Physician as Leader III: From Theory to Practice Regarding General Competencies

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In their exploration of leadership among physicians, McKenna and Pugno (2006, p. 59ff) not only introduced the DISC model of leadership and provided richly insightful quotations from practicing physicians regarding leadership, they also provided concepts from other authors and results from research they conducted regarding the competencies most valued among physician leaders. In focusing on competencies, McKenna and Pugno look at knowledge, skills and abilities. These are all competencies that can be learned through training, education, and ongoing experience in preparation for and while serving as a physician leader. Alongside competencies, we find character in the writing of McKenna and Pugno. While character usually refers to attributes such as ethics, consistent alignment with certain values, and enduring commitment to certain actions, many of the physician leaders that McKenna and Pugno turn to will provide a list that includes both competencies and character.

While it is common and appropriate to intermix competencies and character (since they are often closely connected to the actions taken by leaders), it is also important to note that Character is often not learned. Like personality, the character we display in our lives often is either inherited or formed early in life. It is also molded, in part, by the culture in which we live. We can offer courses on ethical behavior (and might even mandate them in our organization): however, the actual engagement of ethical behavior (especially under stressful conditions) will often abandon some leaders—unless there are specific incentives or penalties associated with engagement or non-engagement of this behavior. We know that perspectives on ethics and the acquisition of accompanying values can evolve (Kohlberg, 1984; Gilligan, 1982; Gilligan, 2023); however, some people (and some leaders) never seem to move beyond an early stage of development concerning ethics and values (Perry, 1970).

These reflections on competencies and character are being offered because the mixture of these two elements of leadership can often lead to confusion regarding the goals of a leadership development program or, more broadly, the assessment and modification of ongoing leadership performance. Certain elements of leadership can be learned and modified (given useful feedback). However, other components are much more difficult to influence and often provide some of the greatest challenges concerning the training and education of leaders and their initial selection.

With this caveat in mind, I turn to McKenna and Pugno's identification of general (generic) leadership competencies—and character elements. I then consider how these competencies and character elements are impacted by the culture in which physician leaders.

General Leadership Competencies and Character Elements

Throughout their book, McKenna and Pugno offer lists of leadership competencies that they have borrowed from other leadership scholars, from their research findings and from their own experiences of working in health systems.

I first offer a very traditional list of competencies that comes from John MacArthur's biblically based study of leadership. Twenty-six competencies are listed by McKenna and Pugno (2006, p. 133):

1. A leader is trustworthy.
2. A leader takes the initiative.
3. A leader uses good judgment.
4. A leader speaks with authority.
5. A leader strengthens others.
6. A leader is optimistic and enthusiastic.
7. A leader never compromises the absolutes.
8. A leader focuses on objectives, not obstacles.
9. A leader empowers by example.
10. A leader cultivates loyalty.
11. A leader has empathy for others.
12. A leader keeps a clear conscience.
13. A leader is definite and decisive.
14. A leader knows when to change his mind.
15. A leader does not abuse his authority.
16. A leader doesn't abdicate his role in the face of opposition.
17. A leader is sure of his calling.
18. A leader knows his own limitations.
19. A leader is resilient.
20. A leader is passionate.
21. A leader is courageous.
22. A leader is discerning.
23. A leader is disciplined.
24. A leader is energetic.
25. A leader knows how to delegate.
26. A leader is Christlike.

I would offer several comments regarding this list. First, like many traditional lists, this is comprehensive. One would truly have to be "Christlike" if they were competent in all of these areas. This list does not account for specific leadership roles, specific leadership challenges, or the culture of a healthcare organization or system in which one is working. Furthermore, like many of the analyses we will be introducing in this essay, some of the items on this very ambitious list actually relate not to competencies, but rather to character. Being passionate and resilient, or knowing one's calling and being "Christlike" have much more to do with one's character (values, ethics, motives) than with one's knowledge, skills or abilities.

Earlier in their book, McKenna and Pugno (2006, pp. 74-75) offer a more "practical" list that is based on the practical experiences of Joseph Spalina, FACHE, FAAHC and relates specifically to leadership of clinical programs:

- Operational and clinical research expertise

- Service and technology evaluation and design
- Organizational management
- Financial and business planning, evaluation, and management
- Quality assessment process design and management
- Information systems management
- Strategic planning
- Physician relations management
- Marketing and promotions
- Facility programming and planning.

There are several important points worth noting in Spalina's list. First, his frequent use of the term "management" (rather than "leadership") is indicative of the movement from the large, lofty characteristics of leadership offered by MacArthur. Distinction between leadership and management. I would suggest that whether one is serving as a "leader" or "manager" in a health care system depends on the specific role this person is playing in the organization, as well as the aforementioned organizational culture in which this person is operating—those in the professional, alternative (and advocacy) cultures prefer to be called "leaders." Those operating in the Managerial culture (as the name implies) preferred to be called "managers." They often consider the term "leader" to be rather arrogant. It is to be used by puffed-up politicians. It is not to be used by those in health care systems, like Spalina, who are diligently operating health care programs.

