation Council for Graduate Medical Education, 2019). The decision is not made lightly and requires a bidirectional choice from the aspiring physician as well as the receiving organization (Johnson et al., 2017).

Following a residency, physicians may elect to pursue a fellowship in an area of sub-specialization such as medical oncology, nuclear radiation, or colon and rectal surgery (Accreditation Council for Graduate Medical Education, 2019), further defining a physician's expertise and consequently professional identity (Chan et al., 2018). The fellowship is designed for physicians to build upon previously earned experience and clinical knowledge with a goal of developing a deepened base of knowledge and expertise (Johnson et al., 2017). The fellowship experience fosters an awareness of the new physician's self-perception as a physician (Tagawa, 2019) and encourages identity formation when the fellow's expertise has recognized value by peers (Chan et al., 2018).

Molleman and Rink (2015) found several positive outcomes from a strong specialist professional identity, including better collaboration among same-specialty peers, stronger

enthusiasm for contributing to patient care, and willingness to collaborate with different specialties. Strong professional identities can produce variation among different specialties related to patient care (Keller, Vogelzang, Freed, Carr, & Collins, 2016) despite a general agreeance about positive outcomes from developing a strong professional identity (Molleman & Rink, 2015). When asked to evaluate the importance of cardiovascular imaging, groups of physicians from internal medicine, cardiology, emergency medicine, radiology, and cardiovascular surgery each produced different ratings (Keller et al., 2016).

Though variation among specialties was strong, consistency among physicians sharing the same specialty was significant. Responses were consistent within each of the specialties enabling Keller et al. (2016) to identify and categorize specific identity characteristics and identity descriptions for each of the groups suggesting professional identity is derived from both education and experience alike. Multiple studies indicate the importance of medical education in the development of physician professional identity formation (de Lasson et al., 2016; Sharpless et al., 2015; Tagawa, 2019). Designing medical education to explicitly aid in the formation of professional identity and professionalism is crucial (Forouzadeh, Kiami, & Basmi, 2018).

Professionalism. In the field of medicine, professionalism can be traced back to Hippocratic Oath, which is comprised of two major components related to a set of commitments physicians make when entering the profession (Heubel, 2015). Professionalism plays an important function in the formation of professional identity and many physicians argue the lack of formal education to develop professionalism threatens the entire medical community (Forouzadeh et al., 2018). Phillips and Dalgarno (2017) found students transitioning from medical school through residency to autonomous practitioner, attaining professional identity is

fostered through observation, emulation, and internal reflection while learning professionalism is attained through experience. Determining what attitudes to adopt, which behaviors to imitate, and what values to internalize is a challenge facing students attempting to define what makes a good doctor (Muddiman et al., 2019).

With an increase in patients with complex disease states, defining what characteristics comprise the ideal physician role model varies by level of specialization (Muddiman et al., 2019). Accepting an ideal role model becomes a centerpiece of professional identity formation as the physician-in-training chooses which behaviors and attitudes to emulate (Sharpless et al., 2015). Muddiman et al. (2019) found groups on a continuum of specialization have varying degrees of expectations when asked to rank a series of statements related to being a good doctor. The group of generalists, practitioners who could be considered primary care provider, ranked excellent communication skills and broad clinical knowledge as the highest priorities.

The lowest rankings of the generalist group were related to high levels of expertise and being the final decision-maker of a multidisciplinary team (Muddiman et al., 2019). The group of specialists viewed a depth of clinical knowledge and connections between specialties highest, the specialists ranked attaining subspecialty status and top tier compensation lowest. The last group, subspecialists, prioritized becoming highly specialized and career driven as important. The findings become the impetus for aiding students in the transition from medical school to practicing physician (de Lasson et al., 2016).

A close relation exists between clinical performance and professional identity of new physicians during the challenges associated with transitioning between the structure and formality of medical school and the less structured clinical nature of residency (de Lasson et al.,

2016). Providing supportive interventions during the time of transition may result in an easier adoption of desired behaviors once impersonated as an early medical student (Sharpless et al., 2015). Supportive interventions can take many shapes ranging from support groups to group-coaching to mentoring (Clyne, Rapoza, & George, 2015; Gallagher et al., 2017).

One approach to developing professionalism in aspiring physicians is to provide group coaching sessions (de Lasson et al., 2016). The goal of the coaching sessions is to support medical students' transition from medical school to clinical practice. A certified coaching team comprised of a physician-nurse dyad led multiple sessions over a four-month period with transitioning students targeting specific areas of personal and professional development. Uncovered during the coaching sessions, was an emerging theme of the student physician's reluctance to espouse the physician identity and the responsibilities associated with the role.

A lack of experience caused discomfort with clinical decision making and many felt patients would be best treated by specialists versus student physicians (de Lasson et al., 2016). The beliefs shared by the coached students were of self-doubt and insecurity resulting from an absence of professional competence. Professionally, the new physicians reported fear and apprehension of choosing a specialty, which can be the beginning point for refining professional identity (Chan et al., 2018).

Physician Identity

Physicians attend four years of medical school, followed by a residency in a chosen specialty and an optional fellowship before being allowed to practice medicine autonomously (Naveh et al., 2015). A great deal of consternation occurs during the process of choosing a residency because the single choice often defines a clear but narrow career trajectory. Due to the

significance of choosing a specialty, a substantial amount of pride and professional identity attached to a clinical role (Andersson, 2015; Quinn & Perelli, 2016). Once in a clinical role, physicians are often nominated or selected to participate in formal leadership roles based on clinical expertise but receive little or no training (Snell et al., 2016). Some physician leaders transition fully from providing direct patient care, but many physicians struggle. Other physicians believe continuing a clinical practice is necessary in order to maintain credibility or stay in touch with the day-to-day realities of colleague physicians sustain professional identity, separate from administrative (Naveh et al., 2015).

In a study to evaluate the experience of clinicians making a transition to formal administrative roles, Spehar et al. (2015) found physicians experience significant differences in perceptions of professional identity when compared to nursing counterparts. Historically led by a dyad of a nursing leader in conjunction with a physician leader, the country's healthcare organizations lacked a profession neutral structure. The Norwegian Specialist Health Services Act sought to unify a leadership model traditionally rife with unclear roles, responsibilities, and accountability. Thirty clinical managers were interviewed with a sample comprised of 16 nurses, 13 physicians across a continuum of specialties. Of the 30 participants, 17 were female, 13 were male and ranged in ages from 36-65. The average age of physicians was 55 and the average age of nurses was 49.

Several themes emerged from the interviews related to the experiences of physicians transitioning to leadership roles or physicians in leadership roles (Spehar et al., 2015). Physicians had trouble resolving the duality of the clinical role with the administrative role. Emphasizing clinical work as a source of legitimizing the administrative position, physicians reported clinical

work as a source of significance and gratification. The duality of role identity supports the findings of prior studies deriving the same conclusion (Saxena et al., 2015).

Physicians reported an increased sense of responsibility for clinical performance and outcomes after assuming an administrative role (Spehar et al., 2015). Professional identity of physician leaders transcends specialties and surgeon leaders specifically reported a need to maintain surgical competence as a foundation of commanding respect and authority when assuming a leadership role. In opposing experiences, some physicians reported a desire to abandon a clinical practice as a result of limited time available for seeing patients. Administrative physicians described a sense of disillusionment and a lack of preparation when transitioning into leadership roles. One physician reported a desire to abdicate a leadership role but was conflicted about creating an imposition for peers not interested in leadership responsibilities.

Deeply entrenched in clinical professional identity, the response to identity threats can be predicted based on medical discipline (van Os, de Gilder, van Dyck, & Groenewegen, 2015). When placed into situations where negative critical patient events occurred, the responses of nurses varied from the responses of physicians, while both groups experienced a desire to maintain positive professional identity and favored the participant's own discipline. Physicians lacked a need for validation of the work produced in response to the critical event and demonstrated a sense of preeminence. As opposed to full administrative or managerial autonomy, physician professional identity is intertwined with clinical autonomy and may be demonstrated through a sense of superiority (Salavatore, Numerato, & Fattore, 2018). In response to the same patient situation, nurses were quick to point out the actions taken above and

beyond what was expected with a desire to receive positive affirmation for the work or actions (van Os et al., 2015).

Tension of professional identity is connected to perceived patient care (Dadich, Jarrett, Robards, & Bennett, 2015). Results indicated minor children nearing teenage years, entered the general practitioner clinic with a preconceived notion of the role of the physician being basic-level care, not capable of handling complex issues which created physician stress and tension. While research has shown professional identity is crucial for clinical distinction, little is known about perceptions of identity of physician administrative leaders (Berghout et al., 2017; Quinn & Perelli, 2016).

Chapter Summary

Delivering healthcare continues to be complex, with an increasing emphasis on extensive documentation, clinical performance, care quality, and patient experience (Galstian et al., 2018). To navigate complexities, many institutes are led by career administrators who have business-related degrees and many years of experience and share the belief healthcare administration is the administrators' exclusive domain (Neal, 2019). A growing number of physicians are taking on administrative roles and are capable of providing valuable insight into the clinical impact of operational decisions, performance/process improvement initiatives, and organizational changes (Angood, 2015; Ennis-Cole et al., 2018).

The importance and advancement of the physician leader role continues to be a critical factor the future topography of healthcare (Fernandez et al., 2016; Hudak et al., 2015). Physician leaders are constantly in a vigorous battle to navigate between operational and clinical foci (Berghout et al., 2017; Spehar et al., 2015). Literature on the development of leadership

interventions for clinical leaders exists in abundance (Mianda & Voce, 2018). Unique perspectives provided by physicians are principal to guiding complex healthcare organizations (Angood, 2015; Styhre et al., 2016). The need to develop a strong professional identity is an important concern of the medical society (Molleman & Rink, 2015). Physician professional identity formation occurs in medical school, though identity can be further refined as a consequence of additional training (Chan et al., 2018).

The literature review section was divided into six main topics related to leadership and the experience of practicing physician leaders, clinical versus non-clinical leadership, physician leadership, and physician identity. A review of formal education was followed by an analysis of clinical leadership versus non-clinical leadership. Physician leadership was presented through an examination of leader characteristics and skills, followed by an exploration of the dual nature of physician leader roles, and a survey of clinical leadership development interventions. Remaining topics included physician leadership development and professional identity formation and concluded with physician identity.

