

Learning to Lead in Health Care:
A Narrative Inquiry of Physician Leadership

by

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A thesis submitted to the Nova Scotia Inter-University Doctoral Administrative Committee
and the Mount Saint Vincent University Faculty of Graduate Studies
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Educational Studies

Halifax, Nova Scotia

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Abstract

Active physician leadership within health care organizations can shape the way health care is delivered and contribute to improving and strengthening the system. Yet physicians often struggle to be effective in organizational leadership positions due to lack of leadership experience and the preparation that helps develop requisite competencies and skills. Informed by a qualitative narrative approach, this doctoral study explores the question of how physicians who transition into formal leadership positions learn to lead.

Twelve physician leaders based in Halifax, Nova Scotia, were interviewed to gain their perspective on this particular adult learning experience. Categorical content analysis was applied in a multi-stage coding process that yielded four main themes: professional identity, organizational culture, workplace context, and leadership learning, along with relevant sub-themes. Communities of practice, organizational learning and transformative learning theories served as a theoretical framework to inform the analysis.

Findings illustrate that the reality of formal physician leadership in health care organizations is ill-matched to the core values and professional identities of doctors. Physicians move along a path through a social learning landscape, negotiating a sense of identity that spans multimembership in different practice communities. For some, the product of this cross-boundary learning is the creation of a superordinate leader identity. For others, it seems to be the understanding and appreciation of a dual identity — physician *and* leader — the relative importance and weight of each varying over time and context.

This study emphasizes that physician leadership development can be enhanced by attending more explicitly to *how* people learn and, concomitantly, supports the assertion

that adult education theories and practices can make a significant and valuable contribution to enhance leadership development in medical contexts.

Dedication

It is with tremendous pride that I see myself as a reflection of my parents. This doctoral achievement is dedicated to my mother, Marilyn Therese Boyle, and to the loving memory of my father, Ronald Leonard Jolemore. Thank you for crafting a childhood that nurtured and promoted my intellectual curiosity and helped me to develop a love of learning that continues to this day.

Acknowledgments

This journey could not have been completed without the assistance, encouragement and support of a number of people to whom I am sincerely grateful. I would like to use this opportunity to thank these individuals.

I am deeply indebted to my partner, Tracey and our young son, Maxwell. You both provided me with a supportive environment to do this work as well as a haven of escape from it. Thank you, Tracey, for your love, patience, and for always reminding me that I could do it. And to Max: May you never lose your already remarkable self-confidence and enthusiasm for learning. Continue to ask questions, reach for the highest goals, and become everything you can be!

Much gratitude to my doctoral supervisor, Dr. Patricia Gouthro. Your dedication, encouragement and guidance helped to keep me focused and to learn so much about myself and my abilities. Thank you for sharing your knowledge with me. Many thanks also to my committee members, Dr. Donovan Plumb and Dr. Robert White, who always found time to discuss my process and provided me with important and meaningful insights that led to new perspectives and kept me moving forward.

Thank you to Ruth Ann Brown for always making time for me any time I would show up at the doctoral program office with a “problem” or just to check in.

Thanks also to my valued colleagues Chelsey Millen and Lorie Campbell for listening to me ramble on at the office about my research and for always providing genuine feedback. Special thanks goes to Chelsey for providing skillful copy editing, proofing and formatting support.

Finally, I wish to acknowledge the physician leaders who gave of their valuable time in order to participate in this study. You are all personally and professionally committed to providing the best in health care to benefit the many patients, families and communities of Nova Scotia and beyond. This work would not be possible without your willingness to share the stories of your experiences with me. I have learned so much from you all.

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Chapter 1: Introduction

Introduction

In the Canadian health care system, provincial governments are responsible for setting strategic policy direction, priorities, and standards for the health system, and ensuring accountability for funding and for the measuring and monitoring of health system performance. Regional health authorities operate at arm's length from government and are responsible for determining health service priorities through engagement with the communities they serve, and delivering those health services while allocating resources appropriately. Within this context, medical doctors have an important role to play as leaders as well as direct care providers. Physicians play a critical role in the delivery of health care; they direct, coordinate, advocate for, and deliver health care across the entire spectrum of patient care and population health. Physician leaders are strong advocates for high-quality patient care, and provide a necessary perspective to their administrative-leader counterparts, who often are not health professionals.

Stoller (2008) argues that leadership is different from clinical practice and requires that physicians develop a different skill set from that learned in medical school. However, there are few formal opportunities for physicians to engage in leadership learning until they have actively taken on leadership positions.

This dissertation addresses the question of how physicians who transition into formal leadership positions within the health care system learn to lead. Following a qualitative narrative inquiry approach, I use the first-person accounts of leadership learning experiences from twelve physician leaders in an academic health sciences centre. It is important to obtain insights directly from medical practitioners by interviewing them

to discover their personal insights and wealth of lived experiences. I draw upon communities of practice, organizational learning, and transformative learning theories as a theoretical framework to both set the background and inform the analysis as I explore the physician perspective on this particular adult learner experience. The findings of this study support the assertion that adult education theories and practices can make a significant and valuable contribution to enhance leadership development in medical contexts.

Statement of the Problem

When physicians actively and effectively participate in leadership roles they can improve health care system quality outcomes (Canadian Medical Association, 2012; King's Fund, 2012; Goodall, 2011; Snell, Briscoe & Dickson, 2011; Dickinson & Ham, 2008). However, "physicians are trained as professional experts who fulfill a role in direct and immediate patient care" (Snell, Eagle, & Van Aerde, 2014, p. 331), infrequently integrating themselves into administrative structures to improve the "system" (Baker & Denis, 2011). Moreover, physicians often struggle to be effective in formal leadership roles due to lack of leadership experience and the preparation that helps develop requisite competencies and skills for management or organizational leadership positions. Dubinsky, Feerasta, and Lash (2015) offer the explanation that

historically, physician leaders have either been co-opted to the role (in some cases) or selected because of their excellence in domains such as their academic achievements or their clinical expertise. While these experiences are valued, it is felt by many healthcare organizations that they are insufficient to ensure that

physician leaders have the necessary knowledge and skills to ensure the organization optimizes its quality, fund raising and other initiatives. (p. 42)

Much of what physicians bring to leadership comes from their medical training and subsequent clinical experience, however, physicians must develop new skills and knowledge required of successful health system leaders, shifting from an individual patient focus to a broader systems focus. This involves strategic thinking, business planning and results orientation, collaboration, building strategic partnerships, team building and conflict management, emotional intelligence, effective communication, etc. — all of which are addressed minimally, if at all, in medical training.

Thus, physicians are sometimes underprepared for leadership roles in health care, especially as health care systems continue to become increasingly complex and diversified. As a result, they enter into medical leadership with little or no formal preparation or orientation and, argue Baker and Denis (2011), without the necessary knowledge and skills to fulfill organizational physician leadership responsibilities or to contribute to health system transformation. Physicians must have the self-awareness to recognize their own skill gaps, and the internal motivation to seek learning opportunities to address them. This can take the shape of formalized training, but more often occurs through a variety of non-formal and informal means. In addition, the health care system needs to provide educational supports and modify system structures to support the leadership roles that physicians are expected to fulfill. Through employing adult education theories and practices, organizations can create an environment in which meaningful leadership learning can occur.

Background/Significance

The need for stronger leadership for the Canadian health care sector to adapt and grow into the future has been articulated by individuals and health agencies across Canada. Strong leadership is needed if the system is to be sustainable and responsive to the health needs of Canadians into the future (Dickson, 2007). The importance of active physician leadership within health care organizations is also well established (Baker & Denis, 2011; Spurgeon, Mazelan, & Barwell, 2011; Weiss, 2011). “Medical leadership is seen as a key ingredient bridging the clinical and the managerial world that structures the day-to-day functioning of health care organizations” (Baker & Denis, 2011, p. 360). Physicians themselves also recognize this need. While working in continuing professional development in the health care system, I frequently heard physicians articulate an awareness of their unique opportunity to shape the way health care is delivered and to contribute to improving and strengthening the system.

While there is a substantial body of literature on leadership and management development, limited studies have included an exploration into the lived experience of leaders or the experience of learning to lead in a health care setting. Little is known about the experience of transitioning from practising medicine (or another clinical discipline) to practising leadership in a management role. We also know very little about the meaning associated with such a shift or the critical learning elements required to enable a successful transition.

Both anecdotal and published data show that most leadership education fits into a traditional professional development model that is frequently didactic in nature, and often informed by business/management theory, which tends to be more focused on describing

outcomes versus looking at the complexities of how people engage in critical learning processes that may lead to significant learning/transformation. Medical leadership development can be enhanced by attending more explicitly to *how* people learn and, concomitantly, to valuable learning theory orientations such as communities of practice and transformative learning. Therefore, it is essential to focus on the actual process of how learning can be fostered and to map out strategies to support learning and development for other physician leaders.

At the time of this research study, my employment involved developing continuing professional development programs in leadership and management topics on behalf of a regional health authority. Specifically, I helped physicians identify, develop, and enhance leadership qualities and skills through facilitating self- and 360-assessments, development planning activities, and various educational workshops. Also, within my leadership development team, we provided access to online leadership learning resources and customized, one-to-one sessions with an executive leadership coach. The goal of this work was to provide emerging and formal physician leaders with resources and supports to improve their leadership effectiveness to respond to system challenges in order to improve the quality of patient care.

Since my background is in education rather than medicine, I was well positioned to help these highly skilled medical professionals develop leadership capabilities by drawing upon the research and theories offered by other disciplines that can inform better management practices. My background in adult education and lifelong learning exposed me to major research areas and theories that can add insight into the workplace learning of professionals. These include the assumptions of andragogy (i.e., the method and

practice of teaching adult learners) as presented by Knowles (1984), Mezirow's (1991, 2000) transformational learning theory (i.e., adult learning that involves an activating event to challenge learners' assumptions and advance developmentally through the use of critical reflection), communities of practice theory (Lave & Wenger, 1991; Wenger 1998) (i.e., social learning situated in a particular practice community), and also more critical theoretical perspectives that critique social conditions (e.g., unjust dominant ideologies) and analyze learning dynamics and environments (Merriam & Bierema, 2014).

Over time I began to wonder: Does learning to be a physician leader involve specific kinds of learning? While there is a substantial literature on leadership, including within the health care sector, there is a dearth of research on the leadership learning process of health care leaders themselves. What is that experience like? What does it look like, feel like? Are there moments of existential crisis? I was also focused on practical concerns such as: How well are medical leaders prepared to take on the responsibilities of leading or coordinating health care units that involve overseeing/managing other professionals? What can educators in roles such as mine do to provide training that will facilitate the development of important leadership skills?

This curiosity translated into a qualitative research study exploring physicians' personal experiences of learning and how these contributed to their leadership practice (and the process of transitioning into a leadership role). This study informs education in health care on many fronts including: knowledge, practice, policy, and action.

Knowledge. This study offers insights into the nature of medical leadership and its associated challenges as well as providing scholarly insights informing both adult learning and leadership theory. Adult learning theory is an important factor in the

leadership development equation; however, there appears to be little leadership development research focusing on physician or health care leadership that intentionally incorporates adult learning theory. It generally receives only a cursory mention in the literature. For example, Goleman, Boyatzis, & McKee (2002) suggest that leadership development initiatives should be “based on the principles of adult learning and individual change” (p. 234) but do not expand beyond that. Furthermore, much leadership research in Management/Business or Human Resource Development usually focuses on *what* leaders learn, while this study adds to knowledge on *how* leaders learn. To better support leadership development, deliberate efforts should be made to support adult learning in ways consistent with the precepts of adult education theory.

My research provides an opportunity to foster critical and important learning opportunities at the intersection of medical leadership and educational studies, connecting two disparate bodies of scholarly knowledge in a medical/health care context, elucidating this particular adult learning experience and offering insights into the process of learning to lead. It is also framed in a lifelong learning context, recognizing that much important learning occurs outside of formal education.

Practice. I am also interested in practical concerns, such as: How well are medical leaders prepared to take on the responsibilities of leading or coordinating health care units that involve overseeing/managing other professionals? What can educators working in the health sector do to provide training that will facilitate the development of important leadership skills? Frequently used models for leadership development in the Canadian health system, such as the LEADS in a Caring Environment framework, focus on aspirational capabilities a leader should possess, the *what*, but not on *how* leaders learn

those capabilities. A number of learning strategies have emerged through participant data collection offering insights into participant experiences and perceptions on leadership learning and the specific processes of learning involved. This information can assist adult educators and leadership development practitioners in their efforts to better design learning interventions and other workplace supports that have maximum impact for and capture the interest of adult learners. I am confident that my findings will be of particular interest to health care organizations that want to improve the effectiveness of learning interventions designed to support leadership development for physicians and other formal leaders in the health care sector.

Policy and action. Finally, in terms of policy and action, findings can contribute to the literature used to inform frontline changes in the design and development of leadership learning and development to support medical leadership. This study draws focus to necessary changes needed to incorporate talent management, succession planning, and recruitment and retention of physician leaders. I argue that changes should include implementation of formal policies by regional health authorities for orientation, onboarding, and mentoring programs for new physician leaders. I was honoured to explore and learn from the lived and told stories of participants. The insights from these stories will inform recommendations that can foster improved educational contexts for physicians in health care leadership positions.

Purpose of the Study

The objective of my research study was to explore how leadership learning takes place in the health care workplace, gaining insights through physicians' own accounts of learning experiences and how these contributed to their leadership practice (and the

process of transitioning into a leadership role). Through hearing their stories I sought to develop a better understanding of both the personal learning processes as well as the contextual influences that surround leadership learning in health care settings.

Research Questions

The study aimed to answer the central research question: What is the process of learning among physicians who transition into formal leadership positions?

Sub-questions include:

- What types of leadership learning experiences do formal physician leaders have (both the explicit and tacit dimensions of learning)?
- What particular learning experiences (and contexts) do formal physician leaders perceive as helpful in developing leadership?

Defining Physician Leadership in the Context of this Study

It should be noted that the use of the term “leader” or “physician leader” throughout this dissertation refers to physicians in formally designated leadership positions. These positions are also described as “formal” leadership roles, given they are assigned based on the authority of a formal position/role.

In Canada, there is much variety in how physicians provide services to the public. The majority of physicians are private, independent contractors who provide insured medical care services in accordance with their respective provincial or territorial health insurance plan. Depending on their licensure and area of practice these services can be provided in a private office or publically funded setting such as a hospital or any other type of health care facility operated under provincial or territorial jurisdiction. In this context physicians can either bill the provincial medical insured services plan directly for

the services or may enter into various alternative compensation arrangements with provincial governments and health care organizations depending on volume and type of service or health system need. This, argue Van Aerde and Dickson (2017) in a white paper from the Canadian Society of Physician Leaders, can be “inconsistent and disorganized” as “the different types of relations are invented province by province or region by region, sometimes with involvement of government and/or the medical association. In many instances, these relationships are negotiated ‘one-off’ by the individual physicians themselves” (p. 12).

Much like the varied clinical arrangements, the current state of physician leadership in Canadian health care organizations can also vary. There is much disparity in leadership roles, responsibilities, remuneration, time allocation, and contracts. The setting for this study was a mid-sized academic health sciences centre with over 12,000 employees, physicians, and learners in the central zone of the Nova Scotia Health Authority located in the Canadian city of Halifax, Nova Scotia. All participants held leadership roles within the health sciences centre. Most participants were late in their career and held senior-level, formalized leadership positions. Roles/position titles of participants included *medical director*, *chief* and/or *head* of department/division, and *senior medical director*. Most of these positions are constituted in the medical staff bylaws of the organization such as the chief/head role, or were created and integrated into the formal leadership structure of the organization to lead specific portfolios (e.g., senior medical director). The position of department chief/head has an added complexity in that it is a cross-appointed position with the faculty of medicine at the local university, so this role comes with a dual reporting and accountability relationship to the two organizations.

Each of the aforementioned leadership positions has a formalized contract and position description outlining the specific responsibilities and accountabilities of the role. All but two physicians in this study were contracted by the health authority or university for a portion of their time to function in these leadership roles, yet also maintained a medical practice providing patient care. Most often, the ratio of leadership time to clinical time for each position is negotiated between the physician and the organization or university and is largely determined by the scope and deliverables of the leadership role.

Alternatively, physicians sometimes take on less formal leadership positions. Physician departments in academic health centres typically create department-specific leadership roles to ensure a certain level of quality and service provision within the specialty area. These positions are often given to emerging or other senior physicians and the two aforementioned doctors were in such positions (e.g., *director* of a program or service).

Overview of the Dissertation

This section will provide an overview of the content of each chapter in this dissertation. In Chapter 2, I introduce the concept of continuing professional development (CPD) as the predominant approach to educating physicians in leadership and skill development. I discuss the related concept of continuing medical education (CME), and how both CPD and CME tend to focus on formal and structured methods of learning. I present the relevant theories about informal learning and the workplace context, including experiential learning, reflective practice, and situated learning in communities of practice, and their importance to adult learning processes. I then review the literature specific to leadership and leadership development, including leadership theories and competencies

such as those in the LEADS in a Caring Environment framework, as well as leadership competencies specific to physicians. I describe the importance of transformative learning in connection to adult education and more specifically, to leadership learning. I introduce the broad concept of professional identity, and relate how the physician professional identity is shaped by the strong professional subculture within medicine. I then provide an overview of the leader identity and the importance identifying with the leader role has to successfully performing that role. I summarize the power that organizational culture and the unique composition of subcultures that exist in health care organizations have in influencing the ways in which physicians buy in to the leader identity. Finally, I highlight the differences between two major interacting subcultures within health care organizations, namely physicians and managers.

In Chapter 3, I describe the methodology used for this study: a qualitative narrative approach. I outline the rationale for this research design, which was to understand the learning process as the participants lived it through their own stories of their experiences. The objective of this study was to understand, describe, and analyze physicians' stories of lived experiences of learning over time, and the qualitative narrative methodological approach allowed me to do so. I relate how this approach has been used to study other topics within the field of adult education, and why it makes sense to use narrative inquiry to learn more about personal learning experiences in the context of adult education. I then describe the site and population of interest for the study, the recruitment process for the twelve study participants, and the demographics of the participants. I detail the qualitative interview data collection process as well as the analysis and interpretation stages, including an overview of coding strategies, and the use

of memo writing and field notes. I present the approval of research ethics boards and the gathering of informed consent from participants themselves. I analyze the risks and benefits to study participation, and describe the handling of research data.

Chapter 4 presents the research findings resulting from the study. The data analysis stage identified four main themes in the learning process of physician leaders: professional identity, organizational culture, workplace context, and leadership learning. These themes further break down into sub-themes, which are discussed in detail in this chapter. The theme of professional identity in this context includes the characteristics of individual autonomy and self-reliance, being a medical expert, problem solving, and a patient-centric focus. Organizational culture, which emerges as a barrier to physician leadership success, showed up in the data as conflicting priorities, lack of time and financial support, and inadequate administrative structures. Learning within the workplace context included observational learning, learning from experience, informal mentoring relationships, and coaching. The final theme, leadership learning, represents the capacities described as necessary to succeed as a physician leader, and included a learning orientation, self-awareness through reflective practice, systems thinking, and collaboration. These direct insights from participants could provide guidance for those developing leadership development supports for physicians and are a practical outcome of the study. Themes will be discussed further Chapter 6 in terms of recommendations for future policy and practice.

Chapter 5 provides a discussion of the findings of this study, expanding on how the four themes and their respective sub-themes interact with each other to create the conditions for learning leadership. The discussion provides an interpretation and analysis

of the data in connection to the published literature. I draw principally upon theoretical perspectives on situated learning theory pioneered by Lave and Wenger (1991) and Wenger (1998) including learning through legitimate peripheral participation in a community of practice as part of identity negotiation and construction. Additionally, I relate the physician leadership to trajectories of participation, learning through and across boundaries, and managing multimembership in and accountability to different communities of practice in a larger landscape. I then explore Mezirow's (1991, 2000) conceptualization of transformative learning, and his main theoretical concept of perspective transformation fostered by critical reflection in order to examine physician leadership learning as an individual transformative trajectory across a complex landscape.

Chapter 6 concludes the dissertation with study implications, limitations, and recommendations for future research in educational studies and lifelong learning and also for policy and practice. The recommendations for future research include specific follow-up topics, highlighting aspects of some subjects which were merely uncovered within the scope of this research. The recommendations/implications for policy and practice include several suggestions for improving leadership learning in a health care workplace setting. In closing, I offer my own perspective on the value of the contributions made by this study, and of the importance of physician leadership for improving health care systems in Canada.

Chapter 2: Literature Review

Introduction

In this chapter I provide a brief summary of pertinent literature to situate and support this research study. I begin with a discussion of continuing professional development (CPD), as this is currently the predominant approach to education to support leadership and skill development amongst physicians. In the next section, I discuss the business and management literature on leadership and leadership development, including the focus on leadership competencies, which often informs current medical education and leadership-related development. I then provide a brief overview of relevant adult education/learning literature that offer insights into leadership learning. In the two sections of the literature review I look at professional identity and organizational culture, both of which set the context for where and how leadership learning occurs and may help us to better understand the learning processes of leaders in health care.

Continuing Professional Development in Health Care/Medicine

Continuing education or continuing professional development (CPD) is the current term used in literature and practice to denote the (usually formal, planned, and deliberate) process of the ongoing education and development of health care professionals. Although it “conjures the image of a large group session held in a hotel or conference setting” (Davis, Davis, & Johnson, 2013, p. 163), CPD refers to “an array of educational activities that health professionals undertake to maintain, develop, and enhance the knowledge, skills, professional performance, and relationships they use to provide care for patients, the public, and the profession” (Sargeant, Borrduas, Sales,

Klein, Lynn, & Stenerson, 2011, p. 167). An Institute of Medicine (2010) report defines CPD as “the system for maintaining, improving, and broadening knowledge and skill throughout one’s professional life” (p.18) and specifies that CPD focuses on promoting effective practice and effecting practice change. Continuing medical education (CME) is a related but not synonymous term that is commonly used in health care. Described as a “gestalt of short courses” (Davis & Davis, 2009, p.113), CME “credits” are a form of clinical update focusing on the skills and knowledge directly related to improving medical expertise (Peck, McCall, McLaren, & Rotem, 2000). CPD is considered to be a broader approach to professional development than CME, seeking to achieve more than just a clinical update. CPD can also encompass content such as interpersonal and communication skills, problem solving, self-directed learning, practice management, patient advocacy, and/or team-building skills, in addition to pure medical expert content (Peck et al., 2000; Institute of Medicine, 2010). These are all skills that may be useful learning opportunities for physician leaders.

As an adult educator I have designed educational interventions for physician leaders myself, and have worked with others in the health care setting to provide education to interprofessional groups. Designing educational interventions is also referred to as “instructional design” and training design and development. People who design CPD are often called instructional designers and professionals in the field usually work with an effective framework for program design and delivery in order to impact learning, performance, and results (Hutchinson & Estabrooks, 2009; Casimiro, MacDonald, Thompson, & Stodel, 2009). In my work experience inside the health sector, there is little focus on instructional design and even less on understanding the processes of learning

and the evaluation/measurement of “effectiveness” of non-clinical instructional interventions such as topics in leadership. Anecdotally, the actual impact of CPD programs in health care may be far less than their potential. Questions remain regarding the effectiveness of methods, models, and frameworks (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006; Hager, Russell, & Fletcher, 2008). I regularly witness the use of traditionally dominant didactic techniques that involve passive instruction, such as reading or lecture, despite the fact that they have been found to have little or no impact on learning outcomes (Bluestone, Johnson, Fullerton, Carr, Alderman, & BonTempo, 2013; Satterlee, Eggers, & Grimes, 2008). Critical reviews of the effectiveness of lectures and conferences have shown that these educational interventions on their own have little impact on changing complex care practices (Davis & Willis, 2004; Forsetlund, Bjorndal, Rashidian, Jamtvedt, O’Brien, Wolf, & Oxman, 2009; Spivey, 2005). Bloom (2005) notes that ineffective means for changing physician practice such as these are also the most widely used, perhaps because they are familiar, convenient, and relatively inexpensive. In my experience, many people who work in education in health care may or may not have a deep knowledge of adult learning theories. Rather than a graduate-level adult education specialization, many educators in health care have solely clinical or technology backgrounds, with some possessing a certificate in adult education. And it may be that the people designing these programs are not as familiar with other educational approaches.

Bluestone et al. (2013) examined in-service training within a health care workforce and they found that effective techniques can lead to improvements in knowledge, skill outcomes, and clinical practice behaviours. Their findings support:

- the use of multiple interactive techniques that help participants process and apply information;
- case-based learning, clinical simulations, practice, and feedback as effective educational techniques;
- repetitive interventions, rather than single interventions to improve learning outcomes;
- simulated workplace environments to improve skill acquisition and performance;
- computer-based learning as equally or more effective than live instruction and more cost efficient if effective techniques are used.

Medical education is very current in terms of these best practice techniques, but this is often not the case in continuing professional development contexts outside of medical schools, or for non-clinical content areas such as leadership and management.

A Cochrane Effective Practice and Organisation of Care Group review by Forsetlund et al. (2009) assesses the effects of educational meetings (i.e., courses, conferences, lectures, workshops, seminars, and symposia) on professional practice and health care outcomes. The authors conclude that educational meetings alone or combined with other interventions can improve professional practice and the achievement of treatment goals by patients, but the effect is small. The review claims that the use of strategies to increase attendance at educational meetings, utilizing both interactive and didactic formats, and focusing topics on outcomes that are likely to be perceived as serious may increase the effectiveness of educational meetings. There is also solid evidence that mixed interactive and didactic education approaches can be more effective

than didactic education alone (Davis & Willis, 2004; Forsetlund et al., 2009; Spivey, 2005).

It should be noted that continuing medical education and other forms of continuing professional development in health care seem to privilege forms of learning and training that are more formal and structured to allow for a planned and deliberate process of instruction. This may not recognize the multiple conditions of learning in the workplace and the unplanned, accidental, and undeliberate learning and development experiences that are significant and frequent. There is a widely held view among practitioners and developers alike that the key lessons of becoming a successful leader are best derived from experience (McCall, 2004). Additionally, formal leaders who have to handle constant interruption and juggle a relentless barrage of demands think and learn in the context of action (Weick, 1983) that involves a variety of situations and context.

Mentoring is one way to learn in the context of action. Mentoring can be defined as “off-line help by one person to another and making significant transitions in knowledge, work or thinking” (Megginson & Clutterbuck, 1995, p. 13), and Billett (2003) claims that learners benefit from workplace mentoring by learning knowledge that would not otherwise be learned alone. Formal mentoring relationships are often assigned relationships, overseen and guided by an employer-sponsored mentoring program. Contrary to that, informal mentoring relationships develop on their own, such as when a person approaches a possible mentor and that person agrees to form a mentoring relationship (Buell, 2004). Baker and Lattuca (2010) advocate, “mentors and mentoring relationships provide career support (sponsorship, exposure and visibility, coaching, protection and challenging assignments) and psychosocial support (sense of competence,

identity and work-role effectiveness)” (p. 810). A systematic review on mentoring in academic medicine by Sambunjak, Straus, and Marušić (2006) showed that mentoring plays an important role in the personal growth and career development of mentees. Specifically, mentoring has an important influence on personal development, career guidance, career choice, and research productivity. Taylor, Taylor, and Stoller (2009) explore mentoring and role modelling in terms of the career development of physician leaders. They offer observations regarding mentoring in physician leadership development:

- Mentorship of physician leaders often occurred through a series of short-term interactions with different individuals rather than through a longstanding, longitudinal experience with a single individual.
- Mentees described their mentors providing emotional and psychological support as the most valued feature of the relationship. (p. 1134)

The apprenticeship model as an educational approach is pervasive in medical education. Mentoring is one of many experiential and informal learning methods that this study may uncover as an essential aspect of the leadership learning process for physicians. New physician leaders can benefit from mentoring relationships with experienced physician leaders whose lived experiences are similar to their own.