This second list of competencies also is noteworthy in that it includes competencies related to the management of healthcare tasks--such as clinical research expertise, service and technology evaluation and design, information systems management, marketing and promotion, and facility programming and planning. However, the list also includes management of human relationships—such as organizational and physician relations management. Many of the items on the list (ultimately, perhaps all of them) require a blending of task and relationship management—noteworthy are operations, business planning, quality assessment process design and management--and strategic planning.

A critical distinction was drawn many years ago between task and relationship (Blake and Mouton, 1985; Hershey and Blanchard, 1977). A similar distinction is drawn between transactional (task) leadership and transformational (relationship) leadership—though "transformation" is a term that is loaded with much more than just a focus on relationships. The task/relationship distinction continues to be important, though, as in the case of Spalina's list, effective leadership often requires a balancing and even blending of tasks and relationships (Forsyth, 2019). The second sector in the leadership/management models offered by Blake and Mouton, as well as by Hershey and Blanchard, incorporates an orientation to both task and relationships.

McKenna and Pugno (2006, p. 87) turn to yet another physician leader, Richard Birrer, MD, MPH, MMM, CPE, to identify the competencies that all those who effectively lead a health care system should have acquired:

- management of medical staff relations (including conflict resolution, the issuing of credentials and privileges, network management, and recruitment and retention)
- efficiency practices (including those involved in informatics, staff performance and compensation, and managed care/insurance)
- quality management (including quality assurance, clinical benchmarking, outcomes and disease management, resource utilization, risk management)
- legal and regulatory issues
- liaison functions (including mergers/affiliations and operations)
- cost management (including finances, cost accounting, cost containment, profit/loss statements)
- technology assessment
- decision making in uncertain situations
- clinical medicine
- organizational issues (including sales/marketing analysis, negotiation of contracts, strategic planning, governance).

I introduce this list because it might more accurately reflect how "real" physician leaders think about what they need to know in a challenging mid-21st Century healthcare environment (Fish and Bergquist, 2022, Fish and Bergquist, 2023a; Fish and Bergquist, 2023b). I would also note that Birrer was more task-oriented than Spalina in identifying the competencies needed by "physician executives" (another term often used by those in the Managerial culture). While management of medical staff relations certainly requires a blending of task and relationship-based competencies, the remaining items on the list are primarily task-oriented. "Executive action" often points the way to a focus on "getting the job done" without major concern for the input of all relevant parties.

In bringing this brief review of McKenna and Pugno's lists of leadership competencies to a close, I wish to share what I think is one of their most insightful summaries of what makes a successful leader in contemporary health care. McKenna and Pugno (2006, p. 129) frame this list as a set of "stepping stones" that one should take into account when preparing to be a physician leader:

> Stepping Stones to Successful Leadership
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> **Credibility**
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> Successful leaders exhibit competence (skills, knowledge, ability) and character (values, beliefs and behaviors). Credibility is the starting point for anyone who desires to earn other's trust and respect.
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> **Clarity**
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> Successful leaders provide clear direction; they clearly communicate a compelling vision that attracts others to contribute toward the achievement of that vision.
>
> **Collaboration**
>
> Successful leaders create cohesive teams of diverse individuals who respect one another and are deeply committed to the purpose they share.

Coordination

Successful leaders ensure decision and actions, resources and processes are aligned with key goals and priorities; they manage and measure the achievement of results.

Change

Successful leaders equip themselves and others with the resilience and the capacity for renewal that are necessary to withstand the pressures of continuous change and the ongoing quest for further innovation and improvement.

While this list of "stepping stones" is certainly "softer" (more relationship-oriented) than the list offered by Birrer, I propose that it provides just as relevant tools (competencies) for mid-21st Century leadership as those identified by Birrer. Many of the "executive" actions to be taken by Birrer require that we first gain credibility, often clarity, engage in collaboration, provide coordination—and most importantly be "equipped" for the change and change curves (Bergquist, 2014) that inevitably are required given the volatility, uncertainty, complexity, ambiguity, turbulence, and contradiction (VUCA-Plus) to be found in contemporary health care systems (Fish and Bergquist, 2023b).

I would also suggest that effective leadership requires the engagement of five best practices. Jeannine Sandstrom and Lee Smith (Sandstrom and Smith, 2017) identified and described these. No one leader in a healthcare system needs to provide all five practices—this is to be the "Christlike" leader that John MacArthur describes. However, one should be aware of the benefits these five best practices serve and ensure that all five practices are provided by one or more leaders in one's healthcare system. Furthermore, critical, accompanying competencies, values, perspectives, and practices have been identified by McKenna and Pugno--as I shall note in the next essay in this series regarding each of the five best practices. Joined together, the insights regarding healthcare leadership offered by McKenna and Pugno and more general insights regarding the best practices of leadership offered by Sandstrom serve as valuable guides for anyone seeking to provide these critically needed services in our current healthcare system.