Authentic leadership theory provided the theoretical underpinnings upon which this qualitative phenomenological study was based (Avolio & Gardner, 2005). This qualitative phenomenological study was necessary in order to fill the literature gap between the professional identity of administrative physicians and development programs, and the evolving role of physician leaders in healthcare. Physician professional identity is a critical aspect of physician leader efficacy and developing a better understanding of how physicians view professional identity is critical (Quinn & Perelli, 2016). While many studies exist on the professional identity

of nurses (Choudhry et al., 2017; Hensel & Laux, 2014), a gap occurs in relation to physicians' professional identity (Andersson, 2015; Naveh et al., 2015).

This qualitative phenomenological study may contribute to the knowledge base by providing data on actual experiences of physician leaders, and the meanings the leaders provide regarding personal lived experiences. Major findings from the literature review included the complex nature of healthcare demanding physician engagement, requiring physicians to employ unique skills, and relying on specialized expertise within the context of professional identity. The literature provided background information and analyzed prior studies, supporting the case for the approach for this proposed qualitative phenomenological study.

The following chapter covers the methodological approach utilized to determine how professional identity is interpreted and to find commonalities in the shared meaning among the participants. A review of the proposed research design and rationale provide the substantiation for a qualitative phenomenological approach. Research procedures are described, the population and sample selection are explained as well as an overview of the instrumentation and data collection methods. Data preparation and techniques for data analysis are followed by a review of processes to ensure reliability and validity. The chapter concludes with a review of ethical procedures and participant protections.

Chapter 3: Methodology

The purpose of this qualitative phenomenological study was to determine how professional identity of practicing physicians in leadership roles is established. This study was designed to examine professional identity experiences of physician leaders in administrative roles, explored professional identity perceptions of physician leaders, and allowed meaning attributed to the perceptions of physician leaders to be uncovered. This study was necessary to create greater awareness and appreciation of the physician leader role among all stakeholders: physicians, nursing staff, hospital administrators, and patients. Physician professional identity is a critical aspect of physician leader efficacy and developing a better understanding of how physicians view professional identity is vital (Quinn, 2013).

While many studies exist on the professional identity of nurses (Choudhry et al., 2017; Hensel & Laux, 2014), a gap occurs in relation to physician's professional identity (Andersson, 2015; Naveh et al., 2015). The problem is administrative physician professional self-identity is unknown. Collaboration and healthy clinical provider relationships improve patient outcomes (Naveh et al., 2015); conversely, risk for patient harm and strained relationships between physicians and other care providers will continue if physician professional identity research is not conducted.

This study contributes to the knowledge base by discovering lived experiences of physician leaders and by sharing the ascribed meanings derived from those experiences (Quinn & Perelli, 2016). Information adds to the limited research on useful models of development for practicing physicians in leadership roles. Results of this study hold potential for healthcare

institutions and physician educators to develop leadership programs to adequately prepare physicians for leadership roles aligned with actual lived experiences of physician leaders.

A restatement of the study purpose and the research questions is provided. Research design is presented with a thorough discussion of the rationale for choosing a qualitative approach. Next, the role of the researcher as observer, data collector, analyzer and interpreter (Creswell & Creswell, 2018; Marshall & Rossman, 2011) is discussed. An in-depth discussion of research procedures, along with the interview instrument, sample population and selection criteria are examined. A thorough explanation of data analysis, reliability and validity assurances, and actions to ensure ethical procedures is provided. Lastly, a summary is provided in conjunction with an overview of the following chapter.

Research Questions

This qualitative phenomenological study focused on uncovering the lived experiences of practicing physicians in current or previous leadership roles. The goal was to contribute to the furtherance of physician leader development. Qualitative research questions focus and define aspects of the research and are designed to be open-ended and nondirectional (Creswell & Creswell, 2018; Glesne, 2016). The following research questions guided the study:

Research Question One: What are the professional identity experiences of practicing physicians in leadership roles at a hospital in the southeast United States?

Research Question Two: What are the professional identity perceptions of practicing physician leaders at a hospital in the southeast United States?

Research Design and Rationale

This study used a qualitative phenomenological approach to collect data from participants. A qualitative approach was utilized for investigating and identifying meaning individuals or groups assign to a particular situation or experience (Creswell & Creswell, 2018; Glesne, 2016). Data in qualitative studies can be collected through procedures including interviews, direct observation, surveys, and questionnaires. Though frequently personal interaction plays a central role in qualitative research, data collection may or may not involve direct interactions with participants (Creswell, 2009; Creswell & Creswell, 2018; Glesne, 2016). Multiple traditions or methods of qualitative inquiry are well accepted, including ethnography, autoethnography, action research, phenomenology, and narrative analysis. Phenomenology seeks to discover, describe, and analyze meanings of an individual lived experience (Glesne, 2016; Moustakas, 1994; van Manen, 1990). A phenomenological approach was employed because this study sought to understand lived experiences of physician leaders, solicit perceptions of physician leaders, and uncover meanings ascribed to the experiences. Freedom for participants to share stories enabled immersion into the world of physician leaders through rich, thick narrative with the aim of uncovering the meaning ascribed to the shared experiences.

Role of the Researcher

As is typical of qualitative research, in this study, the researcher adopted the role of observer, data collector, analyzer and interpreter (Creswell & Creswell, 2018; Marshall & Rossman, 2011). Setting aside biases, one would embody the role of learner while concurrently being anticipatory, analytic, reassuring, and grateful (Glesne, 2016). The role can be metaphorically described as a miner. Kvale and Brinkmann (2009) elaborated, stating, “The

interviewer digs nuggets of knowledge out of a subject's pure experiences unpolluted by any leading questions." For this qualitative phenomenological study, the role of the researcher was to explore unadulterated thoughts of participants through a questioning dialogue, aiming to uncover nuggets of knowledge.

Participants self-selected into the study after being receiving an invitation by electronic mail or telephone call. While the sample population included hundreds of possible participants, the possibility of a participant from the same organization as the interviewer self-selecting into the study did exist. A tangential relationship existed by all parties being employed by a parent organization. Having relationships with participants can be problematic if there exists an imbalance of power (Glesne, 2016). Possible participants of the organization were employed and managed by the organization's physician group, a separate employing entity. While current working relationships existed among possible participants, there were no conflicts of interest, no imbalance of power, and no incentives were offered.

Research Procedures

This qualitative study of physician leader professional identity was conducted using phenomenological methods. Phenomenology was appropriate for this study as this approach allowed collection of perceptions of lived experiences from participants experiencing a common phenomenon (Creswell, 2007, 2009; Creswell & Creswell, 2018; Glesne, 2016; Moustakas, 1994; van Manen, 1990). A critical element of conducting phenomenological research is identification of an appropriate population and following established research procedures (Creswell & Creswell, 2018; Glesne, 2016).

Population and Sample Selection

There are thousands of licensed physicians practicing in the southeast United States, with a smaller subset holding administrative positions. The target population for this study was physicians in current or previous leadership roles. A well-established range for a sufficient number of participants in phenomenology research is three to ten, with an adequate sample measured by saturation, or the point at which no new information or insights are collected (Creswell & Creswell, 2018). The goal of this study was to include a minimum of ten participants meeting selection criteria. "The idea behind qualitative research is to purposively select participants or sites…that will best help the researcher understand the problem and the research question" (Creswell & Creswell, 2018, p. 185). This study was designed to utilize purposive sampling to identify and contact possible participants. Purposive sampling is utilized when the population meets particular criteria related to the study (Creswell & Plano Clark, 2011; Rowley, 2014). Two participation criteria used were: the participant was a practicing physician, and the physician was or had previously been in an administrative position.

Following an approved application by the American College of Education (ACE) Institutional Review Board (IRB), permission was sought from the respective organization of potential participating physicians (see Appendix G). Participants were identified through online directories of physician leaders and initially contacted by email or phone with an invitation to participate in the study (see Appendix E). Follow-up reminders for nonresponsive invitees were sent at seven-day intervals for a maximum of four contacts (see Appendix F).

Respondents not meeting both criteria were excluded from the study. Informed consent was provided to protect participant rights (see Appendix A). The consent included a written

explanation of the research and participant rights. Written consent forms were provided by electronic mail to participants in advance, allowing time for review, and signed documents were obtained before the collection of data. Additionally, responses were protected from distribution and any identifying information voluntarily provided by participants was redacted from analysis and publication. In accordance with ACE IRB requirements, all research data will be destroyed three years post-collection.

Instrumentation

Phenomenological data can be collected through many approaches, including questionnaires and interviews (Creswell, 2007; Creswell & Creswell, 2018). Questionnaires are useful when sufficient information is known about a particular situation, but opinions or perceptions of respondents are desired (Rowley, 2014) and can be designed with both closed and open-ended questions, allowing for the collection of demographic data as well as narrative responses. Demographic data can be used to produce descriptive statistics such as years in practice, participant age ranges, or years in leadership roles. Qualitative responses from semi-structured interview (Kvale & Brinkmann, 2009) questions can be analyzed with the aim of answering the research questions and can be conducted in person or electronically (Creswell & Plano Clark, 2011).

In this study, data were collected using semi-structured interviews. By design, qualitative research is interactive research (Kvale & Brinkmann, 2009) and requires the interviewer to build rapport and trust with participants to facilitate the open telling of stories (Glesne, 2016). To further the research recommended by Quinn (2013), an interview questionnaire was developed

based on previously identified themes (see Appendix B). While the reference study utilized a mixed-methods approach, this study utilized a single qualitative tradition design.

Instrument Validation

Assessing content validity of an instrument is an important step in substantiating the psychometric properties (Zamanzadeh et al., 2015). After securing permission from the author of the tool (see Appendix C), the interview questionnaire was validated by utilizing a panel of subject matter experts to provide structured feedback using a standard evaluation rubric (see Appendix D). The rubric was distributed to five experts from multiple disciplines and backgrounds. Based on the feedback, minor adjustments were made to the questionnaire to enhance the quality of data collected.