Leadership and Leadership Development

The majority of the literature regarding CPD within health care describes educational interventions designed to close the evidence-to-practice gap in various clinical disciplines, with few studies focusing on health care leadership or management education.

Avolio, Reichard, Hannah, Walumba, & Chan (2009) define leadership development as “training or development to enhance an individual’s knowledge, skills, ability, motivation, and/or perceived self-concept to enable them to exercise positive influence in the domain of leadership” (p. 769). A report by the Canadian Health Services Research Foundation indicates “healthcare organizations spend less on formal workforce development and are less effective than other Canadian organizations at developing leaders for the future” (Penney, 2007, p. 2). Hughes and Bloom (2007) report that leadership development programs are less common in Canadian health care organizations as compared to organizations in other industries, “even though health sector organizations have a potentially greater need than Canadian organizations as a whole to develop future leaders” (p. 1). The implication of this is that there is a lack of resources to prepare physicians for leadership roles exactly when strong leadership is necessary if meaningful transformation of the health system is to occur.

Leadership theories and competencies. There is a prevalence of leadership competency frameworks and theories in the leadership literature and within health care; the demonstration of leadership behaviours on-the-job are often positioned as fundamental to achieving organizational goals in a rapidly changing health system. Leadership competency frameworks can serve as a foundation and compass for leadership behaviour in organizations. Competency models describe leadership from a skills perspective and are very common within the disciplines of Business, Management, or Human Resource Development versus Adult Education and focus on the description of specific skills and abilities rather than learning processes. Within my health care organization, and beyond into the provincial and Canadian health sectors, the

expectations of “leadership” are often wrapped up in transformational leadership theory (Burns, 1978; Bass & Avolio, 1997; Bass & Riggio, 2006) and specifically articulated through competency models such as LEADS in a Caring Environment (Canadian College of Health Leaders, 2013). LEADS (as it is more commonly known) is a memorable acronym that stands for: Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation. There are a total of 20 capabilities, evenly distributed under these five domains. “LEADS is derived from knowledge in the literature, knowledge from practicing leaders (i.e., through interviews and dialogues), and knowledge of existing competency frameworks from across the globe” (Dickson, 2010, p. 1). LEADS is the organizing model for leadership development content and the standard for measuring leadership behaviours within the research study setting and is consistent with Canadian health system directions.

Table 1

LEADS in a Caring Environment domains and capabilities

Domain	Capabilities
Lead self	<ul style="list-style-type: none"> • Self aware • Manage self • Develop self • Demonstrate character
Engage others	<ul style="list-style-type: none"> • Foster development of others • Contribute to the creation of a healthy organization • Communicate effectively • Build teams
Achieve results	<ul style="list-style-type: none"> • Set direction • Strategically align decisions with vision, values, and evidence • Take action to implement decisions • Assess and evaluate
Develop coalitions	<ul style="list-style-type: none"> • Purposefully build partnerships and networks to create results • Demonstrate a commitment to customers and service • Mobilize knowledge • Navigate socio-political environments
Systems transformation	<ul style="list-style-type: none"> • Demonstrate systems/critical thinking • Encourage and support innovation • Orient themselves strategically to the future • Champion and orchestrate change

Note. From *Bringing Leadership to Life: LEADS in a Caring Environment* (p. 24), by G. Dickson and B. Tholl, 2014, London, UK: Springer.

Within Management Studies, over the last couple of decades there has been a significant amount of work written about the concept of transformational leadership, which focuses on the charismatic and affective components of leadership. Burns (1978) posits that the majority of leadership models and practices are based on transactional processes that focus on exchanges between the leader and followers, such as promotions for performing excellent work or punishment for being late. On the other hand, transformational leaders engage with their followers to create a connection that raises the level of motivation and morality in not only the followers, but also the leaders themselves. Furthermore, transformational leaders assess the motivations and needs of followers and help them to realize their full potential while treating them with high regard (Bass & Riggio, 2006; Konorti, 2008). Transformational leaders are notable for the ways

in which they engage others in performance beyond expectations, in being able to suspend personal goals in favour of organizational goals, and in facilitating others in reaching their fullest potential (Northouse, 2013).

According to Bass (1998), who built upon the original work of Burns (1978), the behaviours identified as being characteristic of effective transformational leadership fall into four dimensions that comprise the central tenets of transformational leadership.

- Idealized influence: leaders engender the trust and respect of their followers by doing the right thing rather than ensuring they do things right. When they focus on doing the right thing, they serve as role models.
- Inspirational motivation: leaders raise the bar for their employees, encouraging them to achieve levels of performance beyond their own expectations. They do so by using stories and symbols to communicate their vision and their message.
- Intellectual stimulation: involves engaging the rationality of subordinates, getting them to challenge their assumptions and to think about old problems in new ways. Leaders who engage in this facet no longer answer all their employees' questions; instead, they now help their employees to answer all their own questions.
- Individualized consideration: deals with treating employees as individuals, by being compassionate, appreciating and responding to their needs, and recognizing and celebrating their achievements.

Several other researchers in the field of management, such as Bass and Riggio (2006), Avolio, Walumbwa, and Weber (2009), and Northouse (2013) have continued to extend this discussion of transformational leadership.

Northouse (2016, pp. 178–180) notes several criticisms of the transformational leadership model, including that it has a lack of conceptual clarity because it covers such a wide range of qualities. Additionally, he notes that although transformational leadership is concerned with specific behaviours that people can learn, it also seems to treat leadership as personality trait or personal predisposition that you are simply born with. Despite such criticism, this framework continues to be influential in informing leadership discussions within health care management.

Physician leadership competencies. When considering the identified skills that physicians need to acquire to effectively lead health care organizations, there is limited research.

Stoller (2008) proposes six competency domains required for effective leadership by physicians:

1. Technical knowledge (e.g., of finance and accounting, strategic planning, and legal issues in health care);
2. Knowledge of health care (e.g., of reimbursement strategies);
3. Problem-solving prowess;
4. Emotional intelligence;
5. Communication; and
6. Commitment to lifelong learning.

Schwartz and Pogge (2000) list:

- Interviewing,
- Strategic and tactical planning,
- Persuasive communication,
- Negotiation,
- Team building,
- Conflict resolution, and
- Financial decision making.

The Healthcare Leadership Alliance (2010) offer five primary competency areas required for effective health care leaders. They are:

1. Knowledge of the health care environment (i.e., the understanding of the health care system and the environment in which health care managers and providers function);
2. Professionalism (i.e., the ability to align personal and organizational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation and a commitment to lifelong learning and improvement);
3. Communication and relationship management (i.e., the ability to communicate clearly and concisely with internal and external customers, establish and maintain relationships, and facilitate constructive interactions with individuals and groups);
4. Business skills and knowledge (i.e., the ability to apply business principles, including systems thinking, to the health care environment); and

5. Leadership (i.e., the ability to inspire individual and organizational excellence, create and attain a shared vision and successfully manage change to attain the organization's strategic ends and successful performance).

In a study focused on aspiring and established physician leaders within academic health centres, Taylor, Taylor, and Stoller (2008) grouped specific perceived leadership needs into four themes. "Knowledge", "people skills" (i.e., emotional intelligence), and "vision" were all characteristics of effective leaders and critical to the success of aspiring leaders, while established physician leaders also required an "organizational orientation" (i.e., an understanding of the institution as well as dedication to its success).

Finally, the CanMEDS Physician Competency Framework (Frank, Snell, & Sherbino, 2015) was developed by the Royal College of Physicians and Surgeons. CanMEDS defines the competencies needed for all areas of medical practice, and is used as the foundation for medical education programs in Canada and in numerous international jurisdictions. These competencies are grouped under seven "roles", including medical expert, communicator, collaborator, leader, health advocate, scholar, and professional. According to the competencies described under "Leader," physicians are to be able to:

- Contribute to the improvement of health care delivery in teams, organizations, and systems;
- Engage in the stewardship of health care resources;
- Demonstrate leadership in professional practice;
- Manage career planning, finances, and health human resources in a practice.

(Royal College of Physicians and Surgeons of Canada, 2018).

There are common themes among all of the various competency lists and frameworks, including communicating, gaining emotional intelligence, collaborating, and building relationships, all of which require learning not just a new way of doing things, but a new way of being, which can require a transformation on the part of some physician leaders. It is significant to note that much of the literature in this area sets up expectations for an ideal physician leader, but does not provide a roadmap of how to get there which is a real weakness of most skills-based approaches. This study will add value to this conversation in describing the actual process of learning to be a leader.

Relevant Adult Education/Learning Literature

I will now move on to adult education theoretical literature, which is more focused on the process of how people learn to develop different capabilities. In the adult education field, while there is still much formal learning with clearly set objectives, we also see attention directed to emergent, informal, tacit forms of learning, such as experiential, reflective, and situated learning that occur in the workplace. It is important to connect to this relevant adult education literature to gain deeper insights into the leadership learning that occurs in a health care setting.

Experiential learning. Kolb (1984) refers to the process from which we derive concepts and continuously modify by experience as experiential learning. He argues that “ideas are not fixed and immutable elements of thought, but are formed and re-formed through experience” (p. 26). Kolb was one of the first theorists to construct a cyclical model touching upon all components necessary for learning: experiencing (or feeling), reflecting (or watching), thinking, and acting (or doing). The central tenet of experiential learning is that most of what we learn and understand comes from doing; that is, we take

action, reflect, and learn. It is a “learn it by doing it” model.

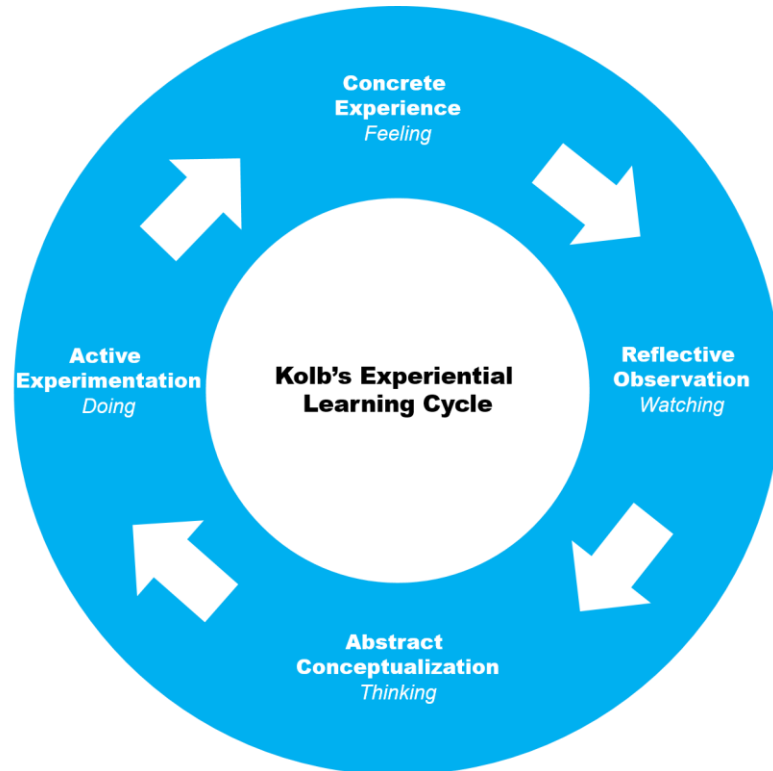


Figure 1. Kolb’s experiential learning cycle. Adapted from *Experiential Learning: Experience as the Source of Learning and Development*, by D. Kolb, 1984, Englewood Cliffs, NJ: Prentice Hall.

Kolb describes a “process whereby knowledge is created through the transformation of experience” (Kolb, 1984, p. 38) and presents adult learning as a cycle that includes concrete experiences, reflective observation, abstract conceptualization, and active experimentation. Experience provides the opportunity for learning with and from others and learning through conscious and frequent self-reflection. Reflection is a process of focused thinking; an in-depth review of events. As Bolton (2014) explains

The reflector attempts to work out what happened, what they thought or felt about it, who was involved, when and where, what these others might have experienced and thought and felt about it from their own perspective. Most significantly, the

reflector considers WHY?, and studies significant theory and texts from the wider sphere ... bring[ing] experiences into focus from as many angles as possible. (p. 7)

Reflexivity is “focused in-depth reflection upon one’s own perspective, values and assumptions” (Bolton, 2014, p.xxiii) and finding strategies to critically question these sometimes limiting perspectives to gain insight.

Kolb’s theory is not without its critics. Merriam and Bierema (2014) note that learners may not move through the process in the order specified by Kolb and that the theory fails to consider contextual factors and “experience and reflection on that experience seem to occur in a vacuum unimpeded by power dynamics present in any social context” (p. 111).

Reflective practice. Schön (1983) also explores the integrative nature of reflection and action. He suggests that the real world poses problematic situations for which linear problem solving skills do not apply, stating:

Problems do not present themselves to the practitioner as givens. Instead they must be constructed from the materials of problematic situations which are puzzling, troubling and uncertain. [Practitioners] must make sense of an uncertain situation that initially makes no sense. (p. 40).

Reflective practice is closely related to the idea of learning from experience. It is the “development of insight and practice through critical attention to practical values, theories, principles, assumptions, in the relationship between theory and practice which inform everyday actions” (Bolton, 2014, p. xxiii). Schön (1983) maintains we reflect on our actions either at the time (reflection-in-action) or at a suitable opportunity thereafter

(reflection-on action). In this regard, the hallmark of reflective practice is informed practice. While Schön does not take on a postmodern or critical stance (like Brookfield, 1991 or Mezirow, 2000), his notion of the “reflective practitioner” remains significant for leaders, managers, and professionals, and is at the centre of continuing professional development activities for many adult educators.

Situated learning in communities of practice. More recent discussions within adult education move away from learning as individual internal cognition and instead consider learning that occurs in networks or communities of practice (Brown & Duguid, 1991; Lave & Wenger, 1991; Wenger, 1998). Lave and Wenger (1991) contend that learning cannot be reduced to a simple process of knowledge transmission, disputing conventional definitions of learning as individual knowledge acquisition. They argue that learning occurs through situated practice that is usually informal or incidental. Learning is an inherent dimension of everyday life and is fundamentally a social process.

These concepts are relevant to leadership learning in the health care workplace where learning rarely occurs in isolation. Formal leaders with broadly similar values and concerns become engaged in “shared ways of knowing” by comparing and contrasting different interpretive understandings. Leadership experience, then, can be said to develop within communities of practice (i.e., through social relationships), or organized groups of people who share a common domain of interest or practice and build relationships that enable the exchange of information (Lave & Wenger, 1991). Emerging or “novice” physician leaders would participate in guided practice within an apprenticeship system, which may be formal or informal in that they learn to participate (i.e., learn to lead) by assisting more experienced members. Novices are “legitimate” but on the “periphery” of

a community. This kind of legitimate peripheral participation is presented as a natural form of learning from the accumulated knowledge of a professional community. When conditions are right, learning is as much from interaction, observing skilled performers, and listening to stories of those with experience as it is from formal, planned instruction. Kempster and Stewart (2010) look at developing leadership from a social and situated perspective suggesting that the “tacit nature of situated learning shaping leadership practice” calls for “innovative approaches to be explored to reveal processes of situated learning” (p. 217). This study intends to explore what these “innovative approaches” might look like in practice; concrete suggestions are discussed in greater detail in Chapter 4. In addition, an exploration of Wenger’s (who now goes by Wenger-Trayner) more recent work (2015) on how individuals may participate in multiple communities of practice will be taken up as a way to explore the challenges that physicians must navigate between different roles as clinicians, leaders/managers, and faculty.

This study aims to examine both the explicit and tacit dimensions of learning and knowing that occur as a result of transitioning to a leadership role. Lave and Wenger’s (1991) communities of practice can explain how, when tapping into the tacit knowledge of a situated physician leadership community, this type of knowledge may be developed and shared.

Transformative learning. We live in a world that calls for adults to learn continuously and transformatively in environments that demand advanced thinking (Argyris, 1999; Humphreys, 2001; Marsick, 1998). This is especially true of the health care environment where continuing professional development and maintenance of competency are vital to delivering quality, safe care. As well, to be a successful health

care leader, transformational leadership skills must be developed (Lanier & Rose, 2008; MacNulty & Kennedy, 2008; McAlearney, Fisher, Heiser, Robbins, & Kelleher 2005; Xirasagar, Samuels, & Curtin, 2006), which include learning self-awareness, listening, and dialoguing (Rice, 2009).

Dirkx, Gilley, & Gilley (2004) suggest that the fields of learning and leadership both struggle with the fundamental question, why is change so difficult? They maintain that at the centre of learning and change in professional development is the “self.” I suggest this study will add to our understanding of the notion of learning as *becoming* or, more specifically, can elucidate the particular adult learning experience, offering insights into the process of learning to lead. Leadership education and development that involves increasing self-awareness through critical reflection on previously held assumptions and worldviews offers the opportunity to bridge discourses between the management literature on transformational leadership with the adult education literature on transformative learning. Leadership literature suggests that to develop into a transformational leader one must undergo a deep change process. Transformative learning is a significant learning process that can alter the way leaders understand themselves, their relationship with others, and the world they live in. It is learning that changes cognitive, emotional, and behavioural routines of perceiving and interpreting things.

Transformative (or transformational) learning theory (Mezirow, 1978, 1991, 2000) explores the process of learning and change. Originating in the field of adult education, transformative learning looks beyond the behavioural aspects of change and explores how learners advance developmentally through the use of critical reflection.

Taylor (2007) highlights how the work of Mezirow, who initiated the theoretical research on transformative learning, remains an iconic and powerful conceptual framework for analyzing adults' learning. Transformative learning is a learning process of "becoming critically aware of one's own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation" (Mezirow, 2000, p. 4). This reflection on one's premises or assumptions then becomes the basis for self-assessment leading to change or transformation.

According to transformative learning theory, through a process of critical reflection, individuals can further examine their feelings, beliefs, and actions and the assumptions that underpin them. Transformation is said to occur through challenging one's assumptions and then identifying new possibilities for thinking, feeling, and acting. Mezirow describes this critical reflection process as a staged model for transformative learning, or *perspective transformation*. He argues that the stages, which start with a disorienting dilemma and end with restored equilibrium, may be experienced in a variety of orders and depths. Cranton (2002) distils Mezirow's process down to seven facets:

- An activating event that typically exposes a discrepancy between what a person has always assumed to be true and what has just been experienced, heard, or read;
- Articulating assumptions; that is, recognizing underlying assumptions that have been uncritically assimilated and are largely unconscious;
- Critical self-reflection; that is, questioning and examining assumptions in terms of where they came from, the consequences of holding them, and why they are important;

- Being open to alternative viewpoints;
- Engaging in discourse, where evidence is weighed, arguments assessed, alternative perspectives explored, and knowledge constructed by consensus;
- Revising assumptions and perspectives to make them more open and better justified; and
- Acting on revisions, behaving, talking, and thinking in a way that is congruent with transformed assumptions or perspectives (p. 66).

Mezirow's ideas have been subject to numerous criticisms — not the least of which relates to the relationship of perspective transformation to social action — and alternative “discourses” (Tisdell, 2012) have emerged in the broader adult learning field. However, this work continues to provide valuable insights into the individual experience of transformation and change that may help us to better understand the learning processes of leaders in health care. Hoggan, Mälkki, and Finnegan (2017) state that “the theory of perspective transformation has proved to be a great asset to the research and scholarship in the field of adult education which has provided a solid theoretical base for understanding complex learning phenomena” (p. 49). Such a process involves new frames of reference in viewpoints, habits, and a fresh perspective for defining identity (Kasl & Elias, 2000; Knowles, Holton, & Swanson, 2005; Mezirow, 2003). Instead of just identifying characteristics of transformational leaders, as in the management literature, it details the psychological and social factors that may engage adults in deeper learning experiences.

A transformational leadership style requires that leaders challenge their beliefs, values, assumptions, and perceptions, which necessitates a deep change process

(Atchison & Bujak, 2001; Huttegger, 2004; Lanier & Rose, 2008; LeTourneau & Curry, 1997). Clinicians who commit to this kind of leadership development can undergo a deep and significant learning process that is largely focused on “leading self” which includes being self-directed in their learning, and a focus on increasing self-awareness. This kind of learning involving reflection is well articulated in transformative learning theory. A transformative learning approach focuses on dramatic and fundamental changes in the way we see ourselves and how we understand the world around us (Merriam, Caffarella, & Baumgartner, 2012). At its core, it is about exposing and challenging the underlying assumptions upon which we function as learners. Kegan (2000) describes transformative learning as an expansion of consciousness. It is more than simply informational learning but, says Clark (1993), is the kind of learning that shapes so that you are “different afterwards, in ways both [you] and others can recognize” (p. 47). At its best, leadership development can have this effect, helping learners increase their self-awareness so they are better equipped to make changes in their leadership behaviours and actions. More recent interpretations of transformative theory, notably the work of Illeris (2014a), also move beyond Mezirow’s initial focus of transformations of meaning perspectives, frames of reference, and habits of mind. Illeris (2014b) offers a revised definition of transformative learning that suggests that the target area of transformative learning should be defined by the term “identity.”

Viewed in relation to the issue of transformative learning, the concept of identity is obviously of interest as meaning perspectives, frames of reference, and habits of mind are substantial parts of the identity. But identity is more than this, as it spans all the dimensions of learning and mental processes: the cognitive, the

emotional, and the social as well as the environmental and societal situatedness of this totality. (p. 160)

The leadership literature in medicine indicates that, for physicians, becoming a transformational leader means becoming something different altogether (Guthrie, 1999, McAlearney et al., 2005; Spinelli, 2006). This occurs, I maintain, as leaders challenge their deeply held assumptions — for example, the idea that their predominant identity is as a physician focused on individual health care — and become aware of conflicting thoughts and feelings. This kind of transition requires a deep change process that involves critical reflection and often requires being comfortable with one's vulnerability (Avolio, 1999; Serio & Epperly, 2006). From my experience, I have observed that it is not always easy or comfortable for highly educated and clinically competent health care professionals to come to terms with the fact that leadership roles require different skills that they may need to develop. Analyzing mistakes or deficiencies is an important part of the process and requires leaders to reflect on their failures and be open to addressing them (Chaffee & Arthur, 2002; McAlearney, 2006). As the literature shows, these kinds of deeper learning experiences are often complicated to understand. By developing better insights into these processes, adult educators in health care may be in a better position to support transformative leadership learning and development to better prepare physicians for leadership roles. There is also a need for physicians to shift their sense of professional identity and be open to working in a more collaborative, rather than individualistic, approach, which may cause leaders to rethink the types of skills and capabilities they need to develop to be effective in a leadership role.

Professional Identity

Medicine has a strong professional subculture that shapes the discrete identity of physicians. As individuals proceed through the educational continuum they successively develop the identity of a medical student, a resident, and a physician (Cruess, Cruess, Boudreau, Snell, & Steinert, 2015). Identity formation for physicians is a dynamic process achieved through socialization that results in individuals joining the medical community of practice (Cruess et al., 2015) and continues to evolve throughout their career. The medical professional identity, then, can shape both psychological and behavioural processes in the workplace. “Historically, the accepted professional identity of a physician has stressed individual accomplishment, responsibility, and accountability, an approach that has been difficult to merge with the reality of modern practice, which necessitates interprofessional collaboration” (Cruess et al., 2015, p. 723). Physicians carry this strong professional identity into their leadership work as well, maintaining the professional identity while in the leadership position (Witman, Smid, Meurs, & Willems, 2010). Kippist and Fitzgerald (2009) found that clinical directors tend to view themselves first and foremost as clinicians, and have very different values and priorities than general managers. Taking on a formal leadership position, then, can require a reconciliation of the professional (medical/clinical) identity with the leadership/management role. Forming a leader identity that is separate from a strong professional identity can be a difficult task.

Leader identity. A leader identity refers to the extent to which an individual self-defines as a leader and considers the leader role as a central part of who he or she is (Day, Harrison, & Halpin, 2009). Spehar, Frich, and Kjekshus (2015) point out that

role transitions in the workplace are facilitated by changes in identity and likewise [can be] hampered by a lack of change in identity. Lord and Hall (2005) argue that a change in “deep structure” factors, such as identity and values, is necessary for a successful transition into a manager role. (p. 354)

One may conclude, then, that a “leader identity” is an important aspect of becoming/being a leader as opposed to simply being a professional (e.g., a physician) with a leadership position. Quinn and Perelli (2016) researched differences in how part- versus full-time physician leaders in American hospitals understand and value leadership roles versus clinical roles, claim leadership status, and identify as physician leaders. Their findings suggest that identity is an important factor in how physicians understand and enact leadership roles, and specifically that reaching an acceptance of a dual identity may be advantageous for success as a physician leader.

Whether it is the creation of a superordinate leader identity or the understanding and appreciation of a dual identity (i.e., physician *and* leader), leader identities serve as an organizing and motivating force necessary for thinking and behaving as a leader and pursuing and engaging in development opportunities (Day & Harrison, 2007). Identity formation is thought to be a key process in motivating someone to seek out leadership learning and development opportunities. If one does not think of oneself as a leader or aspire to lead then there is little motivation to develop or serve as a leader (Chan & Drasgow, 2001; Lord & Hall, 2005; Day & Harrison, 2007; Kark & van Dijk, 2007; McDaniel & DiBella-McCarthy, 2012). It follows, then, that if physicians resist embracing a leader identity, they neither feel like a leader nor do they have the desire to proactively access knowledge related to leadership.

Reluctance amongst physicians to embrace a leader identity may be exacerbated by an “us versus them” mentality that is common in interdisciplinary health care settings. Witman, Smid, Meurs, and Willems (2010) note that if physician leaders are not viewed by colleagues as part of the medical staff they risk losing the power to influence, which rests on being perceived as a great doctor, but not necessarily as a leader. Moreover, organizational culture and structural supports (or lack thereof) may also be contributing factors to disengaging physicians from pursuing leadership or from fully embracing leadership roles they have taken on. Koskiniemi, Perttula, and Syväjärvi (2015) caution that organizations must be careful what kind of message they send about leadership needs and expectations.

If, for instance, the selection of leader trainees in an organization is based more on knowledge related to professions than leadership skills, the message to leader candidates is that the work context will remain generally the same and that there is no use in seeking to shift from a professional identity to a leader identity. (p. 15)

This relates to the power and importance of organizational culture in creating the right environment for physicians to take on a leadership role and to commit to learning the skills to carry it out effectively.

Organizational Culture

Organizational culture is a driving force in shaping the workplace environment, which is highly influential not just on how physician leaders lead, but also on how they learn. Cameron and Quinn (2006) write “An organization’s culture is reflected by what is valued, dominant leadership styles, the language and symbols, the procedures and

routines, and the definitions of success that make an organization unique” (p. 17). It can also be seen the way language is used, power is distributed and decisions are made (Deal & Peterson, 2013). Schein (2010) suggests that organizational culture can be analyzed at three levels:

1. visible artifacts;
2. espoused values, rules and behavioural norms; and
3. tacit, basic underlying assumptions (p. 24).

For Schein, each “level” equates with the degree to which the cultural phenomenon is visible to the observer” (p. 23). Examples of visible artifacts (level 1) might include the architecture of the hospital physical environment, use of specific medical language/terminology, technology, public-facing mission statements, or even the dress code/uniforms of various clinical disciplines. Representations of level 2 might be observed in spoken values/public statements such as “commitment to excellence”, “patients come first”, or “results focused.” While a group may not go against espoused values publically, they may not be universally accepted or congruent with observable behaviour. Finally, the shared, basic assumptions or taken for granted behaviours that Schein calls level 3 are largely unconscious or tacit. These shared ways of thinking and behaving become normalized, and reflect what comes to be seen as legitimate and acceptable within the workplace or organization. Houpt, Gilkey, and Ehringhaus (2015) explore the culture of academic medical centres and their commentary echoes the work of Schein.