However, before exploring ways in which the insights of Sandstrom, McKenna and Pugno might be brought together, there is one other important frame that needs to be introduced. This frame sets up important distinctions to be drawn between the collective values, perspectives, and practices to be found in specific healthcare departments, divisions or an entire organization. These values, perspectives, and practices converge in what can be considered the "cultures" or "subcultures" of a healthcare system. Differing competencies and styles of leadership are required in each culture and subculture.

Leadership Competencies and Health Care Culture

Up to this point, I have focused on what McKenna and Pugno have considered the generic competencies required of all healthcare leaders. However, the leadership portrait becomes more complex. Specific competencies are aligned with specific leadership preferences. These preferences might be grounded in the leader's personal history or the specific role they play in the organization. I turn in the next essay in this series to personal preferences and roles when bringing in the concepts offered by Jeannine

Sandstrom regarding the five best practices of leadership and related them to concepts offered by McKenna and Pugno.

However, there is a third determinant of the competencies on which a healthcare leader will focus. It requires that I provide not only a complex portrait but also a landscape rendering. This determinant is the dominant culture operating in the department, division, or overall organization in which the leader is operating. No leader is immune from the powerful cultural forces swirling all around them. There are values (enforceable norms), perspectives (dominant viewpoints), and practices (repetitive behaviors) that inform what is "proper" to think and do as a leader operating in a specific culture.

I have proposed elsewhere that four dominant cultures exist in all human service organizations (Bergquist, 1993; Bergquist and Brock, 2008; Bergquist and Pawlak, 2008)—including health care (Bergquist, Guest and Rooney, 2002). These are the professional culture, the managerial culture, the advocacy culture, and the alternative culture. I find it informative to see how these four cultures align with McKenna and Pugno's (2006, p. 67) description of four types of healthcare leaders. Perhaps specific types of leadership styles in healthcare systems relate to specific healthcare cultures.

Two of McKenna and Pugno's types are identified as being related to administrative duties—much as is the case with the Managerial and Advocacy Cultures. The other two types are related to clinical duties—which is also the case with the Professional and Alternative cultures that I have identified. McKenna and Pugno also distinguish between leadership roles that are engaged in a specific healthcare organization – such is the case with the Managerial and Professional Cultures—and those that are not confined to one healthcare organization—such as in the role played by the Advocacy and Alternative Cultures.

Given the close alignment between my four cultures and the four healthcare leadership types identified by McKenna and Pugno, I will consider how these models of leadership-type and culture play out together.

Expert Leader/ Professional Culture

McKenna and Pugno identify the key leadership role played by physicians as "experts" in the clinical setting of a healthcare system. This role is played by physician leaders within the confines of a specific healthcare system. The key focus of those serving in this expert role is the achievement of clinical excellence. Those physicians who serve in the role often teach and train clinicians. They might also publish and speak in their specific field of expertise. Competencies are required that relate specifically to patient care. Medical knowledge is particularly important.

The model of physician leader as expert relates directly to the roles played by physicians in a professional culture. Those engaged in medical, clinical and scientific services populate the Professional Culture in healthcare communities. We have effective systems, and successful treatment programs because patients have always come first in the Professional Culture—clinical excellence is the key focus. Members of the Professional Culture look for strategies that promise to increase their control over and opportunity to influence the quality of health care they provide. We have effective systems, and successful treatment programs because patients have always come first in the Professional Culture. The patient comes first because it is through the patient that professional healthcare providers receive

repeated reassurance and all kinds of support for the good job they do. This becomes the central ingredient in the provider's sense of life's purpose.

Those in the Professional Culture often find identity (and meaning) primarily through their affiliation with professional associations. As noted by McKenna and Pugno, members of this culture value technical expertise. They also are inclined to value specialized technical language. They are fully committed to preservation of professional autonomy and have established quasi-political governance processes to ensure this autonomy. These processes have enabled healthcare professionals, over the past hundred years, to strongly influence or even dictate the policies, procedures, and missions of healthcare systems. Members of this culture hold assumptions about the dominance of rationality and technically based procedures in hospitals and other health institutions.

This means that the Professional Culture has been dominant in health care since early in the history of North American health care. Virtually all physicians were aligned with this culture for many years. As McKenna and Pugno (2006, p. 65) note, the display of clinical expertise was the ticket to becoming a "leader":

> Conventional wisdom among clinicians holds that to attain a "position of leadership." Physicians must first "prove themselves" through demonstrated clinical excellence. People who hold this traditional viewpoint believe that only upon being recognized as a clinical expert can physicians gain the respect of peers that is vital for earning the right to lead.