Data Collection

In this study, semi-structured interviews were conducted in person to gather information related to professional identity as physicians in leadership roles. Following receipt of informed consent, participants were scheduled for an in-person or telephone call to conduct the interview. Participants choosing to meet in person were asked to identify a suitable location and time, allocating approximately an hour for the interview. By using a qualitative, semi-structured life world interview, the aim was to identify and explore the themes of the lived experience from the participant's perspective (Kvale & Brinkmann, 2009).

Neither casual nor structure-bound, interviews were conducted using a pre-developed guide focused on the professional identity of physician leaders (Appendix B). First describing the professional role, participants were encouraged to describe experiences in rich detail through follow-up questions and probing. Participants were then be asked to detail experiences

encountered during a transition into leadership roles. Finally, participants were asked to recall specific times when the professional role intersected, positively or negatively, with the leadership role. Following the interview, exiting participants were asked to contribute to data validation through member-checks. Participants opting to be included received an email with a synopsis of themes and draft descriptions of meaning following initial analysis. The process enabled participants to review and validate initial findings and correct any misrepresentations.

With a goal to interview a minimum of ten participants, interviews were digitally recorded with a primary recorder and a secondary back-up and subsequently transcribed. Supplemental notes with preliminary in vivo codes (Glesne, 2016; Marshall & Rossman, 2011) were taken and used as reference points during analysis. Recordings will be maintained in an encrypted electronic file separate from any identifiers.

Data Preparation

Prior to analysis, collected data should be prepared and readied. Recordings from interviews were checked for completeness then submitted for professional transcription. Accuracy was ensured by simultaneously listening to the recording while reviewing the text transcription and editing where required. Unlike quantitative research where codes are often used to count or establish frequency, qualitative research uses codes to uncover themes or patterns, to discover linkages and connections, and to develop meaning (Glesne, 2016). A codebook of words and short phrases was created by re-reading the transcriptions and listening to the recordings. The transcriptions were then uploaded into a qualitative data analysis software platform called NVivo 12 MAC.

Data Analysis

The analysis of data was done through a review of participants' narrative responses. Interpreting meaning from textual transcripts requires the interpreter to look beyond what is said and into the structures and relations of what is not ostensibly obvious (Kvale & Brinkmann, 2009). The inductive nature of this study allowed themes to emerge free of preconceived notions (Patton, 2002) though the alignment of the research questions to the interview guide inherently focused the questions and responses to predetermined topics. Semi-structured interviews allow the participant freedom to choose a specific story or response, irrespective of the question posed. Following the collection process, data were analyzed following a five-step process (Creswell & Creswell, 2018).

First, the data were organized and prepared for analysis by transcribing participant interviews into text and ensuring the accuracy of transcriptions by simultaneously listening to the recorded interviews and visually reviewing the respective transcriptions. Next, each interview transcription was read in its entirety to determine a general sense of the information. During this step, universal ideas shared by participants and overall themes of what is being said were identified. Then, by reviewing each line of text in the individual transcripts, fragments of text were bracketed, open-coded, and categorized according to content.

Significant statements were utilized to generate units of meaning leading to the development of an essence description (Moustakas, 1994). The NVIVO software served as an electronic tool to aid in the documentation and tracking of codes. Subsequently, a second coding process, axial coding, was employed where groupings were sorted first into broad categories then refined as relationships among central themes began to emerge. Finally, the emergent themes and

essence description (Moustakas, 1994) were represented through rich, thick narrative and visually displayed using diagrams, charts, or word clusters (Glesne, 2016).

Reliability and Validity

Integrating elements of credibility, transferability, dependability, and confirmability is critical to the design of a study (Creswell & Creswell, 2018; Glesne, 2016; Kvale & Brinkmann, 2009; Marshall & Rossman, 2011; Patton, 2002). Contrasted with validity and reliability of quantitative research, qualitative studies are assessed by the level of trustworthiness (Patton, 2002). This qualitative phenomenological study utilized triangulation through member checks, reflexivity, peer debriefing, and rich/thick narrative to ensure the collected data and subsequent analysis were accurate and trustworthy.

Member Checks

Member checking was used to ensure credibility. Considered a core data source for triangulation (Patton, 2002), member checking involves presenting participants with a synopsis of the themes (Creswell & Creswell, 2018), portions of the draft analysis (Glesne, 2016), or description of meaning extrapolated from the interviews (Moustakas, 1994). In this study, participants were presented with a synopsis of themes and draft descriptions of meaning following initial analysis. Participants had an opportunity to correct any misrepresentations of statements, if applicable, and have an opportunity to comment on the findings.

Reflexivity

It is important to recognize biases, opinions, and viewpoints which can influence or shape how the data are analyzed, and interpretations formulated (Creswell & Creswell, 2018; Guba & Lincoln, 2005). “Reflexivity entails reflecting upon and asking questions of research interactions

all along the way, from embarking on an inquiry project to sharing the findings" (Glesne, 2016, p. 145). Finlay (2012) added reflexive analysis might be considered as collected data to be analyzed and may incorporate intuitions and understanding to elucidate the participants' perspective. In this study, biases caused by experience, culture, and history were considered by continually asking reflexive questions throughout the study.

Peer Debriefing

In addition to the review performed by participants, having a third-party review is a tactic to enhance the accuracy of the findings and increase validity (Creswell & Creswell, 2018; Mertens, 2009). Described by some peer review (Glesne, 2016), the process employs an individual or individuals with whom open conversation can occur and reactions about the interpretations and findings obtained (Creswell & Creswell, 2018; Marshall & Rossman, 2011). While a third-party can be an uninterested individual, often for graduate students, the dissertation committee serves in this role (Patton, 2002). In this study, the dissertation committee served as the third-party for peer debriefing.

Rich Narrative

Use of rich, thick narrative to share participant perceptions adds to the depth of the analysis and brings forth the exact words and phrases used to describe the phenomenon being studied (Creswell & Creswell, 2018). If participants are to be viewed as co-researchers, as is the perspective of Moustakas (1994), inclusion of participant narrative becomes a central point in supporting the essence of meaning of collected data. Validity, trustworthiness, and transferability are further ensured by incorporating direct quotes, extracted from transcripts.

Ethical Procedures

Distinct and specific measures were taken to protect human participants (Creswell, 2007; Creswell & Creswell, 2018). Informed consent (Appendix A), approved by the American College of Education IRB, was provided to participants. Participants were informed of the study purpose, anticipated duration of potential involvement, the procedures to be followed, and labeling of any procedures deemed to be experimental. The document included any anticipated risks or discomforts, a description of the expected benefits to the participants, limits of confidentiality, contact information for answers to questions about the research or subjects' rights, and a statement of voluntary consent and voluntary withdrawal.

Privacy and confidentiality are paramount to the research process, particularly in qualitative studies employing the use of in-person interviews (Kvale & Brinkmann, 2009). Participant identity was kept confidential and stored separately from collected data. Recordings of interviews were coded to ensure anonymity during storage and to third parties. Data will be destroyed three years after the completion of the study. Member checks of draft reports allowed participants full control over quoted statements with an opportunity to have statements removed from inclusions.

Chapter Summary

The purpose of this phenomenological study was to interview practicing physicians in leadership roles, in the southeast United States, in order to determine how professional identity is interpreted and to find commonalities in the shared meaning among the participants. Phenomenological tradition was appropriate for this study because the approach allowed participants to openly and fully describe the lived experience as physician leaders (Creswell &

Creswell, 2018; Creswell & Plano Clark, 2011). Data were collected through semi-structured, in-person interviews (Kvale & Brinkmann, 2009; Rowley, 2014). Purposive sampling was used to select potential participants for inclusion in the study. Research questions further support a phenomenological approach. This chapter included a discussion of the role of the researcher, research procedures, instrumentation, data collection, data analysis, reliability and validity, and ethical considerations. The next chapter includes a review of research findings and data analysis results with a review of data collection, data analysis, and reliability and validity.

Chapter 4: Research Findings and Data Analysis Results

Physician leadership serves a critical role in the complex environment of healthcare. Clinical expertise developed throughout formalized training provides a foundation upon which administrative duties are often built. The purpose of this qualitative phenomenological study was to determine how professional identity of practicing physicians in leadership roles is established. The problem was administrative physician professional self-identity is unknown. Solutions to administrative challenges presented to physician leaders are often less quantitative and more confounding to navigate than clinical problems (Neal, 2019). The increasing complexity of healthcare highlights the criticality of the physician perspective and the unique capabilities physician leaders provide (Fernandez et al., 2016).

This qualitative phenomenological study focused on uncovering the lived experiences of practicing physicians in current or previous leadership roles. The goal was to contribute to the furtherance of physician leader development. Qualitative research questions focus and define aspects of the research and are designed to be open-ended and nondirectional (Creswell & Creswell, 2018; Glesne, 2016). The following research questions guided the study:

Research Question One: What are the professional identity experiences of practicing physicians in leadership roles at a hospital in the southeast United States?

Research Question Two: What are the professional identity perceptions of practicing physician leaders at a hospital in the southeast United States?

This qualitative study of the professional identity experiences and perceptions of practicing physician leaders at a hospital in the southeast United States was conducted using a phenomenological approach. Phenomenology was an appropriate methodology because the

approach allows for the investigation and identification of meaning derived from individuals or groups experiencing a specific phenomenon (Creswell & Creswell, 2018). For this study, the group of individual studied were administrative physicians and the common phenomenon was the role of leadership.

Data for qualitative studies can be collected through multiple procedures, including surveys, interviews, observations, and questionnaires. Data collection may or may not involve direct interactions. Phenomenology aims to discover, describe, and analyze the meanings of lived experiences (Glesne, 2016; Moustakas, 1994; van Manen, 1990). Moustakas (1994) presents several principles which guide a phenomenological approach including a focus on the appearance of things, a concern with presenting wholeness, a unified vision emergent from many perspectives, meanings derived from personal experiences, thick narrative descriptions of experiences, and the acceptance of an inseparable subject and phenomenon. Over the course of two months, individual physicians were interviewed using a semi-structured interview approach to capture lived experiences and to extrapolate the meanings from individual perceptions.

