DISSERTATION

EXPLORING THE NATURE OF PHYSICIAN LEADERSHIP FOR FAMILY MEDICINE RESIDENT PHYSICIANS: A PHENOMENOLOGICAL STUDY

Submitted by

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ABSTRACT

EXPLORING THE NATURE OF PHYSICIAN LEADERSHIP FOR FAMILY MEDICINE RESIDENT PHYSICIANS: A PHENOMENOLOGICAL STUDY

From solo practitioner in the late 19th century to team leader and policy maker in the 21st century, the physician's role is becoming increasingly complex and often extending beyond the perceived traditional realm of patient care. Such complexity has garnered recent attention for defining and developing physician leadership in order to equip physicians to lead in the shifting landscape of health care.

Nonleader resident physicians are an underrepresented population in the literature on physician leadership. Although a few resident physicians assume formal leadership roles in medical residency, the majority serve as leaders by virtue of their stage in training or as informal leaders to peers and others. Little is known about resident physicians not in formal roles (nonleaders) and how they describe physician leadership through their lived experiences in graduate medical education.

This study explored the nature of physician leadership for nonleader family medicine resident physicians from their descriptions of physician leadership. Guided by the constructivist paradigm, the research question for this qualitative study was, *How do family medicine resident physicians describe and experience the nature of physician leadership?* The conceptual framework consisted of (a) two foundational leadership elements, (b) leadership era paradigms, and (c) three contexts of medical education.

Descriptive phenomenology was selected as the methodology and data were collected from six family medicine residents in two family medicine residency programs in a southwestern state in the United States. The participants met criteria and completed two rounds of interviews and member checking. The data were analyzed through integrative data analysis and yielded themes about *what* was experienced regarding physician leadership, such as (a) the environment created by physician leaders, (b) the attributes and behaviors of physician leaders, and (c) the focus on the followers. These themes were bound by *how* the resident physicians experienced these aspects, such as through the context of the specialty of family medicine, the graduate medical education context, and the apprenticeship structure of medical residency that facilitated day-to-day proximity to physician leaders. Conclusions and recommendations for practice, future research, and theorizing are also presented.

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First and foremost, I acknowledge my Savior Jesus Christ for guiding me throughout this journey. In my early adolescent years, I did not imagine I could have even attended college or accomplished this goal. I am forever grateful for His grace and unending love.

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My peers, Jessie, Jaime, Michael, and others were great friends and challenged me, and I thank them. Also, thanks to my fellow advisees, Ryan, Michael, Chris, and others.

DEDICATION

This dissertation is dedicated to my wife, Stephanie Dewsnap, who has been steadfast and loving throughout the entire process; to my son, Jaxson Dewsnap, whose smile and personality have provided many laughs (as well as gray hairs) in the past few years; and to my dog, Ziggy Dewsnap, who has been an amazing study buddy, always ready to offer a loving snuggle and bark at the slightest change in the atmosphere. This dissertation is also dedicated to my extended family, especially my grandmother, Alice Bryant, whose loving correction about the importance of persistent hard work brought focus in times of disarray. I could not have completed this dissertation journey without the support of those around me.

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CHAPTER 1

INTRODUCTION

Originating in fields such as sociology, the contemporary inquiry of leadership can be traced back to studies by Galton (1869) on hereditary traits in the late 19th century (Northouse, 2013). From Galton (1869) and studies on defining leadership characteristics in the early 20th century to more recent approaches such as Adaptive Leadership (Heifetz, Grashow, & Linsky, 2009) which emphasized the developmental process, the contemporary literature on leadership focused on definition and development (Northouse, 2013). To address the growing complexity of the health care system in the United States, experts in the field of medical education drew on contemporary leadership literature to inform definition and development of physician leadership (Parker, 2013; Taylor, Taylor, & Stoller, 2008). In spite of the heightened attention since the late 1990s and subsequent proliferation of developmental programs (National Center for Health care Leadership [NCHL; 2014; Neeley, Clyne, & Resnick-Ault, 2017), physician leadership in medical education is considered "largely understudied" (Dine, Kahn, Abella, Asch, & Shea, 2011, p. 31) and needing "careful consideration" (Skochelak, 2010, p. S32). This chapter opens with a brief background on medical education, followed by the research problem, purpose, and research question. Next, methodology, methods, and quality criteria are reviewed. Then, the significance of the study and the conceptual framework are described before delimitations, limitations, and terms are defined. The chapter ends with an outline of the organization of the dissertation.

Background of the Study

Medical education in the United States until the late 19th century was often perceived as informal and ineffective (Cooke, Irby, & O'Brien, 2010). Fortunate medical students either

completed medical training by enrolling in one of the few existing schools or apprenticing with practicing physicians. However, most medical students attended physician-owned and -operated proprietary medical schools (Cardinal & Kaell, 2017; Halperin, Perman, & Wilson, 2010). Admissions standards at these schools that were unaffiliated with universities were inconsistent and typically required only a high school diploma. Curricula consisted of 2 years of experience-based lectures and were largely absent of patient interaction (Irby, Cooke, & O'Brien, 2010). At that time, it was common for graduates never to have interacted with a patient. Inconsistent standards and lack of oversight made it difficult to assess the quality of graduating physicians and highlighted the need for change.

The varying quality and structure of physician training at the turn of the 20th century prompted the American Medical Association and the Carnegie Foundation for the Advancement of Teaching to commission Abraham Flexner to study medical schools in the United States and Canada (Ludmerer, 2010). Utilizing Johns Hopkins School of Medicine as a model, Flexner's three core recommendations were (a) standardized admissions criteria that included a rigorous science-based undergraduate degree, (b) a 4-year curriculum that integrated 2 years of basic science class work and 2 years of hands-on clinical science (Irby et al., 2010), and (c) locating medical schools in universities and teaching hospitals where physicians could draw on empirical research and learn to "think like scientists" (Irby et al., 2010, p. 222).

Flexner's 1910 report is largely identified as the foundational document for structuring contemporary medical education and practice (Cooke et al., 2010); however, one critique is that medical education was already moving toward a closer relationship with experimental medicine (Irby et al. 2010; Ludmerer, 2010). Although the impact of Flexner's report is contentious, the report helped to shift medical education from dogmatic tradition to empirical science (Cardinal

& Kaell, 2017) and reframed it as a formalized system. Regardless of the catalyst, medical education and the physician's role in society and health care evolved in the following decades.

During the 1920s and 1930s, the national focus on biomedical research in medical education grew alongside hospital-based residency programs and establishment of medical specialty boards to certify physician training. The emphasis on biomedical research strengthened connections with the federal government and elevated the physician's role in society from clinician to "clinician-investigator" (Irby et al., 2010, p. 223). The growing relationship to the government, in addition to employer-based insurance initiated in the 1940s, helped to increase the demand for biomedical research, teaching hospitals, and specialization through graduate medical education (GME) following medical school (Cooke et al., 2010). The establishment of Medicaid and Medicare in 1965 stoked the demand for health care and garnered federal support for expanding medical school enrollment. These changes, along with the increasing number of teaching hospitals, helped to transform medicine, and medical education, from siloed efforts into a "system of care" (Cooke et al., 2010, p. 16) and clinical enterprise (Timmermans & Oh, 2010).

Medical education enjoyed federal and state financial support through the 1970s, which further expanded medical school enrollment, as well as administrative complexity, through establishment of units such as offices of medical education (Cooke et al., 2010). During this era of expansion, medical education benefited from a growing patient population and dependence on clinical revenue that supported student enrollment in undergraduate medical education (i.e., medical school) and the concomitant need for more clinical faculty. This expansion was short lived as regulatory efforts in the 1980s resulted in policies to contain cost and enhance efficiency. Along with these policies, medical education in the 1990s focused on aspects such as resident physician safety and increasing areas of specialization (Cooke et al., 2010). Orlando

and Haytaian (2012) described the climate of health care for the first 10 years of the 21st century as a "perfect storm: reductions in federal and state reimbursements, downward pressure on price from health plans, increased need for demonstrable quality, demands from employers to control health-care costs and increasing expectations from consumers" (p. 417). Medical education was pressed not only to diversify with regard to specialties but also to inculcate knowledge and skills to match the complexity of emerging challenges in health care (Dickerman, Sánchez, Portela-Martinez, & Roldan, 2018). These challenges urged the physician's role to stretch beyond the traditional physician-patient dyadic relationship.

Since the late 1990s, challenges facing health care have catalyzed a growing interest in defining and developing physician leadership (Neeley et al., 2017). Such challenges include (a) financial constraints (Orlando & Haytaian, 2012), (b) social expectations for accountability and cost (Stoller, 2008), (c) federal changes that required elevated coordination of patient care (Hofer, Abraham, & Moscovice, 2011), and (d) increasing involvement of physicians on interprofessional health care teams (Morrison, Goldfarb, & Lanken, 2010).

The current complexity of health care has created an environment for which medical education may not have equipped physicians adequately (Neeley et al., 2017). In the 19th century, physicians were perceived as solo clinicians and leaders of the physician-patient relationship. The 20th century pushed physicians to become political decision makers and clinical investigators. Recent challenges have compelled physicians to embrace roles such as team leader and team member (Morrison et al., 2010), as well as "manager and system architect" (Bohmer, 2004, para. 6).

Skochelak (2010) analyzed 15 major medical association reports published since 2000 on recommendations for medical education. One major theme was the importance of physician

leadership and a criticism was that efforts to develop physician leadership in medical education were lacking and needed attention. Theobald (2015) supported the importance of physician leadership and stated that developing it is a "critical need" (p. 89) due to the roles of physicians on health care teams. In addition to the physician-patient relationship and teams, physicians enact leadership through managing private practices, directing physician groups (Dickerman et al., 2018), and advocating for health care policies (Snell, Briscoe, & Dickson, 2011). Whether assuming formal positions or informal enactment, it can be said that, in some capacity and "at some level, all physicians are considered leaders" (American Association for Physician Leadership [AAPL], 2017, para. 4).