This traditional viewpoint and dominance of the Professional Culture is now being attacked from all sides. Those in the Professional Culture must now share power with the other three cultures of contemporary health care—especially the Managerial Culture. Now, there are additional pathways to leadership among physicians. One of these pathways is serving in an executive position as the formal manager of people and resources in a healthcare system.

Executive Leader/Managerial Culture

In recent years, physicians have often played this key executive leadership role. They perform this administrative role not in a clinical setting but instead in the administrative offices of their healthcare system. As in the case of physician leaders who identify as experts, the physician leader who serves as executive is operating within the confines of a specific healthcare system. The key focus of those serving in this executive role is the achievement of organizational excellence. However, as McKinna and Pugno (2006, p. 65) have observed, the focus of many physician leaders is on "career survival."

Furthermore, there is often an untested belief that the skills that make the physician a successful clinician are also those that will make them a successful administrator. However, McKinna and Pugno (2006, p. 66) offer a cautionary note in this regard: "some traits associated with clinical excellence can be applicable to the work of leadership. [However] there are many differences between the work of clinicians and the work of administrators." Those physicians who serve in the executive role typically manage staff and resources in their organization. They bring important knowledge regarding clinical needs to this role; however, they must also be knowledgeable about system-based perspectives and

practices. Furthermore, these executive leaders must possess functional skills in such managerial areas as supervision, delegation, and motivation.

An important perspective is introduced regarding the interplay between executive leadership and the Managerial Culture. It is important to note that physician leaders are often drawn to the role of executive because the administrative services and the attendant Managerial Culture bring much value to the healthcare community. Some physicians have chosen to move from the clinical to the administrative setting because of the challenging world in which healthcare now operates in most societies. Specifically, the Managerial Culture builds on the dichotomy between control and chaos. Members of this culture (including physician leaders) fear their loss of organizational control. They are anxious about organizational chaos—a threat particularly apparent in our mid-21st Century world of volatility, uncertainty, complexity, ambiguity, turbulence, and contradiction (VUCA-Plus) (Bergquist, 2020; Fish and Bergquist, 2023b).

Those aligned with the Managerial Culture resolutely hold theories about organizing for maximum effectiveness. These theories concern the achievement of predictability regarding the outcomes of any change effort. Managers look for organizational strategies that will reduce their anxiety regarding organizational chaos and VUCA-Plus conditions. Over the years, healthcare managers have primarily focused on the provision of resources for amelioration rather than prevention of illness and injury. These managers have traditionally believed that they could reduce both their own anxiety and the anxiety of their customers (patients) by demonstrating that they could provide healing services at reasonable costs to their customers.

Members of the Managerial Culture have traditionally valued access. In the past, this emphasis on access helped reduce the anxiety experienced by both managers and clients. Managers could count the number of patients being served and take pride in the provision of maximum service at minimum cost. Some physicians aligned themselves with this commitment to lowering costs. They joined with some healthcare administrators (and many members of the Advocacy and Alternative cultures) in expressing concern about healthcare inaccessibility for some community members because of healthcare costs. They wanted citizens to feel assured that treatment was available if they needed it. Support was given to governmental subsidies, work-based health insurance plans, and the role played by nonprofit (philanthropic) low-cost health care services.

Today, this assurance is no longer warranted. Americans can no longer trust that they will receive adequate treatment—unless they are wealthy. Healthcare managers (including physician leaders) can no longer feel comfortable counting the number of patients served. They now must take costs more fully into account. This often leads to a dramatic reduction in the amount of time spent by physicians with each patient. Those physician leaders who are serving in an executive role are caught in the crossfire between the management of costs and the provision of high-quality and caring patient services.

Accountability is also valued by the Managerial Culture. This emphasis is intended to reduce anxiety for both managers and clients. It is also intended to reduce the anxiety of physician leaders who are trying

to serve as managers and stewards of their organization's resources. Taken to the extreme, this emphasis on accountability can produce a bean-counter mentality—something that most physicians detest. Furthermore, for many members of the Managerial Culture, accountability primarily relates to another managerial value, namely profit. This is a value that most physicians even more virulently detest.

One of McKenna and Pugno's (2006, p. 243) physician leaders stated this about doing the "right thing":

> Is leadership about doing things? It's about doing the right thing. . . .My advice to those who aspire to be leaders is this: Do what you can with the gifts that you have and do things for the right reasons." (Gary Morsch, MD, Family and Emergency Medicine Physician, U.S. Army Reserves, Found, Heart to Heart International).

For those trained to care for patients, the "right thing" has much more to do with the quality of medical treatment than making a profit. On the other hand, profits are required to keep most contemporary healthcare systems in business. Once again, the executive role and executive perspective lead us back to career survival.

In sum, this emphasis on profit and efficiency is intended to reduce only the anxiety of those aligned with the perspective, practices and values of the Managerial Culture. Patients typically care very little about profit. They often even take great offense when they discover that their illness, injury or health is a source of profit for another person or institution. Most physicians have traditionally lined up with their patients rather than those in the Managerial Culture (who traditionally have resided outside the clinical setting). Unfortunately, the Managerial Culture's emphasis on profit creates a climate of indifference when taken to an extreme.