Authentic leadership theory served as the framework of the study and the lens of sensemaking of the collected data (Avolio & Gardner, 2005). Similar to both transformational and servant leadership, authentic leadership includes an explicit element of morality (Northouse, 2019). Authentic leaders recognize and leverage strengths while aligning follower interests for inclusive benefit. The underlying principle of authenticity compels leaders to make decisions and lead from a place of righteousness and virtuosity. Discrete from trait-based theories, authentic leadership is considered a developmental approach due to the ability of a leader to learn or develop behaviors that foster success (Avolio & Gardner, 2005).

This chapter is organized into four major sections. The first section includes an overview of the study and a review of the data collection procedures, participant selection, and participant characteristics. The second section encompasses an explanation of data analysis procedures, which includes procedures for data security and confidentiality, an explanation of data preparation prior to analysis, inductive coding procedures, development of emergent themes, and conclusions based on the collected data. The third section includes a review of procedures for ensuring reliable and valid data, including strategies for safeguarding credibility, transferability, dependability, and confirmability. The third section includes the results of emergent themes which address both guiding research questions. The last section is a summary of the answers to posed research questions and a transition to the next chapter.

Data Collection

In this study, semi-structured interviews were conducted in-person to gather information related to professional identity as physicians in leadership roles. Following an invitation, participants were provided an electronic version of the informed consent, then participants were scheduled for an in-person appointment to conduct the interview. Participants were asked to identify a suitable location and time, allocating approximately an hour for the interview. By using a qualitative, semi-structured life-world interview, the aim was to identify and understand the themes of the lived experience from the participant's perspective (Kvale & Brinkmann, 2009).

Neither casual nor structure-bound, interviews were conducted using a pre-developed guide focused on the professional identity of physician leaders (Appendix B). First describing the professional role, participants were encouraged to describe experiences in rich detail through

follow-up questions and probing. Participants were then asked to detail experiences encountered during a transition into leadership roles. Finally, participants were asked to recall specific times when the clinical role intersected, positively or negatively, with the leadership role. Following the interview, exiting participants were asked to contribute to data validation through member-checks. Participants opting to be included received an email with a synopsis of themes and draft descriptions of meaning following initial analysis. The process enabled participants to review and validate initial findings and correct any misrepresentations.

With a goal to interview a minimum of ten participants, eleven interviews were digitally recorded with a primary recorder and a secondary back-up and subsequently transcribed. Supplemental notes with preliminary in vivo codes (Glesne, 2016; Marshall & Rossman, 2011) were taken and used as reference points during analysis. Recordings are to be maintained in an encrypted electronic file separate from any identifiers.

Participants

The target population for this study was physicians in current or previous leadership roles. A well-established range for a sufficient number of participants in phenomenology research is three to ten, with an adequate sample measured by saturation, or the point at which no new information or insights are collected (Creswell & Creswell, 2018). The goal of this study was to include a minimum of ten participants meeting selection criteria and resulted in eleven participants completing interviews. “The idea behind qualitative research is to purposively select participants or sites…that will best help the researcher understand the problem and the research question” (Creswell & Creswell, 2018, p. 185). This study utilized purposive sampling to identify and contact possible participants. Purposive sampling is utilized when the population

meets particular criteria related to the study (Creswell & Plano Clark, 2011; Rowley, 2014). Two participation criteria used were: the participant was a practicing physician, and the physician was currently in an administrative position or had been in an administrative position in the past.

Following an approved application by the American College of Education (ACE) Institutional Review Board (IRB), permission was sought from the respective organization of potential participating physicians (see Appendix G). Participants were identified through online directories of physician leaders and initially contacted by email or phone with an invitation to participate in the study (see Appendix E). Follow-up reminders for nonresponsive invitees were sent at seven-day intervals for a maximum of four contacts (see Appendix F). All participants responded within seven days and no follow-up reminders were necessary.

Purposive sampling allowed for targeted participant recruitment. All respondents met both criteria and were included in the study. Informed consent was provided to protect participant rights (see Appendix A). The consent included a written explanation of the research and participant rights. Written consent forms were provided by electronic mail to participants in advance, allowing time for review, and signed documents were obtained before the collection of data. Additionally, responses were protected from distribution and any identifying information voluntarily provided by participants was redacted from analysis and publication. In accordance with ACE IRB requirements, all research data will be destroyed three years post-collection.

Table 1 represents the eleven participants included in the study. Of the eleven participants, two were female, nine were male, six held internal medicine specialties, five held surgical specialties, ten held dual clinical and administration responsibilities, one held a full-time administrative role and six held roles with greater than 50% administrative time.

Table 1

Participant Characteristics

	Sex	Specialty	Administrative Time	Clinical Time
Participant 1	M	Medicine	80%	20%
Participant 2	M	Surgery	80%	20%
Participant 3	M	Surgery	80%	20%
Participant 4	M	Medicine	80%	20%
Participant 5	M	Surgery	10%	90%
Participant 6	M	Surgery	80%	20%
Participant 7	M	Medicine	50%	50%
Participant 8	M	Medicine	100%	0%
Participant 9	F	Surgery	20%	80%
Participant 10	M	Medicine	10%	90%
Participant 11	F	Medicine	10%	90%

Data Analysis

Prior to analysis, collected data is prepared and organized. Recordings from interviews were checked for completeness then submitted for professional transcription. Interviews were recorded by two separate devices, an Apple iPad using the Voice Memo application and an Apple iPhone using a proprietary application by Rev.com. Recording were de-identified prior to submission for transcription and file names used a generic naming convention. Following the return and validation of a completed, redundant copies of recordings were destroyed. Accuracy was ensured by simultaneously listening to the recording while reviewing the text transcription and editing where required. Corrections were made to the transcriptions prior to analysis. A codebook of words and short phrases was created by re-reading the transcriptions and listening to the recordings. The transcriptions were then uploaded into a qualitative data analysis software platform called NVivo 12 MAC.

The analysis of data was completed through a review of participants' narrative responses. Interpreting meaning from textual transcripts requires the interpreter to look beyond what is said and into the structures and relations of what is not ostensibly obvious (Kvale & Brinkmann, 2009). The inductive nature of this study allowed themes to emerge free of preconceived notions (Patton, 2002) and the alignment of the research questions to the interview guide inherently focused the questions and responses to predetermined topics. Semi-structured interviews do allow the participant freedom to choose a specific story or response, irrespective of the question posed. Following the collection process, data were analyzed according to the suggested five-step process (Creswell & Creswell, 2018).

First, the data were organized and prepared for analysis by transcribing participant interviews into text and ensuring the accuracy of transcriptions by simultaneously listening to the recorded interviews and visually reviewing the respective transcriptions. Next, each interview transcription was read in its entirety to determine a general sense of the information. During this step, universal ideas shared by participants and overall themes of what is being said was identified. Then, by reviewing each line of text in the individual transcripts, fragments of text were bracketed, open-coded, and categorized according to content.

Phenomenological research demands fully immersion in the data analysis process. To begin, employing epoche, set aside are biases and prejudgments which may prevent the meanings of participant responses from emerging. Next, every statement being analyzed was provided equal value through horizonalization, resulting in the clustering of statements into themes. According to Moustakas (1994), horizons are similar to individual vistas or perspectives of experiences relative to the phenomenon. During the process of horizonalization, each

statement from participant interviews is reviewed, and duplicative or overlapping statements are eliminated, leaving only the horizons. Subsequent themes were then viewed from multiple vantage points and perspectives through imaginative variation, developing composite textural and composite structural descriptions.

Synthesis of meaning derived from the composite descriptions allowed the emergence of essences of the phenomenon or experience. Significant statements were utilized to generate units of meaning, leading to the development of an essence description (Moustakas, 1994). Essence description refers to a singular statement, resulting from the concatenation of structural and textural narratives, portraying the overall experience of the phenomenon.

The NVIVO software functioned as an electronic tool to aid in the documentation and tracking of codes. Subsequently, a second coding process, axial coding, was employed where groupings were sorted first into broad categories then refined as relationships among central themes begin to emerge. Finally, the emergent themes and essence description (Moustakas, 1994) are represented through rich, thick narrative and visually displayed using diagrams, charts, or word clusters (Glesne, 2016).

Identified Codes

As the interviews were reviewed, several codes began to emerge, revealing shared experiences and perceptions. These overarching themes were refined through the detailed review of each line of each participant response and categorized into specific segments. Table 2 provides a truncated view of the codebook along with the frequency of respective participant responses. While frequency is not a consideration of qualitative analysis, the quantification of codes can be useful in determining patterns (Glesne, 2016). The iterative process of coding

allows the essences of participant responses to be refined into succinct themes representing the lived experiences and perceptions of participants. Codes serve as a link across fragments of responses to the underlying thoughts shared by participants.

Table 2

Codes Identified from Participant Interviews

Code	*f*
Leadership Experiences	
Leading other physicians	11
Administrator and physician duality	11
Relationship with non-physician administrators	8
Minimal preparation for leadership role	7
Leading same-specialty physicians	7
Disillusionment about becoming a physician leader	5
Leading physicians outside of leader's specialty	5
Professional Identity	
Physician-centric perspective	10
Physician and administrator dual perspective	8
Specialty-centric perspective	7
Administrator-centric perspective	5
Identity association with title	3
Physician Leader Identity Development	
Choices about specialty were critical	8
Identity formed through observing other physicians	3
Identity formed through mentoring relationships	3
Identity formed through formal education or training programs	2
Leadership Role Determinants	
Desire to make a difference and lead the change	10
Aspiration of expanded influence	8
Drive to improve patient or quality outcomes	8
Wish to give back to upcoming physicians	6
Longing for a new professional opportunity	5
Ambition to achieve professional recognition/prominence	5
Desire for an administrative and physician dual role opportunity	3

Results

First cycle coding is the beginning phase of analysis with the goal of providing a framework for making sense of the data, while second cycle coding reorganizes the initial codes into categories (Saldana, 2016). The data analysis process produced numerous codes, enabling the emergence of five major themes. Responses are provided verbatim when possible, while some responses are edited to protect the identity of the organization or the participant. When included, names have been omitted or a pseudonym was used to ensure privacy of all parties.