Research Problem

Three issues related to the phenomenon of physician leadership as treated in the extant literature guided this study and informed the research problem. They are briefly discussed next.

First, challenges in health care have established the need for defining and developing physician leadership in medical education. However, the literature on physician leadership in medical education is deficient to this end (Dine et al., 2011). The literature is also weighted toward quantitative studies on developmental approaches while lacking qualitative studies on aspects such as the nature of physician leadership (Frich, Brewster, Cherlin, & Bradley, 2014; Webb et al., 2014). Frich et al. (2014) noted that, of 45 studies on physician leadership included in their systematic literature review, 12 were mixed method and only one was qualitative.

Second, the literature on physician leadership is dominated by studies on fully licensed physicians in formal leadership positions (e.g., program directors) rather than on populations such as resident physicians who may not hold formal leadership positions in training but may assume formal or informal leadership roles in professional practice (Kuo, Thyne, Chen, West, & Kamei, 2010; Pettit, 2015).

Third, definitions and developmental approaches in medical education are grounded in literature from other fields (Clyne, Rapoza, & George, 2015; Taylor et al., 2008) and emphasize aspects such as skills or outcomes (Webb et al., 2014). It was evident from the informing literature that the nature of physician leadership based on lived experiences was not adequately addressed in the literature.

The research problem is the evident lack of literature on understanding physician leadership in medical education (Frich et al., 2014; NCHL, 2014; Stoller, 2008; Webb et al., 2014). Dugan (2017) stated, "How people approach the development of leadership is a function of their formal and informal theoretical understandings of the construct" (p. 41). Exploring the nature of physician leadership in medical education is important because how physicians understand the phenomenon informs how they might develop or enact it. Souba (2004a) noted, "How we think about leadership matters a lot. It matters because our implicit leadership theory affects how we exercise leadership, consciously or unconsciously, in our everyday lives" (p. 178). Thus, it is pertinent to investigate the definition, or the nature, of physician leadership in medical education to inform approaches to development and action.

The three issues discussed above point to a gap in the literature. This gap in knowledge in the literature merits exploration and will help to deepen understanding of the nature of physician leadership in medical education from the perspective of an underrepresented population, namely resident physicians, in the essential educational context of GME.

Purpose and Research Question

Given the gap cited above and the needs that are evident in the literature, the purpose of this study was to explore the nature of physician leadership for family medicine resident physicians from their descriptions of the phenomenon through lived experiences in GME. Exploring descriptions that resident physicians ascribe to physician leadership will contribute to

understanding its nature or essences. Patton (2002) stated that essences are shared understandings of "a phenomenon commonly experienced" (p. 106). This study will contribute to the literature on physician leadership by offering a qualitative approach focused on constructing the nature of physician leadership from the lived experiences of an underrepresented population, namely resident physicians, in a medical education context (i.e., GME). The central research question is therefore a phenomenological one: How do family medicine resident physicians describe and experience the nature of physician leadership?

Overview of Paradigm and Methodology, Methods, and Quality Criteria

After determining the purpose and research question, I examined inquiry paradigms and associated core ontological, epistemological, and methodological questions to guide this inquiry (Guba, 1990). Answering the fundamental questions is critical to a study, as the answers situate the study in an inquiry paradigm (e.g., constructivist) and inform aspects such as methodology and methods. The paradigm, methodology, and methods are reviewed in the following subsections.

Paradigm

An inquiry paradigm is considered the philosophical stance (Denzin & Lincoln, 2011), or beliefs, that guides the methodology and methods for a research study. I situated this study in the constructivist paradigm as the assumptions underlying answers to the paradigmatic questions support the purpose and research question. First, the constructivist paradigm answers the ontological question about the nature of reality by holding to a relativist stance (Schwandt, 1998) and multiple realities (Guba, 1990), which informed the study through promoting investigation of the multiple constructed realities of the resident physicians. Next, the epistemological question on the nature of knowledge was answered by stating that knowledge is constructed through an interactive and subjective process (Guba, 1990; Guba & Lincoln, 1994) and accounts

for the influence of lived experiences of the resident physicians on constructions of physician leadership. Finally, the methodological question of acquiring knowledge is addressed by identifying myself as the primary research instrument (Guba & Lincoln, 1994) and close positioning to the resident physicians in order to elicit descriptions and co-construct the nature of physician leadership through a reciprocal process (Guba, 1990).

Methodology

The process of research stemming from foundational philosophical paradigm is defined as methodology (Creswell, 2007; Merriam & Tisdell, 2015). Guided by the constructivist paradigm, I selected a qualitative research design and considered various methodologies to address the purpose of the study and to address the research question. The focus on the nature of physician leadership through descriptions of resident physicians grounded in lived experiences in GME led me to identify phenomenology as the methodology best suited for the study.

Phenomenology is rooted in philosophies of Edmund Husserl (1859–1938) and Martin Heidegger (1889–1962), who established, respectively, transcendental and hermeneutic approaches (Moran, 2000). Husserl focused on the role of directed relationship between consciousness and knowledge (epistemology). For example, consciousness connects the resident physician to the phenomenon of physician leadership (Merriam & Tisdell, 2015). The transcendental approach also supported transparency (epoche) and "bracketing" (Patton, 2015, p. 575) prior interpretations of the phenomenon in order to transcend these interpretations and adhere to the descriptions of participants. Thus, phenomenological methodologies based on Husserl are descriptive and focus on participant descriptions of a lived and, thus, experienced phenomenon.

In contrast, Heidegger elevated the relationship between lived experience and reality (ontology), as well as the focus on the interpretations of the researcher. Rather than

consciousness connecting the subject to the object, being in the world connects subject to object (Vagle, 2014; Van Manen, 1990). To Heidegger, being a physician leader is what connects the resident physician to the phenomenon of physician leadership. Phenomenological methodologies based on Heidegger are interpretive as the researcher's lived experience and interpretations are also emphasized alongside those of the participants.

After reflecting on the research question, I determined that descriptive phenomenological methodology was appropriate for this study. Selecting a descriptive phenomenological methodology is predicated on the research question inquiring about descriptions of a lived and experienced phenomenon (physician leadership), as well as emphasizing directed consciousness (epistemology), as resident physicians are not in official leadership roles.

Methods

The methods for this descriptive phenomenological study include, but are not limited to (a) recruiting three to eight family medicine resident physicians from two family medicine residency programs in a southwestern state in the United States; (b) utilizing criterion-based purposeful participant selection to identify information-rich participants; (c) collecting data through two semistructured qualitative interviews informed by a data collection guide; (d) analyzing data through an integrated approach to descriptive phenomenological data analysis based on Moustakas (1994) and Colaizzi (1978), as illustrated in Figure 1 and elaborated in Chapter 3; and (e) including excerpts from participants to illuminate the descriptions (what) of the lived experience (how) of physician when reporting the data. *What* was experienced, and *how*, with regard to a phenomenon are core components to phenomenological inquiry.

Quality Criteria

Lincoln and Guba (1985, 1986) proposed the criteria of trustworthiness and authenticity to address concerns about the quality of research in qualitative/naturalistic and constructivist

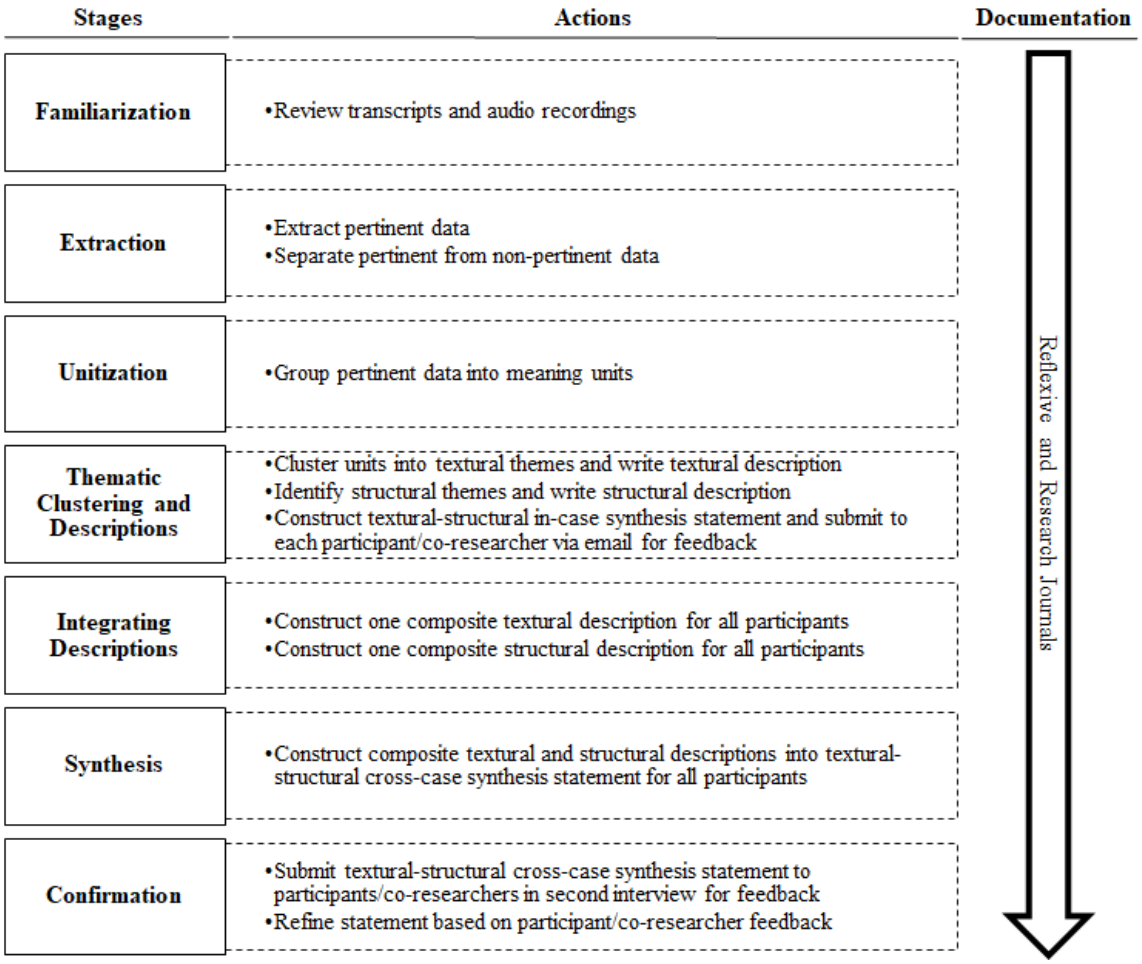

Figure 1. Approach to data analysis identifying the stage, actions, and documentation.

inquiry. Trustworthiness and authenticity were followed by situating this study within the constructivist paradigm to enhance the quality of the study.