Those who reside in the Managerial Culture sometimes lose touch with the real reason for engaging in the business of health care—especially if they work in an administrative setting. Many people from the management Culture, including accountants, information services technicians, insurance agents, and members of the human resource staff, have little direct contact with patients. A dominant concern for profit and lack of personal interaction with patients eventually leads to indifference about the primary customer (the patient) and the primary reason for the existence of the healthcare system (provision of medical services to treat illness and injury).

Activist Leader/Advocacy Culture

In recent years, some physician leaders have served not only as clinical directors or administrators in their healthcare system but also as reforming, activist leaders inside and outside their healthcare system. McKenna and Pugno (2006, p. 110) believe this role is not only quite appropriate but also all-too-infrequently engaged:

> Doctors have consistently been among the most trusted members of our society. In the Hippocratic Oath we as physicians swear to do our best to benefit the sick, do no intentional harm, and ensure our actions are never dictated by external motives. Even now in modern

> twenty-first-century medicine, this ancient code governs the approach to our most important and sacred vocation.
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> . . . [I]t is vitally important [that] we explore the possibility that the values outlined in Hippocrates' writing describe our obligations not just as doctors, but [as] civic leaders. As caretakers for people of all backgrounds and social classes, we have been imbued with implicit rust from our patients. Suitable to this most intimate responsibility, we are regarded as trustworthy, independent, and fundamentally moral and ethical professionals. These traits are not only crucial to effective medical practice, they provide the foundation for effective leadership in virtually all arenas of human interaction.
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> In light of the similarities between successful medical practice and public leadership, it is unfortunate that there are so few doctors currently servicing [in governance positions.]

It is instructive to note that while McKenna and Pugno challenge the assumption that clinical skills readily translate into administrative skills, they tend to support an assumption that values inherent in the Hippocratic Oath readily apply to a physician leader's commitment to social activism. They suggest that is not only acceptable but even commendable that some physicians envision their role to be one of healing not only individual patients but also a sick and wounded society.

Physician leaders and others who reside in the Advocacy Culture serve as activists in response to problems they witness regarding the way healthcare is being delivered in contemporary healthcare systems. Achievement for these activists is to be found in successful healthcare reform. Those physicians who serve in the role must become knowledgeable about health care policies and regulations—so that they can successfully help advocate for reform of these policies and regulations. As advocates, these physician leaders must possess strong interpersonal and communication skills that enable them to be persuasive in promoting needed reform.

The attention of most physician leaders who serve in an activist role is directed toward individual rights. Physician activists and other representatives of the Advocacy Culture provide an invaluable role to the social systems they serve by seeking to ensure the equitable distribution of resources critical to the pursuit of health—or (more broadly) life, liberty, and the pursuit of happiness. Physician activists and other members of the Advocacy Culture find meaning primarily in establishing equitable and egalitarian policies and procedures regarding the distribution and use of healthcare resources within all societies.

Members of this culture emphasize negotiation and compromise, the establishment of solid power bases, the forging of alliances, and the provision of convincing evidence for their points of view. Any organizational strategy that is to be accepted by this culture must address the anxiety associated with social disruption and must take into account politically based strategies. Members of the Advocacy Culture encourage fair bargaining among constituencies with vested interests that are inherently in opposition. These conflicting constituencies might be management and staff, or, at a broader level, the healthcare institution and potential healthcare consumers. Advocates tend to hold assumptions about the ultimate role of power and the frequent need for outside mediation in a viable healthcare system. Most importantly, the Advocacy Culture usually has served as a counterpoint to the Managerial Culture and (to a somewhat lesser extent) the Professional Culture. Fundamentally, the Advocacy Culture and

physician activists have served as a critical bulwark against restricted access, inadequate quality of healthcare service, and inequitable treatment of healthcare workers.

Pioneer Leader/ Alternative Culture

The fourth leadership type identified by McKenna and Pugno concerns the role played by physician leaders as "pioneers." Focusing on medical advances, inventions, and innovations in clinical settings, the pioneer is likely to focus on accelerating discovery in the healthcare world. According to McKenna and Pugno (2006, p. 94):

> Physician leaders who serve as pioneers—champions of change, advocates for the adoption of new innovations—are experts in anticipating future implications of present realities, and guiding the discovery, invention, dissemination, and acceptance of new drugs and devices, new practices, and procedures that create new possibilities for professionals to diagnose, treat, and manage the patients they serve.

The interests and activities of pioneer leaders are usually not confined to a specific healthcare system. They like to see new perspectives and practices being diffused throughout the healthcare community. Ideas are not to be kept in organizational or disciplinary silos. The key focus of those serving in this expert role is the achievement of medical advances in their field of specialization—or even in other fields both inside and outside the medical domain. Those physician leaders who serve in the role of pioneer must acquire or generate cutting-edge knowledge in their area of interest and commitment. They must also become skillful change agencies and learn how to effectively intervene in a system to bring about change and improvement.