Identity Formation Begins Prior to Medical School

All participants in this study are both physicians and administrators, but the journey to becoming a physician leader began much earlier. Many of the participants reported first developing a sense of the physician identity prior to beginning medical school. When asked about the experiences leading to the decision to become a physician, Participant 3 credited parental influence, stating:

> My father, he is my role model. He used to go to poor communities and provide free care for children and adults alike. And then, I saw him leaving the house late at night with his doctor's bag. I asked him if I could come along? A person was in excruciating pain, he had no means to go to a hospital. We went into his modest house where the whole family lived. My father examined the man, gave him a pain medication and planned to transport him to the hospital. I was smitten by that event. It stayed with me for many years, I guess it still does.

Participant 8 stated:

> I had an intense love of the science of biology, biochemistry and other related fields. So that was real. It became easy for me… I really did like the idea of a vocation that has purpose. I tell people all the time, "I'm so glad I don't work in making widgets or selling cars or something like that." Not that I couldn't be good at those, but it's just there is a bigger purpose to what we end up doing. And I think that was a gradual evolution through my education that got me into medicine and made me say, "Yeah, this would be really cool to satisfy really some fundamental values about service."

For Participant 9, the desire to become a physician evolved from experiences during undergraduate education:

> Six months prior to graduation I realized that I was better suited for a healthcare profession rather than working on Wall Street, as I thought perhaps I might. So those last six months rather than continuing on with my original major, I switched to premed, which required an extra two years to complete. And I did research at Cornell University in Manhattan along with the hospital for special surgery to strengthen my candidacy for Medical School. And I did that for another year and a half after which I applied to Medical School.

The decision to become a physician triggered a series of educational endeavors leading to the eventual specialty of practice. The development of professional identity associated with the chosen specialty was similar for most participants. Early leadership experiences were formative to the eventual ascension to an administrative position for the majority of participants.

Early Leadership Experiences Form the Basis for Future Roles

Many participants reported learning the foundations of leadership during high school. The rationale for accepting or actively seeking leadership roles was similar to the rationale of seeking or accepting leadership roles as physicians later in life. When asked about prior leadership roles, Participant 9 stated,

> A perfect example is high school, as a freshman in high school I took a two-year curriculum to become a peer counselor and at that high school you become a peer counselor as a junior and senior in high school. And so, two years of training to become a peer counselor and then the final two years of high school I was a peer counselor. Within that capacity I not only counseled my peers for various both minor and tragic issues, but I also created a program within my borough in New York City to advance the education of low to middle income public high school students to help avoid risky behavior and exposure. If I think back to my youth, I can identify this need, this desire to lead and to innovate.

Another participant reported early responsibility for leading people and ensuring the safety of others. Participant 8 responded:

> That said, I had some early work life experiences. For example, when I was in high school, I worked at a little place called Six Flags Over Texas. And when I was 17 years old, they gave me the responsibility for a roller coaster and a team of people. I was 17! They gave me responsibility for a roller coaster and a team of people, so they must have seen something in my way of working with others that led them to believe that I had the capacity to do something like that. They'd never given that kind of responsibility to somebody who was 17 before.

Early experiences in both formal and informal leadership roles provided the foundations for future leadership positions. Participants described learning critical people-management skills, change management techniques, and personal accountability. As a result of successful experiences in early leadership roles, participants often described a newfound confidence and desire to seek more expansive future leadership positions.

Desire for Greater Impact Drives Physicians into Leadership Roles

While each participant provided specific examples of experiences leading to a leadership role, the common theme was the desire for greater impact. Many participants reported a desire to impact a greater population rather than providing clinical care to one patient at a time. When asked about the reasons behind taking on a leadership role, Participant 2 replied, stating:

> I guess a desire to make things better. I'm probably fairly competitive by nature, and if you don't take the leadership position, if you are... Well, regardless, whether you're leading, or you're a member of the team, you have to exhibit certain components of leadership, or influence to be able to achieve the goals that you would like. Some of the challenges I've seen in physicians is they get very concerned about the title, and not actually what is their scale and scope of responsibility. The title doesn't really provide you any authority, though in hierarchical organizations, like most AMC's [academic medical center] being the chair gives you certain rights and responsibilities, et cetera. Certainly, that was how many AMC's were organized, and some still are.

Participant 2 further reported an inquisitive desire for knowledge and questioning the status quo, replying:

> Oh, because of why. Why do you do it that way? Why is it that way? Why don't you do that? It's not accepting change. I mean, it's not accepting the status quo. That's wrong,

> you could do this better. You could make this better, you could change this. Look what they're doing, that's better. Unless you have a seat at the table, you can't bring around change, so you've got to do that. And given the right environment in my early career, I achieved great things by force of nature. Determination, energy, driving, outworking people. As I progressed through my career, I've turned down the volume on that. I'm never going to be the quiet, silent individual that speaks fluent management passive-aggressive nonsense, that's not me. But I certainly am more of a listener than I used to be.

Said another way, Participant 6 explained the drive for greater impact led to accepting a leadership role though the experience was not as expected:

> In other words, be the best. The ability to make a difference, to come in and leave a mark on something. I think most of those things. I was warned before I came here that I would find working here very frustrating compared to where I had been in my previous career. Large academic institutions are very frustrating. They have their way of doing things that have persisted for 200 years, or whatever it might be. But I did underestimate how frustrating it would be here, and I struggled with that for a year. Badly.

In each response, physicians defined what greater impact meant. Participant 1 bluntly stated the reason for accepting a leadership role was to, "…make a difference. And at that point in my career, making a difference meant how you going to change or advance the care of lung cancer patients."

Participant 3 explained the greater impact meant creating change through opportunity, stating:

> Most people want today to be just like yesterday. I want tomorrow to be better than today and for that to happen, change is paramount. Those who cannot change will never change anything. Where people see difficulty, I see opportunity. Every day somewhere, somehow there is going to be a challenge. So, I think, today is going to be filled with plenty of choices to make a difference. I am responsible for my actions. I can make things better; I can change them. And that's a good thing.

Various environments provide the motivation to create different opportunities. Participant 7 stated:

> Hey, we've all been in academic medicine or some of the more higher functioning private practice locations, which is more or less where I specifically recruited from. What are the things that we hated about our former jobs? What are the things that we wish we could

> have done for our patients? How could we potentially do that here?" And some of that stuff we've had success with, others we haven't had success with, but it was our failures and our successes.

Regardless of allocated administrative time, physician leaders shared similar desires to create change beyond clinical care. As specialists or subspecialists, physicians voluntarily chose to complete additional training and education in the respective field and are often recruited to organizations based on specialized expertise. For some participants, reducing clinical time and increasing administrative time felt counter-intuitive as the shift decreases the number of individual patients benefitting from the extensive training. Some participants reported an internal struggle to provide individual patients with exceptional clinical care being offset by a desire to leverage deep clinical knowledge for exponential impact.

Physician Leaders Experience a Duality of Roles

Physician leaders reported sharing many similar experiences leading up to becoming an administrative clinician. One of the most significant experiences reported was the duality of the physician professional identity. Participant 2 reported:

> I think there's probably a large, various, in how folks think of my role. I'm not sure that a lot of them have a true [sense of my role]. You can go up and down these offices, and probably have very differing ideas of what the role is, or what the responsibilities are. I come at it, in just trying to create a value proposition in with whatever we're doing. There are certain things that, I guess, I'll prioritize over other things, because I think that. Whether the Willie Sutton rule, that's where the dollars are, or from a care delivery component. These are just gaps we can't live with, but I'm not sure. I honestly don't know how the non-physician administrators truly view my role. I get a sense that that is all over the map.

Participant 5 reported a dissonance with becoming a physician leader but the duality of the role forces clarity of decision-making:

> I have never felt or seen that I'm an administrator. I always say that when ... And you have to be very careful with the words and I don't want to make general statements, but

> some physicians, when they become administrators, they become part of the problem and not part of the solution. And I think that sometimes they lose sight, or they get caught up in a different environment. I think that successful administrators who are physicians at the same time must not give up or forget what it is like to be in the operating room, to be in clinic, to be in the wards. None of the correct decisions in healthcare are made in the marble floor conference executive room. I think that the decision should be made in patients wards, in the operating room, in clinic, because that's the reality of patient care. And I think that's at the risk of forgetting the human side of healthcare, both from the patient's perspective but also from the physician's perspective.

Participant 6, with vast leadership experience shared:

> I see my role as bringing 25 years of national and international level leadership in clinical and academic fields, with a unique experience from both sides of the Atlantic. And therefore, having a network and a vision in building programs that is not deliverable by an administrative background. There are people I know that my dyad partner clearly cannot know. I've spent 25 years building programs by integrating clinical needs with academic, educational, and clinical skills, and recruiting people to develop those programs.

Participant 7 articulated two versions of self, embodying the essence of duality:

> I think there's at least two different professional selves. Because I think how I carry myself as a clinician and what I do there is very different than I think as a leader and as an administrator. The clinician part is easier, right? Because I think that's pretty well kind of spelled out. I think patients have some expectations of what they expect from physicians. And some of it is dependent on what I can provide as a physician, and some of its dependent on my staff and what they can provide in support. So, I think that how I am as a physician, if you look at it over the last five and a half years since I've been here, probably hasn't changed a lot.

Additionally, Participant 7 reported dual responsibilities, dual identities, and dual pressures:

> …that's kind of how I look at my job, is half of my job is being a representative of the organization and saying, "This is the big picture. This is the direction that the organization wants to go in. I have to sell this to the physicians." But at the same token, I'm really the one that's supposed to be advocating for the physicians to administration. And so, the same way, if there's two physicians that have a dispute, you have to balance it, it's the same way I feel on the big picture, is that I have to represent both. Because if I only represent the physicians and the organization can't move ahead because our department's holding them back, well, I'm not going to last around here very long.

When asked about the role of the physician leader, Participant 11 summarized the theme of

duality, stating:

> I think when we kind of intertwined the clinical aspects and the administrative aspects, I think it... I mean that's a learning process. That stuff we're picking up on the fly, that we're learning along the way. Typically, we're not...We don't have an MBA and an MD, some people do, but I don't. So those conversations, I'm always... If I understand what I'm talking about, I'll talk about it. If I don't, then I'm asking for somebody to help give me input.