Trustworthiness. Trustworthiness aims to ensure that the procedures that are employed enhance the quality of the study in that the procedures are executed correctly in the manner for which they were designed (Frey, 2018). Trustworthiness criteria include (a) credibility, (b) transferability, (c) dependability, (d) confirmability, which are identified in Table 1 with specific strategies (Lincoln & Guba, 2013).

Table 1

The Quality Criteria of Trustworthiness

Criterion	Strategies
Credibility	Peer review, member checking
Transferability	Word-for-word examples, thick description
Dependability	Audit trail in research journal
Confirmability	Critical awareness and suspension in reflexive journal
	Disclose perspective and positionality

Credibility refers to confidence in the data and interpretations of a study (Lincoln & Guba, 1986; Lincoln & Guba, 2013). To satisfy credibility, I submitted my reflexive journal to a professional peer for review before both rounds of interviews, data analysis, and after construction of the final cross-case synthesis statement; I also submitted my research journal frequently to ensure construction of themes in data analysis. I satisfied credibility by returning the individual textural-structural statements in the fourth stage (thematic clustering and descriptions) along with the cross-case synthesis statement in the final stage (confirmation) back to the participants for feedback. Transferability is the relevance of findings to different contexts or participants (Lincoln & Guba, 2013) and was addressed herein by including word-for-word responses in the detailed accounts in order to construct a thick description (Lincoln & Guba, 1986). Thick description draws the reader into the lived experiences of the participants and helps to determine applicability of the study. Dependability is determined by "whether the results are consistent with the data collected" (Merriam & Tisdell, 2015, p. 251). The audit trail detailed in my research journal was designed to satisfy dependability. Confirmability determines whether

the findings result from a dependable process of inquiry (Lincoln & Guba, 2013). Utilizing a reflexive journal to document critical awareness and suspension of prior interpretations addresses confirmability.

Authenticity. Alongside trustworthiness, authenticity is utilized for judging the quality of inquiry (Lewis-Beck, Bryman, & Futing Liao, 2004) and ensuring that the procedures/methods are aligned with the governing inquiry paradigm. The criteria for authenticity include (a) fairness, (b), ontological, (c) educative, (d) catalytic, and (e) tactical (Guba, 1990; Lincoln & Guba, 2013) and are detailed below in Table 2, along with specific strategies.

Table 2

The Quality Criteria of Authenticity

Criterion	Strategies
Ontological	Disclosing perspective and positionality, reflexive journal, participant feedback
Educative	Review cross-case synthesis statement
Catalytic	Semistructured interviews, returning to cross-case synthesis statement, voice of underrepresented population
Tactical	Inclusive posture of inquirer, participants as co-researchers

Over all, I provided a balanced representation of the various descriptions of the phenomenon of physician leadership as understood by family medicine resident physicians to ground the criteria in fairness (Lincoln & Guba, 2013). My reflexive journal assisted in documenting critical awareness and suspension of interpretations. Ontological authenticity promotes awareness of various constructions and underlying assumptions (Guba, 1990) of

physician leadership, which is satisfied by disclosing my perspective and positionality and offering opportunities to review in-case textural-structural statements via email and the cross-case synthesis statement in the second interview. Similarly, educative authenticity is the degree to which people are more understanding of perspectives other than their own not only through reviewing but also through providing feedback on the cross-case synthesis statement. Catalytic and tactical authenticity refer to how the inquiry process empowers action (Lincoln & Guba, 2013). Catalytic and tactical authenticity are addressed through an emergent research process that is exemplified in the collaborative nature of the inquiry, specifically through semistructured interviews and returning to the participants, also identified as co-researchers, for feedback on individual textural-structural in-case synthesis statements, and informs the final cross-case synthesis statement. The findings offer a voice to resident physicians, an underrepresented population in the literature on physician leadership.

Ethical requirements. In pursuit of ethical requirements, I was obligated to ensure anonymity of participating resident physicians and confidentiality of data by utilizing ethical measures. First, the study was vetted through the appropriate entity at Colorado State University (CSU), the public university, and the organization associated with the sites to ensure that the study satisfied standards for human subjects research. Next, ethical measures included, but were not limited to, coding responses, security of data, and clearly communicating aspects such as the purpose of the study, along with any potential risks, when securing informed consent through a document or verbally, based on templates provided by the office of Research Integrity and Compliance Review at CSU (CSU, 2018a; Patton, 2015). Acknowledging my role as researcher apart from my professional role alleviated any perceived power dynamic. I assured participants

that I had no influence over evaluation and reaffirmed my role as a researcher, as well as the confidentiality of the data.

Significance

A gap in the extant literature exists regarding how physicians understand the nature/essence of physician leadership. Dine et al. (2011) pointed out the extensive general literature on leadership in contrast to the paucity of literature on physician leadership. Approaches to leadership development in medicine typically focus on aspects such as individual skill development or outcomes (Webb et al., 2014). Souba (2004a, 2004b) suggested that developing skills through traditional curricula or programmatic interventions is insufficient and that exploring the nature of physician leadership merits attention as it guides language and actions. Dugan (2017) agreed and stated that how people develop leadership is based on formal and informal understandings of the concept. Investigating nature/essence through descriptions of physician leadership provides complementary knowledge when crafting developmental interventions.

The context of GME and the primary care specialty of family medicine are important due to their pivotal roles in medical education and health care (Accreditation Council for Graduate Medical Education [ACGME], 2014; Hofer et al., 2011). GME is perceived as a critical component of medical education (ACGME, 2017b) and a time of significant development for resident physicians (Cooke et al., 2010). Family medicine physicians are important because they are points of entry to the health care system (Blumenthal, Bernard, Bohnen, & Bohmer, 2012).

A goal of this study was to offer a qualitative approach that explores the nature of physician leadership through the descriptions of resident physicians of the phenomenon as experienced in GME. Tavakol and Sandars (2014) suggested that qualitative inquiry is key to research in medical education when there is "little knowledge about new phenomena or new

meanings of phenomena . . . [and] can shed light on phenomena not accurately understood in teaching and practice" (p. 750). This study contributes to the literature on the phenomenon of physician leadership by co-constructing a nature of physician leadership situated in and arising out of (Iran-Nejad & Houser, 2013) the lived experiences of family medicine resident physicians in the context of GME. Studying resident physicians who are not in formal leadership positions is a new perspective in the literature that highlights an underrepresented population in a pivotal educational context (i.e., GME). Investigating the nature/essence of physician leadership through resident physicians' descriptions from GME supports the importance of the personal understanding of physician leadership and lived experiences to developmental efforts.

Conceptual Framework

I selected to approach this study conceptually rather than theoretically. I perceived that limiting inquiry of physician leadership to particular theories was not strongly aligned with the chosen methodology. Utilizing a theoretical framework in phenomenological inquiry is contentious. It can help to locate the study in a field but should be set aside (Giorgi, 2009) because it can constrain inquiry if utilized to sort data deductively into preconceived categories rather than inductively allowing the data to be co-constructed (Creswell, 2014; Vagle, 2014). After reviewing phenomenological studies in health care (Pettit, 2015; Pregitzer, 2014; Sorbello, 2010), I determined that setting aside the theoretical framework was not sufficiently executed. For the purpose of inductively exploring the nature of physician leadership through the descriptions of resident physicians, I utilized a broad conceptual framework to determine the focus and scope of the literature review and study.

The conceptual framework (Figure 2) consists of a synthesis of (a) Dugan's (2017) foundational leadership elements of definition and development, (b) Rost's (1993) historical leadership era paradigms, and (c) the three contexts of medical education.