A broad perspective is required when one is a pioneer exploring a new territory. One must be aware of everything that is moving and acting in this novel environment. Ultimately, the goal of a pioneer is wilderness survival in the midst of discovery. This is certainly the case for physicians who serve as pioneer leaders. They are working on behalf of new healthcare perspectives and practices while seeking to keep their innovation alive and well—on behalf of the life and wellness of the patients they are serving. In alignment with this commitment of physician pioneers, other members of the Alternative Culture similarly tend to view health care as a process that should sustain and enhance life. Unlike members of the Professional Culture, those who are most aligned with the Alternative Culture tend to think of disease in direct contrast with a well-lived life. The alternative perspective concerns not the fact that dis-ease inevitably comes with a life that is out of balance. Members of this culture are most afraid of being seen as quacks or judged to be crazy, wicked, or foolish.

The Alternative Culture inevitably creates and needs a community of believers. Whether this is a Tai Chi club, a group of people dedicated to eating a particular diet, or an institution formed around a set of spiritual beliefs, there is a clear set of beliefs and a community that provides support. Members of the Alternative Culture focus on the retention of flexibility and the promotion of continuing dialogue and innovation, while also demonstrating thoughtfulness and credibility in a still-skeptical outer world. McKenna and Pugno (2006, p. 94) offer a telling observation about the challenges and opportunities faced by pioneer leaders:

> Many physicians, in fact many people in general, find rapid change unsettling and sometimes quite stressful. But disequilibrium can also be a good thing. . . . [D]isequilibrium can be a catalyst for positive improvements to come about. Without disequilibrium, most of us would become too entrenched in the status quo to take risks and consider fundamentally new perspectives or, as some would say, to "think outside the box.'

The inevitable disequilibrium also requires the pioneer to create or find a community of believers who provide both support and guidance. It is not advisable for any pioneers to "go it alone." Collaboration and the honoring of diverse resources are prerequisites for viable and successfully sustained innovation.

Perhaps in part because of the disequilibrium, the Alternative Culture has always played a marginal role in the North American healthcare system. The "pioneering" villages have been populated by faith healers, herbalists, and foreign-trained practitioners of ancient healing arts. Alternative healers have operated spas, provided massage, and offered televised instruction regarding new models of health and happiness. Some of these practitioners have been charlatans, while others have been visionaries and insightful innovators—including pioneering physician leaders. Alternative healers and their often-controversial methods have usually served as counterpoints to the dominant medical orthodoxy of their time. Much as the Advocacy Culture stands in opposition to the Managerial Culture, the Alternative Culture stands in opposition to the Professional Culture. Both the Advocacy and Alternative Cultures find that their *raison 'd-etre* is based on this opposition.

Specifically, alternative medical practices have often been set against those medical practices that are represented in and by the Professional Culture and, to a varying extent, also represented in and by the Managerial Culture. When we move past this theme of contention and anti-establishment opposition, we discover that alternative practitioners—and pioneer physician leaders--find meaning primarily in formulation of new programs and activities. Meaning is particularly centered on innovative programs that provide comprehensive healthcare that crosses traditional healthcare boundaries. It is assumed in the Alternative Culture that a patient's community and support systems can be engaged to make a difference in how the patient copes with illness and creates health. Those medical practitioners aligned with this culture focus on empowering each individual to find and understand what illness, death, and pain actually mean for them. Alternative practitioners encourage their patients to listen to their own voices and create their distinctive mode of healing and health.

In recent years, with the introduction of the Internet Revolution in all late 20th Century and early 21st Century societies, we have witnessed the emergence of a new culture in healthcare systems – and in virtually all sectors of society. Elsewhere (Bergquist and Brock, 2008; Bergquist and Pawlak, 2008) I have labeled this *the Virtual Culture*—with its primary characteristic being the boundary-shattering access of most people to information and relationships that are not constrained by either distance or time. In these publications, I have also suggested that another culture has emerged. *The Tangible Culture* serves as a counter to the Virtual Culture, much as the Alternative Culture serves in opposition to the Professional Culture, and the Advocacy Culture serves in opposition to the Managerial Culture. Each of

these cultures has attracted physicians and has provided a platform for physicians to serve in new leadership roles.