Every organization has invisible assumptions and values that underlie its visible behavioural norms, its artefacts (overt signs of the culture), and its performance

(tangible results). Culture has to be understood as comprising both the visible and invisible; it is the context in which a leader succeeds or fails.” (p. 8)

Organizational culture sets the stage for the kind of leadership effort that physicians will put forth. If they see their work as valued and valuable, they will bring the best of their skills and knowledge to their leadership work. In health care organizations, however, organizational culture is complex and multi-faceted, and can sometimes act as a barrier to physician leadership participation.

Health care organizations. MacLeod (2012) notes that the issue of culture is fairly straightforward for most workplaces because they are often one organization with a single culture. In contrast, health care organizations have multiple interacting cultures so “things tend to be more complicated” (p. 12). Braithwaite, Herkes, Ludlow, Testa, and Lamprell (2017) define workplace culture specific to health care organizations as “a specific type of subculture involving an identifiable grouping within an organization. In health care, such a ‘workplace’ may be a unit, ward or department, or a professional group, eg, medicine or nursing” (p. 2). Schein (2010) notes “subcultures share many of the assumptions of the total organization but also hold assumptions beyond those of the total organization, usually reflecting their functional tasks, the occupations of their members, or their unique experiences” (p. 55). The attitudes, language, and working behaviours of health professionals appear to be firmly rooted in the culture and histories of their specific discipline. Employees who come from different professional disciplines with distinct occupational cultures can identify themselves as a distinct group and often form organizational subcultures (Gioia, Price, Hamilton, & Thomas, 2010; Robertson, 2011) or silos defined in relation to departments or disciplines (Cilliers & Greyvenstein,

2012). “Silos develop easily around professional disciplines, each with their respective norms, familiar jargon, collegiality and common interests. Each profession focuses on meeting its functional expectations without knowing (or often caring) a great deal about the others” (MacLeod, 2012, p. 12). This can inhibit collaboration and communication and induce conflict, often creating an “us versus them” situation.

Differing subcultures and socialization processes within health professions can be a barrier to working collaboratively in the health care workplace. Pecukonis, Doyle, and Bliss (2008) use the term *profession-centrism* to describe a process by which professionals view the world from the perspective of their own professional cultural frames. “Profession-centrism” or professional centric thinking is a “constructed and preferred view of the world held by a particular professional group developed and reinforced through their training, educational, and work experiences” (Pecukonis, 2014). This often leads to stereotypical views of other professions and the adoption of competitive rather than collaborative attitudes to other health care providers (Hamilton, 2011). These stereotypical views and competitive attitudes do not only exist between health care providers, but can be fostered in any situation where two distinct professional cultures interact. MacLeod (2012) describes physicians and managers as two major interacting cultures; “Sometimes their interactions are relatively smooth; more often they are not” (p. 12).

Physicians versus managers. The different cultures of physicians and administrative managers/formal leaders can often be expressed as values incongruence. Physicians can have difficulty with aligning to the prevailing organizational values and goals, which can sometimes be considered “corporate” ideologies, values, and practices

concerned with budgets, business plans, and “customer” service. Physicians often view managers as being overly concerned about money and not knowing or caring enough about medicine and high-quality patient care while managers can view physicians as being unrealistic and unreasonable in their demands for limited resources (Garelick & Fagin, 2005 in MacLeod, 2012). Riley (1998) offers some examples on differences between physicians and managers.

Table 2

Differences between physicians and managers

PHYSICIANS	MANAGERS
Focused on individual patients.	Focused on population groups.
Not primarily concerned with costs.	Focused on efficiency and resources.
Have face-to-face contact with patients.	Rarely meet patients or families.
Expected to solve all presenting problems.	Choose which problems to tackle.
Have learned to be independent and competitive.	Expect to share responsibilities.
Trained to emphasize the scientific approach	Deal with politics and human motivations.
Expect problems to have solutions.	Expect to tolerate multiple insoluble problems.
Have high social and professional status.	Have medium social and professional status.

Note. From Riley (1998) as cited in “The Physician Leader’s Role in Bridging the Culture Gap,” by L. MacLeod, 2012, *Physician Executive*, 38, p. 13.

The variance in perspectives noted in Table 2 are striking and speak to differences in training and socialization that lead to the distinctiveness of a clinical versus corporate culture. Physicians and managers seem to hold views that diverge markedly and would be problematic in a workplace context. For example, disparate views related to focus alone (i.e., individual vs. collective interests) are seemingly sufficient to thwart achievement of common goals. Gill (1987) provides more examples of how physicians and managers tend to approach issues from decidedly different viewpoints.

Table 3

Differences in the approaches of physicians and managers

PHYSICIANS	MANAGERS
Doers	Designers
Reactive	Proactive, long time span before results
Immediate response	Long-term response
Decider	Delegator
Autonomous	Collaborators
Independent	Participative
Patient advocate	Organization advocate
Professional identity	Organizational identity
Independent professional	Interdependent professional

Note. From Gill (1987) as cited in “The Physician Leader’s Role in Bridging the Culture Gap,” by L. MacLeod, 2012, *Physician Executive*, 38, p. 14.

As evidenced in Tables 2 and 3, physicians and managers approach the world and the workplace from decidedly different viewpoints. Bringing more physicians into leadership roles can help to bridge this gap and build understanding and common ground. However, the distinct cultures and goals of these two groups can seem at times incompatible and pose important questions about how you might shift identity when it also means such a change in perspective.

Conclusion

This chapter outlined the relevant literature that provides the context for this study, helping to situate the current research into the bigger picture of what is known and not known about learning leadership in a health care setting. I introduced the literature on continuing professional development and continuing medical education that tend to privilege formal and structured learning and training over the many informal and non-formal learning and development experiences that are significant and frequent in the workplace. I presented the relevant theories related to informal learning and the workplace context, including experiential learning, reflective practice, transformative learning, and situated learning in communities of practice, and their importance to adult

learning processes in connection to adult education and, more specifically, to leadership learning. I then reviewed the literature specific to leadership and leadership development, including leadership theories and competencies that too often describe leadership development from only a skills perspective rather than attending to the actual process of learning to be a leader. The concept of professional identity in medicine was taken up because physicians seem to carry a strong medical professional identity that shapes both their psychological and behavioural processes in the workplace. I explored, too, the role of leader identity as an important aspect of becoming/being a leader as opposed to simply being a professional (e.g., a physician) with a leadership position. I summarized the driving force that is organizational culture, and how it shapes the workplace environment where physicians lead and learn, and the unique composition of subcultures in health care organizations that can influence the ways in which physicians buy in to a leader identity. Finally, I highlighted the differences between two major interacting subcultures within health care organizations, namely physicians and managers.

This literature review chapter serves to explain the topic of my research and to build a rationale for the problem that I chose to study and the need for additional research. The specific strands of literature and theory presented here serve as the backdrop to my research question and speculative thinking regarding the argument that I am developing.

Chapter 3 will describe the methodology used to carry out this research study.

Chapter 3: Methodology

Introduction

Any researcher, when planning and designing a suitable methodological approach, can experience some uncertainty and complexity on their research journey. Some apprehension is common because there are always inherent strengths and limitations to particular approaches to designing research. However, as a researcher, you have to decide what you feel will work best under the circumstances to get at the information you are seeking. The chief intention of this study was to obtain an understanding of the process of learning to lead through the lived and told stories of those physicians who have moved into leadership roles over the course of their careers. After much reflection, coupled with extensive research and consultation on a number of methodological options (e.g., early rumination on phenomenological and grounded theory designs to considerations of a “basic/generic” qualitative approach), I came to the conclusion that a qualitative narrative approach was appropriate for exploring my topic. As a reflective mode of qualitative inquiry and a way of presenting research accounts, a narrative research design allowed me to capture the “richness of people’s experience in their own terms” (Klenke, 2008, p. 10) and meet the objectives of my proposed study: investigating the ways participants experience learning leadership as depicted through their stories.

Research Design

Rationale for qualitative design. A qualitative approach enables the researcher to gain information about participant perspectives in a natural setting (Hatch, 2002) and allows for a complex understanding of the meaning of a phenomenon as the participants

themselves have experienced it (Merriam, 1998). “Meaning” is identified by Polkinghorne (1988) as an activity — a cognitive process. I sought to explore the behaviours enacted and the stories that are created as a result of meaningful human experience. The notion that meaning is partially or entirely socially constructed is implicit in the philosophical underpinnings of narrative inquiry. This is consistent with social constructivist views on learning and especially relevant to leadership learning given that “leadership” itself is a socially experienced phenomenon.

Qualitative research is about using people’s experiences and stories as the focal point (Strauss & Corbin, 1990). It is concerned with understanding “an event, process or a situation in a great deal of depth” focusing on how individuals experience or understand events in their lives (Llewellyn, Sullivan, & Minichiello, 1999, p. 174). I saw a need to deepen the understanding of the learning that occurs in physician leadership roles, and participant responses on this topic focused on how individuals experienced or understood events in their lives, reflecting a qualitative research tradition that prioritizes the study of perception, meaning, and emotion.

Rationale for narrative approach. I selected a narrative approach to guide my study due to its relevance to “embodied experiential knowledge” (Goodfellow, 1998, p. 67). Narrative inquiry is a subset of qualitative research design in which stories are used to describe action and events are configured into a temporal whole by means of a plot (Polkinghorne, 1995). Merriam (2009) explains that stories are the oldest and most natural ways that we make sense of experiences, hence narratives have become an effective way to collect qualitative data through first person, oral accounts. As the most direct way to share human experience (Clandinin, 2007), narratives are the retelling and

reliving of meaningful experiences in storied form. I used a personal narrative inquiry approach, probing for detailed stories of participant experiences of learning to lead within a health care setting. Elliot (2005) calls this a “first-order” narrative in which individuals tell stories about themselves and their own experiences.

Published studies using narrative approaches are represented within all of the social sciences and medicine (Lieblich, Tuval-Mashiach, & Zilber, 1998) and narrative methods can be considered “real world measures” that are appropriate when “real life problems” are investigated. (Lieblich et al. 1998, p. 5). Narrative approaches are particularly appropriate for researching processes that unfold over time and where the temporal and individual life context of participants’ experiences is of central importance (Hall, 2011). The objective of my study was to understand, describe, and analyze the stories of lived experiences of learning over time shared by physicians, so narrative inquiry was an appropriate methodological approach. Clandinin and Connelly (2000) maintain that “experience happens narratively...therefore, educational experience should be studied narratively” (p. 19). Narrative research has been used fairly extensively in medicine to understand experiences from the perspective of the patient (e.g., the “illness narrative”), but not as commonly to understand the experience of the physician.

Within the field of adult education, narrative, life history, and biographical research has been used to explore topics such as women’s learning trajectories (Gouthro, 2009) and literacy-learning frameworks (Magro, 2008). Hodkinson and Macleod (2010), in an analysis of the conceptual significance of different methods of researching learning, also position this genre of research approaches as helpful in uncovering the significance of informal as well as formal learning.

This literature indicates that taking a more narrative, biographical approach makes sense when researchers are interested in studying adult learning experiences because you are asking participants to think about their learning trajectories across the lifespan, reflecting on critical incidents and learning experiences that impacted on them.

As an adult educator I wanted to learn more about the personal learning experiences of physician leaders in actual workplace settings — to get to their “stories” of learning — so narrative inquiry was particularly well suited. Webster and Mertova (2007) maintain that

if narrative is fundamental to communication, then the use of narrative as a research method may...give us a better understanding of teaching, learning and performance in a wide range of environments and may assist us in generating more appropriate teaching tools and techniques. (p.16)

A narrative inquiry research design utilizes the natural human inclination for “storying” experience by using story as a way to investigate experience and tell about an experience (Clandinin & Connelly, 2000). In this study, participants communicated their first-person accounts of their leadership learning experiences and these formed the data or research “texts.” Reflecting on and learning from participants’ experiences with leadership, thus revealing how they made sense of their experiences, can provide a basis for improved practice for other adult educators in the area of health care leadership and management development.

Site and Population of Interest

The setting for this study was the central zone of the Nova Scotia Health Authority (NSHA) located in the Canadian city of Halifax, Nova Scotia. An academic

health sciences centre with over 12,000 employees, physicians, and learners, the central zone is the largest provider of health services in Nova Scotia, operating hospitals, health centres, and community-based programs that serve a population of about 400,000 people. At the time of this research study I worked as the Leadership Development Coordinator for the Physician Services department within this organization.

Participant recruitment. I used a purposive/purposeful sampling technique that included snowballing methods (Patton, 1990, Morse, 1991) to recruit participants. The maximum variation sampling strategy described by Patton (1990) was also used and my initial sources of variation included gender, race, and levels/lengths of experience in a leadership role. I must clarify that I had hoped to have some variation in ethnicity but the only participants who volunteered all identified as White, which is representative of the composition of medical leaders in this setting. Two participants, however, emigrated from countries outside of North America and completed medical training outside of Canada. The primary selection criteria for inclusion were active physician leaders (i.e., doctors who currently held Nova Scotia Health Authority–affiliated formal leadership positions) who were willing to participate in an interview to articulate their experiences as it relates to the phenomena being investigated: transitioning from clinical practice to a formal leadership role. I was aware of the zone physician leadership group, given my work, and personally sent out by email an invitation (see Appendix A) to participate, targeted to 12 current formal physician leaders in the central zone of the NSHA. In terms of group composition, I took into consideration a range of leadership positions, approximate ages, gender representation, and different medical specialties/areas of expertise and 10 physicians responded positively to my initial request. The sample was

expanded via snowball sampling where one or more participants recommend others to participate and two additional participants were recruited through this approach, bringing the total to 12.

In terms of demographics, there were eight male and four female participants. This participant selection represented the vast majority of the medical leadership group, which is currently, in Nova Scotia, predominantly older white males. With regard to age, one physician was in the 31–40 year age range, three were in the 41–50 range, seven were in the 51–60 range, and one physician was over 60 years old. Eight participants were hospital-based, and two physicians were community-based, and nine different medical and surgical specialties were represented overall.

Table 4

Participant demographic information

Gender	# of participants
Male	8
Female	4
Age	# of participants
31–40	1
41–50	3
51–60	7
60+	1
Years since qualification in medicine	# of participants
<10	2
10–20	1
20+	7
30+	2

Years in formal leadership role	# of participants
<5	1
<10	4
10–20	5
20+	1
30+	1

All study participants were active in formal physician leadership roles such as Department Chief, Division Head, Medical Lead, Site Lead, and/or Program Director. The range of time since qualification in medicine was five years to 34 years (<10 years: two participants; 10–20 years: one participant; 20+ years: seven participants; 30+ years: two participants). The range of time in a formal leadership role was three years to 31 years (<5 years: one participant; <10 years: four participants; 10–20 years: five participants, 20+ years: one participant; 30+ years: one participant).

The goal of qualitative research can be stated as “in-depth understanding” and consistent with the methodological literature in narrative/biographical/life history approaches, this small but representative sample of twelve individuals allowed me to conduct an in-depth exploration of the learning that occurs in physician leadership roles. This sample allowed for an in-depth exploration of a range of leadership learning experiences and a solid understanding of the phenomenon and enough people to allow for thematic saturation and the identification of consistent patterns. A larger sample size would have made this research impractical given the extensive data that is generated in qualitative research of this type. Utilizing the well-conceived interview guide, the 10–15 hour database provided enough data to support this qualitative dissertation. Moreover,

with the time and resources available, this was a reasonably sized project for a non-funded doctoral study.

Data Collection

Research study objectives and research questions were explored through in-depth qualitative interviewing that encouraged recall, promoted thinking and reflection on the physicians' experiences, and produced narrative data. The qualitative interview is the data collection method of choice in many leadership studies (Day, 2014) as it provides in-depth data in the form of rich, in-depth descriptions of the leadership learning phenomenon under investigation from the perspective of the participants. While some consideration was given to adding a supplemental data collection method such as a content analysis of relevant organizational documents, I decided to rely on in-depth interviewing as the overall strategy, given the possible sensitivity of accessing some internal health care/medical staff documents as well as the time and resources available.

Twelve one-hour interviews took place from April 30 to June 27, 2016, in mutually agreeable locations — usually the physician's own office — where privacy was ensured and distractions minimized. Each interview was approximately 60 minutes or longer if the participant so desired. An interview guide was utilized (see Appendix B) and I applied a problem-centered interview method (Witzel, 2000) that combined an open-ended approach with minimal interviewer structuring in the first phase of the interview with a semi-structured second part of the interview that allows for a more focused set of questions by the researcher. Kvale (1996) describes qualitative interviews as “a construction site of knowledge” (p. 2). Careful questioning, listening and responding in

qualitative interviews requires a lot of concentration and effort on the part of the interviewer and it can serve as a learning event for both participants.

Beyond attending to the various practicalities and administrative items involved in setting up and conducting 12 interviews over a two-month period, there is much learning that can take place for the interviewer during the interview sessions themselves. I was able to begin to review audio files immediately following each interview so as to consider improvements for the next. My ability to probe answers, pursuing a line of discussion opened up by the interviewee, improved with each participant. At the beginning, I tended to accept a physician's response and move directly to the next question too quickly, rather than ask for elaborations or clarifications of meaning. Furthermore, I had prepared various generic probes in advance but quickly learned that they felt somewhat detached. It was more genuine to respond to what an interviewee was saying at the moment, in my own words. As I became more comfortable in my abilities, I was able to get people to open up more easily, provide more information, elaborate and expand on what they said. Foundational to this process for me was learning how to really listen and attend to what interviewees are saying, or not saying. An important learning moment for me in the first few interviews was realizing that rather than active listening I found myself engaged in analyzing the way the participants' experiences fit with my own research interests or thinking ahead to the next question.

I also tried to avoid affecting interviewee's responses to questions by not giving cues regarding how they might or should respond to my questions. I realized early on in the process that even my use of the response "yes" (which was a common response from me at the beginning) might have given the impression of approving to the interviewee's

response. I had to become more aware of the type of verbal reactions I made to each participant and also be careful not to ask leading questions.

Data Analysis and Interpretation

The objective of my research study was to develop a better understanding of the adult learner experience of learning to become a leader in health care from physicians' perspectives. Through analyzing participant interview transcripts I was able to explore similarities and differences of participants' experiences in an effort to reveal a more general understanding of this experience. To this end, I applied categorical content analysis, where categories related to the topic are identified and the content of categories are analyzed and compared. This approach was put forth by Lieblich, Tuval-Mashiach, and Zilber (1998) and is considered classical to narrative inquiry. Lieblich et al. (1998) advise that the narrative materials — in my case participant interview data — can be processed analytically by breaking the text into relatively small units of content. “The narrative story is dissected, and sections or single words belonging to a defined category are collected from the entire story or from several texts belonging to a number of narrators” (p.12). The purpose of this “dissection” is to examine the thematic similarities and differences between narratives provided by a number of people. This approach is also known as qualitative content analysis and is similar to grounded theory's constant comparative analysis (Glaser & Strauss, 1967). The strength of this form of analysis lies in its capacity to develop general knowledge about the core themes that make up the content of the stories generated.

The transcription process and the process of identifying themes began with the act of transcribing the interview audio files. I did this by listening with headphones to the

audio files for each interview multiple times and then using the dictation function of my personal computer to “speak” the verbatim data into a Microsoft Word document. I would then listen to the audio again while reading along to the transcript to ensure accuracy, physically typing any edits or corrections. I verified the validity of transcripts through participants’ review of their own transcribed text. This form of respondent validation is commonly referred to as member checking and several qualitative researchers have addressed this idea (Creswell & Miller, 2000; Lincoln & Guba, 1985). Through member checking, I asked participants to comment on the accuracy of verbatim transcripts and obtained their approval to use their direct personal quotes in written or verbal reports of the study. All participating physicians were given the opportunity to review, revise, and confirm the transcripts of their interview. Two participants provided corrections to inaudible portions of the interview transcript to provide clarity and one participant modified their transcript for anonymity by removing some identifying components and rewording in a more general way. Doing the interviews myself, and listening to them several times as I transcribed them helped me to become intimately acquainted with the data, which was helpful to the coding process.

Coding strategies. I manually assigned, organized, categorized, and assembled qualitative codes, utilizing a two-phase, *first* and *second cycle* coding procedure as outlined in Saldaña (2013). In phase one, I used an open-ended process called *eclectic coding* that “is intended as a ‘first draft’ or first cycle of coding with multiple methods, followed by a ‘revised draft’ or second cycle coding with a more purposeful and select number of methods” (Saldaña, 2013, p. 193). It involved applying two or more first cycle coding methods and I utilized *emotion*, *values*, *in vivo*, *process*, and *versus* coding.

“Emotion codes label the emotions recalled and/or experienced by the participant, or inferred by the researcher about the participant” (Saldaña, 2013, p. 105). “Values Coding is the application of codes onto qualitative data that reflect a participant’s values, attitudes, beliefs, representing his or her perspectives for worldview” (p. 110). In vivo codes draw from the participant’s own language using their own words or short phrases as codes and is one of the most well-known coding methods in qualitative research. Process coding uses only gerunds (*-ing* words) for codes “to connote observable and conceptual action in the data” (Saldaña, 2013, p. 266). Finally, “Versus Codes identify in dichotomous or binary terms the individuals, groups, social systems, organizations, phenomena, processes, concepts, etc., in direct conflict with each other” (Saldaña, 2013 p. 115). This is appropriate for “qualitative data sets that suggest strong conflicts or competing goals within, and between participants” (p. 115), which was the case with many study participants.

I diligently applied first cycle coding methods to the data, several times, and then transitioned those codes to second cycle methods.

The choice to hand analyze data rather than use a qualitative data analysis software tool was a conscious one. Creswell (2012) notes that a by-hand analysis may be preferred when you are analyzing a small database of fewer than 500 pages of transcripts because it allows for a closeness to the data and hands-on feel. Hand analysis can be time consuming given that is a labour-intensive activity. I applied first cycle coding by hand (i.e., hand-written notes on hard-copy transcripts), but then transferred the set of initial codes into Microsoft Word tables and utilized the various relevant functions in the

software program to sort, organize, and locate words in the text database, enhancing coding organization and management.

Next, I cut and pasted and maintained the data in a Microsoft Excel spreadsheet for a second cycle of *focused* coding, which categorizes coded data based on thematic or conceptual similarity (Saldaña, 2013). This “second cycle analytic process is a streamlined adaptation of classic grounded theory’s axial coding” (p. 213) and “the primary goal during Second Cycle coding is to develop a sense of categorical, thematic, conceptual, and/or theoretical organization from your array of First Cycle codes” (p. 207). This method was appropriate for my qualitative study and its primary aim to develop major categories or themes from the data. The layout of the spreadsheet was such that first cycle and second cycle codes each received their own columns, enabling comparison and analytic induction as rows and columns were scanned and later grouped into emerging categories. Cells were colour coded to enhance analysis as sets of initial codes progressed through subsequent levels of analysis, condensing from the full set of codes to a selected list of categories into the study’s central themes or concepts.

Memo-writing and field notes. Memo-writing and field notes informed the development of analytical memos and were an important element of the iterative process of analysis and interpretation. I wrote short analytic memos both during and after data collection that provided opportunities to reflect on and write about concepts and patterns that I saw emerging in the data and possible connections of categories, themes, concepts, and assertions.

Additionally, I “shop talked” throughout the study, sharing my emerging themes with colleagues working in several universities to get their ideas on the process, and in

my regular one-to-one conversations with my dissertation supervisor. Talking regularly about the data and the iterative process of analysis and interpretation is helpful because, as Saldaña (2013) points out,

This person can ask provocative questions the researcher hasn't considered, discuss and talk through the data analytic dilemmas you're facing, and offer fresh perspectives on future directions with the study. If we're lucky, he or she may also intentionally or inadvertently say that one thing to us that pulls everything together. (p. 206)

In addition, continuing to read the literature simultaneously with data analysis and interpretation also influenced the process, for it prompted me to focus on emerging themes of particular interest. Questions arose as I compared, re-ordered, and re-compared categories; and, together with analytic memos, these were recorded in various notes files/documents linked to emerging major themes and sub-themes. Memos comprised reflective comments and verbal "mind maps" and bolstered the stages of coded material by providing ways of conceptualizing and linking themes and concepts to one another.

Focusing strategies such as these help to connect back to the original research questions and also to clarify reasoning. Saldaña (2013) points out that

Sometimes we become overwhelmed by the magnitude of our studies and thus need to intentionally focus the parameters of our investigation in progress to find its core. Forcing yourself to select a limited number of various ideas that emerge from your study encourages you to prioritize the multiple observations reflect on their essential meanings. (p. 247)

Qualitative data analysis can be challenging and sometimes overwhelming. Familiarity with the data is important and dealing with large volumes can be daunting. There was the occasional epiphany during the process, and at other times an emergent set of codes or categories seemed uninspiring. In the end, focusing in and reflecting on what the data was telling me is how I fit the puzzle together.

Ethical Considerations

Approval. I completed ethics applications for both my research site at Nova Scotia Health Authority (NSHA) (see Appendix C) and my university, Mount Saint Vincent University (see Appendix D). I obtained full approval from research ethics boards at both the research site (Nova Scotia Health Authority Research Ethics Board) and my university. I received full approval from the NSHA research ethics board on March 21, 2016, and full clearance from my university on April 15, 2016.

Participant information and consent. I personally conducted the informed consent process. Participants were sent an informed consent form and information package (see Appendix E) by email to read in advance of their interview. I reviewed this information again with participants at the beginning of the interview appointment and provided an opportunity to ask questions and indicate their choice to participate in the proposed study or not. All recruited participants consented and signed on to participate and were aware that their participation was voluntary. Participants were free to withdraw or discontinue their participation at any time. If participants decided to withdraw their contributions, all their information was to be destroyed immediately. None of the participants withdrew from the study. All participants expressed an interest in reading the findings of this research study and I informed them that once the requirements for the

degree have been completed, they will receive a document summarizing the study.

Risks and benefits to participation. Potential harm stemming from involvement in this study was deemed no greater than those encountered by participants in those aspects of their everyday life that relate to the research. Therefore, the benefits of this study to the participants, participating organizations, and research community outweighed the risks to participants. Two possible areas of risk were noted in the ethics application and communicated to participants in the informed consent process.

Psychological harm/risk. Participants were encouraged to share narratives about their lives and experiences within the context of the research interview. Potential emotional harm/impacts of participation can include unexpected distress due to recalling and discussing sensitive issues such as past workplace conflict, difficult decisions, or issues of fairness and equity.

Social and/or professional harm/risk. Sharing stories about learning to become a leader can involve talking about challenges or difficulties that were difficult to overcome. Physicians may be reluctant to reveal their struggles at their place of work because of possible negative reactions from peers or others in leadership positions. Therefore, it was important to allow participants to have complete control over what information they chose to share. By returning transcripts for review, participants had the opportunity to edit or amend the information that they shared. In addition, measures were taken to ensure confidentiality that included screening out identifying details. This affected the way I represented data in the findings chapter, including, de-identifying, removing medical specialties, and rolling up demographic information. Only one participant modified their transcript for anonymity in such a way that some potential

quotations were no longer viable to include in the final document.

Benefits to study participation. Direct benefits for participants included the opportunity to assist in the advancement of knowledge and the possibility of benefiting others (e.g., new and emerging physician leaders), both of which can be a source of immediate satisfaction. Furthermore, the retelling of life stories enabled leaders to reflect upon their values, emotions, and critical learning events that shaped their leadership identity and approach.

Indirectly, this research may benefit the larger physician leadership group within the research site and beyond. Learning from individual participant experiences of becoming a leader is significant to the performance of leadership and leadership development and can help to advance young doctors/emerging physician leaders. There is potential for the addition of new knowledge to the discipline of medical leadership that will benefit future generations and the welfare of the physician leadership community and the larger health care system.