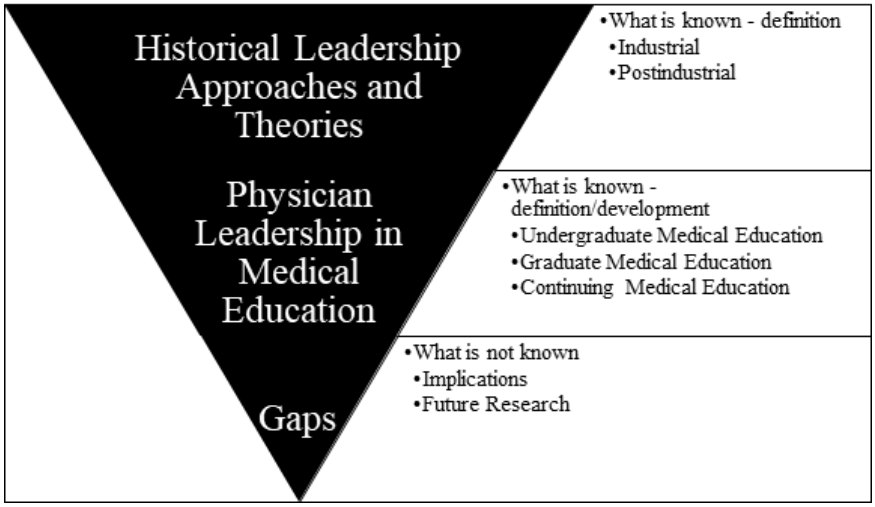

Figure 2. Synthesized conceptual framework of physician leadership in medical education.

Dugan's (2017) foundational leadership elements of definition and development are the first components of this framework. Including both elements is critical because they are intertwined. "How people approach the development of leadership is a function of their formal and informal theoretical understandings of the construct" (Dugan, 2017, p. 41). Developmental choices are influenced by assumptions and values underlying understandings of leadership (Heifetz, 2010). The second component includes approaches and theories of leadership. Rost's (1993) era paradigms provide insight into how leadership has been defined since 1900. Examining the broad literature is key to understanding how leadership is historically understood. The third component is the field of medical education. Findings on defining and developing physician leadership are grouped into the three contexts of undergraduate medical education (UME), graduate (GME), and continuing medical education (CME; Aschenbrener, Ast, & Kirch, 2015). The rationale for including this component in the framework is to be intentional about conducting a study that considers the broad (e.g., GME) rather than specific (e.g., clinic,

hospital) educational contexts in medical education (Dine et al., 2011; Howieson & Thiagarajah, 2011; Parker, 2013).

Delimitations and Limitations

Roberts (2010) described delimitations as the parameters of a study that show the reader how the scope has been narrowed. Marshall and Rossman (2006) depicted limitations as the inherent restrictions of a study that are derived from the research design. Considerations regarding delimitations and limitations of this study are discussed.

Delimitations

I chose a qualitative design and a phenomenological methodology to focus on descriptions of the experienced phenomenon of physician leadership (Patton, 2002). Through two rounds of semistructured interviews, resident physicians described the phenomenon of physician leadership through their lived experiences in GME. From these descriptions, a descriptive data analysis process based on Moustakas (1994) and Colaizzi (1978) and grounded in the quality criteria of trustworthiness and authenticity, a nature/essence of physician leadership for participants was co-constructed. Criterion selection was utilized to select from three to eight participants with experiences that were "likely to be information rich" (Patton, 2002, p. 238) from two family medicine residency programs in a southwestern U.S. state. The selection strategy did not classify based on aspects such as gender due to focusing on recruiting participants with possible rich experiences, regardless of classification. Participant selection was guided by redundancy (saturation), which reflects the constructivist paradigm by ceasing data collection when saturated with repetitive and richly descriptive aspects of resident physicians' understandings of physician leadership (Lincoln & Guba, 1985).

The study was delimited to the medical specialty of family medicine because leadership by family medicine physicians is perceived as a "vital role" (ACGME, 2014, p. 1) and a growing

need because of their roles on health care teams (Theobald, 2015) and as entry points to the health care system (Blumenthal et al., 2012). Furthermore, the study was confined to two family medicine residency programs in a southwestern state, predicated on my professional role in a health science center and close physical proximity. I situated the study in GME because it is an "essential dimension" (ACGME, 2017b, p. 1) of medical education and formative experience for resident physicians due to increased responsibilities, patient interaction, and experiential learning (Cooke et al., 2010).

Limitations

Design, methodology, and methods aid in collecting and analyzing "richly descriptive" data (Merriam & Tisdale, 2015, p. 17); however, this descriptive phenomenological approach has ensuing limitations. First, nature/essence of a phenomenon could be perceived as a singular reality and postpositivist (Creswell, 2007). I agree with Moustakas's (1994) counter to this critique in that a phenomenon's nature/essence constitutes the shared aspects of the descriptions by participants limited to a particular context and/or time. This perspective also aligns with the constructivist inquiry paradigm through the distinction of the multiple "sociohistorically relative" (Schwandt, 1998, p. 243) constructed realities of the participants in which a nature/essence of physician leadership is synthesized from the descriptions. Second, the methodology focused on recruiting participants with "a wealth of detailed data" (Patton, 2015, p. 257) and did not include requirements based on aspects such as gender. This could be perceived as a limitation, as there may be differences in how resident physicians understand physician leadership that are rooted in such aspects as gender identity. Third, the study was not designed to describe the universal nature/essence of physician leadership for other family medicine resident physicians, medical specialties, or contexts of medical education (e.g., undergraduate). Rather, I aimed at understanding the nature/essence of physician leadership from the lived experiences in GME of

participating nonleader resident physicians. This aim was critical, as the study should be viewed as exploratory rather than broadly definitive.

Perspective and Positionality

As the primary instrument for qualitative data collection and analysis, I briefly disclose my perspective and positionality. I detail my perspective and positionality in Chapter 3.

I am a male serving in a faculty and administrative role at a college of medicine in UME at a public university. My roles in UME since 2009 have consisted of Assistant Professor, Coordinator, Director, and Lecturer. Through my roles and responsibilities in UME, I have interacted with medical students, resident physicians, and fully licensed physicians at various career stages. In addition, I am the spouse of a family medicine physician and further understood the experience of medical school and residency through the lived experience of my wife. Through my roles, responsibilities, and lived experience alongside my wife, I have gained insight about the field of medical education, as well as faculty, administrators, resident physicians, and medical students. Thus, I am positioned with a valuable perspective to investigate the phenomenon of physician leadership.

Definition of Terms

It is important to define and construct a working lexicon of terms related to medical education, nature, and meaning in order to increase understanding of the context and the phenomenon under study. The working terms defined below are (a) clerkship, (b) continuing medical education/professional practice, (c) graduate medical education, (d) meaning, (e) medical education, (f) medical student, (g) physician, (h) physician leadership, (i) nature, (j) resident physician, (k) specialty, and (l) undergraduate medical education.

Clerkship

Clerkships are structured educational experiences in specialties within UME. Various specialties are required (e.g., pediatrics), whereas others are elected and based on interest (Wojtczak, 2003). Typically, clinical training through clerkships is completed by medical students in UME after finishing classroom-based coursework in basic, or preclinical, medical sciences. Clerkships often take place in academic medical centers or other settings affiliated with those centers (e.g., clinics). The purpose of the clerkship is to educate medical students through hands-on learning experiences (Wojtczak, 2003).

Continuing Medical Education (CME)/Professional Practice

CME occurs after GME and is the continuous process of enhancing knowledge and skills throughout professional practice (Wojtczak, 2003). Specifically, CME includes "activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance" (Accreditation Council for Continuing Medical Education (ACCME) and American Medical Association (AMA), 2017, p. 4). The term CME is used synonymously with *professional practice* in this dissertation, as education in professional practice takes the form of CME.

Graduate Medical Education (GME)

GME is the period after completion of medical school and prior to professional practice. Medical students matriculate into a medical residency program that is focused on a particular specialty (e.g., family medicine) to complete training under the supervision of senior physicians. Time spent in GME as a resident physician is separated into post graduate years (PGY) such as PGY-1, which denotes the first year of GME in medical residency (Royal College of Physicians and Surgeons of Canada, 2012).

Meaning

Meaning, in this study, refers to how resident physicians make sense (Weick, Sutcliffe, & Obstfeld, 2005) of, or define, the phenomenon of physician leadership. In agreement with the constructivist inquiry paradigm (Guba, 1990) and rooted in transcendental phenomenology (Moustakas, 1994), meaning is crafted in consciousness through interactions and interpretations of lived experiences of the phenomenon. In this sense, meaning is epistemologically focused from the subject (resident physician) to the object (physician leadership) in a directed relationship (Vagle, 2014) and explicated through description. This is a critical point, as resident physician participants are not presumed to be in formal leadership positions or roles but rather focusing on their epistemological descriptions of physician leadership. Describing physician leadership from a formal position would denote an ontological focus.

Nature and meaning inform this study's research question, *How do family medicine resident physicians describe and experience the nature of physician leadership?* A nature of the phenomenon of physician leadership is constructed from descriptions of the resident physicians. Although meaning was not the focus of this study, as that would denote a hermeneutic approach, I recognize that meaning shapes perceptions and subsequent descriptions of the phenomenon (Moustakas, 1994).

Medical Education

The education and training of students and professionals in the practice of medicine is considered medical education (Wojtczak, 2003). As a specific sector within higher education focused on a professional field, medical education is "divided into undergraduate, postgraduate [graduate], and continuing medical education" (Wojtczak, 2003, p. 12). Medical education occurs after students have completed requirements in postsecondary education (i.e., college).

Medical Student

A medical student is a student who is engaged in UME and has not completed the necessary requirements to advance to GME and practice as a resident physician.

Nature

The nature, or essence, of a phenomenon, as referred to in this study is the "essential structure" (Holloway & Galvin, 2017, p. 234) of what and how the phenomenon was jointly understood through lived experiences. *Jointly understood* refers to shared aspects of how participants describe physician leadership. This definition does not posit a singular perspective, or reality, of physician leadership. Rather, a phenomenon's nature is constructed through coalescing the shared aspects of relativistic descriptions by resident physicians through their lived experiences in GME.

Physician

A physician is a "professional, qualified by education and authorized by law to practice medicine" (Wojtczak, 2003, p. 16). Physicians practice medicine in a multitude of settings (e.g., hospitals, clinics) and may have responsibilities such as teaching or administration in addition to patient care.