Emergent Culture One: Virtual Culture

The Virtual Culture has produced the role of Virtual physician-leader. This person now serves as a leading proponent of digitalized medical records, computer-aided medical treatments, and (more recently) the use of Artificial Intelligence (AI) in all medical services. The Virtual world exists at a distance from the actual provision of medical services. As in the case of those operating in the Advocacy and Alternative Cultures, residents of the Virtual Culture operate outside the boundaries of a specific institution. This culture actually has shattered most of the institutional boundaries, as well as the boundaries that exist between medical specialties. Peter Geerlofs, MD, one of McKenna and Pugno's (2006, p. 100) frequently cited physician leaders, offers an expansive vision that results in large part from the introduction of new communication technologies:

> Even with managed care and the advent of large practices and IDNa, healthcare remains largely a cottage industry—with each organization or clinic operating as though it were an island. Physician leaders must help physicians grasp how infinitely better healthcare could be if we changed our minds and decided to operate as regional and national teams on behalf of our mutual customer—patients!

While Geerlofs' 2006 observations might seem a bit dated now, given the even greater impact of the Virtual Culture on the structure of healthcare organizations, there is still the sense that healthcare organizations operate as islands—thanks in part to the pushback by those aligned with the Tangible Culture.

More broadly, those involved in the emerging Virtual Culture find meaning in their work when answering the challenges of vastly expanded and accelerating knowledge generation and the growing capacity to disseminate medically related information. Those aligning with this culture tend to value the global perspective of open, shared, responsive information systems. These cutting-edge leaders are often identified as (and identify themselves as) "Geeks." While they offer important new perspectives and practices, these physicians rarely are viewed as "leaders" in their health care system. We return to the observations made by Peter Geerlofs (McKenna and Pugno's (2006, 97):

> "Geek" physicians who love technology aren't always the best leaders to help an organization transform. The nature of early adopters is that they are sometimes more interested in the technology itself than the transformed processes the technology could enable. They tend to quickly move from one new technology to another, never pausing to discover what it could do for the organization.

A more charitable interpretation of the "geek physicians" move from one technology to another is that they are looking for the "technological fix." Where is the technology that will solve our swirling VUCA-Plus challenges? More generally, Virtual physician leaders and others affiliated with the Virtual Culture hold untested assumptions about their ability to make sense of the fragmentation and ambiguity that exists in the postmodern world of VUCA-Plus. They conceive of their healthcare institution's enterprise

as linking its informational resources to global and technological resources thus broadening the global healthcare network. Somehow, this linking and new related technologies will make our world safer, healthier—and perhaps a bit more sane!

As representatives of a newly emerging culture, those aligned with the Virtual Culture have had to find good reasons for the existing cultures of health care to offer support for this new set of perspectives and practices. Links to other cultures have been established (or at least promoted) that tend to be aspirational. Those who promote the use of new, virtual technologies speak of how it enhances existing clinical practices (the professional Culture) and helps to reduce the drudgery of administrative paperwork (Managerial Culture). New technologies are also offered as ways to deliver new forms of medical service (Alternative Culture), while being presented to those in the Advocacy Culture as a way to increase access of populations throughout the world to medical services.

Peter Geerlofs offers one example of the benefit derived from a new technology (McKenna Pugno, 2006, p. 99):

> Rick O'Neil was a physician leader in a medium-sized internal medicine practice. . . He began wondering what constraints and bottlenecks were typical in the medical practice of internists and what might be done about them. He recognized that the most expensive resource is the clinician, but they often spend their time doing work which lower paid staff could do just as well [or AI could now do.] So using process re-engineering and information technology, he completely redesigned his practice. The last time we spoke, the group of internists at his practice were seeing almost 40 patients per day, patient satisfaction was never higher, and his physicians were happy, didn't feel overworked, and were getting home at a reasonable time every night.

Emergent Culture Two: Tangible Culture

It is not surprising that a reactive Tangible Culture emerged given the swirling emergence of "alternate realities," robotic relationships, and even the introduction of AI "assistants" to surgeons, psychiatrists, and a host of other healthcare providers. It is no wonder that a counterculture has emerged that reasserts benefits accruing from "real" relationships, enduring values, and brick-and-mortar institutions. Those who align with this culture assert the power of continuity. Like those in the Professional and Managerial Cultures, those in the Tangible Culture operate within the boundaries of their specific institution. In fact, they promote and reinforce these boundaries and the distinctive identity of their healthcare institution even more than those in the Professional Culture or Managerial Culture.

These traditionalists find meaning in the roots of health care – Hippocratic Oath and all. Integrity is all important in the Tangible Culture. McKenna and Pugno (2006, p. 134) contribute their own thoughts about the role played by integrity within the traditions of healthcare:

> Integrity is essential for success as a physician leader. Other words, such as "trustworthiness" or 'High moral values" may be substituted, but the point is that integrity is consistently identified as the number one reason why an individual is considered capable of leadership. Integrity is the number one reason why others will follow someone.

With integrity as the foundation, those aligned with the Tangible Culture find meaning and purpose in establishing and maintaining healthy "trustworthy" communities. Furthermore, they often look for and appreciate the spiritual grounding of these communities. McKenna and Pugno (2006, p. 151) comment on this spiritual orientation:

> While physicians' religious backgrounds are, of course, as diverse as those of the patients they treat, most physicians share a deep regard for the sacredness of life. And for many, that includes a respect for patients' spiritual condition, as well as their physical and emotional health status.