The duality experienced by physician leaders are derived from reported lack of preparation and sometimes a lack of role clarity. A few participants shared frustration with organizations elevating physicians into leadership roles, assuming the physicians' clinical leadership skills translate directly into administrative competencies. To resolve the internal conflicts, participants relied on familiar and embedded professional identity.

Physician Leaders Are, Above All, Physicians First

Although many of the physician leaders were able to articulate the experiences which enabled future success, a key theme was despite a prominent professional duality, physician leaders are above all, physicians first. Participant 5 stated the interconnectivity of dueling professional identities saying:

> I think I'm very focused, perhaps sometimes too focused, on my profession. As I said, you cannot separate profession from the rest of our lives. It's ... They're blended into each other by the nature of our profession. We're always available, phone calls in the middle of the night, we're in holidays, birthday parties, time on vacation. Our routine from our own patients, from other people asking for help. I on a daily basis answer calls from a lot of people I had never heard of, either physicians or patients or relatives or friends who are asking for advice, who are asking for help, sometimes even about things that is not my area of expertise, but they are just looking for help. So, it is very intense. Sometimes it causes certain detachment because this is something that's difficult to share with other people. Not everyone will understand what it is that you do, but at the same time it's very rewarding.

Participant 5 reported the view of identity is clearer, declaring, "I think it's a wonderful way of serving and I see being a physician as a service, as something that again uses science not on an

occupation or something you do in a certain time of the day."

When asked to describe the professional self, Participant 4 succinctly affirmed, "…certainly clinically my professional self is very, very well established because we were trained for it throughout."

Explaining the experience of leading other physicians, Participant 8 was clear about the necessity and benefit of being a physician leader, stating:

> And I may emphasize probably a little bit more with the physicians my frontline research responsibilities, so they know I'm kind of in the trenches. Physicians need to know you're in the trenches with them. They need to know that you have both survived and thrived in the day-to-day grind. I'm not sure that's a facet of my position that really you or other administrative leaders need to hear, but it resonates with the physicians, that comradery of the war stories of all the things we've survived. I would also say that as a physician leader administratively, it's important for my administrative colleagues to know that we have kindred spirits in many ways.

Regardless of role or function, physicians complete additional training and education in chosen specialty which extends well beyond medical school. In some cases, newly graduated physicians complete a five-year residency followed by a multi-year fellowship to develop highly specialized expertise. Participants reported the result of the extensive training is a deep-seated professional identity which often becomes inseparable from the individual.

Reliability and Validity

Integrating elements of credibility, transferability, dependability, and confirmability is critical to the design of a study (Creswell & Creswell, 2018; Glesne, 2016; Kvale & Brinkmann, 2009; Marshall & Rossman, 2011; Patton, 2002). Contrasted with validity and reliability of quantitative research, qualitative studies are assessed by the level of trustworthiness (Patton, 2002). This qualitative phenomenological study used triangulation through member checks,

reflexivity, peer debriefing, and rich/thick narrative to ensure the collected data and subsequent analysis are accurate and trustworthy.

Member Checks

Member checking was used to ensure credibility. Considered a core data source for triangulation (Patton, 2002), member checking involves presenting participants with a synopsis of the themes (Creswell & Creswell, 2018), portions of the draft analysis (Glesne, 2016), or description of meaning extrapolated from the interviews (Moustakas, 1994). In this study, participants were presented with a synopsis of themes and draft descriptions of meaning following initial analysis. Participants had an opportunity to correct any misrepresentations of statements and had an opportunity to comment on the findings. Participants' feedback concurred with the findings and no changes were made.

Reflexivity

Reflexivity includes setting aside biases, opinions, and viewpoints which can influence or shape how the data are analyzed, and interpretations formulated (Creswell & Creswell, 2018; Guba & Lincoln, 2005). “Reflexivity entails reflecting upon and asking questions of research interactions all along the way, from embarking on an inquiry project to sharing the findings” (Glesne, 2016). Finlay (2012) added reflexive analysis might be considered as collected data to be analyzed while employing intuitions and understanding to elucidate participants’ perspective. In this study, biases caused by experience, culture, and history were identified by continually asking reflexive questions throughout the study.

Peer Debriefing

In addition to the review performed by participants, having a third-party review is a tactic to enhance the accuracy of the findings and increase validity (Creswell & Creswell, 2018; Mertens, 2009). Described by some peer review (Glesne, 2016), the process employs an individual or individuals with whom open collaboration can occur to obtain reactions about the interpretations and findings (Creswell & Creswell, 2018; Marshall & Rossman, 2011). While a third-party can be an uninterested individual, often for graduate students, the dissertation committee serves in this role (Patton, 2002). In this study, the dissertation committee served as the third-party for peer debriefing.

Rich Narrative

Use of rich, thick narrative to share participant perceptions adds to the depth of the analysis and brings forth the actual words and phrases used to describe the phenomenon being studied (Creswell & Creswell, 2018). If participants are to be viewed as co-researchers, as is the perspective of Moustakas (1994), inclusion of participant narrative becomes a central point in supporting the essence of meaning of collected data. Validity, trustworthiness, and transferability are further ensured by incorporating direct quotes, extracted from transcripts.

Chapter Summary

This chapter included an overview of the data collection process, participant selection, and participant characteristics. Following an explanation of the data analysis process, the findings were presented and organized by five themes that emerged from the data. Physician leaders shared perceptions and lived experiences of administrative positions. The processes for

ensuring valid and reliable results were described in conjunction with strategies for safeguarding credibility, transferability, dependability, and confirmability.

The concluding chapter includes an overview of the findings, interpretations, and conclusions. Study limitations, recommendations for further research, and implications for leadership are presented. The chapter is summarized with a conclusion which captures the essence of the study.

Chapter 5: Discussion and Conclusion

Extensive clinical training and experiences uniquely qualify physicians to serve in critical leadership roles. Tension of navigating the duality created by an engrained professional identity, as well as an administrative position, is unique to physicians. The purpose of this qualitative phenomenological study was to determine how professional identity of practicing physicians in leadership roles is established.

This qualitative study of the professional identity experiences and perceptions of practicing physician leaders at a hospital in the southeast United States was conducted using a phenomenological approach. The research, conducted over two months, was guided by the following questions:

Research Question One: What are the professional identity experiences of practicing physicians in leadership roles at a hospital in the southeast United States?

Research Question Two: What are the professional identity perceptions of practicing physician leaders at a hospital in the southeast United States?

The previous chapter included a comprehensive review of the data preparation and analysis procedures utilized to reveal the findings from the study. Relating to the first question of professional identity experiences of practicing administrative physicians, many participants reported developing an early sense of physician identity before entering medical school. Additionally, early experiences in both formal and informal leadership roles shaped the foundations for future professional leadership positions. While physician leaders experience a duality of roles, many participants shared a primary reason for becoming physician leaders – a desire for a more significant impact. The second research question about professional identity

perceptions of physician leaders was answered nearly unanimously – physician leaders are first and foremost, physicians.

Research of professional identity within other professions is plentiful, but studies relating to the professional identity of physician leaders are scarce. As healthcare continues on a path of increasing complexity, physician leadership becomes more critical. This study utilized a phenomenological approach to allow for the investigation and identification of meaning ascribed to shared experiences and perceptions of participants. Participants were selected from physicians with current or past leadership roles. Interviews were conducted using a semi-structured questionnaire, allowing for the freedom of participants to share stories and enabling immersion into the world of physician leaders.

This chapter includes an overview of the study and research questions, highlighting the necessity to conduct this research. The study findings, interpretations, and conclusions are presented in the results of the study. An examination of limitations, recommendations for further research, changes in policies, and enhanced practices are discussed. The chapter concludes with a discussion of implications for leadership.

Findings, Interpretations, Conclusions

The literature review illustrated the necessity for physician leadership in an increasingly complex future of healthcare as well as identified a gap in the literature related to the professional identity of physician leaders (Fernandez et al., 2016; Hudak et al., 2015). Additional findings from the literature included the criticality of the unique perspective of physician administrators (Angood, 2015), requiring physicians to employ a distinctive combination of skills (Ennis-Cole et al., 2018), and relying on particular expertise within the context of

professional identity (Neal, 2019). The literature provided background information and prior studies supporting the case for this qualitative phenomenological study.

Physician professional identity is a critical aspect of physician leader efficacy and developing a better understanding of how physicians view professional identity is essential (Quinn & Perelli, 2016). While many studies exist on the professional identity of nurses (Choudhry et al., 2017; Hensel & Laux, 2014), a gap occurs in relation to physicians' professional identity (Andersson, 2015; Naveh et al., 2015). Literature was reviewed to highlight physician leadership through an examination of leader competencies and traits, followed by an exploration of physician leader role duality, and a survey of clinical leadership development interventions. Further topics included physician leadership development and professional identity formation and concluded with physician identity.

Authentic leadership theory served as the framework of the study and the lens of sensemaking of the collected data (Avolio & Gardner, 2005). Similar to both transformational and servant leadership, authentic leadership includes a perspicuous element of morality (Northouse, 2019). Authentic leaders recognize and leverage strengths while aligning follower interests for general group benefit. The underlying principle of authenticity obliges leaders to frame decisions and lead from a basis of righteousness and virtuosity. Discrete from trait-based theories, authentic leadership is considered a developmental approach due to the ability of a leader to learn or develop behaviors which foster success (Avolio & Gardner, 2005).

Eleven participants were interviewed utilizing a semi-structured approach and a standard interview guide (Appendix B). Participants were asked first to provide an overview of personal and professional backgrounds, then to share leadership experiences, concluding with questions

related to perceptions of physician leaders. Interviews were first transcribed, then coded using a two-cycle approach according to the process outlined by Saldana (2016). During the first cycle coding process, several codes emerged, derived from the review of individual responses, followed by a second cycle coding process where the codes were collated and categorized into themes. The data generated the following five themes: identity formation begins prior to medical school, early leadership experiences form the basis for future roles, desire for greater impact drives physicians into leadership roles, physician leaders experience a duality of leadership roles, and physicians are, above all, physicians first.