Physician Leadership

Although contested and variable between specialties and contexts, Snell et al. (2011) generally defined *physician leadership* as the responsibility "to set direction for positive change in health and wellness in a health system, to exercise that responsibility in a caring and compassionate fashion, and to influence others to work together to achieve those changes" (p. 953). In short, physician leadership in medicine is often perceived as behaviors and skills to influence positive outcomes (Webb et al., 2014) for the physician and the organization.

Resident Physician

Resident physicians are medical students who have secured "an accredited training program [medical residency] following undergraduate training leading to certification or attestation in a recognized specialty or subspecialty; a GME trainee" (Royal College of Physicians and Surgeons of Canada, 2012, para. 8). Resident physicians practice under the full medical licenses of faculty physicians (Wojtczak, 2003).

Specialty

Focusing on a specialty occurs in GME once UME is completed. It is the period of training in GME that is focused on competence in a specific area of practice such as family medicine (Cooke et al., 2010; Wojtczak, 2003). Once GME is completed, resident physicians can select to subspecialize in an area of focus, such as sports medicine.

Undergraduate Medical Education (UME)

Also known as basic medical education, UME occurs when students enroll in medical school after completion of general requirements in postsecondary education. This period of education and training is typically separated into preclinical and clinical training (Wojtczak, 2003). In medical school, or UME, medical students study subjects such as anatomy in classroom-based preclinical training or conduct physical examinations through clerkships in clinical training. Developing foundational knowledge, skills, and values is key to this period of education (Cooke et al., 2010).

Organization of the Dissertation

This dissertation is organized into five chapters. Chapter 1 provided the study's background, problem, purpose, and central question. In addition, this chapter provided an overview of the intended phenomenological methodology, descriptive methods based on Moustakas (1994) and Colaizzi (1978), and quality criteria before outlining the significance,

conceptual framework, delimitations, ensuing limitations, and defining terms. Chapter 2 is a literature review that examines historical literature on defining leadership since 1900 and literature on physician leadership situated within the three contexts of medical education. Through an integrative literature review methodology (Torraco, 2005) framed by guiding questions, Chapter 2 also addresses how the reviewed literature informs the body of literature on physician leadership and supports the nature of the problem and the need for this study. Chapter 3 provides rationale for and describes the paradigmatic location, methodology, and methods for the study and why they were well suited to investigate the phenomenon of physician leadership. Chapter 4 presents the analysis and findings. Chapter 5 presents a discussion of the conclusions and recommendations for practice, future research, and theorizing.

CHAPTER 2

INTEGRATIVE LITERATURE REVIEW

The increasing complexity of health care in the United States has sparked broad interest in physician leadership since the late 1990s (Neeley et al., 2017). Financial constraints (Orlando & Haytaian, 2012), evolving social standards (Stoller, 2008), federal changes that affect coordination of patient care (Hofer et al., 2011), and the growing need for interprofessional and multidisciplinary teams (Morrison, et al., 2010) are a few challenges complicating health care and creating a demand for physicians to expand their understanding of leadership in medicine. Although the demand for understanding and developing physician leadership in medical education has grown in the past 20 years, the literature suggests that the topic is underresearched and needs attention (Dine et al., 2011; Skochelak, 2010). Current efforts are criticized for being rooted in historical leadership literature that was not cognizant of the contexts within medical education (Parker, 2013).

The purpose of this review is to integrate historical literature on leadership and contextual literature on physician leadership in medical education and to identify areas for study. To this end, the following questions guided this review: (a) What is known about how leadership is defined, or understood, by historical approaches and theories in leadership studies? (b) What is known about how physician leadership is defined, or understood, in the three contexts of medical education? (c) What is known about how physician leadership is developed in the three contexts of medical education? (d) What are the ensuing unknowns and their implications, including for future research about physician leadership in medical education? First, the conceptual framework, methodology, and methods for this review are discussed. Next, findings and

implications of historical leadership approaches and theories, as well as physician leadership in medical education, are presented. Last, implications for future research are addressed.

Conceptual Framework

This integrative literature review is framed conceptually rather than theoretically. The rationale for this approach is that the topic of physician leadership is emerging and rooted in historical leadership approaches and theories (Torraco, 2005). Utilizing a theory may constrain findings and be counterproductive to integrative review methodology (Callahan, 2010); it is also contentious to the phenomenological methodology (Creswell, 2014; Giorgi, 2009; Vagle, 2014). The conceptual framework for this study consists of (a) Dugan's (2017) foundational leadership elements of definition and development, (b) Rost's (1993) historical leadership era paradigms, and (c) the three contexts of medical education. These components are illustrated in Figure 2 as an inverted funnel moving from what is known in the broad historical literature on leadership to what is not known (gaps).

Foundational Leadership Elements

Dugan's (2017) foundational leadership elements of definition and development are the first components of this framework; they determine focus. Definition is how one understands leadership. Development is how leadership is refined. Including both elements is critical because they are intertwined. "How people approach the development of leadership is a function of their formal and informal theoretical understandings of the construct" (Dugan, 2107, p. 41). Choices about development are influenced by assumptions and values underlying understandings of leadership (Heifetz, 2010). In this sense, definition and development are two sides of the construct and including both can provide a fuller understanding of the phenomenon of physician leadership. Before describing the leadership era paradigms and the contexts of medical education, it is important to frame definition.

Sensemaking

The literature on organizational sensemaking was considered to assist with Dugan's (2017) leadership element of definition as sensemaking investigated how people understand events, and phenomena, in organizations. Weick (1995) described sensemaking as a process of creating understanding and initially distinguished it from meaning making. The seven properties of sensemaking according to Weick (1995) are (a) grounded in identity construction, (b) retrospective, (c) enactive of sensible environments, (d) social, (e) ongoing, (f) cues, and (g) driven by plausibility rather than accuracy (p. 17). These properties are summarized in Table 3.

Table 3

Weick's Sensemaking Properties

Property	Characteristics
Identity	Identity and role in organizations are continually shaped by experiences
Retrospective	Interpreting past lived experiences help inform current, and future, events
Environments	The co-constructed context provides a lens to interpret experiences
Social	Interactions with others, culture, and the organization shapes meaning
Ongoing	Continuous and iterative process of action, interpretation, and change
Cues	Based on past experiences and interactions, certain cues are elevated
Plausibility	Focusing on cues that reinforce plausible interpretations of events

Note. Adapted from (a) "Sensemaking to create high-performing virtual teams," by G. Hinrichs, J. Seiling, & J. Stavros, pp. 131-152 in J. Menior, M. Beyerlein, L. Bradley, & S. Beyerlein (Eds.), *The Handbook of High-Performance Virtual Teams,* 2008, San Francisco, CA: Jossey-Bass; and (b) "Making Sense of Sensemaking: The Critical Sensemaking Approach," by M. J. Helms, A. Thurlow, & A. J. Mills, 2010, *Qualitative Research in Organizations and Management: An International Journal, 5*(2), 182-195.

Weick et al. (2005) clarified that Weick's (1995) process sequentially unfolds from ambiguity through interpretation (meaning) to articulation. Thus, meaning is grounded in existing knowledge (Maitlis & Christianson, 2014). From Weick's (1995) early perspective, defining leadership is conceived prior to interpreting meaning in the sensemaking process. In short, leadership is first defined by what it is perceived to be, followed by interpretation of what it means.

Since the publication of Weick's (1995) seminal text *Sensemaking in Organizations*, perspectives of sensemaking differ on aspects such as construction and process. Some proponents adhere to sensemaking being individually, and cognitively, constructed (Klein, Moon, & Hoffman, 2006), while others propose that it is more socially constructed (Weick et al., 2005). Weick (1995) advocated a retrospective process, while others suggested that it can also be prospective (Gephart, Topal, & Zhang, 2010). The literature on sensemaking expanded to include modified forms (e.g., cultural) and related constructs (e.g., sensebreaking; Maitlis & Christianson, 2014). Additional areas of contention included the centrality of action and contemporary linking of interpretation and meaning (Weber & Glynn, 2006). To modify Weick (1995), Cornelissen (2012) defined sensemaking as an inclusive process "of meaning construction whereby people interpret events and issues within and outside their organizations" (p. 118). For Cornelissen (2012), sensemaking involved interpretation. This is what leadership is *through* what it means.

Weick's (1995) contested sequential understanding to sensemaking raised concern, as definition is framed as being informed by understandings of leadership that may be laden with meaning (Dugan, 2017; Heifetz, 2010). Based on a more inclusive perspective of sensemaking (Cornelissen, 2012), definition is viewed as understanding that includes meaning (through).

Leadership is framed through what it means. For example, defining a leadership approach as servant could infer that a leader enacts leadership through service-oriented assumptions. In alignment with the paradigm and methodology, this broad perspective on sensemaking supports the process of this review by integrating interpretive elements, exemplified in the implications subsections, alongside descriptions.

Leadership

The second component of the conceptual framework includes approaches and theories of leadership. Rost's (1993) era paradigms help to focus exploration of historical findings on how leadership has been defined since 1900. Examining this broad literature is key to understanding how leadership is historically understood. Literature on development is limited to the contexts of medical education, since a review of historical literature on development is beyond the scope of this review. Rost (1993) examined works on leadership from 1900 to 1990 and categorized them as industrial (1900 to mid-1970s) and postindustrial (mid-1970s to 1990 and beyond) era paradigms.