In terms of findings, I received information about the effectiveness of specific tactics used within our leadership development programming and can facilitate the use of this information to implement improvements and maintain successes. A number of learning strategies emerged through data collection offering insights into participant experiences and perceptions on leadership learning and the specific processes of learning involved. This can assist adult educators and leadership development practitioners in their efforts to better design learning interventions and other workplace supports that have maximum impact for adult learners within health care.

The research community can benefit from greater understanding of the nature of medical leadership and its associated challenges as well as the experience of transitioning from practising medicine (or another clinical discipline) to practising leadership in a management role.

Handling of research data. Interview data was stored on a password protected computer in my locked office. Identifiable information/participant contact information was kept and stored separate from the participants' interview data in an encrypted file on a separate password protected storage device locked in a secure cabinet in my office. I had access to the study data and de-identified participant interview data was occasionally shared with my doctoral supervisor via secure/encrypted files on a portable storage device.

Records will be archived securely in my home office in password-protected computer files and also on my university's secure server (located within Canada) for 7 years as per relevant research study policy. Additionally, the following measures were employed to protect participant information:

- *Recruitment:* potential participant personal identifiers and contact information were kept apart from study data and securely stored.
- *Consent process:* written consent forms were stored separately from participant identifying and contact information and other information collected during study.
- *Data collection and analysis:* an alphanumeric code was assigned to information obtained from each participant and the key to the code kept in a password-protected file or locked cabinet.

- *Data storage:* participant interview data was/is stored in digital form, encrypted and password protected. Any hard copy notes are kept by me in a locked cabinet.

Researcher Positionality

I was confronted with a role duality, having responsibilities as both a researcher and adult educator/leadership development coordinator within the research site. I was conscious that this positionality as an “insider” could potentially lead to perception of bias or conflict of interest. I realize, too, as a qualitative researcher, complete objectivity is not possible and there is a possibility that my values and beliefs can influence the research study. I possess certain assumptions and potential biases given my role, experience, pre-existing knowledge of participants, and awareness of the leadership and learning landscape within my organization. It was my responsibility as the researcher to be self-aware of my reactions, reflections as part of the researcher-participant relationship, reducing the possible effect of my influence through reflexivity. Reflexivity involves the researcher’s self-awareness and the strategies the researcher uses to manage potentially biasing factors while maintaining sensitivity to the data. I utilized a reflective research journal to manage my personal views and beliefs and allow the voices of the participants to be at the forefront. “Reflections, questions, and decisions on...problems, issues, ideas” (Merriam, 2002, p. 27) can be recorded in a journal and can form an important audit trail. Member checks are an additional method for ensuring quality in qualitative research (Merriam, 2002) and I also sought validation of themes as they emerged from participants in the research process.

I do not foresee incompatible interests, however, with my positioning in this study. I am aware that my familiarity with the research topic might have led to a loss of objectivity. To combat this, I worked to constitute an explicit awareness of the possible effects of perceived bias on data collection and analysis, respecting the ethical issues related to the anonymity of the organization and individual participants and considered and addressed the possible issues of a researcher's insider status related to possible coercion, compliance, and access to privileged information, at each and every stage of the research (Sikes & Potts, 2008).

It is also important to note impact of gender on data collection in qualitative interviews and my positionality as a white male researcher. Perceptions of me as an interviewer who is a white male may have caused female participants to speak less openly, and conversely may have made the white male participants more comfortable in sharing their stories, voluntarily revealing further personal experiences. Also, my positionality may have limited how much gender-specific information I received from the women in the study, but I tried to create a comfortable rapport when speaking with the female participants and the interviews took place in the relative safety and comfort of their own offices.

Conclusion

This chapter outlined the methodological choices made and the various logistical and ethical considerations that went into designing this research study. Given that the intention of this study was to understand how physicians learn to lead, a qualitative narrative approach was a logical choice, allowing me to capture the lived experiences of

study participants and interpret the data presented via their own stories. Chapter 4 will outline the findings gained from this methodology.

Chapter 4: Research Findings

Introduction

In Chapter 4 I present data obtained from individual interviews with twelve participants in this study examining the process of learning among physicians who transition into formal leadership positions. The analysis yielded four main themes, which were identified and categorized through a multi-stage coding process as described in Chapter 3. These themes are expressed as:

- physician professional identity,
- organizational culture,
- workplace context, and
- leadership learning.

With reference to the first two major themes noted above, I want to acknowledge that there is some interrelationship between the expression of *identity* and *culture* within the literature and recognize that there may be minor tensions in the language used to describe these terms (e.g., professional identity vs. professional culture; organizational culture vs. organizational identity). I landed on the choices of physician *professional identity* and *organizational culture* for the following reasons. Identity alludes more to an individual perspective (i.e., who we are or believe ourselves to be as individuals), which is clearly represented in the interview data. Organizational culture involves the system structures (i.e., hospitals, universities, health districts) in which individuals function. My findings point to manifestations of the broader organizational culture affecting professional identity dynamics of individual physicians.

I present a model of leadership learning, as outlined in Figure 2, which comprises the main themes, sub-themes, and their interrelationships.

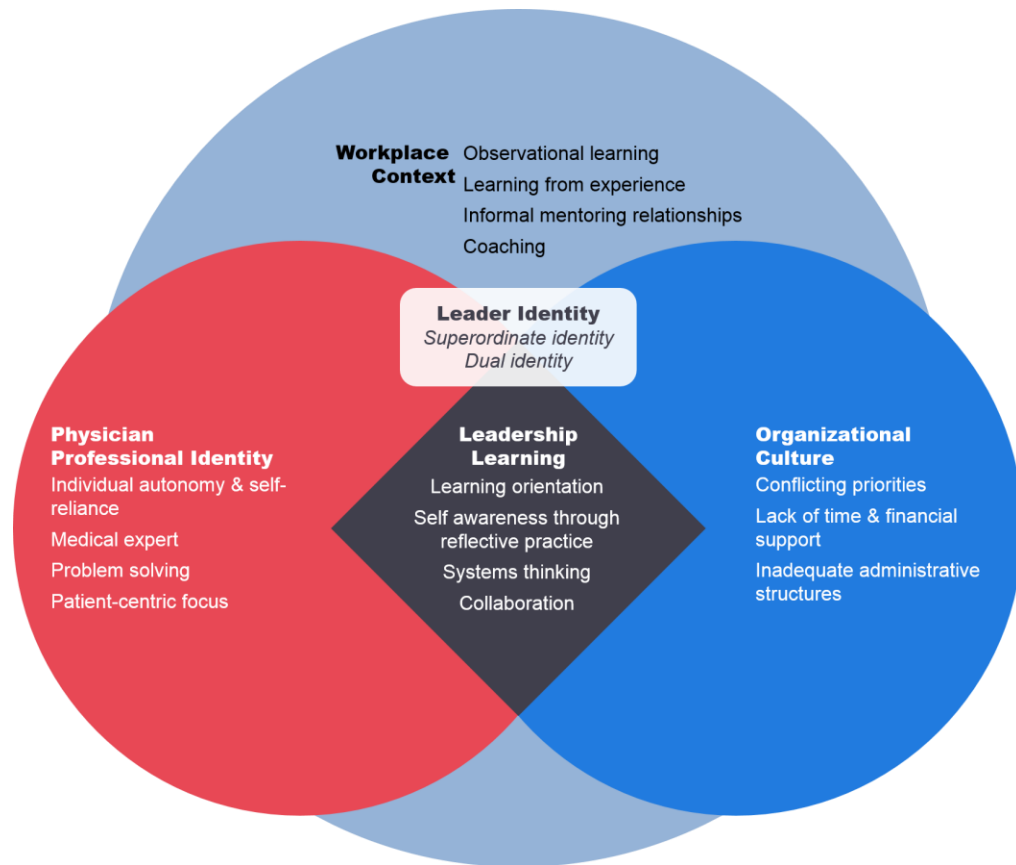


Figure 2. Key themes and sub-themes represented in a model of leadership learning.

Physician professional identity and *organizational culture* represent an ongoing dynamic within this model and also make up the problem statement of the thematic framework: the physician experiences the workplace through the lens of the professional clinical physician identity, which does not encourage characteristics or objectives linked to formal leadership (and in some ways even works against it), and the organizational culture sets up expectations for leadership without really preparing physicians to succeed or compensating them adequately for the effort. Physicians navigate this fraught interaction within the *workplace context*, which allows for informal (and a few formal)

learning opportunities; real *leadership learning* occurs given the “right” mix of conditions, which include a learning orientation on the part of the physician, self-awareness gained through reflective practice, engaging in communities of practice and an ability to engage in systems thinking, and willingness to collaborate. The product of this learning interaction seems to be the formation of a leader identity that serves as an organizing and motivating force necessary for thinking and behaving as a leader and pursuing and engaging in development opportunities. For some physicians it is the creation of a superordinate leader identity while for others it seems to be the understanding and appreciation of a dual identity — physician *and* leader — the relative importance and weight of each varying over time and context.

The remainder of this chapter is a discussion of the four main thematic categories identified from the interview data, as presented in Figure 2. Each section will explore a theme, its code categories (i.e., sub-themes) derived from the data analysis procedures, and include representative quotations to illustrate and support the thematic framework.

Physician Professional Identity

The first major theme is physician professional identity. Professional identity can be understood to refer to ways of being and relating in professional contexts. A useful operational definition is offered by Ibarra (1999), who proposes that “identity...is the relatively stable and enduring constellation of attributes, beliefs, values, motives and experiences in terms of which people define themselves” (p. 2). Gradually, a profession’s value system becomes a part of each individual professional’s worldview.

The literature on professions views medical doctors “as members of one of the most stereotypical professions, characterised by extensive autonomy, medical rationality,

evidence-based treatment, natural science, knowledge expansion and devotion to duty” (Martinussen & Magnussen, 2011, p. 194). Many of these characteristics of physician professional identity emerged in the data analysis and findings for this research study. In each of the following subsections I will focus on the four sub-themes of physician professional identity emerging from inductive data analysis. They are:

- individual autonomy and self-reliance,
- medical expert,
- problem solving, and
- patient-centric focus.

Individual autonomy and self-reliance. Physicians are trained primarily in clinical management (i.e., managing patients) and accustomed to autonomy and primary responsibility in their medical practice. Performing a leadership role requires a change in one’s understanding of their professional identity. Physicians may need to reconcile the feeling of loss of high individual social and professional status when undertaking administrative leadership work. They must shift their thinking as they become a leader of a medical program or department, working as part of a team, rather than seeing themselves as autonomous and independent of organizational structures.

One physician pointed out the individualistic process of gaining admittance to medical school, acquiring knowledge through years of study, securing a residency, and then ultimately being responsible for the sometimes life-and-death, autonomous decision making that happens in clinical practice. In terms of independence and accountability, he explained that

As a physician you go through medical school and you have exams and you pass them or fail them. You don't fail them as a team; you pass them or fail them yourself and get kicked out if you're [not good enough]. Then you have to apply to a residency and you get there yourself, you don't get there as part of a team, and then you're evaluated and examined yourself to be sure you've got the skills and you're going to have a patient in front of you. It's *you* that has to make the decision; *you* have to know the stuff. You know, with all due respect, I don't blame doctors or anybody who's in that responsible position for a patient in front of them, that they have to be, have to know how to do the cognitive skill thing.

As this participant shows, the training and evaluation that most physicians have had in learning medicine has emphasized this individual responsibility.

Despite the claim throughout health care organizations that the system cultivates and runs on high-functioning inter-professional teams that make collaborative decisions, multiple participants admitted that working with others is not natural for physicians, nor is it desirable. As one participant reported,

There are not too many docs that have actually come out of collaborative, interdisciplinary teams. They are not used to doing that. They're in a team, but they're the boss of the team. Like I say, they write the orders and it happens.

Many participants also touched on the shock of realizing that they might have to work collaboratively with others. "I think that for a lot of physician leaders that is a bit of a surprise moment for them, in terms of realizing that they're dependent on others," explained one physician. Another senior physician leader summed it up this way:

You have to be able to first work in a group, and that's something that physicians over many years haven't been doing as much. Over the last 10 to 20 years there have been lots of changes and physicians have had to learn to work in a group and accept that they're part of the group and not just a decision maker on their own.

Medical expert. Medicine is considered an expert culture with a strong hierarchical status. Physicians are highly accomplished academically, and attain power and prestige through their mastery of specific subject matter.

As professional experts, physicians are sometimes expected to know it all. "Let me tell you this is *the* physician thing," professed one participant. "You get 'MD' and you've got instant cachet. You walk into the room — you're the doctor, man! And that's part of the problem." The "problem" in question relates to leadership knowledge and skill, and admitting you may not necessarily have it. While physicians are natural leaders on clinical teams when it comes to making decisions in the interest of the patient, this does not necessarily translate to having the leadership capacities for success in an administrative role, supporting the organization's objectives. Administrative leadership is different than clinical leadership and requires a different set of capabilities, attitudes, and strategies. Instead of being the authority figure, in charge of the clinical decision making, as organizational administrators physicians need to access skills to work collaboratively within sometimes unclear and slow moving bureaucratic structures. Physicians are so invested in the medical expert role — as is the rest of the health care system — that it becomes an even stronger part of the identity that they have as a professional clinician and makes it challenging to invest in learning different skills required to function well in a leadership role.

Furthermore, medical culture appears to undervalue leadership roles, privileging other aspects of a physician leader's professional accountability above leadership within the broader health care organization. A majority of participants acknowledged this reality, with one senior leader explaining:

Yes. That's notorious in medicine: whatever you do clinically is what you are valued for; and your education piece and your administration piece is not really recognized. Research is [recognized] if you're a prolific researcher and getting lots of peer-reviewed publications, but teaching, education, leadership — I don't think we value that well enough at all. It's some of the hidden curriculum of medicine, that that stuff's not important.

Multiple physicians in the interviews echoed this prevailing attitude within medical culture explaining that, for physicians in leadership roles, it is not necessarily effective leadership behaviours that gain respect from peers but rather that you have established sufficient clinical credibility and distinction *before* taking the leadership job. Witman, Smid, Meurs, and Willems, (2010) describe medical prowess as “cultural capital in the medical world” (p. 490), adding that “Only when their medical colleagues consider them to be wise men [*sic*], are they actually able to influence the clinical activities and state of affairs of the group” (p. 491). “You actually have to be a better clinician than your peers if you want to do leadership. You have to almost work harder than them because they almost expect that from you,” explained one participant. Another physician explained it this way:

How do you become a credible leader if you're not a credible clinician? People would look at someone and say, 'excellent surgeon', so if he's going to get up and

talk about leadership, rightly or wrongly, that's what's going to make me say, 'I'm going to listen to this guy'.

The criteria for effective leadership in terms of gaining credibility and followers from the perspective of the physician population is that the leader have outstanding clinical skills, but this is not always helpful in actually carrying out the act of leading. That is to say it helps in that physicians will garner respect from other medical doctors and that they have proven that they have expert knowledge in their particular area, but does not necessarily provide them with the skillset needed for an organizational leadership role.

Problem solving. Physicians are taught to be problem solvers who employ the “clinical method”; this involves linear thinking along steps in a process of making a diagnosis and then intervening with effective treatment. This ability is honed through their medical training and is necessary to effective patient care, but it does not always translate well to the sometimes bureaucratic world of administrative leadership where problems are multi-faceted and complex and processes require involvement from multiple stakeholders. A senior physician explained:

As I've said, doctors are pretty hung up on the clinical method — take the history, do an examination, I get a diagnosis, I announce the plan — and they bring that into their administrative activities.

A majority of participants alluded to problem solving as a reaction to an issue that is presented; often quickly “diagnosing” and “treating” any administrative leadership matter that comes before them. Also, focusing on only “the facts” and responding with speed seemed of paramount importance. “When leading doctors, you're still dealing with

people that are back in the mindset of, ‘okay, so there’s the facts, there’s the problem, there’s the solution; why aren’t you doing it?’” Another participant described it this way:

Doctors are problem solvers so they tend to look at clinical situations and take the facts at hand. They’re used to rapidly moving into, ‘okay here’s my impression of the situation; here’s what I think we have to do.’ They’re kind of action oriented so they want to do ‘*that*.’

Obviously, reactions often need to be quick when making life-or-death clinical decisions; however, when applied to administrative leadership roles, reactive decision making can sometimes be problematic. According to one participant,

It’s your medical training. Physicians are very reactive people. If you put blood work or a lab result in front of me, I react to it. I think that’s what we do automatically. That’s not necessarily the best thing for leadership.

Another physician added,

I think what happens, especially for physicians and where maybe we fall down, is that a patient sits in front of you and you’re in the moment in medicine and you have to make a decision immediately, because it’s life or death. Perhaps what we do as physicians is that we are too much jumping to solutions, rather than taking the time to think about what the possibilities might be. That can be a huge challenge for physician leaders. How do you make yourself slow down to get to the answer? That’s what you need to do.

Moreover, physicians are trained in the scientific method. This means that they are data-driven, fact-based, deductive/analytical, and, as described above, often focused only on the “black and white.” For many participants moving forward quickly with “a

fairly black-and-white, ‘okay I’ve got what I need and here’s what we’ve got to do’” attitude was standard.

Multiple participants demonstrated an awareness that administrative work is often less clear cut, and can involve more shades of grey. As one participant acknowledged, I know I started off that way as well and it is a learning curve for everybody when you get into administration that you have to realize that, in general terms, there is not necessarily one solution or one assessment of the situation. It’s pretty rare that you actually have all the facts at your disposal.

One of the reasons physicians are such an important voice at the administrative table is that, despite the shades of grey, they remain a strong advocate for the best interests of patients.

Patient-centric focus. It is the job of the physician to focus on each individual patient, and to deliver quality patient care. Many participants expressed this same viewpoint, relating the focus on individual patient outcomes through the lens of a code of ethics and the duties of a doctor. Leadership roles require a broader focus, considering things like system decisions, policies, processes, and resource allocation with the perspective of the whole population in mind. Deciding where to allocate limited resources at an administrative level, while being the best decision for the wider population, can at times be bad for individual patients.

A senior physician leader remarked:

I think if you look at the [Canadian Medical Association] code of ethics — I can’t remember exactly what the first line is — but it reads something like, ‘your first responsibility is to the patient’ so that sums it up as a practicing physician. Your

responsibility is, first and foremost, to an *individual* patient. So when you're in the trenches working as a doc you tend to be fighting for your group of patients; the patients that you are looking after. So you see everything from that lens.

This perspective shows that the point of view of the practicing physician is narrower than the one they are expected to exhibit as a formal leader in the health care system.

Similarly, through the concept of *duty of care*, multiple physicians returned to a patient-centric focus during their interviews, declaring, "You're advocating for an individual patient because that's your job. That's your number one job. It says right in the code of ethics. *That's* your job. *That's* your responsibility." Another participant echoed this principle explaining, "Your focus is very much centered on an individual patient and their problem or a collection of those patients."

This is both why we need physician leaders — their valuable perspectives on the real problems patients face — and also what appears to make it difficult for them to balance the perspectives of larger system issues with the individual people they serve.

A senior physician leader summed up the physician professional identity this way: I think most people that choose medicine — not all, but most people that choose medicine, and even a larger percentage of those that end up in leadership roles — tend to be smart to start with, they tend to be efficient, organized, and tend to be very black and white and autonomous and used to giving orders. I say that probably 95% of physicians in leadership roles are like that. At least in adult medicine. Paediatric medicine or psychiatry maybe not as many but in adult medicine and surgery, those are the type of people that gravitate towards leadership roles. Decisive dictators. Highly opinionated type-A people.

This speaks to the type of person who naturally gravitates toward the medical profession. To be a successful physician, you need to be independent, authoritative, and an individual expert. It seems, however, that the traits that medicine selects for are the opposite of what we ask of our leaders in a health care system that is transitioning towards a more collaborative leadership model. This is the reason leadership learning is necessary for those who take on these roles.

Organizational Culture

The second major theme to discuss from the findings relates to *organizational culture*. “Meanings, norms and values, and routines and rituals [are] phenomena that are variously collected under the heading ‘culture’” (Pope, Braithwaite, & Hyde, 2010, p. 2), and it is well established in the literature that organizational culture has a large impact on processes within organizations. Schein (2010) defines culture as a collection of traditions, values, policies, beliefs, and attitudes that constitute a pervasive context for everything we do and think in an organization; more simply, it can explain “the way we do things around here” (Deal & Kennedy, 1982, p. 4). These definitions suggest a pattern of organizational behaviour and action supporting the notion that culture is “one of the most powerful and stable forces operating in organizations” (Schein, 1996, p. 231).

My findings indicate that the organizational culture within the Canadian health care system emerges as a frequent barrier to physician leadership success. Participants recounted stories of feeling constrained by disempowering structures and organizational pressures that place financial sustainability of the health care system in competition with high quality, patient-centred care. Study data suggest that there is a lack of understanding on the part of the organization (as represented and headed, notably, by a group of non-

physician administrators) of the clinical realities faced daily by physicians, and how these are often at odds with organizational expectations of the physician leader. Participants also conveyed considerable dissatisfaction with basic organizational arrangements (i.e., human resources support, leadership development, succession planning) that fail to adequately support physician leaders to be successful.

I will now focus on the following sub-themes of organizational culture:

- conflicting priorities,
- lack of time and financial support, and
- inadequate administrative structures.

Conflicting priorities. The sub-theme of conflicting priorities relates to the connection that physician leaders have to organizational culture. Participants noted feeling at odds or cross-purposes with the organization, as evidenced through divergent objectives that require physicians to navigate between the clinical and administrative leadership worlds. Many physicians questioned the organizational objectives of “the administration,” stressing that their (i.e., physicians’) priority was to meet the needs of the patient, while the administrative work asked of them by the organization took time away from patient care. One participant offered the following view:

The conflict — especially in our system — is the patients are coming through the door, and coming through the door, and coming through the door. That’s our business. Our business is to take care of the patients that you get. For the AFP guys, the academic funding plan [physicians who receive a specified amount of funding per year, as opposed to physicians who receive a “fee-for-service” per patient visit], they were typically funded, 10 years ago, at a 70-30 split. So 70

percent clinical, 30 percent academic/administration/education, that kind of thing. Well that was pushed to 75-25. Now it's being pushed to 80-20. The clinical piece keeps growing but the support for the academic side, the academics and the leadership side, that's just not there.

Additionally, physicians described a bureaucratic organizational leadership culture that demonstrated poor communication and lack of inclusion of physicians in decision making, leaving them feeling unappreciated and devalued as leaders. "Really it's all culture. Who's at the top and what's the culture of the place," offered one physician, in an attempt to explain what was at the root of physicians' sometimes negative view of the bureaucratic organizational culture.

Another participant explored some systemic concerns that touch upon conflicting values and "ironies" of the health care system.

One of the ironies of the Canadian system is that physicians cost money, right? In a lot of other systems, physicians generate revenue. We don't. In Canada we cost the system money, so we're looked at in a different light I think. I don't know but I wonder if that's part of the reason why physician engagement is not always desired within the hospital structure. And maybe that's part of it: that we tend to advocate for patients; we're the ones yelling and screaming that there are 16-hour waits in the emergency department. That's our job, right? As physicians — Hippocratic oath, everything we do, and everything we stand for — we are trying to advocate for what's best for the patients and that causes hospitals problems, if you're in a scenario where treating patients costs money.

These values conflicts, or feelings of administrative leadership work being at cross-purposes with the mission of providing and advocating for the best patient care, only serve to further incubate an attitude that is already present in many physicians' perspective of the health authority: that physicians are separate from the organization, or that it is "us versus them." One participant described navigating this divide:

I'm sort of working as a middleman between the institution and my division; sort of sitting in the middle of a fight, not invested fully on one side or the other. But as the leader of my group, I need to do *that* and as the leader appointed by Nova Scotia Health I need to facilitate *this* resolution.

For some physician leaders, the "*that*" required of them by their physician group and the "*this*" asked of them by the organization are often misaligned or at cross-purposes, exacerbating feelings of values incongruence.

Lack of time and financial support. All participants expressed how the demands of formal leadership positions coupled with day-to-day clinical workloads often leave them feeling overwhelmed and conflicted. Every physician leader in the study — as is common in the Canadian health care system — maintained some percentage of clinical practice in conjunction with performing in a leadership role. "Juggling the administrative load plus the clinical load has been a huge problem," said a senior physician participant. She explained further that

In the physician world one of our biggest challenges is we're supposed to do all of this administrative work simultaneous with continuing to do clinical care looking after patients. That is extremely challenging so if you are designated in a big administrative job with 50% administrative time and 50% clinical time, which is

what I am in currently, I would say that your week is going to be 80 or 90 hours every week.

These percentages can often be pushed to increase the expectations for clinical time at the expense of “administrative” time because “patients [are] coming through the door that need to be seen, period, full stop.” One participant described it this way:

I have nominally an administration day to help with, to do education stuff and my associate chief stuff, once a week. But, if we are short of [doctors] and patients need to be seen, (snaps fingers) it’s gone and I’m back in the clinic and I’m trying to stuff meetings into a full clinical day. The patients don’t go away, ever.

Despite this reality of patient care trumping dedicated administrative (i.e., leadership) time, many participants also described an organizational culture of “meetings” where “full-time administrators” fail to appreciate something as seemingly obvious as physicians’ practice hours. One senior physician leader noted that an average week for her included “26 hours of booked meetings...yet you’re supposed to do clinical work.” She explained that, in addition to carrying a large clinical burden,

The administrative world also expects you to be available for all of their meetings on their time schedule, which does not respect clinical work and physicians’ and patients’ time at all. So, when the director calls you up and says, ‘I need to meet with you today!’ I’m like, ‘I’m scrubbed and in the operating room all day.’ ‘Well, I need to meet with you today. It’s urgent.’ What am I supposed to do? Let the person die? No, I can’t do that.

The organizational culture, as represented by the expectations of physician leaders by administrative leaders, supported a lack of sensitivity to the time demands of clinical work.

The lack of financial support was also a significant sub-theme within the data set. Compensation for physician leadership positions can vary significantly and participants cited that they were being asked to “take on fairly large tasks and large blocks of time with very little compensation.” Accepting a leadership role, then, could be “a total financial sink” as payment “may be 30% of what [you] would make if [you were] billing clinically.” One mid-level physician leader echoed the importance of adequately compensating leadership duties, since medicine is a “business,” after all. He offered the following assessment:

You’re the senior guy, you’re the division head, you’ve got to do this for five years, to go to these meetings, and it interrupts your golf game, and you can’t see patients and whatnot. And so it becomes something that [physicians] resent because it’s costing them money to do something they don’t want to do. If that is the mindset that you have going in, “this is a downer for me”; it downs my income, downs my spare time. The effectiveness in the role is going to be down also. You’re going to be disinvested.

Another more junior physician leader noted:

The time that I spend [in my two leadership positions] is not compensated at all. Not one cent from [the university] or the hospital. The department gets a budget for academic activities, but none of it is specifically earmarked for me. So the only way that I can do this is through the grace of my peers who are willing to sit

there and do work and read the cases and see the patients to free me up so that I can do some administrative stuff. And that only goes so far.

Another participant described the way in which their physician group has worked around the administrative structures to ensure that leadership work is fairly compensated:

One of my legacies is that I've developed a divisional practice plan for which we pool income and share amongst ourselves. So I've incorporated in an allotment of compensation for nonclinical activities and, in my case, for administrative roles.

So I'm okay but *I* was the maker of that. I have colleagues who are in similar positions where this is done for free.

This illustrates even further the disconnect physicians experience: rather than identifying a need and navigating the system to try to address it (i.e., create a paid position), they work outside of the system because they assume they will not find the support they require. Organizations demonstrate what they value as important by where they focus their time, attention, and money. These physician leaders clearly indicated experiencing an organizational culture that expects but does not value their leadership contributions.