Identity Formation Begins Prior to Medical School

When asked about the experiences leading to the decision to become a physician, many participants reported having interests related to the medical profession or having been influenced by someone whose opinion was genuinely valued. Participant 3 described having a father, a physician, as a positive role model, while Participant 10 explained his experiences during undergraduate education initiated the formation of professional identity. These findings are supported by prior research indicating the process of professional identity development occurs over time through individual experiences, feedback from mentors, observing respected colleagues, and from formal education (Chan et al., 2018; Cruess et al., 2015; Quinn & Perelli, 2016). Stated by Participant 9, “Six months prior to graduation I realized that I was better suited for a healthcare profession rather than working on Wall Street, as I thought perhaps I might.”

Early Leadership Experiences Form the Basis for Future Roles

Hammond et al. (2017) found significance in both the environment and the methods in which leadership skills are developed while Hammond et al. (2017) concluded leaders develop

competencies across multiple domains such as community, family, friends, or work. This study revealed physician leaders often learn leadership skills early in life, which form the basis for future leadership roles. Participant 8 stated, "…when I was in high school, I worked at a little place called Six Flags Over Texas. And when I was 17 years old, they gave me the responsibility for a roller coaster and a team of people. I was 17!". Participants recounted learning necessary skills for leading teams of people while being accountable for the performance of others.

Desire for Greater Impact Drives Physicians into Leadership Roles

The desire to create positive change and a more significant impact beyond the care of individual patients served as a critical driver to become a physician leader. Stated Participant 3, "Most people want today to be just like yesterday. I want tomorrow to be better than today and for that to happen, change is paramount. Those who cannot change will never change anything. Where people see difficulty, I see opportunity." As a physician transitions into a leadership role, the ability to influence grows. These findings confirm prior studies found as physicians assume more managerial responsibilities, the impact of physician leadership may grow exponentially (Scott, 2015).

Physician Leaders Experience a Duality of Roles

Physician leaders experience a constant state of tension between operational and clinical foci (Berghout et al., 2017; Spehar et al., 2015). Dichotomous situations frequently occur in leadership roles but become increasingly nuanced when the leader is a physician (Berghout et al., 2017). The experience of some participants illuminated two distinct roles occurring in harmony, while other participants experience two discrete roles operating on parallel tracks but never intersecting. Participant 5 reported,

> I have never felt or seen that I'm an administrator. I think that successful administrators who are physicians at the same time must not give up or forget what it is like to be in the operating room, to be in clinic, to be in the wards.

Participant 7 stated, “I think there's at least two different professional selves. Because I think how I carry myself as a clinician and what I do there is very different than I think as a leader and as an administrator.”

Physician Leaders Are, Above All, Physicians First

Irrespective of specialty and administrative time allocation, all participants reported an internalized primary professional identity of a physician. Though for some, the competing identities of administrator and physician were reported as an internal struggle when making hard decisions, the locus of control resides in the central physician identity. Succinctly stated by Participant 5, “I think I'm very focused, perhaps sometimes too focused, on my profession. As I said, you cannot separate profession from the rest of our lives. They're blended into each other by the nature of our profession.” Quinn and Perelli (2016) drew a similar conclusion in a study uncovering the differences of experiences of part-time physician leaders from full-time physician leaders.

Limitations

This qualitative research was limited to practicing physicians in current or previous leadership roles located in the southeast United States. Quantitative research often requires large populations from which to draw statistically representative samples enabling generalizable results (Creswell & Creswell, 2018). The specific nature of the population for this study precluded the utilization of a quantitative approach. Qualitative research often utilizes a smaller, purposive sample from which to derive information-rich data relative to a central phenomenon

enabling transferable results (Glesne, 2016).

The qualitative approach of phenomenology was chosen for this study to allow the emergence of themes from the participants' own lived experiences. This study set a goal of ten participants, and though eleven physician leaders chose to participate, results from this study may not directly align with the experiences and perceptions of physician leaders in other healthcare settings or other geographic areas. Interviews were conducted in person, and while the semi-structured questionnaire did allow flexibility for participants to respond within an acceptable comfort level, the question set did establish limits on the topics explored.

Trustworthiness is an accepted measure of qualitative research rigor (Glesne, 2016). Multiple strategies were employed to contribute to the trustworthiness of this study. Triangulation through member checks, reflexivity, peer debriefing, and rich/thick narrative were utilized in this study to ensure collected data and subsequent analysis were accurate and trustworthy. During the review of findings, emergent themes were exemplified by the use of rich, thick narratives, directly quoting participant responses. Additionally, individual transcripts were provided to each respective participant to allow for the validation of responses and to ensure responses reflected an accurate representation of experiences or perceptions. Following the analysis of the data, participants were provided with a summary of emergent themes and findings, allowing for the confirmation of results.

The questionnaire was developed specifically for this study. Following the approach described by Zamanzadeh et al. (2015), an expert panel was utilized to provide feedback, ensuring alignment of interview questions to research questions, clarity of each question, and free from bias. The rigorous review process enabled responses to be considered valid and

reliable. The instrument was not further evaluated for use beyond the scope of this study, subsequently limiting utilization.

Recommendations

This qualitative study was designed to explore the experiences and perceptions of physician leaders. The sample population was limited to physician leaders within one hospital system in the southeast United States. Recommendations are organized into four categories: perceptions of colleagues, variation of specialties and time allocation, expansion of geography, and training and preparation.

Perceptions of Colleagues

To develop a more comprehensive view of professional identity, further research should include the perspective of colleagues working alongside physician leaders. These populations should include non-clinical administrators, administrators from other clinical professions, direct reports of physician leaders, and perhaps individuals from accrediting bodies. Future research exploring how physician leaders view individual professional identity compared to how others perceive the professional of the same population would be useful in establishing the accuracy of outward expressions of professional identity.

Variation of Specialties and Time Allocation

While this study included participants from multiple medical and surgical specialties, not all recognized specialties were represented in the data. Participants with various allocations of administrative versus clinical time were well represented. Future research focusing on physician leaders in full-time administrative roles would serve to provide a unique and necessary perspective.

Expansion of Geography

This study was limited to participants from a hospital system located in the southeast United States. Further research should include a more expansive population of physician leaders across various geographic regions. Though physician training is consistent as a result of accrediting body regulations, the functions and scope of physician leaders may vary in different geographic locations.

Training and Preparation

The findings of this study indicate physician leaders often have similar, but sometimes unplanned experiences which serve as preparation for leadership roles. This study uncovered an opportunity to develop intentional, physician-oriented leadership development courses, leveraging the well-developed professional identity shared by the participants. Medical schools and graduate medical education programs should be explored for possible perspectives of aspiring physicians. For example, the American College of Obstetrics and Gynecologists developed a 3-day training program based on a set of ten competencies, specific to physician leadership (Fernandez et al., 2016).

Implications for Leadership

A gap in the literature was identified relative to the professional identity of administrative physicians yet, the importance of physician leadership in the complex industry of healthcare is essential to the success of organizations and the care of patients (Andersson, 2015; Naveh et al., 2015). Physician leaders begin to develop professional identity before becoming an autonomous practitioner, though aspiring physicians are provided little formal preparation for such roles. The

findings of this study may be beneficial to organizations responsible for creating physician-specific leadership development programs.

The findings of this study revealed participants have a desire to exert influence for greater impact beyond individual patient care. Healthcare leaders should harness the desire by creating pathways for potential physician leaders to grow and develop competencies required to deliver on the goal of improved quality and safety for better patient outcomes. The information distilled from this study can form the basis for leveraging entrenched professional identities and incorporating leadership skill development throughout physician training. Aspiring physicians spend many years in formal education and clinical training (Accreditation Council for Graduate Medical Education, 2019; Liaison Committee on Medical Education, 2019). Medical schools may consider evaluating curricula for placement of progressive leadership skill development. Professional identity is deepened as newly graduated physicians transition from medical school to residency (Phillips & Dalgarno, 2017). Residency and fellowship programs may consider incorporating opportunities for new physician graduates to apply theoretical leadership knowledge in a controlled clinical setting. Through direct observations and feedback, program leaders may foster an embedded dual professional identity, preparing graduate physicians for future leadership roles.

Future studies should use the findings from this study to explore the formation and manifestation of professional identities in various settings, both private practices as well as hospital-employed practices. The second opportunity for future research exploration is in the area of physician leader role clarity and functional responsibilities. More research is warranted to correlate both clinical and non-clinical outcomes of physicians with formal leadership training

compared to physician leaders receiving no leadership training. Finally, future research should be considered to explore training efficacy and impact, where applicable.

Conclusion

This chapter included research findings related to experiences and the development of professional identities of physician leaders. The emergent themes reflected progressive identity formation beginning prior to medical school but resulting in an identity inseparable from the individual. As students advance through medical school and graduate medical education programs, the professional physician identity becomes more deeply entrenched, setting future physician leaders up for internal conflict.

Participants in this study reflected on similar early experiences where foundational leadership skills were established and commonly shared a desire to seek leadership roles enabling exponential impact. The main goal for participants was to advance patient care. Once in leadership positions, participants experienced a duality of two discrete roles – administration and clinical care. Regardless of specialty or amount of time dedicated to administration functions, participants shared one common theme – physician leaders are physicians first.

One key benefit of having physicians in leadership positions is the lens through which decisions are made, and solutions are sought. The specific clinical training and expertise enables a unique perspective afforded only to physicians but is felt throughout the organization. Physician and non-clinical administrators may share the goal of improving patient care, but each has a distinct role in executing on strategies to achieve the desired outcomes.

Providing opportunities for aspiring physician leaders to develop a dual administrative professional identity would only serve to harness the unique capabilities of physicians to help

organizations navigate future challenges. Future physician leaders will be responsible for designing and delivering care in a new model of an increasingly consumer-centric environment. Not only will organizations rely on physicians to lead the way, but patients will continue to place critical trust in the hands of physician leaders. “One of the things that I think is extremely important for this health system is how we develop better physician administrators,” said Participant 2.

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Appendix A: Informed Consent

Prospective Research Participant: Please read this consent form carefully and ask as many questions as you like before you decide whether you want to participate in this research study. You are free to ask questions at any time before, during, or after your participation in this research.