Medical Education

The third component of the conceptual framework is the field of medical education. Findings on defining and developing physician leadership are grouped into the three contexts of UME, GME, and CME (Aschenbrener et al., 2015). The rationale for including this component in the framework is to be intentional about constructing a review that accounts for inconsistently considered aspects, such as context, noted in the literature (Dine et al., 2011; Howieson & Thiagarajah, 2011; Parker, 2013). UME, GME, and CME limit the scope to general, rather than specific, contexts (e.g., classroom, hospital).

Dugan's (2017) elements, Rost's (1993) era paradigms, and the three contexts of medical education offer a conceptual framework that delineates the focus and scope of this review.

Findings are organized in alignment with the conceptual framework, as illustrated in Figure 2. By investigating what is known, what is not known, and implications, this inquiry constructs an understanding of physician leadership in medical education.

Methodology and Methods

Crotty (1998) described methodology as the "process or design lying behind the choice and use of particular methods" (p. 3), whereas methods are the techniques to gather and analyze data. Crotty (1998) also stated that methodology and methods are governed by philosophical assumptions or paradigms (Guba, 1990). The governing inquiry paradigm, Torraco's (2005) methodology, and the methods for this review are discussed in the following subsections.

Methodology

The constructivist inquiry paradigm, as described by Guba (1990), governed this review, which was guided by Torraco's (2005) methodology. Thus, ontological reality is taken to be constructed from varying perspectives rather than from a singular viewpoint (Guba & Lincoln, 1994). This assumption infers that what is known and what is not known about physician leadership in medical education is constructed through integrating literature, or varying perspectives, in accordance with Torraco's (2005) methodology. The nature of knowledge, or epistemology, in the constructivist paradigm is subjective (Denzin & Lincoln, 2011) and suggests active involvement by the researcher. Therefore, ongoing analysis and critique are essential. Context is important to the constructivist paradigm (Creswell, 2007) and in this review refers to the three general contexts of medical education (e.g., undergraduate) rather than specific settings.

Torraco (2005) stated that an integrative methodology for a literature review is appropriate if the topic is emerging and would benefit from a synthesis of what is known to construct a "new perspective" (p. 358) for study. Callahan (2010) agreed with Torraco's (2005)

emergent criteria and added that integrative literature reviews must explore the roots of the topic in foundational literature. This approach integrates empirical and nonempirical literature to "more fully understand the phenomenon" (Whittemore & Knafl, 2005, p. 547). Based on the emerging topic of physician leadership and its roots in historical leadership studies, this review adheres to Torraco's (2005) integrative literature review methodology, including (a) establishing a need in a field, (b) conceptual framework, (c) methodology and methods, and (d) critical analysis and implications for future research.

Methods

Following Torraco's (2005) methodology and guided by the conceptual framework, this review includes diverse bodies of literature and places the researcher close to the literature for iterative analysis and critique (Callahan, 2010). Following is an overview of the methods used for collecting and selecting the informing literature.

Criteria for data collection and selection. Literature was collected between summer 2016 and spring 2017 through Google Scholar, PubMed, ERIC, Academic Search Complete, and ProQuest databases with the date parameters of 2007–2017. All databases except PubMed were accessed through a public university-sponsored pathway. The date parameters were set to identify the recent literature on historical leadership approaches and theories, as well as physician leadership in medical education. Sources prior to 2007 were examined if they were cited in the literature within the date parameters and were deemed beneficial. Integrative reviews are broad (Torraco, 2005) and allow for varied sources (Whittemore & Knafl, 2005); therefore, peer-reviewed articles, organizational websites, books, and dissertations were included.

Search terms included *physician leadership*, *physician AND leadership*, *physician leadership in medicine*, *physician leadership AND medicine*, and *physician AND leadership*

AND medicine. The initial inquiry with the filter of search terms occurring anywhere in the literature resulted in 84,056 hits. To determine relevant literature, the filter of including the search terms in the title identified 393 entries. Next, the filter of full text availability was included and yielded 146 items.

The next step was to review and organize the 146 entries into the three contexts of medical education using EndNote® by assessing the titles, surveying the abstracts, or reviewing the full text. Items that discussed definitions of leadership were identified apart from those that addressed development. Unrelated resources were either deleted or grouped (Callahan, 2010; Torraco, 2005). Books were utilized as they organized the evolution of leadership approaches and theories in the 20th and 21st century according to Rost's (1993) paradigms.

As references were reviewed, 17 sources prior to date parameters were added as they assisted with understanding the topic. A general search engine was also utilized with the following search terms: *defining physician leadership*. This search yielded 15 entries in six websites. The overall process culminated in 76 references: 52 peer-reviewed articles and empirical studies, 8 organization websites, 12 books, and 4 dissertations.

Analysis of selected literature. A literature matrix was created to analyze this search; the matrix consisted of the categories of (a) purpose, (b) topic, (c) framework, (d) methodology, (e) methods, and (f) findings. The constant comparative method (Lincoln & Guba, 1985) aided in moving back and forth between the bodies of literature (e.g., historical, medical education) and the matrix to identify pertinent information, as well as to sort (Fram, 2013; Grove, 1988). Specifically, the iterative analysis process aided in identifying "regularities" (Grove, 1988, p. 275) or themes to get a sense of what is known or what is not known in the literature.

The findings from data analysis and initial implications are presented in the two following subsections. First presented are findings on historical leadership approaches and theories. Second presented are findings on the definition and development of physician leadership, grouped under the three general contexts of medical education.

Findings and Initial Implications: Historical Leadership Approaches and Theories

The literature on physician leadership development in the 20th and 21st centuries noted the use of historical leadership approaches and theories (Dine et al., 2011; Parker, 2013). Framed by Rost's (1993) leadership era paradigms, historical leadership literature aids in understanding the roots for defining physician leadership in medical education.

Industrial Era

Rost's (1993) industrial era paradigm was influenced by industrial era ideology that perceived leadership as management of an organization through such aspects as efficiency and productivity (Dugan & Komives, 2011; Northouse, 2013). The subsections below discuss great man and trait theories as well as behavioral and situational approaches that typified this era.

Great man and trait theory. During the first 30 years of the 20th century, the study of leadership focused on innate characteristics (Dugan & Komives, 2011). In 1869, Galton's seminal study quantitatively analyzed males based on characteristics identified as hereditary (e.g., intelligence). Galton laid the foundation for great man and trait theories, which expanded leadership from innate characteristics to traits such as self-confidence (Northouse, 2013).

Stogdill's pivotal 1948 and 1974 studies investigated a total of 287 works on leadership traits publishing between 1904 and 1970 (Bass, 2008; Rost, 1993). Stogdill (1974) selected quantitative literature in which leadership was defined in terms of personal traits. The results of these studies prompted research into skills, behaviors, or situations of leadership (Rost, 1994).

Stogdill (1974) ushered in "a new approach to leadership research that focused on leadership behaviors and leadership situations" (Northouse, 2013, p. 20).

Behavioral, situational, and contextual. Although trait approaches emphasized inherent and fixed characteristics, skills and behavioral approaches that emerged in the mid-1900s shifted from defining leadership based on the leader's personhood to behaviors (Dugan & Komives, 2011; Northouse, 2013). For example, quantitative research led by Stogdill (1974) conducted in the field of psychology in the late 1940s and 1950s studied behaviors of leaders in military, educational, and industrial settings (Northouse, 2013). These studies laid the groundwork for approaches in the 1960s that emphasized leadership being defined as a behavior.

Trailing this era, the followers and context for enacting leadership became increasingly important with situational approaches and theories in the late 1960s and early 1970s. The situational approach defined leadership as effectively diagnosing a situation and prescribing behaviors (Dugan & Komives, 2011). Closely related to the situational approach is contingency theory, which emphasized matching a leader's style to the context. In the early 1970s motivating members toward a goal became a focus with path-goal theories.

Initial implications of industrial era leadership approaches and theories. Rost (1993) succinctly summarized leadership in the industrial era paradigm as leaders with certain traits "influencing followers to do what the leaders wish in order to achieve group/organizational goals" (p. 180). Findings from this industrial era were focused on defining leadership in terms of the leader and outcomes. Leadership was perceived as characteristics of leaders and the negotiating relationships with passive followers (Northouse, 2013; Rost, 1993).

An implication for future research would be a qualitative approach to address questions aimed at nature. The works cited above were approached quantitatively and reflected a

postpositivist perspective aimed at deductively answering why rather than question what leadership is (Creswell, 2007). Quantitative approaches deductively identified attributes or behaviors regarding the efficacy of leadership, but fell short of exploring its nature (what).

Post-Industrial Era

The post-industrial leadership era paradigm departed from the industrial era's view of leadership as born leaders who were "all-knowing, all-powerful heroes" (Rogers, 2003, p. 451). The following is a discussion of findings from the post-industrial era paradigm, including servant, transformational, chaos, and systems leadership.

Servant and transformational leadership. In the 1970s, servant leadership was described by Greenleaf (2010) as the empowerment of followers through the leader's service. Servant leadership advanced communal and service-oriented values and challenged the fixed leader and follower roles prevalent in the industrial era paradigm (Bass, 2008). Dugan and Komives (2011) stated that, although servant leadership was still leader focused, it promoted communal values and acted as the "theoretical bridge between the industrial and post-industrial [era] paradigms" (p. 43). Laub (1999) identified characteristics such as developing people and sharing leadership. Although scholars disagreed on a definitional list (Van Dierendonck, 2011), Greenleaf (2010) shifted the paradigm of leadership from definitions based on the leader to a definition based on reciprocal relationships.

Burns (1978) extended a definition of leadership to include transactional or transforming elements. *Transactional leadership* was defined as the exchange of necessities and wants, whereas transforming or transformational leadership (Bass, 2008) elevated producing change through empowering relationships. Transformational leadership promoted the concept that leadership was "power 'to' rather than power 'over'" (Rogers, 2003, p. 453). Leadership was defined as the ability to develop followers rather than to exert power over them.