Compounding the feeling of lack of time and support to do the leadership work is the fact that many physician leaders in academic health sciences centres are dealing with two separate administrations, being cross-appointed to the university in addition to their health authority leadership role. In an earlier paper I wrote with a colleague I summed up some of these issues, speaking to competing demands on physicians' time and how that further impacts leadership development for this unique group:

Physicians have busy lives, both professionally and personally, and with increasing time demands from multiple areas, such as clinical, teaching, and

research, the additional expectation to create time to develop leadership skills can be difficult. Maintenance of competency is required for all physicians. Those with academic appointments are also required to have periodic evaluations linked to continued appointment and are strongly encouraged to seek academic promotion as part of academic career development. Thus, additional requirements for leadership development must consider other competing priorities and develop opportunities for acquiring leadership capabilities that are respectful of the increasing demands from other areas of the system. (Jolemore & Soroka 2017, p. 152)

Inadequate administrative structures. Physicians described facing a considerable burden of responsibility resulting from their formal leadership positions, yet noted significant deficits in organization-sponsored support structures to help them succeed. Despite rhetoric from administrative officials about supporting doctors to engage in leadership positions, the majority of participants expressed the view that the organizational culture seldom appeared to be supportive. Physician leaders described specific organizational deficiencies in the areas of administrative/human resources assistance, leadership development, and talent management/succession planning.

Physicians “don’t have very much administrative support to do their part of the administration,” said one participant. Many senior physician leaders echoed this, with one in particular noting the contrast between her situation and that of her non-physician, director co-lead:

The other thing is that I think physicians, as a rule, have very little administrative support. [My administrative co-leader] has a great big office and has a secretary

and a businessperson and whatnot. I have my half a secretary that does my full clinical practice, has no knowledge of accounting, budgets or even how to open or run an Excel spreadsheet. And she has to do all of the support work for the administration side of everything from dealing with patient complaints to writing proposals to government for this, that, and the other thing, to budgets.... And she just has to run my little practice of however many thousands of patients that I have.

The sub-theme of inadequate support extends to leadership development opportunities offered to physician leaders.

I definitely don't see a lot of support for physician leaders, zero, to be honest.

There's very little support. Once you're a leader there's very little development of leaders, that I can see, and maybe I just missed it, to be honest.

Referring to the organizational system/structure, one participant noted,

It's not built in to keep you on track with your leadership skills. There's nothing in my job that actually helps me to ensure that I have leadership skills — either getting better at them or I'm maintaining — other than what I do for myself at this point. There's nothing.

Complicating matters further is the apparent lack of attention and planning from the organization for recruitment and selection of future physician leaders. Many participants commented on the often-haphazard physician leadership selection process and dearth of formal performance appraisal systems and succession planning. "Right now...succession planning and who's a leader is almost a crapshoot," offered one participant. Another physician expanded on this, admitting

Sometimes we don't plan ahead well; we don't have time to choose and then you get stuck and you pick whoever is available. But sometimes you do it the right way and try to bring the best person for the job.

A participant who was very new to formal leadership offered an insight as to why there is a lack of support from the organization, linked to a perception that all physicians are viewed as "leaders." This, she felt, may result in a lack of proactive talent management and succession planning for physician leadership posts.

As a physician, I think [the biggest challenge] is the expectation that you already are a leader and therefore you don't need to learn it. That's, I think, the biggest challenge. And again, I'd say the same thing for teaching. So it's the same thing in medicine and teaching. You're assumed that you're a teacher so why would you need to learn how to teach? So if people already assumed that you can lead, they're not going to put a lot of time or training into making you be a better leader.

This touches on similar themes addressed in the sub-theme 'medical expert' — the skills that make you a clinical "leader" are not necessarily leadership skills, and don't transfer to an administrative role. "There may need to be some way of vetting people for leadership because if they're really not well suited to it it's an uphill battle for them," offered one senior leader who was also an accomplished surgeon.

I've learned that good doctors aren't always good leaders.... It's a huge jump, it's a huge jump, and it's not easy to do and most people can't do it. They feel if I'm a good surgeon then I'm going to be good at whatever I do.

Study participants did not speak directly to issues of skill transfer from their clinical leadership roles but the majority did acknowledge that administrative leadership was different and required different skills and supports. “It’s not related to your skill as a doctor; it’s a different kind of skill.” One participant summed it up nicely saying,

If you’re going to put people into administrative roles, recognizing that they were trained in a situation where they got none of that [leadership] training, you have to invest in them. Otherwise, you’re setting yourself- not just them- you’re setting yourself up for failure.

Finding themselves in a leadership role with inadequate administrative structures including a lack of leadership development opportunities and formalized succession planning, physicians felt left to seek their own learning opportunities within the workplace learning context.

Workplace Context

In this section I will explore the third major theme in this study — *workplace context* — which provides an overall frame for the specific leadership learning experiences of the physician participants: *how* leadership was learned. The health care/hospital workplace emerged as the primary environment for learning leadership knowledge, skills, and attitudes.

When asked about their specific leadership learning experiences, participants provided examples along a learning continuum from informal to formal methods. “My learning journey is a mixture of formal courses that you learn about and then mentorship, and then learning on the job and learning by experience and dealing with situations and

having support from the group around you,” summarized one participant. Eraut (2004, p. 250) explores the notion of a continuum of learning tactics explaining:

Characteristics of the informal end of the continuum of formality include implicit, unintended, opportunistic and unstructured learning and the absence of a teacher. In the middle come activities like mentoring, while coaching is rather more formal in most settings.

While some physicians recalled attending one or two formal leadership learning initiatives during their career, such as a seminar, workshop, or presentation delivered by a professional instructor, these kinds of structured training events were infrequently described as valuable. In contrast, all physicians recounted stories of “living in the trenches,” learning through “trial and error,” and getting “advice and guidance along the way.” This kind of learning through work activities and situations was dominant in participants’ responses, and emphasized the dynamics of everyday learning and interaction, highlighting the interactive relationship between physicians, their colleagues, and their work environment.

Specifically, study participants described a range of informal strategies including observation, conversation, informal mentoring, and reflection. The sole predominant method of structured learning reported to be of tremendous value was one-to-one executive coaching. I will now focus on the specific learning behaviours that participants had in common through each of the following sub-themes of workplace context:

- observational learning,
- learning from experience,
- informal mentoring relationships, and

- coaching.

Observational learning. Participants frequently mentioned learning leadership by “just watching” other people in leadership roles. “It’s seeking out the opportunities to being a leader and learning, paying attention while you’re there,” offered one participant. While only one physician specifically named it “observational learning,” this method was echoed by many.

Watching people in public or even in one-to-ones; just seeing how they approach stuff is a great way of learning. Would that be something you’d ever want to use yourself? Or, you just say, ‘I wouldn’t do it that way’ or ‘I would do it a different way.’

Observing undesirable leadership practices, or the “how *not* to do it,” was very common. “Some of it has been more negative learning. I’ve certainly been in many, many meetings where I cringe at how poorly run they are and so from doing that you learn what not to do,” offered one physician. Another senior physician leader remarked,

Just watching how people approach things is just fascinating to me. Watching how people interact has been a really good way to learn what you would or would not do. And that’s at all levels. Seeing how that turned out, I wouldn’t do it that way.

Watching people lead poorly can also lead to feelings of disappointment, however, and one participant described it as “negative learning.” Another physician who was a relatively junior leader related a story of being let down and disillusioned when she became part of a leadership team and witnessed poor displays of leadership from people whom she personally and clinically held in high regard.

The folks around the room were a lot of the people that I would have considered possible mentors. They had leadership roles and I would've considered them mentors so watching them 'lead' really threw me for a loop, for sure, because it was like, 'oh these people that I thought were excellent at this from my perspective as a resident, actually are not excellent at this at all!' It felt like things were getting dropped and things were getting missed, and people weren't showing up. There was just all of this stuff happening, it really did make me step back and say, 'okay wait, if I'm going to be in this group we either need to change how this group works or I need to change my thinking about how to lead in this type of environment.' I do think that for me was sort of an aha moment where I was like, 'whoa.'

Negative role models can provide powerful and memorable learning experiences, especially when, as in the scenario above, the person in question's actions did not align with the observer's expectations. There was a sense among some of the participants that negative role models left more of an impression than positive ones. One participant described learning from both negative and positive role models, and the value of gaining experience with positive role models:

I've had many, great people I've interacted with at the VP level and the department head level and in HR and my managers and directors, and I've learned from each one and it really makes a big difference in how you grow and how you move on. And then when you deal with so many good people and then there's one or two people that are not as good you know how to handle them because you

know what's a prototype of a good person (laughs) and what you have to handle when they're not as good.

Although the negative role models were often more memorable, one participant summed up the experience of observational learning from good leaders: "Every day, I guess, there are examples of things when I say, 'oh, I really need to be more like *that*'."

Further to learning by *watching* was learning by *doing*.

Learning from experience. Participants specified that most of what they had learned about leadership came from actually *doing*. Participants recounted on the job, experiential examples of "trial and error" but noted, too, the importance of reflecting on and learning from the event. So, for the purposes of this study, learning from experience will be interpreted as informal workplace experiences that, when paired with or followed by reflection, serve as a catalyst for learning.

Reflecting upon experiences appeared to be central to physicians' leadership learning. Respondents conveyed the importance of being able to reflect on their actions, any subsequent learning, and gaining insight into themselves and their interactions within the workplace context. One physician explained that

Somehow, for me, I tend to analyze what I've done and look inwardly to myself to figure out what I need to do next. I know that sounds a bit odd but I don't pick up the phone say, 'hi, what's going on? How did you do this?' I seem to be able to look into myself and say, 'how would I do that differently? What would I do next?' and kind of sort it out that way.

This internal reflection on action was consistent among the majority of participants.

Furthermore, learning from mistakes was highlighted as key to leadership learning. One

physician, when asked about encountering significant events that have helped him to grow as a leader responded,

There's a few things I've done: number one is I recognized early on that I learned a lot more from my mistakes than I did my successes. So every time things didn't go well, then I've actually blocked off time to think about why it didn't go well and what I might have been able to do differently. That, over the years, has helped me a great deal. And one of the things I've always said to my guys is, 'you know, I'm going to make mistakes. If I'm not making mistakes I'm not doing the job. But what I do pledge to you is I'm not going to make the same mistake over and over and over.' And so that's what I try to make sure is that maybe there are people out there who just can innately do it and get it right the first time, but that's not me. I'll do it. I'll make mistakes. I'll reflect on the mistakes and then, hopefully, I won't make the same mistake again. And that's really held me in good stead over time.

Additionally, virtually all participants mentioned significant people in their stories of learning from experience. One summed it up this way:

I would say that I've learned from lots of different people, little things over time, either by interacting with them or seeing them in action. Chatting to them, getting their advice or just simply making my own mistakes and talking to someone about it after getting some advice about how to move it forward.

Often, talking to someone and getting advice led to informal mentoring relationships.

Informal mentoring relationships. For many study participants, mentors were an important source for leadership learning. "The vast majority of what I've learned

around leadership has been from informal mentoring,” explained one physician. Another added, “I’ve encountered people in leadership roles and then sort of sought out mentorship when needed.”

For the purpose of this study, mentoring will be defined as the process of one person supporting, teaching, leading, and serving as a role model for another person. Mentoring is often divided into formal and informal types. Formal mentoring relationships are often assigned relationships, overseen and guided by an employer-sponsored mentoring program. Contrary to that, informal mentoring relationships develop on their own, such as when a person approaches a possible mentor and that person agrees to form a mentoring relationship (Buell, 2004). It is this informal mentoring relationship that is apparent in the findings.

For some, the mentor was quite often their immediate superior (e.g., department chief), and participants recalled learning informally from that person and not as part of the formal requirements of the job. A participant offered this perspective on a mentor:

Well certainly the number one most significant person has been my [department] chair just because he’s one of the people I’ve observed. He’s had success and does a lot of things really well. And he does a lot of things that I think he could improve upon and he’s always open to discussing those with me. He’s kind of made it his goal to mentor me so I can bounce anything off of him and have that high-level discussion.

The prevalence of examples of mentors who were the direct superior to the physician is unsurprising given the proximity and regular exposure of physicians working in the same clinical area. As well, the hierarchy of medical culture suggests that junior doctors would

look up to senior ones for advice and leadership. In this vein, one more junior physician leader indicated, “I actually solicited [advice]. I asked. I said, ‘I want to learn from you, I want your honest opinion of this stuff.’”

Additionally, peer mentors were common and all participants revealed seeking advice to some degree from a trusted/respected colleague, or “skilled administrator.” Said one physician, “There’s a director within [a department] who’s quite a skilled administrator and he’s been very useful as far as getting advice on how to proceed.” Another participant explained, “definitely there were people I would go to if I needed some sound advice or I needed some, just some level-headed discussion about something, or I felt like I need some direction.” Developing intentional networks and proactively “reach[ing] out to people to help you and give you advice” and support also seemed to be a key thread throughout the majority of participants’ histories.

I’ve certainly gone out of my way to contact and develop relationships with key leaders. So, no one specific event but it was probably a good decision on my end, taking the time to think about whom are the people that I need to learn from and develop.

A senior physician leader who clearly supported and utilized informal mentoring recalled not always feeling that way.

It’s funny because sitting here, I remember 10-15 years ago I heard somebody talking about mentorship and I was like, ‘oh, this is overrated.’ But now I realize, no, it’s not overrated. It’s really important. It’s definitely very important to have someone guide you slowly through the process.

Another participant felt that mentoring should be a formalized requirement for leaders at all levels, stating that

you probably should have a mentor if for no other reason than just for someone you can go to to say, ‘you know I’m in this pile of crap, what would you do?’ Just to bounce it off of even if they were of no help to you. At least it’s someone you could talk to about it. Someone, in confidence, that you can bounce problems off of. I think that that would be very valuable.

Beyond the importance of mentoring relationships, many participants echoed the value of having “Someone, in confidence, that you can bounce problems off of.” For many, that person was a leadership coach.

Coaching. The lone predominant formalized intervention described by the bulk of physicians as being beneficial to their leadership learning was coaching. I use the term “formalized” to describe this learning intervention because the coaching was structured, employer-sponsored (i.e., no cost to physicians), and delivered by a certified executive coach/instructor who was an employee of the organization.

Leadership coaching is broadly defined in terms of a relationship between a client and a coach that facilitates the client becoming a more effective leader. For the purpose of this study, coaching is specifically understood to be a structured one-to-one relationship, “in which the coachee and coach collaborate to assess and understand the coachee and his or her leadership developmental tasks, to challenge current constraints while exploring new possibilities, and to ensure accountability and support for reaching goals and sustaining development” (Ting & Hart, 2004, p. 116).

Many physician participants found leadership coaching to be significant to their learning, describing it as an “unbelievably useful” and “absolutely critical and key,” with the coach “being able to help me to start to think of things in a more structured way.” One physician reflected on the beginning of her leadership journey, describing coaching as “absolutely, enormously helpful” and “potentially the most helpful [thing] in my leadership role.” She continued, noting,

I have, ever since then, now for almost close to five years, been meeting with a leadership coach about once a month. And that has been unbelievably helpful, both in my personal and professional life, because the two are so closely linked of course. It’s been so helpful to help me get clarity on what I’m doing, to help give me perspective. And the coach never tells me what to do...It’s just the sort of questions and the listening and asking the relevant questions.

Another physician described the value of the individualized learning tactics a coach can provide, explaining,

I think the leadership coaching is critical because I think the coach — an experienced leadership coach — can guide you into what direction you need to go in because it’s all context-sensitive and people have different requirements and come to the table with different levels of development of skills. I think it’s important that they can sort of guide you around the various options.

In addition to getting clarity and perspective on tasks and actions, other physicians recalled the coach’s “ability to help me get to know my leadership style and to get to know the core things that I’m all about,” suggesting that coaching interventions may help to increase self-awareness.

Those participants who noted coaching as part of their leadership learning strategy also appreciated that coaching focused on specific, real-time needs while providing a built-in accountability mechanism for them. Said one physician,

It was focused on individual needs and in that coaching relationship the coach holds you accountable for making change or performance and that sort of thing, which is very important.

Of significance to this study is that coaching seemed to provide the necessary structure and conditions for self-reflection, leading to increased self-awareness. “To be a good leader you really have to know what you’re all about yourself and a lot of people like me will not take the time, for the most part, to actually sit down and do that,” said one physician. Another participant offered a similar view, noting that

Just checking in on a regular basis promotes reflection and helps move things along and I’ve changed permanently based a lot of these things. It’s really important; you have to spend some time with an open mind to having people guide you.

Physicians also reported that the regular one-hour appointment format helped to focus their learning and make it more deliberate and intentional. Said one senior leader, “[the coach] was forcing me to think about things in a very structured way and my decisions, I think, got better just simply because I was spending more time thinking about what I was supposed to think about.”

Leadership Learning

The fourth major theme emerging from the data is *leadership learning*, which represents the specific critical capacities described by participants as essential for a

physician to succeed as an effective formal leader within a large health care organization.

In this section I will explore the following sub-themes, which represent these key capacities:

- learning orientation,
- self-awareness through reflective practice,
- systems thinking, and
- collaboration.

Learning orientation. Continuing professional development is critical for both clinical maintenance of competence and for leadership and administrative skill sets. Just as good physicians pursue continuing medical education and work to maintain competence and confidence, good leaders never stop working to become better leaders by emphasizing mastery and increasing levels of competence. Physician leaders need specific skills to lead effectively, most of which are not acquired during medical training or daily clinical experience. Surprisingly, intentional learning and willingness to engage in *leadership* learning among physicians is not always common.

However, a majority of study participants appeared to have a high leadership learning orientation and described learning intentionally from practice and work experiences, and taking on leadership development challenges in a deliberate and consciously planned approach. “I try to improve myself every which way you can imagine. That’s just me. I’m a little different than a lot the regular physician leaders, probably,” offered one participant. He continued to explain that

Medical school teaches you how to be a doctor, not how to be a leader. And so very rapidly I figured out that if I’m going to do this I better figure out which end

is up and do it soon because there's people depending on me. So I started getting all kinds of books on leadership and actually eventually found John Maxwell and I read a lot of his books. I've also joined the maximum impact club. Every month I get audiotapes and go through the audiotapes and those were great because I could actually pop them in my vehicle when I'm coming in or going home and so they were great. They help me fill the time and it actually helped me get some real learning behind it.

The physician leaders in this study largely seemed to show a genuine willingness to engage in leadership learning. One physician described having “the understanding that you have to be willing to learn and have an open mind to learn.” Furthermore, some participants openly described themselves as being “an amateur at leadership,” “ridiculously unqualified for the job,” “out of my depth,” and “a student of leadership right from the beginning,” which seemed to give impetus to deliberate learning. One senior physician leader reflected on his leadership learning this way:

One of the things I always say is when I walk onto the unit I'm going to learn something new this week. It can be something about the disease process I haven't seen before. It can be something that I haven't seen in a long time or can be something about a surgical procedure that I didn't know. But every week I have to learn at least one new thing and I tried to do the same thing with leadership.

Self-directed learning focuses on the process by which adults take control of their own learning, set their own learning goals, locate appropriate resources, decide on which learning methods to use, evaluate their progress, among other things. The use of technology and social media was mentioned as a platform for self-directed learning. A

senior physician leader recalled wanting advice on how to balance work and family so utilized Facebook.

I have talked to those who also have multiple leadership roles and who seem to have their act together. There is also a group, interestingly a Facebook group, of Canadian physician moms and that actually has been quite helpful for some networking and problem-solving in terms of how does everybody else figure out the balance of mommy-hood and doctor-hood and all of the other stuff that comes with the academic side of that.

Self-directed approaches were common amongst participants and, I believe, linked to learning orientation/deliberate practice qualities shared by the participants of this study.

Self-awareness through reflective practice. A common view of leadership usually centres on visible individuals and their talents, their contributions, and their measurable achievements. Accordingly, leadership development is often seen as an external process. However, participants mostly described a continuous inward journey of self-discovery and self-growth resulting in improved self-awareness.

Self-awareness can include having a basic and fundamental awareness of one's own self-assumptions, values, principles, strengths, and limitations. Reflective practice is closely related to the idea of learning from experience (as explored in the workplace context section). It is the process of thinking about the work we undertake in a self-critical way. Physicians who observed themselves and their leadership practice from points of view outside of themselves were able to better understand the links between their actions and leadership effectiveness. A senior surgeon observed that leadership is “not related to your skill as a doctor; it's a different kind of skill. It's a matter of being

interested in things outside of yourself.” Another participant echoed this standpoint, corroborating the importance of self-awareness by stating,

I’m very fully aware of the fact that to be a leader is not to be a surgeon. I’m very humble about my need to learn how to be a leader and learn what that requires...I understand dealing with my weaknesses and trying to evaluate that. Constantly trying to reflect on those things.

Many participants suggested that a lack of self-awareness was a contributing factor to leadership failures. “The problem is that we don’t know what we don’t know, and we’ve got people in place who have no idea,” offered one senior physician leader. “To me, the first thing you always should be doing as a baseline is understanding yourself, understanding how you think, what makes you react or not react,” added another. One participant stated, “You need to understand what you’re good at and what you’re not and improve one and utilize the other.” Moreover, the ability to become more self-aware and “see things differently” offers an opportunity to identify and acknowledge deficits in specific leadership skills.

One of the things I keep telling myself is if you just keep doing the same things over and over you’re never going to get better. You’ve got to stretch and you’ve got to do new things if you’re actually going to develop. So I just look upon those things as my learning opportunities.

Building self-awareness through this regular reflective practice seems to set the stage for a broader, systems-level perspective. One physician described the value of reflection:

Taking the time to sit and think about your leadership and try to express it in writing or verbally, that’s very helpful as well. That’s our problem in life, we just

rush, rush, rush, rush. Just sitting down and thinking about the process is very important.

As in Figure 2, this acquired self-awareness helps the physician leader to move beyond the narrow perspective of professional identity to work more broadly within the organizational culture.

Systems thinking. All physicians in this study recounted stories about making decisions independently and autonomously regarding the care of individual patients. However, all were also keenly aware of the many factors involved with decision making at a system level. Holding a systems view — understanding interdependencies and seeing connections rather than only parts — does not come naturally to physicians because from “a practicing physician’s point of view, you’re advocating for an individual patient because that’s your job” (as noted in the professional identity section). Reflecting on their many years of clinical training, the majority of participants described a deep understanding of their medical specialty, yet revealed a narrow view of large, integrated health systems that are becoming the norm in Canada. One participant recounted:

I’ve got to develop systems and habits of things. You see, the structure and organization of the system is different as a leader than as a clinician. As a clinician I just do what’s coming at me and it’s like a snowstorm of work coming at you. So you’re there, you’re in the operating room or clinics, you just do it and you’ve done your job. But administration, leadership, you have to organize your time around things and then you have to look at priorities.

To be an effective leader, participants recognized the need for physicians to develop methods of critical thinking that enable them to solve problems and implement

effective processes across systems and stakeholders. “You can’t work as one individual. You can’t work in a vacuum,” stated one participant. One senior physician leader recounted a story of teaching a professional ethics unit to first-year medical students and a discussion about the legal and ethical responsibility of a physician.

Things always came back to making a decision about a patient. Always whatever is right for *that patient*. That’s where the bottom line fits. You know what? You did that for this particular patient, it’s really not what’s best for a whole group, but that’s not your responsibility. Your duty of care is to that individual patient. The duty of care, so to speak, at a higher level is much broader than that. Then you have to find balance so as a practicing physician it’s easy to sort of get grounded back and say I’ve got to do what’s right for that individual person. But in a leadership role, at a high-level, you can’t do that, because that doesn’t move the whole system ahead and sometimes a decision might need to be made that might not directly benefit that individual patient but benefit the group as a whole to move forward.

The degree to which physicians identified with the larger organization in which they were situated was crucial to developing this “systems thinking” perspective, and their leadership. They were still leading for the benefit of patients, just larger groups of them.

This understanding that larger system decisions can actually have more impact was summed up well by a senior physician participant who, in addition to being a celebrated surgeon, also served in leadership roles with a community-based health network/coalition.

I was president...for three years and that's again an instance where as part of my efforts we ended up getting [provincial government] legislation in and I really reflected that I probably did more for [the health of the population] with *that* than all the surgery I've done. So you start to look at the big picture. And, again, it's not natural for surgeons to do that. Or for doctors.

This reflection gets to the heart of the transition to a systems thinking approach: the ability to see the real difference that can be made through employing a broader perspective and working for the whole population instead of just the individual patient. It is not easy, or natural, for physicians to shift to this perspective, but as one participant described, it is necessary:

I think the other thing is we're in a time when there has to be real change. We can't just keep doing what we've been doing. You need to have someone that has a focus on the bigger picture. I don't think that this is a time for a manager; I think this is a time when you need leaders. You need people who are going to look at the big picture and figure out how to make the big picture changes. Not, 'how do I manage this little bit of this?'

To make these big picture changes, physician leaders need not only to gain a systems perspective, but also to learn to better collaborate with multiple stakeholders within that system.

Collaboration. Embracing a systems perspective allowed for physicians to better consider how they related to other leaders, their team, and the larger organization.

Although for some it was "a big learning curve," a better understanding of the complex health care system led to a heightened emphasis on collaboration to improve outcomes

for patients. One participant admitted that

Once you start to figure that other people have information, that other people have interpretations, you start to realize that when you're confronted with the problem you can depend on other people to offer you help; to help you solve the problem.

Increasing levels of collaborative planning and implementation often meant building trust and mutual respect amongst professional subcultures. One participant described some of the difficulties inherent in this process:

I think sometimes there is tension between different allied health professionals and physicians, depending on who has a leadership role. There are some physician leaders who think that nurses shouldn't have super high up positions and I think that kind of thinking is not helpful to an organization. So I think collaboration is probably one of the number one skills you need to be a leader.

Learning to collaborate also meant moving away from a "win-lose" mentality of autonomous physician authority and power to a focus on working with others to achieve common solutions to complex problems.

You have to be willing to listen to others and learn from them and rethink your decision if you have to based on the feedback that you're getting from other people. It's very important to work in a group.

Relying on and trusting others to work in a purposeful partnership was a learned skill for most participants. "There are many professions in healthcare that work together so you have to be able to have this interaction and this relationship. You need to develop trustworthy relationships with the people that you're working with," said one participant. Another senior physician leader felt "that for a lot of physician leaders that is a bit of a

surprise moment for them, in terms of realizing that they're dependent on others.”

Another physician further explained that

I think that probably goes back to one of the other aha moments along the way. At some point I went from, 'I am the physician leader and I am going to make this happen' to 'okay, if I want to make this happen, we're going to have to work with a whole bunch of people and they're all going to have to get on the same page'. It will happen much better if we work with a team.

Learning to collaborate with others for the sake of bigger picture results revealed to many participants the benefits of developing interpersonal communication and relationship building skills. One physician recognized “the importance of having the relationship, being part of the community and not just focusing on your work and dealing with it [alone].” Another participant echoed this, adding, “definitely communication and interpersonal relationships is a really important thing in leadership.” Another physician identified one aspect of collaboration as the ability to help others learn and grow.

Giving feedback properly, too, is very important to learn. At least for me that was one of the things that I needed to learn and to improve. And I need to continue to improve on it, how to give constructive and honest feedback for people to improve around you. And you have to understand it's not that you're criticizing anybody it's just helping them to grow and you're helping the system to improve.

This recognition of the direct line between leadership learning and broad system improvement illustrates well the value of investing time in leadership learning for individuals, and investing resources in improving leadership development for

organizations. Attending to *how* leaders learn these skills will lead to improved system outcomes in health care.