Thus, for McKenna and Pugno, this spiritual orientation—which stands hand-and-glove with integrity in the Tangible Culture—leads not only to support of a spiritual foundation in the healthcare communities they join and the sense of being engaged in a "sacred" pursuit as a health care provider but also an appreciator of their patient's spiritual life.

Even more broadly, tangible-oriented physician leaders cherish the predictability of a value-based, face-to-face encounter with patients. While the Virtual Culture operates at a distance from the patient (a distal perspective), the Tangible Culture operates at a close personal level with the patient (a proximal perspective). Wearing the traditional uniform (white coat and stethoscope, or colorful smock or scrubs), the tangible physician leader prefers (usually requires) that their patients always come to a specific physical location—usually the physician's office. As a rule, they also insist on being called "Doctor" rather than being called by their first or last name. These healthcare leaders often hold untested assumptions about the ability of old systems and technologies to address current healthcare challenges. In the role of teacher, supervisor or mentor, the tangibly oriented physician leader looks forward to instilling long-standing caring values in newly minted physicians. Ultimately, their institution's chief enterprise is to honor a fundamental medical legacy: abate illness and heal wounds.

In some ways, the Tangible Culture is the oldest of all healthcare cultures' however, it operated in a very tacit manner being just the "given way" in which those working in healthcare thought of their work. After all, healthcare has been around in some form as long as humans have been ill or wounded. Nevertheless, it is only in recent years that the Tangible Culture has emerged as a distinct entity with its own champions. As is the case with those operating in the Virtual Culture, those who helped to reinforce the Tangible Culture needed to find ways to form alliances with the existing cultures. The alliances that have been formed tend to be appreciative (Bergquist, 2003; Cooperrider and Whitney, 2005). The Tangible Culture is not in the business of helping to improve the functioning of the other cultures (an aspirational perspective); rather, the Tangible Culture is intended as a vehicle for acknowledging and honoring (appreciating) the contributions being made presently by the other four cultures. The only "improvement" to be made is ensuring an allegiance with those in the other four cultures (particularly the Alternative and Advocacy Cultures) who reside in the institution where they are all operating.

Those aligned with the Tangible Culture do offer a cautionary note: changes to be made must be carefully considered before being implemented. Furthermore, these changes must be introduced gradually in a manner that does not disrupt existing perspectives and practices that are "doing just fine." Those physicians aligned with the Tangible Culture are particularly resistant to recommendations

regarding change offered by those who reside "outside" the medical community. One of McKenna and Pugno's (2006, p. 132) physicians put it this way:

> Docs want someone who understands our world and sets an example. We're turned off by platitudes—like business management fads. For example—'promoting excellence' is receiving a lot of attention. Most docs feel excellence is core to their profession, so for an outsider to push it as a 'new initiative' seems silly to us. Physicians are pretty hard on themselves and our leaders. We expect a very high level of integrity [Randall Oates, MD, Family Physician, President of Doc, Inc.]

As is the case with those in the Tangible Culture (and Professional Culture) in many other sectors of mid-21st Century societies, there is not much tolerance for faddish notions introduced by "outsiders" regarding healthcare operations. It's almost as if sacred space has been invaded!

Conclusions

A clear message regarding physician leadership is being conveyed by McKenna and Pugno. They focus on competencies, character, and culture. There are certain basic competencies that a physician needs if they are to be effective leaders – and these competencies are not necessarily the same as those required to be effective providers of medical services. The character of a physician leader also seems to be of great importance—especially given the trust that patients and the general public have traditionally placed in not only the competence of physicians but also their intentions.

Given the wrenching of healthcare priorities away from healing to profitability, physicians must remain committed to core values. This commitment must be sustained in the face of growing pressures to be accountable to a bottom line rather than patient welfare. This is where character comes to the fore. Words such as integrity, trustworthiness—and even courage—come to mind when considering the nature of effective physician leadership.

Then, there is the matter of culture. Leadership is not engaged in a vacuum. It occurs within and is strongly influenced by the culture(s) that influence (and even dictate) the perspective and practices of those working in this culture. Physicians are often the powerful carriers of culture in a healthcare organization. A physician leader can swim against the strong current of the dominant culture in the organization where they chose to lead; however, this oppositional physician leadership is exhausting and usually unsuccessful. A burned-out leader and alienated membership typically are left on the battlefield at the end of a contentious engagement.

I am not leaving behind the critical interface between leadership and culture as I move to the next essay in this series. I turn to physician leadership competencies and character as they relate to the five basic leadership practices identified by Jeannine Sandstrom and Lee Smith (Sandstrom and Smith, 2017). Each of these practices relates to specific leadership functions that often are required in certain sectors of a healthcare system—and are served most effectively in specific healthcare cultures.

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