Chaos or systems leadership. Approaches such as authentic and team leadership (Northouse, 2013) in the 1990s focused on relational aspects that originated in the works of scholars such as Greenleaf. Other approaches and theories in this paradigm identified as "chaos" or "systems" (Dugan & Komives, 2011, p. 41) emphasized adaptation, ethics, chaos, systems, and culture (Dugan & Komives, 2011; Heifetz, 2011).

One of the early scholars, Heifetz (2010), described leadership as a role and ethical responsibility to help followers working in complex systems (Cojocar, 2008). Heifetz et al. (2009) reframed leadership as a process that facilitated the growth of the members and consequently the system itself. Heifetz et al. (2009) defined *adaptive leadership* as "the practice of mobilizing people to tackle tough challenges and thrive" (p. 14). Although studies on adaptive leadership are sparse, Randall and Coakley (2007) utilized it in a study to analyze leadership challenges of a small private college. Adaptive leadership and other theories shifted the definition of leadership from relationships to a complex process.

Initial implications of post-industrial era leadership approaches and theories. What is known from findings in the post-industrial era paradigm is that leadership highlighted (a) mutually influential relationships, (b) active followers who shared leadership roles, (c) the process and complexity of leadership, and (d) transformation over transaction (i.e., negotiating) (Bass, 2008; Dugan & Komives, 2011; Northouse, 2013; Rogers, 2003; Rost, 1993). Defining leadership shifted from the leader, and even the follower, to the organization or system. Leadership became an "effect rather than a cause" (Day, 2000, p. 583).

The post-industrial era paradigm implies that, as the study of leadership aged, definitions of leadership became increasingly complex. For example, leadership was not defined merely as a product of the leader or a reciprocal relationship with the follower; it was also a process.

Ethics and systemic aspects are involved in the process of constructing leadership. These aspects suggested that the study of leadership should consider such complexity.

As leadership evolved, scholars increasingly disagreed on definitions of leadership (Dugan, 2017; Northouse, 2013). Prior to Greenleaf (2010), Burns (1978) proposed that the nature or "essence" (p. 1) of leadership was not adequately understood. Rost (1993) argued that the lack of understanding of leadership was due in part to the focus on aspects such as innate traits rather than "essential nature" (p. 5).

Fairhurst and Grant (2010) posited that leadership is more than individual inputs and outputs but is complex and socially constructed. With regard to medicine, Swanwick and McKimm (2011) stated, "Leadership is often described within the contexts in which it is exercised" (p. 23). An implication from the post-industrial era paradigm is that inductively exploring nature may allow for complexity otherwise that are not addressed deductively.

Findings and Initial Implications: Physician Leadership in Medical Education

The following subsections discuss findings on what is known in the medical education literature about how physician leadership is defined and developed. First, the three contexts in which the literature is situated are briefly discussed. Findings on the definition and development of physician leadership are examined in each of these contexts.

The Three Contexts of the Medical Education

The three contexts of medical education are UME, GME, and CME. In medical school, or UME, medical students study subjects such as the cardiovascular system in a classroom or conduct physical examinations in clerkship. In this context, medical students are equipped with the foundational knowledge, skills, and values of the medical profession (Cooke et al., 2010). After UME, medical students matriculate into a medical residency program (i.e., GME) as resident physicians, where they complete training under the supervision of senior physicians.

The ACGME (2017b) described residency as "an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education" (p. 1). Upon completion of residency, resident physicians either continue in GME by subspecializing or enter professional practice in such areas as administration or patient care. CME is comprised of the "educational activities that assist physicians in carrying out their professional responsibilities more effectively and efficiently" (ACGME, 2015, para. 2). CME also assists physicians with maintaining medical licensure (ACGME, 2015). The context of professional practice and CME are used interchangeably in this review.

Defining Physician Leadership in the Three Contexts of Medical Education

The following subsections explore how physician leadership is defined, or understood, by clustering findings in the three contexts of medical education. Following each context is a discussion of the initial implications for future research.

Undergraduate medical education. The Liaison Committee on Medical Education (LCME; 2017) sets accreditation standards by which participating medical schools are evaluated (Association of American Medical Colleges [AAMC], 2014). These standards include such aspects as the mission to service by medical students (p. ii). In the 2017 accreditation standards, leadership was mentioned 10 times. Seven related to leadership roles of administrators or faculty, two referred to faculty professional development, and one discussed a learning objective of "leadership" (p. 25) for an education track.

In 2014, the AAMC stated that program directors of residency programs had become increasingly concerned about the abilities of entering resident physicians. The AAMC then defined 13 professional activities for medical students that would help them to succeed in medical residency and professional practice (Neeley et al., 2017). Two matches surfaced when searching the document for the terms *leader* or *leadership*. The first match was a competency in

the Interpersonal and Communication Skills domain, defining leadership with regard to "a health care team or other professional group" (AAMC, 2014, p. 101). The second match was in the Personal and Professional Development domain in relation to "leadership skills" (p. 102) to improve the team. Physician leadership was not defined other than as a formal position on a health care team, skills, or an outcome such as team functioning.

In a journal-based meta review of articles discussing leadership curriculum since 1980, Webb et al. (2014) found that, as the methods of leadership delivery varied, so did the definitions. For example, one program defined leadership as motivation and feedback skills, whereas another program defined it as quality improvement or managing group dynamics. Clyne et al. (2015) found that leadership was defined as "an essential aspect of the physician identity and professional responsibility" (p. 37). From this finding, the concept of the identity of the physician leader was identified as pertinent to physician leadership.

Although the majority of studies in UME were about mode of delivery of physician leadership curriculum (Webb et al., 2014), Varkey, Poloquin, Reed, Lindor, and Harris (2009) conducted a mixed-methods study to capture perspectives on leadership from leaders in health care, physician educators, and medical students. Participants defined leadership as qualities such as emotional intelligence.

Initial implications of defining physician leadership in undergraduate medical education. There has been a lack of concise definitions of physician leadership in UME. Webb et al. (2014) addressed definitions based on what outcomes or characteristics were desired. Clyne et al. (2015) and Varkey et al. (2009) contributed perspectives on physician leadership related to identity and qualities of physician leadership.

An implication of the literature on defining physician leadership in UME is that there is a desire for medical students to understand leadership due to future roles that would identify them as leaders (AAMC, 2014). The literature is weighted to skills, outcomes, or qualities rather than the identity of the physician leader (Clyne et al., 2015) or the nature of physician leadership. These aspects aligned more with the industrial era paradigm, which emphasized the leader, skills, or behaviors (Northouse, 2013). It could be argued that the literature highlighted team leadership and reflected the post-industrial era paradigm; however, the emphasis was on the outcome of efficient team functioning rather than on development of team members.

Although the concepts of nature and identity of physician leadership in this context are intriguing, they are not yet clearly presented and merit future study. The next subsections follow a similar pattern and discuss accreditation bodies before addressing studies or information from professional organizations.

Graduate medical education. The ACGME (2017a, 2017b) establishes and oversees educational standards in GME; the group defined physician leadership as an outcome. Similar to the ACGME, the AAMC (2016) inferred that physician leadership in academic medicine is creating new knowledge, educating, and contributing to patient care (para. 2). Detsky (2011) agreed with the AAMC's (2016) focus on outcomes but emphasized academic physician leadership as defined based on settings such as academic medical centers (AMCs; Stoller, 2009). Fairchild, Benjamin, Gifford, and Huot (2004) omitted patient care and defined physician leadership specific to research, educational, and administrative roles.

In agreement with Fairchild et al. (2004), Lobas (2006) found that internal medicine department chairs valued administrative aspects (e.g., financial) in addition to research, education, and patient care. Although Lobas (2006) supported inclusion of administrative

aspects in defining academic physician leadership, Kornacki (2017) and Oandasan et al. (2013) were skeptical about aspects that were not considered academic. The Oandasan et al. (2013) study was intriguing because they examined how definitions of academic physician leadership changed based on career stages.

Pettit (2015) conducted a phenomenological study that involved defining physician leadership from the perspectives of co-chief residents of various specialties. Participants noted skills such as collaboration, innovation, and task orientation as aspects of physician leadership. One critical point was that no literature was found on defining physician leadership from the perspective of resident physicians who were not in leadership roles.

Initial implications of defining physician leadership in GME. Similar to UME, literature in GME pointed to leadership being defined as skills (Pettit, 2015) or outcomes (ACGME, 2017a) exemplified by the industrial era paradigm. Whether it is creating new knowledge, educating medical students, or treating patients, the focus rests on physician leadership being defined as a skill or outcome. A distinct difference between literature in UME and literature in GME is the consideration of context (Detsky, 2011), roles (Fairchild et al., 2004; Pettit, 2015), and career stage (Oandasan et al., 2013) in defining physician leadership. Although the industrial era paradigm gravitated toward context with situational and contingency theory, the post-industrial era paradigm illuminated the complexity of leadership by including context along with aspects such as culture (Dugan & Komives, 2011). Similarly, the literature in GME includes aspects such as context (e.g., AMCs) in defining physician leadership.

An implication of the above is that future research should be cognizant of aspects such as context, roles, and career stages. The difference in context, role, or career stage may result in different perspectives on physician leadership. Another implication for study is the lack of

literature on defining physician leadership from the perspective of resident physicians who are not in leadership roles. It would be interesting to examine how nonleaders in medical education (i.e., resident physicians) define physician leadership, as opposed to the definitions proposed by those in formal leadership roles.