Conclusion

This chapter discussed the findings of this research study, including the four main themes that emerged — professional identity, organizational culture, workplace context, and leadership learning — along with the sub-themes identified for each. Professional identity in this context included the characteristics of individual autonomy and self-reliance, being a medical expert, problem solving, and a patient-centric focus. Organizational culture, showed up in the data as conflicting priorities, lack of time and financial support, and inadequate administrative structures. Learning in a workplace context included observational learning, learning from experience, informal mentoring relationships, and coaching. Leadership learning represented the capacities described as necessary to succeed as a physician leader including learning orientation, self-awareness through reflective practice, systems thinking, and collaboration. Chapter 5 will discuss the implications of these findings in greater detail.

Chapter 5: Discussion

Introduction

In this chapter I continue to explore the process of leadership learning for physicians who have moved into formal health care leadership roles over the course of their careers by examining connections and interpretations of the study data in relation to adult education theory and literature on workplace learning. I will draw principally upon theoretical perspectives on situated learning theory pioneered by Lave and Wenger (1991) and Wenger (1998). Key aspects of their communities of practice framework, such as learning through legitimate peripheral participation in a community as part of identity negotiation and construction, are important aspects of this study. Moreover, recent progressions by Wenger-Trayner (formerly Wenger) and colleagues (2015) that relate to trajectories of participation, learning through and across boundaries, and managing multimembership in and accountability to different communities of practice in a larger landscape also illuminate my findings. Furthermore, Mezirow's (1991, 2000) conceptualization of transformative learning, and his main theoretical concept of perspective transformation fostered by critical reflection offers possibilities for analyzing study findings as an account of physician leadership learning as an individual transformative trajectory across a complex landscape, negotiating a sense of identity that spans multimembership in different practice communities.

Situated Learning in Communities of Practice

The concept of situated learning in communities of practice as articulated by Lave and Wenger (1991) and Wenger (1998) is useful to provide insight into the development of physicians' leadership practice as outlined in this study. Lave and Wenger (1991)

contend that learning cannot be reduced to a simple process of knowledge transmission, disputing conventional definitions of learning as individual knowledge acquisition. They argue that learning is “situated” in the practice environment and is usually informal or incidental. Learning is an inherent dimension of everyday life and is fundamentally a social process.

The situated learning concept is particularly helpful in providing insights to this study as the findings indicate that frequently physicians learn to lead informally. Much of their learning occurs predominantly through participation in local/workplace contexts. While this study also notes the cognitive acquisition and construction of new leadership knowledge and skill via some structured/formal learning events, most leadership learning appears to be related to physicians’ social participation and engagement in domain-specific discourse and community (Wenger, 1998). Specifically, study participants described a range of informal learning including observation, conversation, informal mentoring relationships, and self-reflection — all situated within the defined domain of the health care workplace. Numerous examples of many of these methods of informal learning were shared in this study, such as this participant’s description of leadership learning:

I would say that I’ve learned from lots of different people, little things over time, either by interacting with them or seeing them in action. Chatting to them, getting their advice or just simply making my own mistakes and talking to someone about it after getting some advice about how to move it forward.

Situated learning relates closely to our understanding of informal learning and is consistent with learning as outlined in Eraut (2004) that “draws attention to the learning

that takes place in the spaces surrounding activities and events with a more overt formal purpose, and takes place in a much wider variety of settings than formal education or training” (p. 247). The notion of learning in the *spaces in between* more formal events/activities in the workplace is consistent with my data, as most learning was social and situated within the organizational context in which physicians work. One participant noted learning what not to do from poorly run meetings, while another talked about turning to a trusted colleague for advice on how to proceed in difficult situations. Participants provided examples along a continuum from informal to formal methods, but mainly learning taking place without explicit teaching, which is what Eraut (2000, 2004) describes as implicit, unintended, opportunistic, and unstructured learning.

Viewing leadership from a social and situated perspective suggests that the tacit nature of situated learning shapes leadership practice. Situated learning theory, together with its components of legitimate peripheral participation and communities of practice can explain how, when tapping into the tacit knowledge of a situated physician leadership community, this type of knowledge may be developed and shared. James (2007) notes the dynamic processes involved in the formation and reproduction of communities of practice.

Communities of practice can be located in different space-time contexts, generating different and competing conceptions of the world within and between members. They may be characterized by varying degrees of consensus, diversity or conflict among those who identify themselves, or are identified by others, as belonging to those communities (Contu & Willmott, 2003). (p. 132)

In this study, participants retained their roles as physicians who maintained a clinical practice that constituted membership in a community of practice that was often of primary significance to their sense of professional identity, regardless of their shift into leadership roles. Moreover, physicians regularly manage multimembership in and accountability to different communities of practice within the larger health care landscape, as they often belonged to a community of practice as a leader in the administrative structure of the health authority and many of the participants also were connected to the scholarly community of practice as faculty in the university as well. While shifting from a community of practice centred on clinical care to a leadership role provides opportunities to effect change and build a systems perspective, there are also challenges such as negotiating sometimes-conflicting priorities and identities. Also, unlike other people who may belong to multiple communities of practice in their personal lives such as community or sports organizations, the challenge for these participants is that the various communities are all within one workplace.

Social Learning Theory

Participants often mentioned learning leadership by observing leaders, with one participant stating, “Watching people in public or even in one-to-ones; just seeing how they approach stuff is a great way of learning.” This strategy aligns with social learning theory: Learning by observing the practice of others is a recognized factor of social learning theory (Bandura, 1986). Social learning theory “posits that people learn from observing other people. By definition, such observations take place in a social setting” (Merriam and Caffarella, 1991, p. 134). According to Bandura (1977, p. 22):

Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do.

Fortunately, most human behaviour is learned observationally through modeling: from observing others one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action.

Through observing others in action, participants noted that they learned a great deal about what worked and what did not — the coded information Bandura refers to. One participant noted, “Watching how people interact has been a really good way to learn what you would or would not do. And that’s at all levels. Seeing how *that* turned out, I wouldn’t do it that way.”

Raelin (2007) notes that through observing other people, especially experts, we gain ideas of what can be done, which can guide our actions in the future. Kempster and Parry (2014) explore the role of observational learning in leadership development, arguing that it has been relatively under-theorized and noting the role and importance of “significant others” on leadership learning. This study makes prominent the significance of observational learning to leadership practice, and participants described the significant influence of “watching leaders in action”, explaining that observing significant others allowed them to see the consequences of leaders’ behaviours, good and bad. One participant noted a number of people at different levels within the organization that he had observed and interacted with, stating that “I’ve learned from each one and it really makes a big difference in how you grow and how you move on.” Another participant reflected that “Every day, I guess, there are examples of things when I say, ‘oh, I really need to be more like *that*’.” As Kaufman and Mann (2013) point out,

This relates the notion of situated learning closely to role modelling, as the senior members of the community enact through their behaviours, both tacitly and explicitly, how problems of the discipline are approached, how colleagues are regarded and how knowledge is built and used. (p. 21)

Observation and role modelling were key to participants' self-described leadership learning processes. Participants described engaging in these modes of situated learning intentionally, and benefiting greatly from exposure to what they perceived as good and bad leadership styles.

A majority of physicians in this study described forming informal mentoring relationships that helped them to learn about leadership skills. Baker and Lattuca (2010) advocate, "mentors and mentoring relationships provide career support (sponsorship, exposure and visibility, coaching, protection and challenging assignments) and psychosocial support (sense of competence, identity and work-role effectiveness)" (p. 810). Study findings support that notion, and mentoring was described by several physicians as a series of focused or "strategic" interactions with various significant others about specific professional issues, rather than a formal, longitudinal relationship. These arrangements supported self-development and continuous improvement through meaningful and purposeful conversation. As one participant noted, "I actually solicited [advice]. I asked. I said, 'I want to learn from you, I want your honest opinion of this stuff' and at some level it was a little strategic on my part." Another described informal mentoring as the "vast majority of the quote-unquote leadership learning that I've done." Participants also noted passing the pertinent leadership advice along to the next generation of emerging physician leaders, thus becoming the mentors and teaching some

of the lessons of experience collected over the span of their careers, as described in Lave and Wenger's (1991) theory of gaining full entrance into a community through legitimate peripheral participation. As one participant summarized,

recruitment and grooming people and mentoring them and trying to build up their skills [is important] because I don't want to be doing this job forever. I want to be able to move on and I want to be able to pass it on to people in good hands. Leave it in good hands.

Legitimate Peripheral Participation

Lave and Wenger's (1991) studies of apprenticeship led to their first instance of a theory of learning as a trajectory into a community through "legitimate peripheral participation", which "concerns the process by which newcomers become part of a community of practice" and "subsumes the learning of knowledgeable skills" (Lave & Wenger, 1991, p. 29). Legitimate peripheral participation occurs when a person enters the fringes of a new community of practice, initially usually as an observer and then as a participant in low-stakes, or peripheral, activities. Through this peripheral participation they gain experience and eventually mastery, enabling them to fully participate in ways that are more integral to the community's practice. Legitimate peripheral participation is the form that situated learning takes and a community of practice is the locus or site of that learning. In a 2016 conversation published in the *British Journal of Educational Studies*, Wenger explains that a community of practice is "a learning partnership related to a domain of practice" and does "not primarily refer to a 'group' of people *per se*. Rather it refers to a social process of negotiating competence in a domain over time" (Farnsworth, Kleanthous, & Wenger-Trayner, 2016, p. 143).

The central premise of legitimate peripheral participation is that the learner or apprentice (i.e., the *newcomer*) participates in the practice of an expert (i.e., the *old-timer*) but on the periphery with limited responsibility. As they take on more responsibility in the community, learners move towards the centre and participate increasingly in the community's practice. With increased participation comes increased competence and learners come to understand the particular knowledge that distinguishes one community from others.

The physicians in this study readily described learning leadership from more experienced physician leaders (i.e., exemplars such as role models, mentors). As one participant stated, "The vast majority of what I've learned around leadership has been from informal mentoring." Another described a valuable relationship with a department chair who was willing to openly discuss his successes and failures. Many individuals appear to move over time from legitimate peripheral participation to full participation in the leadership community. Others were thrust into a leadership position and resisted it or only participated minimally, and then over time were able to embrace the role more fully.

According to Wenger's theory of communities of practice, the movement from the periphery to the centre occurs in stages, proceeding from observation to imitation, then to carrying out uncomplicated tasks, culminating in more complex activities (Lave & Wenger, 1991; Wenger, 1998). When conditions are right, learning appears to be as much from interaction, observing skilled performers, and listening to stories of those with experience as it is from formal, planned instruction. This theory suggests that physicians taking on leadership positions need to consider how they can learn leadership skills through their work and participation in practice, by watching, doing, talking, and sharing

stories so as to gradually develop the practices of the community (Lave & Wenger, 1991). The apprenticeship model is an educational approach that is pervasive in medical education, and legitimate peripheral participation is similar to what is sometimes considered the traditional medical/surgical learning method of “see one, do one, teach one,” that “is based on acquiring increasing amounts of responsibility that culminate[s] in near-independence” (Kotsis & Chung, 2013). Physicians learn leadership by starting with observational learning, then moving from only watching to experiencing the actual hands-on doing of it.

Negotiating Multimembership in a Landscape of Communities

Recent evolutions in community of practice theory by Wenger-Trayner (formerly Wenger) expand the simple trajectory into one practice community via legitimate peripheral participation to a more complex trajectory through a “landscape” of different communities of practice. “The notion of a single community of practice misses the complexity of most ‘bodies of knowledge.’ Professional occupations, and even most non-professional endeavors, are constituted by a complex landscape of different communities of practice” (Wenger-Trayner & Wenger-Trayner, 2015, p. 15). A physician might experience this landscape of practice within the health care system as a member of a specialty or discipline, an interprofessional care team, an academic faculty, and a leadership team, at a minimum.

The focus of this research was to explore the transition of physicians from medical practice to formal leadership. Considering a whole landscape of interrelated practices rather than a single community offers the opportunity to analyze physicians’ various disciplinary roles and identities. Physicians in this study described multiple

domains of competence were required in their workplace to fulfil their various roles including medical/clinical, research/scholarly, leadership/management, and also teaching/faculty. Competing demands of membership within these disciplinary and professional role-related communities of practice requires participation in and alignment with the traditions and values of each disciplinary community (Lave & Wenger, 1991). This meant that doctors retained the physician identity in seeing patients, assumed a leadership role in working at an administrative level, and also took on a teaching role as a university instructor. Moreover, physicians bring with them already formed knowledge, expertise, skills, attitudes, values, and experience. Within the context of this study, physicians were newcomers to the organizational leadership in taking on administrative or managerial roles in the health care community but they were entering with already established credentials in medicine and a strong professional identity as physicians.

Participants shared how participation within one community may at times threaten identification with others, often leading to tension between professional values of physician care and organizational leadership expectations. Wenger (1998) argues that identity involves a “nexus of multi membership” whereby “an identity combines multiple forms of membership through a process of reconciliation across boundaries of practice” (p. 163). Understanding how physicians learn leadership, then, requires exploring the diversity of role expectations that seems to exist for physician leaders working in different practice communities in which their medical professional identity may not always align.

Organizational-professional conflict. The findings of this study support previous research that has emphasized the persistence of the physician professional

identity (e.g., Quinn & Perelli, 2016; Karmali, 2012). All study participants strongly internalized their physician identity with most self-categorizing as a clinician first, communicating a strong affiliation to their physician peer group and a lesser attachment to organizational goals and objectives, and with that, to the professional identity of manager/organizational leader and/or university instructor.

The physician identity is rooted in individual autonomy and self-reliance, which contributes to becoming a medical expert — which in turn may lead to being selected for a formal leadership position. Quinn and Perelli (2016), in a paper exploring social identity theory and physician “professional self”, point out that “the individual, in this case the physician, adopts an identity focused on the primary function (of diagnosing and treating patients), which is given a superior priority and distinction” (p. 713). One participant described the duty of caring for the individual patient as the “number one job,” while another pointed out that “You actually have to be a better clinician than your peers if you want to do leadership,” demonstrating the value placed on clinical work by physicians. Moreover, Angood and Shannon (2014) point out that “clinical training provides physicians with a deep, yet sometimes, narrow understanding of healthcare” (p. 278). This difference in perspective was expressed by one participant while describing the difficulty of taking a broad, systems focus while also caring for individual patients: “Your responsibility is, first and foremost, to an *individual* patient. So when you’re in the trenches working as a doc you tend to be fighting for your group of patients.”

Viewing the workplace through the lens of the professional identity of a practicing physician, then, provides both strengths and challenges for physicians when they take on these formal leadership roles. To become successful leaders, physicians must

learn to break habits of reactive problem solving (the inclination to diagnose and prescribe) in favour of a broader, systems perspective. Their strength lies in their patient-centric focus, as well as the years of practical experience that translates into a lot of experiential knowledge of the challenges facing patient care in their particular area of specialization.

Given their patient-centric focus, health organizations need physicians at the leadership table, making decisions, but there seems to be a systemic problem linked to organizational culture when, instead of encouraging physicians to continue patient care as needed and accommodate administrative responsibilities when possible, the organization is actually, at least from the perspective of the study participants, frequently asking the opposite. The organizational message that physicians related was: attend these meetings, do these administrative activities on “our” nine-to-five timetable, and patient care and time management are really your own responsibility to manage. One participant stated, “The administrative world also expects you to be available for all of their meetings on their time schedule, which does not respect clinical work and physicians’ and patients’ time at all.”

This tension between professional values and the organizational management objectives can be described as “organizational-professional conflict”, which is “a term used to describe the situation that occurs when an organization’s values are incompatible with the professional values of its professional employees” (Parry & Murphy, 2005, cited in Braithwaite, Hyde & Pope, 2011, p. 46). If the physician leader is used to prioritizing immediate patient care, and the non-clinical management is used to prioritizing other tasks, conflict may arise. Shafer, Park & Liao (2002) argue that

Organizational-professional conflict is a direct measure of compatibility between the individual and the organization. Employees who perceive conflict between organizational and professional imperatives are experiencing a schism between their personal commitment to the values of their profession and organizational demands for behaviour that compromises those values. Thus, organizational-professional conflict may be viewed as one aspect of person-organization fit. (p. 52)

Study participants expressed experiencing this conflict in a variety of ways, from concerns about the overall workload — “Juggling the administrative load plus the clinical load has been a huge problem” — to managing administrators’ expectations about availability and urgency — “So, when the director calls you up and says, ‘I need to meet with you today!’ I’m like, ‘I’m scrubbed and in the operating room all day.’ ‘Well, I need to meet with you today. It’s urgent.’” Others described 80 to 90 hour weeks due to the various competing demands on their time.

The lack of time and financial support further outlines the clear values-conflict the organization has: the organization indicates that it wants leadership from physicians, but only really pays for patient care. A participant outlined the discrepancies between the supports available to administrative versus physician leaders: “[My administrative co-leader] has a great big office and has a secretary and a businessperson and whatnot. I have my half a secretary that does my full clinical practice.” Another described the leadership role as a “downer”: “it downs my income, downs my spare time. The effectiveness in the role is going to be down also. You’re going to be disinvested.” Accordingly, the physician leader feels that their professional values are out of step with

the organization, and that the organization's espoused values — that is, its expressed desire to engage physician leaders in the work of health care administration — do not match up to its actions. This is solidified through inadequate internal services and structures to support physician leaders' administrative/human resources needs, leadership development, and succession/leadership career planning. One participant referred to succession planning as a “crapshoot”, stating, “Sometimes we don't plan ahead well; we don't have time to choose and then you get stuck and you pick whoever is available.” The product of this is an organizational culture that contributes to a low level of person-organization fit, and appears to stifle even the best of physician leaders' intentions, often leaving them feeling frustrated and even slightly hopeless. Anderson and Anderson (2001) note the significant influence of organizational culture.

Culture is to organizations as mindsets are to individuals. Culture is the sum of all the individual mindsets rolled into one set of common agreements. Within the culture lies the company's core values, its norms and operating principles, its myths and stories. Culture is the way of being of the organization, exerting influence over people's morale and spirit. (p. 98)

Study participants often expressed their experiences of organizational culture as negative, leaving them feeling at times demoralized and devalued. Despite “system” claims regarding the importance of physician leaders being engaged with organizational objectives, this study demonstrates that structural and cultural barriers continue to exist within health care organizations that appear to limit the full participation of physicians in formal leadership roles. Participant descriptions demonstrate a belief that the prevailing culture and structure — as represented through language and communication, ethics,

norms, values, and beliefs — is incongruent with the physician professional identity and disciplinary aims. This can result in a strained relationship between the hospital administration and the physician leaders. This prevailing organizational culture affects expectations and perceptions of the physician leaders as well as their commitment, loyalty, job performance, and motivation. The implications of this are broad and far reaching. To foster engagement of physician leaders, and to encourage new leaders to take on administrative roles, non-clinician leaders may need to address the environment that is being created within their organizations and consider structural and cultural changes.

Kippest and Fitzgerald (2009) explore organizational-professional conflict within clinicians who are “hybrid clinician managers” explaining that “this dual role has a divergent set of objectives that require individuals to navigate between achieving clinical and managerial objectives” (p. 643).

Hybrid clinician managers have reportedly experienced internal conflict when tensions manifest, such as when requirements for autonomy and patient care clash with organizational needs or fiscal constraints (Shafer et al., 2002). There is evidence that hybrid clinician managers experience some internal conflict when they see the increasing time commitment of their management role intruding on, what they feel, is their primary job, their clinical role (Dawson et al., 1995; Harrison and Miller, 1999). (p. 643)

The internal conflict that Kippest and Fitzgerald (2009) relate was clearly evidenced in the present study. One participant provided an example of this type of conflict when attempting to keep up with the administrative workload: “if we are short of [doctors] and

patients need to be seen, (snaps fingers) it's gone and I'm back in the clinic and I'm trying to stuff meetings into a full clinical day.” The complexity of the interrelationships between the formal physician leadership group and the social and organizational environment of the hospital system often requires the balancing of paradoxical principles, not the least of which is the division of values orientations between the medical professional identity and organizational bureaucratic structures.

Physician leaders can contribute significantly to improved patient care *and* better leadership on behalf of the system; however, the organization must provide sufficient guidance in defining roles and supporting physician leadership development. Leading in the health care system means balancing the tension of the administrative hierarchies with the clinical line silos (Scott, 2010). A study by Shafer, Park and Liao (2002) examines the relationships among professionalism, organizational-professional conflict, and various work outcomes for a sample of Certified Management Accountants. Findings showed that individuals who perceived higher levels of organizational-professional conflict were less committed to the organization, had lower levels of job satisfaction and also had higher turnover intentions.

This research points to a similar connection in that physician leaders acknowledged a low level of compatibility between individual and organizational values, which results in high organizational-professional conflict and, thus, low levels of commitment to the health authority. This is highly problematic when physicians in formal leadership roles are expected to lead on behalf of the organization, yet feel a low sense of commitment to that aim. A widely cited definition of organizational commitment originates in Mowday, Steers, and Porter (1979) noting “1) a strong belief in and

acceptance of the organization's goals and values; 2) a willingness to exert considerable effort on behalf of the organization; and 3) a strong desire to maintain membership in the organization” (p. 226). I contend that when a group with a strong professional identity, like physicians, experiences significant levels of problems posed by this type of dilemma, they invariably retreat further into their clinical professional identity and away from any organizational allegiance. Values congruence is widely considered to be a determinant of both commitment and job satisfaction and shared values as key to positive organizational culture (Kouzes & Posner, 2007).

As Wenger (1998) notes, some individuals may be long-term members of a community but excluded from full participation. This study suggests that while physician leaders may experience lower levels of organizational commitment due to higher levels of organizational-professional conflict, they are also sometimes marginalized and excluded from full participation in the leadership community. Alternatively, and as noted above, this lack of full participation may reflect a choice by doctors to simply resist the practices of the organization’s leadership community (due to a strong values and identity incongruence) and to engage only provisionally with them (Ibarra, 1999). In some instances, it appears to be a combination of these two factors. One participant noted a possible reason that physicians may not be granted full participation, pointing out that physicians “are trying to advocate for what’s best for the patients and that causes hospitals problems, if you’re in a scenario where treating patients costs money.” Another saw himself as a middleman between physicians and the organization, “sort of sitting in the middle of a fight, not invested fully on one side or the other.”

The notion of landscapes of practice seems to relate strongly to this research. In health care, no one profession exists or works autonomously, and no person works completely within their profession without in some way influencing the larger landscape, or system. The process of learning leadership involves learning how one can intentionally influence the system to achieve specific results; the medium for this intentional influence over the larger landscape is the concept of boundary crossing.

Boundary crossing. This study illustrates the importance to physician leadership practice of leading through and across boundaries. This is consistent with Chreim, Langley, Comeau-Vallee, Huq, and Reay (2013) who assert that boundary work is essential to leadership practices in health care. They describe leadership within interprofessional health care teams as “involving the practices of influencing how boundaries are drawn and managed” (p. 204). Boundaries can refer to physical, cognitive, relational, structural, knowledge-based, or any other delimitations that separate one entity from another (Chreim et al., 2013). According to Wenger-Trayner and Wenger-Trayner (2015), boundaries of practice are unavoidable because “a practice of any depth requires sustained history of social learning, and this creates a boundary with those who do not share this history” (p.17).

Physician leaders must learn to work across multiple inter- and intra-organizational boundaries that can complicate and exert tensions at the individual and systems levels. Navigating various distinct communities of practice including clinical, academic, leadership/administration, combined with the public and political spheres can be challenging due to differences in organizational culture, decision-making processes, and accountability mechanisms. Furthermore, the interprofessional environment within

the larger system produces strong social and cognitive boundaries that can be significant barriers to learning and change between different professional groups and increase organizational-role conflict within a landscape of practice. In response to this kind of scenario, Wenger-Trayner and Wenger-Trayner (2015) offer the following:

How do I modulate my identification with various locations in an increasingly complex landscape? How does the modulation of identification and dis-identification create an individualized claim to knowledgeability over time and across contexts? Are there places in which my identification across the board is expressible? Negotiating a manageable identity of knowledgeability is becoming quite a task. It is a central challenge for professional learning today—and to a large extent, for learning more generally. (p. 25-26)

Study participants appeared to initially struggle with working at and through the boundaries between various roles, professions/professional practices, hierarchies, knowledge, the organization, and the larger health care environment/system. Kubiak, Cameron, Conole, Fenton-O’Creevy, Mylrea, Rees, and Shreeve (2015) point out that “individuals are involved in a range of different communities of practice and may identify to different extents with each regime of competence. Living within this nexus of multimembership requires that people reconcile these competing demands” (p. 64). Physicians experience their positions in particular communities of practice as incongruent and their positioning at the nexus of multimembership as challenging. As Kubiak et al. (2015) note, “practices cultivated in one community of practice may be unacceptable or even offensive in another” (p. 65). A lack of shared history means that boundaries can give rise to “misunderstanding and confusion arising from different regimes of

competence, values, repertoires, and perspectives. In this sense, practices are like mini-cultures” (Wenger-Trayner & Wenger-Trayner. 2015, p.17).

Some physicians in this study revealed considerable incongruence working at the boundary of the leadership community of practice. They shared accounts of limited engagement, sometimes participating only in a very narrow range of activities. As one participant stated, “There’s lots of people who actively avoid being responsible for that kind of [leadership] stuff.” Another described a formal leadership role that he knew would eventually be pushed on him given his seniority, recalling the uncertainty of wanting to take it on:

I knew it was going to come to my lap only by default....And I thought, ‘I don’t know if I really want to do this’. It was yucky at the beginning and now it’s tolerable because you understand the games better and you’re willing to say, ‘no, this is bullshit, I’m not going to participate in that’ and whatnot.

Participant stories reflect early participation on the periphery of a community, with a gradual movement into the centre. Some physician leaders, however, may remain on edge and their identification can be described as “unengaged alignment” (Kubiak et al, 2015, p. 72). There appears to be some cases of considerable ambivalence and dissonance on physicians’ part due to the strength of institutional forces. When values conflict occurs, physicians seem to retreat behind the boundaries of their strongly established professional identities, effectively sealing themselves off from neighbouring communities of practice. This results in physicians who dis-identify with leadership practice, or more broadly, with organizational culture, and physician leaders who are only provisionally identifying with the organizational leadership role. Either way, this scenario excludes physicians from the

negotiation of participation, which generates the meaning making that creates engagement (Wenger, 1998).

Although personally and emotionally difficult, “incongruence” often presents opportunities for learning. Boundaries can hold great potential, as “the meetings of perspectives can be rich in new insights, radical innovations, and great progress” (Wenger-Trayner & Wenger-Trayner 2015, p. 17). Many leaders in this study described learning leadership by trial and error; this is one type of deliberate effort to cross boundaries into leadership practice. Edwards (2010) describes the range of “boundary practices” to help groups cohere. They are:

- Clarifying purposes and being open to alternatives;
- Articulating personal expertise and values in order to negotiate practices with others;
- Knowing what matters to other practitioners in order to “press the right buttons” when working with them;
- Willingness to reorient one’s approach; and
- Preparedness to take risks and bend the rules.

These practices are instructive and reaffirm the importance of systems thinking, critical reflection, collaboration, and self-awareness to the leadership practice of physicians. Together with situated learning in communities of practice, Mezirow’s (1991, 2000) conceptualization of transformative learning offers possibilities for further analyzing study findings.

Transformative Learning

Mezirow's (1978, 1991, 2000) conceptualization of transformative learning, and its main theoretical concepts of perspective transformation fostered by critical reflection offers possibilities for analyzing study findings that offer an account of physician leadership learning as an individual transformative trajectory across a complex landscape, whereby physicians' worldview and perspectives undergo significant change as they negotiate a sense of identity that spans multimembership in different practice communities.