Project Information

Title: Professional Identity of the Physician Leader: A Qualitative Phenomenological Study
Researcher: Gary L. Owens, Jr.
Organization: American College of Education
Phone: 407-455-3332 | **Email**: garylowensjr@me.com
Supervising Faculty: Dr. Katrina Schultz
Organization and Position: American College of Education, Core Faculty
Email: Katrina.Schultz@ace.edu

Introduction

I am Gary Owens, and I am a doctoral candidate at American College of Education. I am doing research under the guidance and supervision of Dr. Katrina Schultz. I will give you some information about the project and invite you to be part of this research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words you do not understand. Please ask me to stop as we go through the information and I will explain. If you have questions later, you can ask them then.

Purpose of the Research

The purpose of this study is to gather information from physicians about their leadership experiences. The information I am seeking relates to physician education and specialty training and the experiences associated with transitioning to a leadership role. The information gained through this study will help us better understand how to better prepare physicians for leadership roles.

Research Design

This study will use a qualitative phenomenological design. This research will involve your participation in an individual interview and will take about an hour.

Participant Selection

You are being invited to take part in this research because as a physician leader, you can contribute much to our understanding of the professional identity physicians assume when taking on administrative roles.

Voluntary Participation
Your participation in this research is entirely voluntary. It is your choice whether to participate. The choice you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Procedures
We are asking you to help us learn more about the experiences of physicians in leadership roles. We are inviting you to take part in this research project. If you accept, you will be asked a series of questions in an individual interview format to describe your education and training and your experiences as a physician leader. We would like to understand how you view yourself in the context of both the practice of medicine and the role of administrator.

Duration
The research will take place over two months. During that time, I will arrange an in-person visit to conduct a single interview, which will take approximately an hour.

Risks
The researcher will ask you to share personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion if you don't wish to do so. You do not have to give any reason for not responding to any question.

Benefits
While there will be no direct financial benefit to you, your participation will help us better prepare physicians to take on leadership roles.

Reimbursement
Your participation is voluntary, and no reimbursement will be available.

Confidentiality
I will not share information about you or anything you say to anyone outside of the research team. The information we collect will be kept in a locked file cabinet or encrypted computer file. Any information about you will have a number on it instead of your name. The nature of this research requires the inclusion of direct quotes. These quotes will be reported anonymously and without any identifying information. Only I will know your number and I will secure that information.

Sharing the Results
At the end of the research study, the results will be available for each participant. It is anticipated to publish the results so other interested people may learn from the research.

Right to Refuse or Withdrawal
Participation is voluntary. At any time, you wish to end your participation in the research study, you may do so without repercussions.

Questions About the Study
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact Gary Owens at 407-455-3332 or garylowensjr@me.com. This research plan has been reviewed and approved by the Institutional Review Board of American College of Education. This is a committee whose role is to make sure research participants are protected from harm. If you wish to ask questions of this group, email IRB@ace.edu.

Certificate of Consent
I have read the information about this study, or it has been read to me. I acknowledge why I have been asked to be a participant in the research study. I have been provided the opportunity to ask questions about the study, and any questions have been answered to my satisfaction. I certify I am at least 18 years of age. I consent voluntarily to be a participant in this study.

Participant:

Printed Name	Signature	Date

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this Consent Form has been provided to the participant.

Lead Researcher:

Printed Name	Signature	Date

Appendix B: Interview Guide

1. Can you give me a short overview of your personal and professional background?
    a. Can you describe your education and training?
    b. Can you tell me about your current role?
        i. Are you directly involved in providing direct patient care?
    c. Can you tell me about what influenced you to become a physician?
    d. Describe why this was a role/organization that appealed to you.
    e. Can you tell me about any leadership roles that you currently hold or have held in the past?
        i. What led you to take on those roles?
    f. What were your past roles?

2. For full-time administrators: Tell me about the day you decided to stop practicing as a physician to become an administrator.
3. How would you describe your professional self?
4. Imagine you are greeting an unknown physician. How would you introduce yourself?
5. Now imagine you are greeting a non-physician administrator. How would you introduce yourself?
6. Can you describe your interactions with the physicians you lead?
    a. For mixed-specialty roles: Can you describe your relationship with physicians not sharing your specialty?
    b. For same-specialty roles: Can you describe your relationship with physicians sharing your specialty?
7. How do you approach resolving conflict with other physicians?
8. How do you believe non-physician administrators view your role?
9. Is there anything about your professional role you would like to share that I have not asked about?

Clarifying Questions, to be used when appropriate:

a. What led up to the event or situation?
b. When did this happen?
c. Who was involved?
d. What did they say or do?
e. What were you thinking and how did you feel?
f. What was the result?

Appendix C: Permission to Use Rubric

PERMISSION TO USE AN EXISTING VALIDATION RUBRIC FOR EXPERT PANEL (VREP)

August 27, 2019

To: Gary Owens

Thank you for your request for permission to use VREP in your research study. I am willing to allow you to reproduce the instrument as outlined in your letter at no charge with the following understanding:

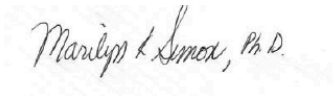
- You will use this survey only for your research study and will not sell or use it with any compensated management/curriculum development activities.
- You will include the copyright statement on all copies of the instrument.
- You will send your research study and one copy of reports, articles, and the like that make use of this survey data promptly to our attention.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to me.

Best wishes with your study.

Sincerely,

Marilyn K. Simon, Ph.D



Signature

More information can be found in Simon and Goes's Dissertation and Scholarly Reseach: Recipes for Success, 2018 edition.
http://www.dissertationrecipes.com/

I understand these conditions and agree to abide by these terms and conditions.

Signed Gary L. Owens, Jr. Digitally signed by Gary L. Owens, Jr. Date: 2019.08.29 14:36:11 -04'00' **Date 08.29.2019**

Expected date of completion: December 2020

Appendix D: Validation Rubric

Survey/Interview Validation Rubric for Expert Panel - VREP©

By Marilyn K. Simon with input from Jacquelyn White

Criteria	**Operational Definitions**	**Score** **1=Not Acceptable** (major modifications needed) **2=Below Expectations** (some modifications needed) **3=Meets Expectations** (no modifications needed but could be improved with minor changes) **4=Exceeds Expectations** (no modifications needed)				Questions NOT meeting standard and need to be revised. Please use the comments and suggestions section to recommend revisions.
		1	2	3	4	
Clarity	The questions are direct and specific. Only one question is asked at a time. The participants can understand what is being asked. There are no *double-barreled* questions (two questions in one).					
Wordiness	Questions are concise. There are no unnecessary words					
Negative Wording	Questions are asked using the affirmative (e.g., Instead of asking, "Which methods are not used?", the researcher asks, "Which methods *are* used?")					
Overlapping Responses	No response covers more than one choice. All possibilities are considered. There are no ambiguous questions.					
Balance	The questions are unbiased and do not lead the participants to a response. The questions are asked using a neutral tone.					
Use of Jargon	The terms used are understandable by the target population. There are no clichés or hyperbole in the wording of the questions.					
Appropriateness of Responses Listed	The choices listed allow participants to respond appropriately. The responses apply to all situations or offer a way for those to respond with unique situations.					
Use of Technical Language	The use of technical language is minimal and appropriate. All acronyms are defined.					
Application to Praxis	The questions asked relate to the daily practices or expertise of the potential participants.					
Relationship to Problem	The questions are sufficient to resolve the problem in the study The questions are sufficient to answer the research questions. The questions are sufficient to obtain the purpose of the study.					

The operational definition should include the domains and constructs that are being investigated. You need to assign meaning to a variable by specifying the activities and operations necessary to measure, categorize, or manipulate the variable For example, to measure the construct *successful aging* the following domains could be included: degree of physical disability (low number); prevalence of physical performance (high number), and degree of cognitive impairment (low number). If you were to measure creativity, this construct is generally recognized to consist of flexibility, originality, elaboration, and other concepts. Prior studies can be helpful in establishing the domains of a construct.

Permission to use this survey and include in the dissertation manuscript was granted by the author, Marilyn K. Simon, and Jacquelyn White. All rights are reserved by the authors. Any other use or reproduction of this material is prohibited.

Comments and Suggestions

Appendix E. Invitation to Participate

Dear Physician,

I am Gary Owens, and I am a student at American College of Education. I am doing research under the guidance and supervision of Dr. Katrina Schultz. The purpose of this study is to gather information from physicians about their leadership experiences. The information I am seeking relates to physician education and specialty training and the experiences associated with transitioning to a leadership role. The information gained through this study will help us better understand how to better prepare physicians for leadership roles.

You are being invited to take part in this research because as a physician leader, you can contribute much to our understanding of the professional identity physicians assume when taking on administrative roles.

If you would like to participate, please respond to this email or call me at 407.455.3332. I will provide more detail about participation requirements and I provide you with a written informed consent which explains the multiple aspects of this study.

Thank you for considering participating in this research.

Best,
-Gary L. Owens, Jr.

Appendix F: Participation Reminder

Dear Physician,

I am following up on an invitation to participate in a research study regarding physician professional identity. As a physician leader, your insight and your experiences could contribute to our understanding of physician identity.

If you would like to participate, please reply to this email or call me at 407.455.3332. I will provide more detail about participation requirements and I provide you with a written informed consent which explains the multiple aspects of this study.

Thank you for considering participating in this research.

Best,
-Gary L. Owens, Jr.

Appendix G: Organizational Permission

Logo Redacted for Privacy

October 30, 2019

American College of Education
Institutional Review Board
Ms. Becky Gerambia, Chair

Dear Ms. Gerambia,

It is my pleasure to provide permission for Gary Owens, doctoral candidate, to use the premises to conduct his dissertation research study as identified below, contingent on approval from the American College of Education Institutional Review Board. I understand that appropriate measures will be taken to ensure participant and organizational privacy.

Further, I authorize Gary Owens to recruit subjects for his dissertation study, as identified below, contingent on approval from the American College of Education Institutional Review Board.

Study information:

Title of Study: Professional Identity of the Physician Leader: A Qualitative Phenomenological Study

Principal Investigator: Gary L. Owens, Jr.
E-mail: garylowensjr@me.com
Phone: 407-455-3332

Dissertation Chair: Dr. Katrina Schultz
E-mail: Katrina.Schultz@ace.edu
Phone: 817-713-2294

Signature Redacted for Privacy

Vice President

[redacted]