Physician leadership often involves becoming something different altogether (Guthrie, 1999, McAlearney et al., 2005; Spinelli, 2006), or as one study participant summed up, "To be a *leader* is not to be a *surgeon*." Transformative learning theory focuses on dramatic and fundamental changes in the way we see ourselves and how we understand the world around us (Merriam, Caffarella, & Baumgartner, 2007). It is more than simple informational learning, but is the kind of learning that shapes so that you are "different afterwards, in ways both [you] and others can recognize" (Clark, 1993, p. 47). It involves new frames of reference in viewpoints, habits, and a fresh perspective for defining identity (Kasl & Elias, 2000; Knowles, Holton, & Swanson, 2005; Mezirow, 2003). Mezirow (1990, p. xvi) defines transformational learning as "the process of learning through critical self-reflection, which results in the reformulation of a meaning perspective to allow a more inclusive, discriminating, and integrative understanding of one's experience. Learning includes acting on these insights."

Perspective transformation. At its core, transformative learning relates to exposing and challenging the underlying assumptions upon which we function as

learners. Mezirow (1991) maintains that questioning assumptions is crucial to understanding how one's perceptions constrain views of the world and limit one's ability to be open to other perspectives and alternatives. Perceptions are open to transformation when a person confronts a major dilemma and cannot resolve it through previously established norms such as adding new information, learning new skills, or increasing competencies. Through a process of critical reflection, which is examining the underlying beliefs and assumptions that affect how we make sense of our experiences, individuals can further examine their feelings, beliefs, and actions and the assumptions that underpin them ultimately acting upon this revised understanding. He calls this process "perspective transformation."

Perspective transformation is the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about the world; changing these structures of habitual expectation to make possible a more inclusive discriminating, and integrative perspective; and finally, making choices or otherwise acting upon these new understandings.

(Mezirow, 1991, p. 167)

Perspective transformation encompasses both significant internal changes in how an individual thinks, as well as external changes in their actions. As presented in Chapter 2, Cranton (2002, p. 66) outlines the steps in this transformation process:

- An activating event [or what Mezirow calls a "disorienting dilemma"] that typically exposes a discrepancy between what a person has always assumed to be true and what has just been experienced, heard, or read;

- Articulating assumptions, that is, recognizing underlying assumptions that have been uncritically assimilated and are largely unconscious;
- Critical self-reflection, that is, questioning and examining assumptions in terms of where they came from, the consequences of holding them, and why they are important;
- Being open to alternative viewpoints;
- Engaging in discourse, where evidence is weighed, arguments assessed, alternative perspectives explored, and knowledge constructed by consensus;
- Revising assumptions and perspectives to make them more open and better justified; and
- Acting on revisions, behaving, talking, and thinking in a way that is congruent with transformed assumptions or perspectives.

Transformative learning was chosen as a theoretical lens because of its explanatory value for processes described above that can lead to in-depth personal development. In the remaining part of this discussion, I will link study findings to Cranton's (2002) discussion of steps in the transformation process.

For all participants, the leadership role involved negotiating multiple practice boundaries in the health care landscape and that process can include experiences of failure marked by strong emotions (Fenton-O'Creevy, Dimitiadis, & Scobie, 2015). The experience of taking on a formal leadership post in health care, being faced with expectations of successfully demonstrating specific leadership skills that the individual has not been trained in, and realizing that there is an expectation to use the lens of the organization's overall objectives rather than a patient-centric focus, may lead to a

disorienting dilemma or activating event for a physician that assumes a leadership role. This disorienting dilemma may result in the individual questioning the adequacy of a prior meaning-making scheme and serve as a catalyst for transformative learning. One participant described feeling shocked at going from writing physician's orders that were carried out without question to taking on a leadership role "to find out that, 'gosh, here's the answer and ta-da let's make this happen' and everybody goes, 'well, no, there's no money' and 'we can't do that because...'" Another expressed feeling "ridiculously unqualified" for the new leadership role, while a different participant stated that "it makes you feel very vulnerable" — "*it*" being the realization that he did not have the skills for the job.

Clinicians taking on new leadership positions can find it initially very difficult to enact their new roles and deliver on the expectations of leadership according to their prior clinical and medical perspectives. Meaning perspectives filter the way we make sense of our experiences, very much like the professional identity of the physician colours the way they see the world. As a result, discrepancies between what they, as physicians, have always assumed to be "true" and what they now experience as leaders are regularly brought to light. One participant described his shift in perspective when he realized the impact he could have as a leader versus as a physician: "we ended up getting [provincial government] legislation in and I really reflected that I probably did more for [the health of the population] with *that* than all the surgery I've done." Consequently, participants reported starting to consciously reflect on the leadership role expectations and questioning their existing leader role models and dominant paradigms of "leadership" and "management."

Critical reflection. This study supports the vast amount of research literature that highlights the importance of conscious and frequent reflection about experience, noting its significance for leaders. Reflective practice — especially theories developed by Kolb (1984), Schön (1983), and later by Mezirow (1978, 1991, 2000) — is a crucial if not determining factor in leadership learning and development. Reflection involves examining underlying assumptions and challenging presuppositions and contradictions between what has worked in the past and one’s current needs and realities. One participant expressed the value in learning from the past: “So every time things didn’t go well, then I’ve actually blocked off time to think about why it didn’t go well and what I might have been able to do differently. That, over the years, has helped me a great deal.” Mezirow (1991) defines reflection as “the examination of the justification for one’s beliefs, primarily to guide action and to reassess the efficacy of the strategies and procedures used in problem solving” (p. xvi). The practice of using reflection in order to reconsider previous problem solving experiences and to correct distortions in one’s beliefs, judgments, and actions constitutes critical awareness. Mezirow maintains that being aware of the powerful role that habits play in shaping personal expectation and therefore frames of reference is crucial to understanding the meaning attached to experience. “To make meaning, means to make sense of an experience” (p. 1), and reflection is an essential component in that process.

Given that many leadership situations cannot always be resolved based on their knowledge from previous clinical experience, physicians begin to reflect and ask critical questions about their own assumptions regarding leadership issues in health care. In many instances, this critical reflection is initiated during and guided by a formal coaching

process, which provides a safe environment for discussing feelings about competence to operate in a leadership role, and can act as a catalyst for further learning. In the context of this study, coaching refers to the one-on-one process of executive leadership coaching through which leaders “confront their competency to lead and develop an awareness of the road they need to walk to mastery of this capability” (O’Flaherty & Everson, 2005, p. 2). Physicians viewed the role of formalized coaching as an important direct performance enhancing intervention. One participant noted one of the benefits of working with a coach: “Just checking in on a regular basis promotes reflection and helps move things along and I’ve changed permanently based a lot of these things.”

The major benefits to adult learning through coaching that participants in this study emphasized were an increase in physicians’ confidence, self-awareness, recognition of “blind spots”, and the development of their emotional intelligence. The surfacing of assumptions, transforming of perspectives through developing and increasing self-awareness, and better understanding of behaviours and their impact on others are evidence of transformative learning principles and approaches that were evident in the coaching scenarios brought forth by physicians. As well, Mezirow’s (1995, p. 53) notion of *discourse* and “seek[ing] the best judgment of the most informed, objective, and rational persons we can find” and entering into “a special form of dialogue” to validate new perspectives can be said to be realized in the coaching relationship.

Crucial to these several outcomes seems to be the confidentiality that the designed coaching relationship provides. The coach often serves as a sounding board or confidante, creating the safety necessary to take risks in discussing insecurities or difficulties being faced in their capacity as leaders. This again emphasizes the influence of the professional

identity where, in this instance, the “medical expert” is at risk of seeming unskilled. Doctors appear to need to preserve/protect parts of their professional identity as they increase competency in their own leadership, so the link to perceived safety of the leadership coaching relationship is paramount. This confidential relationship is also highly valuable in a work environment where, even as formal leaders, physicians actually have little positional control over the physicians they are leading, who are largely contracted service providers who cannot be easily terminated. The coaching relationship provides an environment where physician leaders can craft individualized strategies to address problems, resolve or mitigate conflict, and encourage collaboration.

Further to learning through discourse and dialogue with others, physicians often reported learning through relationships with other leaders, trusted significant others, and role models. Physicians may see that others have gone through the same process, so this may lead them to start validating prior beliefs through collaborative discourse, becoming open to alternative viewpoints. This leads to action planning, including seeking out new information, testing new roles, agreeing on new relationships, and developing new competencies, capabilities, and self-confidence. Goldman, Plack, Roche, Smith, and Turley (2011) showed the strategies emergency medicine residents used to learn clinical versus leadership skills varied drastically. “Learning clinical skills was approached with rigor; involved senior residents, attending and consulting physicians, and peers; and took place constantly” (p. 322), while few intentional instances for learning leadership skills were identified beyond trial and error. Although study findings here corroborate the often-informal “trial and error” nature of leadership learning amongst physicians in health care, the majority of leaders in this study displayed a strong learning orientation

toward leadership, revealing a strong level of accountability to their leadership practice, and to learning in general. One participant applied the same learning strategy from his clinical practice to learning leadership, namely that “every week I have to learn at least one new thing and I tried to do the same thing with leadership.”

Finally, transformed perspectives may then be integrated into everyday practices as physician leaders may shift their sense of identity and allegiance to different communities of practice within the health care workplace. A participant noticed this integration in his own leadership practice: “So you start to look at the big picture. And, again, it’s not natural for surgeons to do that. Or for doctors.” Existing frames of reference are altered or transformed; in some cases the culmination of this transformation is the development of a leader identity, sometimes integrated with and sometimes in addition to, the physician identity.

Creation of a leader identity. Mezirow’s original definition of transformative learning as primarily relating to changes in the learner’s meaning schemes and meaning perspectives can be bolstered by more recent interpretations of the theory, notably the work of Illeris (2014a), who argues: “If transformative learning shall not be an empty phrase, there must be something to transform, something that has a meaning and anchoring with the learner” (p. 55). For Illeris, that something is *identity* and his focus is on how it is developed and changed through transformative learning. He offers a revised definition of transformative learning: all learning that implies a change in the identity of the learner. Identity is also a central concept in communities of practice theory. Learning is viewed jointly with the notion of *becoming*. According to Wenger-Trayner (in Farnsworth, Kleanthous, & Wenger-Trayner, 2016),

The theory is an attempt to place the negotiation of meaning at the core of human learning, as opposed to merely the acquisition of information and skills. And for human beings, a central drive for the negotiation of meaning is the process of becoming a certain person in a social context — or more usually a multiplicity of social contexts. (p. 145)

Transitioning between roles held by a physician is a boundary crossing activity involving a psychological movement for the individual (Ashforth, Kreiner, & Fugate, 2000).

Wenger-Trayner and Wenger-Trayner (2015) maintain

Learning to become a practitioner is not best understood as approximating better and better a reified body of knowledge. Rather it is developing a meaningful identity of both confidence and knowledgeability in a dynamic and varied landscape of relevant practices. (p. 23)

The process by which we negotiate identity as we enter a new community involves both identity regulation and identity work (Alvesson & Willmott, 2002) and building an identity as a successful leader in health care means showing you can adopt practices seen by the community as legitimate. Physicians face threats to their established professional identities as they travel across the boundary of practice to leadership. They must respond to organizational culture and institutional requirements moving from a situation where they felt, and were seen as, highly competent to experiencing varying levels of incompetence that results in a “disconfirmation” of their identity as a competent person as their trajectory crosses a major boundary between communities of practice (Fenton-O’Creavy, Dimitiadis, & Scobie, 2015). They must work to form, repair, maintain, or revise their perceptions of self (Alvesson & Willmott, 2002) and for many in this study

this involved creating a hybrid version of their professional selves in the form a *leader* identity. One participant described leadership work as “a different mind space than what we do as doctors.” Another expressed inhabiting a sort of dual identity:

Clinical medicine is not administration. Once you come to that realization that come 6 o'clock when I'm on call things are going to move like that (snaps fingers quickly). And then come 6 AM when I have a meeting with so-and-so at such and such about this and that, it's going to move at a different pace. You just turn it on and turn it off.

Systems thinking. This study points to the degree to which physicians identify with the larger organization in which they are situated as key to developing a leader identity. Leadership success in the health care system appears to be linked mainly to gaining a systems perspective, which leads to learning the value of collaborative approaches and working successfully with others to achieve organizational results. As identified within chapter four's presentation of the theme of physician professional identity, medicine focuses on decision making at the individual doctor-patient level. Leadership, however, necessarily involves stepping away from the individual relationship and examining problems at a systems level. Systems thinking is the ability to see the sum of the system's parts, or what Heifetz, (1994) calls “a balcony perspective” that allows leaders to see the whole system. This is counterintuitive to most doctors given their training; my research indicates that a systems view is seen as a decline in the commitment to the classical model of the doctor-patient relationship. Physicians who choose a path of formal leadership, however, learn to appreciate the potential positive impact on health care on an organization-wide (i.e., systems level) basis. They are able to

see the whole, the sum of all the parts (Guthrie, 1999).

Physician leaders in this study largely acknowledged this systems perspective as an opportunity to have organization-wide impact and that a transformation in physician attitudes toward organizational contexts is needed, because it can lead to improved outcomes for patients and the organization as a whole. One participant summarized well the transformation in perspective that has to occur:

You did that for this particular patient, it's really not what's best for a whole group, but that's not your responsibility. Your duty of care is to that individual patient. The duty of care, so to speak, at a higher level is much broader than that. Then you have to find balance so as a practicing physician it's easy to sort of get grounded back and say I've got to do what's right for that individual person. But in a leadership role, at a high-level, you can't do that, because that doesn't move the whole system ahead and sometimes a decision might need to be made that might not directly benefit that individual patient but benefit the group as a whole to move forward.

A way forward seems to be for doctors to learn a systems perspective early in their career, even during medical school or residency. The earlier doctors can learn to mediate medical versus managerial conceptions of what is required to "lead", the more likely it is they will be able to appreciate the importance of their role in improving patient care at the systems level. If the organization is able to take steps to mitigate the factors that contribute to organizational-professional conflict, physician leaders can learn to fully participate in system-level change without compromising care at the bedside.

Conclusion

As physicians move along a path through a social learning landscape, negotiating a sense of identity that spans multimembership in different practice communities, they unquestionably acquire specific knowledge and skills. Perhaps more significantly, though, they also appear to change as people. As this research shows, the reality of formal physician leadership in health care organizations is that it is ill-matched to the core values and professional identities of doctors. “If we seek to enable and enrich cross-boundary learning,” argue Fenton-O’Creevy et al. (2015), “we should start from the explicit acknowledgment that it involves experiences of failure, challenges to your sense of who you are, even sometimes abandoning cherished beliefs and values” (p. 42). All participants alluded in some way to having to enter into some level of personal negotiation, reconciling multiple facets of their identity. This study emphasizes the *becoming* of individuals who inhabit the medical landscape with an identity whose dynamic construction reflects the trajectory through the larger health care landscape.

Physician leaders seem to “engage in strategic moves to maintain productive multimembership”, often “modulating their identity by identifying in one mode and not others” (Kubiak et al., 2015, p. 79), reflexively finding ways to maintain some form of identification that allows congruence with their multimembership. For some, the product of this cross-boundary learning is the creation of a superordinate leader identity. For others, it seems to be the understanding and appreciation of a dual identity — physician *and* leader — the relative importance and weight of each varying over time and context. Congruence in a landscape of practice suggests functional and fully engaged multimembership, engaging in and aligning with various practices. This appears to be

true for those doctors who have worked through organizational conflict, values incongruence, disorienting dilemmas, identity threats, all of which result in “a strong sense of alignment with and accountability to their way of doing things” (Kubiak et al, 2015, p. 75). Saxena, Walker, and Kraines (2015) contend that

A reconciliation of several common dualities in physician leadership is conducive to increasingly meaningful and effective leadership by physicians. Although oppositional, the common dualities of physician leadership are not mutually exclusive but represent a complex, dynamic and interdependent relationship. (p. 28)

This research suggests that health care leadership for physicians requires managing the delicate tension between reinforcing *and* eliminating boundaries, which, “are necessary but problematic at the same time” (Chreim et al., 2015, p. 224).

Most fundamentally, learning leadership in the context of this study is about the transformative growth of the person, and springs from creating meaning from direct experience of everyday leadership practices and interactions. Drawing from theories of learning as becoming, I argue that as physicians learn leadership they in fact develop a leader identity, which seems to contribute to reconciling the tension between professional identity and the realities of system-level leadership in health care.

In Chapter 6 I will offer a set of concluding statements, study implications, limitations, and recommendations for future research in educational studies and lifelong learning and also for policy and practice. Suggestions for future research will relate to the findings of this study including some specific follow-up topics that may illuminate aspects of some subjects which were only merely uncovered within the scope of this

research. I will also provide recommendations/implications for policy and practice, including several suggestions for improving leadership learning in a health care workplace setting.

Chapter 6: Conclusions and Recommendations

Introduction

In this final chapter, I will provide some conclusions and recommendations that stem from this research. First, I highlight some of the implications of my findings for practice and educational theory. Then I will provide a summary of potential study limitations, followed by several proposed recommendations both for further study and for policy and practice. I conclude the chapter by offering some final thoughts about the relevance of this study to the current health care landscape and, more generally, about the value of supporting learning for physician leaders for the sake of improving the Canadian health care system.

Implication of Findings

The objective of this research study was to explore how leadership learning takes place in the health care workplace. A narrative inquiry approach allowed me to probe for detailed personal stories of the physician experience, thus gaining insights through physicians' own accounts of learning, and how this contributed to their leadership practice (and the process of transitioning into a leadership role). Through hearing participants' stories, the study sought to develop a better understanding of both the personal learning processes as well as the contextual influences that surround leadership learning in health care settings.

This study has extended the current literature on physician leadership learning by bringing in a theoretical analysis from an adult education perspective. Much existing research in this area draws upon the disciplines of health, business or management to focus on *what* health care leaders learn, while this study also adds to knowledge on *how*

leaders learn, enhancing our understanding of the particular kind of adult learning experienced in the process of learning to lead. The in-depth exploration of the learning processes of medical professionals who transition into leadership roles presented in Chapters 4 and 5 illustrate the importance of adult education theories being applied in the workplace and in leadership development and offer theoretical implications for educational studies and adult learning theory. Furthermore, the findings and analysis offer insights into the nature of medical leadership and its associated challenges and may lead to several policy and practice implications for the health care sector.

Policy and practice implications. The first major practical contribution of this research is that findings should inform health care organizations that want to critically examine educational contexts for physicians in health care and improve learning interventions specifically designed to support leadership effectiveness. A second important implication of my study derives from findings that point to gaps in organizational talent management, succession planning, and recruitment and retention strategies/programs for physician leaders. This research can be leveraged to inform changes to such supporting infrastructure so that physicians are better prepared/equipped to transition into leadership roles. Changes could include implementing formal policies for orientation, onboarding, and mentoring programs to ensure that new physician leaders are supported in learning the skills required for success in health care leadership. Moreover, my findings also suggest that the focus of leadership learning and development be broadened beyond the current predominant emphasis on what individuals should learn and do to include and explore larger systemic and contextual dimensions, such as organizational administrative policies and practices, and the values needed to

play system leadership roles. The research also points to the value of informal learning processes that occur outside of a formal curriculum such as mentoring. There is a clear need to better understand the informal learning that is taking place and better support these kinds of learning opportunities in an organizational learning context.

Theoretical implications. As stated in Chapter 1, this research provides an opportunity to foster critical and important learning opportunities at the intersection of medical leadership and educational studies, connecting two disparate bodies of scholarly knowledge in a medical/health care context, elucidating this particular adult learning experience and attempting to respond to the literature gap by seeking to understand the particular process of adult learning. While many health care organizations aspire to be learning organizations and spend a great deal of time and energy defining the skills and capabilities required of their leaders, they are unlikely to succeed in producing either leaders or learners without a solid grasp on how to create the conditions required for people to learn, adapt, grow, and flourish.

This study contributes to the leadership and learning literature by showing that leadership learning in this context was an emergent, evolutionary process of active experimentation, engagement, and interaction. Although the experiences of individuals varied significantly, some consistent themes emerged related to the value of informal learning processes such as mentoring, the importance of learning systems thinking and collaboration, and the critical role self-awareness and reflective practice play in the learning process. Additionally, the frequent descriptions of the tensions between and reconciliation of disciplinary boundaries show that leadership in this setting is fundamentally a social function: a process of influencing across relationships, systems,

and workplace sub-cultures. Understanding the nature of how one learns to engage in this social function required paying careful attention to the nuanced differences of each participant's particular learning journey. Employing a qualitative narrative approach helped to illuminate the learning process of each participant, as each shared first-person accounts, drawing on their stories to make sense of their professional and personal experiences.

The process of attaining leadership capabilities included developing technical or functional expertise in management and leadership competencies through learning that was principally situated in the practice (i.e., workplace) setting, but also appeared to require a shift in focus and a need for physician leaders to assimilate and integrate undefined or seemingly competing values inherent at the boundary between the two cultures of administrative management and the medical profession. My findings revealed that most medical practitioners have an allegiance or strong connections to a medical community of practice connected to their physician professional identity. The socialization process of becoming a physician involved internalizing specific norms that the profession values, but moving into a leadership role required them to consider and adjust the ways they have been taught to think and interact. This included exploring and challenging their personal mental models and the worldviews that can sometimes restrict physicians from engaging in the broader health care system and realizing their full potential as leaders.

Accordingly, this study contributes to the larger scholarly conversation surrounding a more unified theory of transformative learning. It adds to our understanding of the complexities surrounding personal perspective transformation

through identity negotiation and formation in the professional workplace and how people learn when connected to multiple communities of practice. While most physicians seem to orient to individual practice communities within the health care workplace, physician *leaders* appear to broaden personal frames of reference through critical reflection, so are able to broker between the boundaries of clinical/medical and managerial/leadership (and other) professional communities in order to maintain and enhance the performance of the larger organization.

This study also points to the need for organizational changes to acknowledge the discrepancies in expectations and supports among members of different communities of practice. Administrative leaders, or people in non-physician leadership roles, often have expectations around scheduling that do not align to the demands of a practicing physician leader's availability, and also often have higher levels of support in terms of staff and office space/equipment. There is a need for not only individual learning supports, but also for changes to accommodate the unique demands placed on physician leaders. Having other areas in health care acknowledge and accommodate these unique needs will ultimately enrich health care, as it accentuates the importance of a learning culture. Organizational cultures must transform their ability to learn and to think, becoming aware of biases, utilizing reflective practices, engaging in dialogue, and demonstrating a general spirit of inquiry.

Finally, an important implication of this research that blends the theoretical with the practical stems from the finding related to self-awareness through reflective practice. Leadership development programs should provide physicians opportunities to reflect on and learn from their own experiences in leadership, including opportunities to discuss the

assumptions made in a leadership decision-making situations, to analyze how those assumptions shaped the outcome, and to receive feedback and different perspectives from peers, mentors, or coaches. Equally important is encouraging a change in non-physician leaders' attitudes about and perspectives on their physician colleagues. These administrative counterparts often operate under the assumption that doctors are arrogant or difficult, without a good understanding of the challenges that they are encountering. Building understanding between these two groups can help to build relationships and strengthen co-leadership teams.

Limitations

Several possible limitations pertaining to this study have been identified. One possible limitation relates to the sample size. In response, I argue that this small but representative sample allowed for an in-depth exploration of a range of leadership learning experiences and a solid understanding of the phenomenon and enough people to allow for thematic saturation and the identification of consistent patterns. Future studies of this type could possibly benefit from a larger number of participants from wider geographical areas/other health jurisdictions. I considered recruiting more people to the study (or possibly expanding data collection methods to include a more widely distributed electronic survey), however, given the extensive data that is generated in qualitative research of this type, it was important for me to maintain a high level of quality and manage various logistics for this time-limited, non-funded study.

In future a larger study with more participants might facilitate a clearer picture, possibly revealing a regional or national trend regarding the physician leadership experience. Furthermore, a content analysis of organizational texts and artifacts such as

leadership education plans or strategy/business/policy documents could serve as an unobtrusive supplemental data collection measure, potentially providing another perspective. The study may have also benefitted from a more diverse composition of participants. The majority of physicians were late in their career, trained in Canada, and at a very senior leadership level, with only three considered to be more junior in their formal leadership roles. As well, only four of twelve participants were female and just two represented cultural ethnic backgrounds and medical training outside of Canada. This composition was simply a result of participant response and reflects the current physician leadership demographic within the research setting. The fact is that a very small percentage of formal physician leaders in Nova Scotia are non-white and the majority are male. Future studies could possibly involve more participants at various levels of experience (including more junior/mid-range physicians) as well as seek out, if possible, a more culturally diverse sample. This might also be easier to do in a city that has a more ethnically and culturally diverse population, such as Toronto or Vancouver.

Also, study findings were generated from self-reported perceptions of a specific group of participants, which includes potential sources of bias. Similarly, employing interview as the single data collection method might be seen as potentially limiting. Both of these possible limitations were deemed to be low risk given the focus of the research on the personal narratives of each participant.

Finally, regarding the concept of generalizability, I would like to recognize that qualitative research does not strive to generalize results/findings across populations. Its strength relates to an in-depth exploration of topics with rich description as opposed to a focus on application to broad populations. My findings are interpretive in nature and

representative of a specific workplace learning context and no attempt was made to generalize study findings beyond the participants involved. The cumulative building of knowledge and insights from smaller scale studies such as this one can help to inform a bigger picture of some of the challenges faced in health care. Generalizability of the “results”, then, is left to readers as they compare their own particular contexts to the descriptions detailed here.

Recommendations

Scholarly work such as this study initiates as many questions as it answers, paving the way for future practice and research to build on findings like those presented here. I present some recommendations for future research in this section, along with the hope that this work may help other researchers to further focus their unanswered questions.

Recommendations for future research. The following recommendations for further study will touch upon specific follow-up topics that upon closer examination may illuminate aspects of some subjects which were merely uncovered within the scope of this research.

Identity/leader identity. This research offers some insights into leadership learning that is about more than simply learning to *do* but is also about learning to *be*. This provides opportunities to explore the role and effectiveness of identity-based leadership development. Furthermore, the role of transformative learning cannot be overlooked in physician leadership as this research reveals the role of individual perspective transformation: transformative growth as a *person*, along with development of capability / competency as a *leader*. The negotiation of a new professional identity — either that of a superordinate leader or a dual identity of physician and leader — and

learning to reconcile seemingly competing identity claims, would benefit from further research. Additionally, the first order, ontological narrative approach (Elliot, 2005) helped me to get a sense of this shift in identity as participants drew upon their personal life histories to make sense of their identities in the process of telling and retelling of their stories. It may be, then, that further research using similar methodological approaches could be informative.

Boundary spanning. Physicians can demonstrate their full participation in leadership practice by acting as boundary spanners within the health care system, “brokering” boundary encounters for other professions, especially in the context of interprofessional collaboration. The concept of brokering encounters at boundaries of different communities was taken up by Burt (2005) and Wenger (1998) who both explain that “brokers work at the boundaries of the landscape building connections between different practices, introducing practices from elsewhere and facilitating cross-boundary experiences” (Kubiak, Fenton-O’Creevy, Appleby, Kempster, Reed, Solvason, & Thorpe, 2015, p. 81). Brokers strive to support boundary crossing by facilitating the translation, coordination, and alignment of different perspectives and meanings. Whether they are consciously aware, physicians regularly walk the various boundaries of health care and can help to influence the definition and management of any demarcations in the landscape of practice. It would be helpful to capture qualitatively the experiences and perspectives of physician leaders who are uniquely positioned to span boundaries and broker cross-community partnerships. Moreover, they can influence the definition and management of a boundary that at times may require the encouragement of integration while at other times involve maintaining the separation.

Organizational-professional role conflict. Further research might also explore frictions between the *professional* (medical) world and the formal leadership or *managerial* world that became evident in this study. Competing professional and managerial work ideologies and organizing “logics” and the forces of organizational culture on physician leadership would benefit from further research. Schein (2010) notes the importance of cultural fit to help organizations operate smoothly and cope effectively with changes in their environment and argues it is the role of leadership to build such organizational cultures. It would be interesting to explore whether physicians in leadership roles can lead culture change similar to what Smits, Bowden, and Wells (2016) research from the American perspective.

Recommendations for policy and practice. The following recommendations for future policy and practice will include several suggestions for improving leadership learning, preparation, readiness, and the overall physician experience in a health care workplace setting.

Physician engagement. Physicians are essential to the health system and physician leaders are vital to system leadership and transformation, yet this study demonstrates that structural and cultural barriers continue to exist within health care organizations that appear to limit the full participation of physicians in formal leadership roles. Organizations must meaningfully engage doctors, seeking their input early and often in health system decision-making. Furthermore, to foster engagement of physician leaders, and to encourage new leaders to take on administrative roles, non-clinician leaders may need to address the environment that is being created within their organizations and consider structural and cultural changes. For example, participants

described issues with the organization not considering physicians' working hours, which led to limited engagement with learning and development. A participant described the seemingly simple solution that "having the opportunities available at times that makes sense for physicians would be helpful." This would extend to meetings and other organizational events or initiatives that require or could benefit from physician involvement. This is vital because more active physician leadership will probably support engagement and increased engagement will likely support more informal and formal medical leadership.

Orientation and onboarding. Participants in this study described gaps in corporate talent management, succession planning, and recruitment and retention of physician leaders. New physician leaders would benefit from the implementation of formal policies by regional health authorities for orientation, onboarding, and mentoring programs.

Participants noted that "a proper orientation" was necessary for every physician that comes on staff, as it is lacking or non-existent. One physician suggested "a mini boot camp that you could do at the beginning of each academic year or fiscal year for those that are transitioning to roles, where they could go and have one to two dedicated days of leadership [education]." Furthermore, this research points out that starting to think about leadership earlier in one's medical career and beginning to prepare in advance of taking on a formal leadership role, while a seemingly obvious tactic, is relatively rare. "We need to change the culture of medicine to something that starts the leadership quality being ingrained in physicians from the start. In medical school there's no leadership training....There's no training in anything except looking after patients," offered one

participant. As noted in this study, mentoring programs can also serve to support an onboarding process. “I think everyone who moves into a formal leadership position should formally have a leadership mentor,” offered a participant. A formalized mentoring program could help integrate physicians into leadership roles, and could still be of benefit to more experienced physician leaders.

Leadership development and supports. Physician leadership development appears to remain a low priority for many health care organizations, although physicians discussed the struggles that they faced in developing their capacity to lead. While this research suggests that, at an individual level, physicians could take even more control of their own leadership learning, working to close skill gaps prior to applying for leadership positions, a case can also be made that organizations/hospitals and departments have a responsibility to ensure that physicians are well equipped with the knowledge, skills, attitudes, and values needed to play system leadership roles.

I think you need ongoing support. I would think it would be good to have some combination of some concise or focused courses, like the ones I mentioned, where you have to go for a set amount of time but then it would be good to have some ongoing support as well. It’s like we do in medicine- you have rounds every week. So maybe you could have some ‘leadership rounds.’ You learn about it once a month and you can go if the topic is what you need. Right?

It could also be beneficial to make some leadership education mandatory. Developing foundational modules for new physician leaders (or aspiring physician leaders) would contribute to the themes of starting early, and orientation, mentioned above. One

physician offered his view on why physicians continue to be underprepared for leadership jobs:

No one has taken [leadership learning] on and made it mandatory. And the people who are leading have not necessarily learned that as well, or are not aware. How many of them are not aware? We've built a culture where you come in and it's the research and it's the teaching and everything else, we haven't, you haven't learned. You should know in your residency. It's just something we've forgotten about or we've not realized is missing.

Early education would emphasize not only the importance of specific skill sets to effective leadership, but also the idea that learning leadership is valuable and valued.

While Chapter 4 presented significant learning subthemes under the main theme of “leadership learning,” my findings point to an additional specific set of competency/capability clusters that physicians deemed “essential” to their leadership practice. Further to these “qualities” were suggested supports/strategies related to the physician leadership learning experience. Table 5 provides a summary of each capability/competency area, along with the corresponding domain of the LEADS in a Caring Environment health leadership framework. While many physicians may not be overtly aware of the LEADS framework, it is a pervasive organizing model for leadership development in Canadian health care, and the close alignment of participants' responses to the LEADS domains demonstrates the relevance of this framework to physician leaders' self-prescribed knowledge, skill, and attitude areas.

Table 5

Participant-identified capabilities useful to leadership learning, aligned to LEADS domains and including learning supports and strategies.

Identified Quality or Capability	LEADS Domain
Self-awareness	Lead Self
Reflection / reflective practice; critical reflection / “learning from mistakes”	
Humility	
Accepting feedback	
Doing the right thing	
Listening	Engage Others
Interpersonal communication	
Dealing with conflict/giving difficult feedback	
Collaboration	
Co-leadership	
Building teams	Achieve Results
Decisiveness	
Motivation / commitment	Develop Coalitions
Interprofessional teams	
Intentional relationships and networks	Systems Transformation
Systems thinking / “the bigger picture”	
Learning orientation	
Attitude	
Suggested learning supports / strategies	
Start early	
Prepare before you take the job	
Orientation	
Ongoing support	
Peer support	
Leadership “community”	
Concise/focused (formal learning)	
Interprofessional settings / Learning from each other	
Coaching	
Formal mentorship program	
Make some leadership learning mandatory	
Practicalities / logistics of delivery	

These capabilities, supports, and strategies, as direct insights from participants, can provide guidance for those developing leadership development supports for physicians and are a practical outcome of the study. These address *what* physician leaders need to learn, and should be considered in light of the broader insights from this study about *how*

physicians learn leadership. Increased focus should be placed on developing and supporting physician leaders so physicians who choose to pursue leadership roles are provided with adequate resources, training, and support including clear roles, expectations, and accountabilities.

Much of the research and literature on physician leadership development, including skills-based competency frameworks such as LEADS in a Caring Environment, focuses on describing positive goals or aspirational behaviours/capabilities rather than exploring how people actually engage in learning to help them attain these goals or adopt these behaviours. A final unique contribution of this study is that it attends more explicitly to *how* physician leaders learn, bringing with it an adult education lens and shifting the focus from simplistic outcomes to an exploration of the more complex processes of engaging in difficult learning. This research study has shown that drawing upon adult learning theories such as Mezirow's theory of transformative learning and Wenger-Trayner's work on communities of practice can provide helpful insights into the processes by which learning to lead can be supported.

As I close this dissertation I want to recognize my own individual development and learning. I started this research journey as an emerging scholar and researcher learning to navigate a complex sea of educational theory application. I finish with excitement and the realization that I have made some new connections and that my own tentative thinking and theory building may contribute to the expansion of theoretical discourse in my field. The experience of starting, engaging in, and completing a doctorate has been my own process of becoming: learning, changing, and reflecting.

Concluding Statements

This study offers a profile of physician leaders in a Canadian health care context, including the particular nature of leadership learning in the workplace. An effective health care system is critical to the health of patients, families, and communities, and to society in general. Because of this critical role, health care is an important sector in which to study leadership and learning — an effective system requires strong leadership.

Advancing the understanding of leadership and transitions of medical professionals into formal leadership roles is vital for system improvement. While there are, without question, countless great examples of individual leadership by physicians every day within the health care workplace, the current complexity demands that new skills be promoted and developed to enable physician leaders to succeed. Physician leaders are in a unique position to become a major catalyst in bringing about the development of an integrated organizational culture. They are viewed as credible leaders, whether they feel so themselves or not. Although this research shows the transition of some medical doctors to leadership positions in health care organizations and systems can come with several challenges, it also shows a commitment on the part of physicians to strengthen their ability to effectively lead both clinical and nonclinical colleagues and advance as leaders for the sake of system improvement.

I have been privileged to hear stories of great leadership and courage, as well as setbacks and frustration with organizational inertia. While I heard many examples of cultural differences that impede the communication and collaboration between professional disciplines and limit the interest of physicians for broader organizational roles and responsibilities, I also heard stories of successes and transformations, and of

leaders imbued with a sense of purpose, summed up well in one physician leader's description of why learning leadership is a worthwhile endeavor:

It's a chance to make a difference. You really can, on a larger scale than just one to one patient, make a difference. If you work hard enough, long enough, with enough energy you can change access to care for all of Nova Scotians, all of Atlantic Canada.

Overall, physicians making a real difference through formal leadership roles, modeling commitment to their profession *and* organization to achieve best results, may be the strongest general learning that emerges from this research and suggests a new modus operandi between the system, the organization, and the medical profession.

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Appendix A: Research Interview Invitation

Invitation to Participate in Research Interview

April 20, 2016

My name is Shawn Jolemore and I work as the Leadership Development Coordinator in Nova Scotia Health Authority. I am also a doctoral candidate in the Nova Scotia Inter-University Ph.D. in Educational Studies at Mount Saint Vincent University.

Through my recruitment process for my dissertation, which has a focus on adult learning and leadership in health care, your name was mentioned as someone who has valuable knowledge to share and who might be interested in participating. The goal of my research is to develop a better understanding of the physician perspective on the adult learner experience of learning to become a leader in health care. Your participation in this study would be valuable; the expertise you offer as a leader in health care will provide insight into the process of physicians learning to perform leadership roles and the types of challenges that they may face.

This spring I will be conducting qualitative narrative interviews with 10-12 physicians in the Halifax area. The questions I will be attempting to answer are as follows:

- 1) What is the process of learning among physicians who transition into formal leadership positions?
- 2) What types of leadership learning experiences do formal physician leaders have?
- 3) What particular learning experiences (and contexts) do formal physician leaders perceive as helpful in developing leadership?

I realize that, given your multiple responsibilities within the system, you have an extremely busy schedule. However, I am hoping that this research will inform the development of educational supports that can assist physicians in learning to be effective leaders, and given your background and experience, your participation would be a significant contribution. If you agree to take part in this research study, I will send you an informed consent package to review and also schedule a face-to-face interview of about one-hour in length at a time and place that is convenient for you. I hope to complete the interviews by the end of June.

The interviews for this study will be arranged and conducted confidentially, so that only I will know participants' identity. Interview audio will be recorded and later transcribed by me. They will then be summarized, in an anonymous format, in the body of the dissertation. At no time will any specific comments be attributed to any individual unless your specific agreement has been obtained beforehand. All documentation will be kept strictly confidential.

If you have questions or are willing to participate, please reply to this email or call me at one of the numbers below. Thank you for your consideration of my request.

Sincerely,

Shawn Jolemore, MEd, PhD(c)

[phone numbers and email address removed]

Appendix B: Interview Questions

Learning to Lead in Health Care: A Narrative Inquiry of Physician Leadership

Questions for PhD Interview

1. Can you tell me your story of transitioning into a leadership role? Tell me about your learning journey from medical practice to medical leadership.
2. Can you think of significant events that you have encountered that have helped you to grow as a leader? Did any of these situations surprise you? How did you make sense of or learn from this event?
3. When you think back, are there people or groups of people that were important or had an influence on how you learned to handle these experiences? Can you think of any particular encounters or conversations that were significant to you?
4. What do you think are the most important qualities for a good leader to develop in health care? How have you worked to develop these attributes?
5. What are the biggest challenges to learning leadership? How did you deal with these? What has been the hardest aspect of leadership for you to learn? Why?
6. Have you been involved in educational programs, seminars or professional learning events or programs that have helped you to learn how to be a better leader? How useful have you found these kinds of educational supports to be in learning about leadership?
7. Looking at what you know now, what do you think should be offered in terms of educational or learning supports for individuals who move into leadership roles in medicine?

8. Is there anything else you would like to share about how you have learned to be the leader that you are today, or do you have any other thoughts about this research that you would like to add?

Appendix C: Ethics Approval NSHA



Nova Scotia Health Authority Research Ethics Board
 Centre for Clinical Research, Room 118
 5790 University Avenue
 Halifax, Nova Scotia, Canada B3H 1V7

March 21, 2016

Mr. Shawn Jolemore
 Administration (NSHA)\NSHA Employee
 8
 Halifax, NS B3H 2T8

**Delegated Review
 Full Approval Letter
 (March 21, 2016 to March 21, 2017)**

Dear Mr. Jolemore:

RE: Learning to Lead in Healthcare: A Narrative Inquiry of Physician Leadership

NSHA REB ROMEO File #: 1021027

Thank you for your response regarding your proposed study.

Document Name	Comments	Version Date
Investigator Response/Revisions	Jolemore Clarification letter March 13_16	2016/03/13
Research Protocol	v1.1	2016/03/13

I have reviewed these documents on behalf of the Research Ethics Board (REB) and note that all requested changes have been incorporated.

I am now pleased to confirm the Boards full approval for this research study, effective today. This includes approval / favorable opinion for the following study documents:

Document Name	Comments	Version Date
Researcher's Commitment Form	SI Researcher Commitments	2016/02/21
Letter of Support	SI Letter of Support - Signed and dated by Carmelle d'Entremont	2016/02/24
Certificate of Completion TCPS 2: CORE	Jolemore TCPS2 Core Certificate	2016/01/04
Curriculum Vitae (CV)	Jolemore Abbreviated CV Form	2016/02/10
Review Comments/Correspondence	Jolemore Review Comment External Party	2016/12/16
Letter of Support	Jolemore Letter of Support PI Dept - Signed and dated by Brent Powers	2016/02/10
Researcher's Checklist for Submission	Jolemore Researchers Checklist	2016/02/11
Curriculum Vitae (CV)	SI CV	2016/02/24
Certificate of Completion TCPS 2: CORE	SI TCPS Certificate	2011/11/12
Consent Form	v1.1	2016/03/13
Investigator Response/Revisions	Jolemore Clarification letter March 13_16	2016/03/13
Research Protocol	v1.1	2016/03/13

Continuing Review

1. The Boards approval for this study will expire one year from the date of this letter **March 21, 2017**. To ensure continuing approval, submit a Request for Annual Approval to the Board 2-4 weeks prior to this date. If approval is not renewed prior to the anniversary date, the Board will close your file and you must cease all study activities immediately.

To reactivate a study, you must submit a new Initial Submission (together with the usual fee) to the REB and await notice of re-approval.

2. Please be sure to notify the Board of any:

- * Proposed changes to the initial submission (i.e., new or amended study documents or supporting materials),
- * Additional information to be provided to study participants,
- * Material designed for advertisement or publication with a view to attracting participants,
- * Serious unexpected adverse reactions experienced by local participants,
- * Unanticipated problems involving risks to participants or others,
- * Sponsor-provided safety information,
- * Additional compensation available to participants,
- * Upcoming audits /inspections by a sponsor or regulatory authority,
- * Premature termination / closure of the study (within 90 days of the event).

3. Approved studies may be subject to internal audit. Should your research be selected for audit, the Board will advise you and indicate any other requests at that time.

Important Instructions and Reminders

1. Submit all correspondence to Ethics Coordinator, Pamela Trenholm at the address listed at the top of this letter (do not send your response to the REB Chair or Co-Chair).

2. Login to the Research Portal; click Applications (Submitted - Post Review), browse through files to locate the study in which you wish to make revisions to; click the Events Button and choose the type of revision you wish to make from the table provided; complete the electronic form and attach document under the attachments tab if required and Click on the Submit button.

3. Be sure to reference the Boards assigned file number, Romeo No. 1021027, on all communications.

4. Highlight all changes on revised documents, and remember to update version numbers and/or dates.

Best wishes for a successful study.

Yours very truly,



Anne Marie Krueger-Naug, MD FRCPC PhD
Co-Chair, Research Ethics Board

This statement is in lieu of Health Canada's Research Ethics Board Attestation:

The Research Ethics Board for the Nova Scotia Health Authority operates in accordance with:

- Food and Drug Regulations, Division 5 "Drugs for Clinical Trials Involving Human Subjects"
- Natural Health Products Regulations, Part 4 "Clinical Trials Involving Human Subjects"
- Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2)
- ICH Good Clinical Practice: Consolidated Guideline (ICH-E6)

cc: Lisa Underwood, Director, Research Services

/pt

Appendix D: Ethics Approval MSVU



Associate Vice-President (Research)


Certificate of Research Ethics Clearance

Effective Date	April 15, 2016	Expiry Date	April 14, 2017
File #:	2015-119		
Title of project:	<i>Learning to Lead in Healthcare: A Narrative Inquiry of Physician Leadership</i>		
Researcher(s):	Shawn Jolemore		
Supervisor (if applicable):	Patricia Gouthro		
Co-Investigators:	n/a		
Version :	1		

The University Research Ethics Board (UREB) has reviewed the above named research proposal and confirms that it respects the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and Mount Saint Vincent University's policies, procedures and guidelines regarding the ethics of research involving human participants. This certificate of research ethics clearance is valid for a period of **one year** from the date of issue.

Researchers are reminded of the following requirements:	
Changes to Protocol	Any changes to approved protocol must be reviewed <u>and</u> approved by the UREB prior to their implementation. Form: REB.FORM.002 Info: REB.SOP.113 Policy: REB.POL.003
Changes to Research Personnel	Any changes to approved persons with access to research data must be reported to the UREB immediately. Form: REB.FORM.002 Info: REB.SOP.113 Policy: REB.POL.003
Annual Renewal	Annual renewals are contingent upon an annual report submitted to the UREB prior to the expiry date as listed above. You may renew up to four times, at which point the file must be closed and a new application submitted for review. Form: REB.FORM.003 Info: REB.SOP.116 Policy: REB.POL.003
Final Report	A final report is due on or before the expiry date. Form: REB.FORM.004 Info: REB.SOP.116 Policy: REB.POL.003
Unanticipated Research Event	Researchers must inform the UREB immediately and submit a report to the UREB within seven (7) working days of the event. Form: REB.FORM.008 Info: REB.SOP.115 Policy: REB.POL.003
Adverse Research Event	Researchers must inform the UREB immediately and submit a report to the UREB within two (2) working days of the event. Form: REB.FORM.007 Info: REB.SOP.114 Policy: REB.POL.003

*For more information: <http://www.msvu.ca/en/home/research/researchethics/policies/default.aspx>


Dr. Daniel Séguin, Chair
University Research Ethics Board

166 Bedford Hwy Halifax Nova Scotia B3M 2J6 Canada
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 msvu.ca

Appendix E: Informed Consent Package



Research Ethics Board

Consent to Participate in Research

STUDY TITLE: Learning to Lead in Healthcare: A
Narrative Inquiry of Physician Leadership

PRINCIPAL INVESTIGATOR: Shawn Jolemore
NS Inter-university PhD in Educational
Studies

1. Introduction

You are invited to take part in a qualitative research study, which will be conducted by Shawn Jolemore, a doctoral student at Mount Saint Vincent University, as part of the requirements for his PhD. The study is about the leadership learning experiences and perceptions of physicians who have taken on formal leadership roles within the health system.

A research study is a way of gathering information on a treatment, procedure, or medical device, or to answer a question about something that is not well understood. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take, and what benefits you might receive. This consent form explains the study.

You may take as much time as you wish to decide whether or not to participate. Feel free to discuss it with your friends and family.

Please ask the researcher to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

The researcher will:

- Discuss the study with you
- Answer your questions
- Be available during the study to deal with problems and answer questions

You are being asked to consider participating in this study because you are a physician who is currently holding a leadership position with Nova Scotia Health Authority (e.g. Chief, Department Head, Zone Executive Medical Director, Vice President).

Research Ethics Board

If you decide not to take part or if you leave the study early, your job/position will not be affected in any way – whether you participate in this study or not – and no one will read or add to your personnel record.

2. Why Is This Study Being Conducted?

The purpose of this research is to investigate how leadership learning takes place in the healthcare workplace. This involves exploring the perceptions and experiences of physicians who have transitioned into a leadership role to develop a better understanding of the adult learner experience of learning to become a leader in healthcare from physicians' perspectives.

This research has potential to offer new knowledge to the discipline of medical leadership that will benefit future generations and the welfare of the NSHA community and the larger healthcare system. Much can be learned from the experiences of existing physicians who have transitioned to a formal leadership role. Their personal experiences can offer insights into the nature of medical leadership and its associated challenges.

Findings may provide information about the effectiveness of specific tactics used within leadership development programming and may use this information to implement improvements and maintain successes. The study may also provide scholarly insights informing both adult learning and leadership. Much existing research in this area focuses on *what* healthcare leaders learn, while this study will add to knowledge on *how* leaders learn, adding to our understanding of the particular kind of adult learning experienced in the process of learning to lead.

3. How Long Will I Be In The Study?

Participants will be asked to take part in an interview that will take about an hour to complete. The entire study is expected to take 3 months to complete and the results should be known in about 12 months.

4. How Many People Will Take Part In This Study?

It is anticipated that 10 physicians from Nova Scotia Health Authority will participate in this study.

5. How Is The Study Being Done?

This study will use a qualitative narrative inquiry design and data will be collected through participant interviews. You will be asked to share information about your leadership development across your career, reflecting on critical incidents and learning experiences that impacted on you. Although the one-hour interview will contain some general questions, it will probably seem more like a conversation between you and the interviewer.

6. What Will Happen If I Take Part In This Study?

If you agree to take part in this study, the researcher will contact you to set up an in-person interview at a time and place that is convenient for you. The interview will probably take about an hour to complete.

Audio recording is required for participation in the study and by choosing not to be audio recorded you cannot participate.

During the interview, a digital recorder will be used to record the conversation and you will be asked to sign a form (included later in this document) agreeing to have your interview recorded. You do not have to answer any question that you do not wish to. An interview schedule, which overviews some of the questions that might be asked, is included in this document

The interview will be transcribed into text, and you will be sent a copy of this transcript. If you wish to make any edits to the transcript, you may do so. You also have the right to request if you would like part or all of the transcript to be deleted and your data to be removed from the study.

7. Are There Risks To The Study?

While this research does not involve any interventional treatment, some people may find interviews upsetting or distressing. You will be asked to share narratives about your life and leadership experiences within the context of the research interview. Sometimes, recalling specific challenges or experiences may bring up uncomfortable memories.

To further protect your information, we will not keep your name or other information that may identify you with the interview responses; only a code number. Files that link your name to the code number will be kept in a secure place. Although no one can absolutely guarantee confidentiality, using a code number decreases the chance that someone other than the research staff or other authorized groups or persons will ever be able to link your name to your interview data.

8. Are There Benefits Of Participating In This Study?

We cannot guarantee or promise that you will receive any benefits from this research. However, possible benefits include assisting in the advancement of knowledge and the possibility of benefitting new and emerging physician leaders by sharing your personal experiences of transitioning into a leadership role. This will assist adult educators and leadership development practitioners in their efforts to better design learning interventions and other workplace supports that have maximum impact for physicians and physician leaders.

9. What Happens at the End of the Study?

The results of this study will be part of the doctoral dissertation of the researcher. It is also anticipated that the results of this study will be published and or presented in a variety of forums.

Research Ethics Board

In any publication and/or presentation, information will be provided in such a way that you cannot be identified. You will be informed when the findings are available.

10. What Are My Responsibilities?

As a study participant you will be expected to:

- Participate in a one-hour interview;
- Follow the directions of the research team;
- Report any problems that you experience that you think might be related to participating in the study;
- Optional- review your interview transcript

11. Can My Participation in this Study End Early?

Yes. If you choose to participate and later change your mind, you can say no and stop the research at any time. A decision to stop being in the study will not affect your role/position/affiliation with NSHA or any work performance evaluations you may have. If you choose to withdraw simply inform the researcher, and your interview data will not be included in the study.

Also, Mount Saint Vincent University, the Nova Scotia Health Authority Research Ethics Board and the researcher have the right to stop participant recruitment or cancel the study at any time.

Lastly, the researcher does not anticipate asking anyone to leave the study, however if it appears that participation in this study may be harmful to you, you will be asked if you want to end participation. If you are withdrawn from this study, you will be told the reason why your participation in the study was ended.

12. What About New Information?

Although unanticipated, if there is other new information that might affect your health, welfare, or willingness to stay in the study and will be asked whether you wish to continue taking part in the study or not.

13. Will It Cost Me Anything?

Participation in this study will not involve any additional costs to you.

Research Related Injury

If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your legal rights nor release the principal investigator, the research staff, the study sponsor or involved institutions from their legal and professional responsibilities.

14. What About My Privacy and Confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. If the results of this study are presented to the public, the following precautions will be taken such as removing identifiers connected to you (e.g. age, gender, workplace location, tenure in a leadership role).

However, complete privacy cannot be guaranteed. For example, the researcher may be required by law to allow access to research records.

Access to Records

The research does not involve access to your health records. No one involved in this study will look at your personnel record or health information for any reason.

Use of Your Study Information

Any study data about you that is sent outside of Nova Scotia Health Authority will have a pseudonym and will not contain your name or address, or any information that directly identifies you.

De-identified study data may be transferred to the researcher's doctoral supervisor and committee.

Study data that is sent outside of the Nova Scotia Health Authority will be used for the research purposes explained in this consent form.

The researcher and the other people listed above will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

The researcher will keep any personal information about you in a secure and confidential location for a maximum of five years and then destroy it according to NSHA policy. Your personal information will not be shared with others without your permission.

You have the right to be informed of the results of this study once the entire study is complete. A summary report will be circulated to participants.

The REB and people working for or with the REB may also contact you personally for quality assurance purposes.

Your access to records

You have the right to access, review, and request changes to your interview data. You will be given one month to review your transcript, edit/amend, and return to the researcher. If you wish to make amendments and require additional time for review, please contact the researcher.

15. Declaration of Financial Interest

This study is unfunded and the researcher has no vested financial interest in conducting the study.

16. What About Questions or Problems?

For further information about the study you may call the researcher, who is the person in charge of this study.

The researcher/principal investigator is Shawn Jolemore.

Email: sh

Telephone:

17. What Are My Rights?

You have the right to all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have these questions answered to your satisfaction before you make any decision. You also have the right to ask questions and to receive answers throughout this study.

If you have any questions about your rights as a research participant, contact Patient Relations at (902) 473-2133 or healthcareexperience@nshealth.ca

In the next part you will be asked if you agree (consent) to join this study. If the answer is “yes”, please sign the form.

18. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

Learning to Lead in Healthcare: A Narrative Inquiry of Physician Leadership

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my role/position/affiliation with NSHA.

I agree to audio recordings as described in this consent form.

Signature of Participant _____
Name (Printed) Year / Month / Day*

Signature of Person Conducting
Consent Discussion _____
Name (Printed) Year / Month / Day*

Signature of Investigator _____
Name (Printed) Year / Month / Day*

**Note: Please fill in the dates personally*

I will be given a signed copy of this consent form.

Appendix: Semi-Structured Interview Questions**Learning to Lead in Healthcare: A Narrative Inquiry of Physician Leadership
Questions for PhD Interview**

1. Can you tell me your story of transitioning into a leadership role? Tell me about your learning journey from medical practice to medical leadership.
2. Can you think of significant events that you have encountered that have helped you to grow as a leader? Did any of these situations surprise you? How did you make sense of or learn from this event?
3. When you think back, are there people or groups of people that were important or had an influence on how you learned to handle these experiences? Can you think of any particular encounters or conversations that were significant to you?
4. What do you think are the most important qualities for a good leader to develop in healthcare? How have you worked to develop these attributes?
5. What are the biggest challenges to learning leadership? How did you deal with these? What has been hardest aspect of leadership for you to learn? Why?
6. Have you been involved in educational programs, seminars or professional learning events or programs that have helped you to learn how to be a better leader? How useful have you found these kinds of educational supports to be in learning about leadership?
7. Looking at what you know now, what do you think should be offered in terms of educational or learning supports for individuals who move into leadership roles in medicine?
8. Is there anything else you would like to share about how you have learned to be the leader that you are today, or do you have any other thoughts about this research that you would like to add?