Continuing medical education. Defining physician leadership in CME or professional practice took various forms not found in UME or GME. The ACCME (2017a) included an opening statement in their website about fostering "leadership" (para. 11). Although stated, the ACCME (2017a) did not clearly define physician leadership but rather alluded to it in criteria for accreditation. For example, criterion 33-35 (2017a) discussed research and professional development under the category of "Demonstrates Educational Leadership" (ACCME, 2017b, para. 8, 16).

The AAPL (2017) generally defined physician leadership as "leading the charge in setting and achieving objectives, improving outcomes and contributing to the advancement of his or her organization and health care in general" (para. 1). With regard to a specialty, Mulholland (2015) defined leadership in the specialty of surgery as skills such as leading change or team building. Serio and Epperly (2006) defined leadership in family medicine as aspects such as awareness of culture of practice.

Although definitions differ, another overarching understanding of leadership specific to CME or professional practice is clinical physician leadership. Jonas, McCay, and Keogh (2011) concisely defined *clinical leadership* as "setting, inspiring and promoting values and vision, and using their clinical experience and skills to ensure the needs of the patient are central" (p. 1). Nicol, Mohanna, and Cowpe's (2014) grounded theory study of senior health care leaders'

perceptions of clinical physician leadership supported the focus on clinical leadership being defined more by the patient than by research or education.

In a 2014 study, Pregitzer investigated the practices and perceptions of eight physician leaders. Utilizing a phenomenological methodology, Pregitzer found that physicians in leadership roles such as a medical director defined physician leadership in terms of qualities such as empowering, team oriented, goal oriented, or changing the process or system. Howieson and Thiagarajah (2011) broadened the definition of clinical physician leadership beyond the leader to various levels of an organization (e.g., group). Blumenthal et al. (2012) affirmed these components but emphasized the group's or team's impact on patient care.

Initial implications of defining physician leadership in CME. Literature on CME and professional practice expanded the scope of who defined physician leadership and how. Both historical paradigms were reflected in this context. The AAPL (2017) and Jonas et al. (2011) showed industrial influence on outcomes but also stressed the importance of values and vision. The specialty-specific literature exhibited clearer emphasis on post-industrial aspects such as team building and culture. Howieson and Thiagarajah (2011) specifically included organizational levels when defining physician leadership.

Beyond accrediting agencies and organizations, specialty-specific literature (Mulholland, 2015; Serio & Epperly, 2006) exhibited clearer definitions of leadership than were exhibited in UME or GME. Although clinical leadership was posited as a definition of physician leadership, the definition was not without disagreement. While scholars defined clinical leadership from various perspectives, Snell et al. (2011) generally defined *physician leadership* as setting the "direction for positive change in health and wellness in a health system, to exercise that responsibility in a caring and compassionate fashion, and to influence others to work together to

achieve those changes" (p. 953). This definition has merit for generalizability and combining aspects of both historical paradigms. However, it conflicts with other literature that points to the context- or role-dependent nature of physician leadership (Webb et al., 2014).

An implication of these findings is that, while defining physician leadership varies, clearer literature originates from CME. An important point from this context is that definitions were derived primarily from those in leadership roles. An implication for research is to situate a study from the experience of those who are not in leadership roles. The various definitions of physician leadership in surgery and family medicine supported Webb et al. (2014) and Clyne et al. (2015), who suggested that definition depends on aspects such as context and specialty.

Developing Physician Leadership in the Three Contexts of Medical Education

The findings below focus on what is known about how physician leadership has been developed in the three contexts of medical education. Initial implications for future research are discussed after each context.

Undergraduate medical education. Webb et al. (2014) reviewed articles from 1980 to 2014 that described curricula or initiatives to develop the leadership skills of medical students. Webb et al. (2014) found that the most common approaches to developing leadership skills in UME were longitudinal (71%) and in a classroom setting (50%; pp. 1563-1564). They also found that programs for medical doctor (MD) or Master of Business Administration (MBA) programs were utilized in more than 56 medical schools in the United States.

Neeley et al. (2017) conducted a cross-sectional survey of deans from 144 medical schools in the United States to determine the presence of, and methods for, leadership development. Neeley et al. (2017) found that 54.5% of participating schools had a presence and approximately 30% (p. 2) stated that leadership content was either required or an elective. The delivery methods consisted of formal mentoring (65.1%), dual degree programs (e.g., MD/MBA;

58.1%), workshops (48.8%), and formal courses (18.6%; p. 2). Cocurricular options included student governance and organizations, tutoring, or community service and were prevalent at 89.6% of participating institutions.

As noted by Webb et al. (2014) and Neeley et al. (2017), one commonly utilized approach is the joint degree program. Joint degree programs provide opportunities for medical students to complete a dual degree in such areas as business or public health and are increasing (Crites, Ebert, & Schuster, 2008). The Association of MD/MBA Programs (2015) listed 56 national and three international programs in March 2015, which was an increase from 33 national and 6 international programs in 2001 (Larson, Chandler, & Forman, 2003).

Due to factors such as resources and time, there is a growing emphasis in UME either to create a separate leadership curriculum in house or to embed content in existing curriculum (Stoller, 2013; Webb et al., 2014). For example, in 2004, Wright State University Boonshoft School of Medicine integrated components of MBA and Master of Public Health (MPH) into its curriculum (Crites et al., 2008). Crites et al. (2008) rationalized an integrated approach because "leadership education should not be specific to either a business or public health model" (p. 55). Taylor et al. (2008) challenged this understanding and noted the importance of context. Varkey et al. (2009) found that 85% (p. 247) of medical students in their study stated that physician leadership should be taught in medical school.

Initial implications of developing physician leadership in UME. Studies by Webb et al. (2014) and Neeley et al. (2017) highlighted curricular and formal approaches to developing physician leadership skills in UME. Both groups of authors mentioned the use of formal joint degree programs. The benefits of these approaches could include replicability or time and effort required of faculty from other programs rather than medical faculty. Joint degree programs help

to fill a need (Varkey et al., 2009) if no room in the curriculum exists for leadership development (Stoller, 2013).

These findings imply for future study that there is a significant body of quantitative literature on formal efforts but qualitative literature on informal efforts such as mentoring or how the environment might contribute to physician leadership development are absent. Cocurricular opportunities were mentioned by Neeley et al. (2017) but they were not adequately discussed. Informal approaches and environmental impact could benefit from qualitative inquiry in addition to cataloging efforts. The focus of Webb et al. (2014) and Neeley et al. (2017) was on skills rather than on physician identity or the nature of leadership.

Crites et al. (2008) argued for physician leadership education that transcended contextual boundaries, which departed from the majority of literature found on defining physician leadership. The response by Taylor et al. (2008) aligned with the literature on defining physician leadership and supported the significance of context or even roles for future study. The next subsection explores developmental approaches in GME.

Graduate medical education. In a comprehensive review on leadership development programs in GME, Frich et al. (2014) examined the setting, content, methods, and outcomes of 45 studies between 1950 and 2013. The authors found that programs were situated within single residency programs (42%), lecture based (84%), and longitudinal (76%; p. 658). They noted that 29 of the 45 programs were open to resident or faculty physicians without formal leadership positions and focused on skills and knowledge. The remaining 16 programs were targeted to physicians in formal leadership roles (e.g., directors). An important finding was that, of the 29 programs open to all resident physicians, only 13 listed the number of nonleader resident or

faculty physicians. Participation in these programs was difficult to ascertain based on the provided data.

The NCHL (2014) found that, of the 25 physician leadership development programs surveyed in 2013, 92% targeted physicians in leadership roles (e.g., chief residents, directors). In agreement with Frich et al. (2014) and NCHL (2014), Blumenthal et al. (2012) explained that medical residency programs offered "little or no structured leadership and management training" for resident physicians (p. 515). To rationalize this gap, variables such as specialty, work demands, or environment contributed to disparities in leadership development opportunities for resident physicians (Jardine et al., 2015).

Initial implications of developing physician leadership in GME. Consistent with UME, Frich et al. (2014) found that 84% of approaches were formal, such as lectures followed by group work. Although Frich et al. (2014) listed formal developmental approaches, informal approaches were absent, along with participation and insufficient discussion on the substantive nature of approaches for all resident physicians. Evaluation designs heavily favored quantitative (71%) over mixed (27%) and qualitative (2%) designs (Frich et al., 2014, p. 658). It was evident that little attention was given to resident physicians who did not hold leadership positions and that variables between contexts or specialties affected offerings (Blumenthal et al., 2012; Jardine et al., 2015).

The literature suggested a reliance on traditional didactic approaches and quantitative evaluation methods. Developmental opportunities primarily excluded resident physicians who did not hold leadership positions. The literature (AAMC, 2014; ACGME, 2017b; Cooke et al., 2010; Kuo et al., 2010; Skochelak, 2010; Stoller, 2009; Souba, 2004a; Theobald, 2015) emphasized the need for physician leadership development. Therefore, a sole focus on resident,

or other, physicians in leadership positions could be perceived as exclusionary. Another perception could be that those who are not in leadership positions do not need, or would not benefit from, leadership development. To add to the literature on developmental opportunities and offer new perspectives, future studies could examine the nature of leadership development programs, provide rationale for the lack of programming (Jardine et al., 2015), and situate studies from the perspective of nonleader resident physicians (Kuo et al., 2010). How physician leadership is developed in CME is discussed below.

Continuing medical education. Ackerly et al. (2011) and Stoller (2013) suggested that many physicians in mid- to high-level leadership positions have had no formal training and lack skills that are critical to organizational operation, such as finance and strategic planning. To fill this deficit, formal internal and external development programs exist in CME and professional practice.

In a 2009 survey, the AAMC identified 27 physician leadership programs tailored to practicing physicians in leadership roles. In a recent study, the NCHL (2014) listed 25 internal and 32 external physician leadership programs. The structure and objectives of 25 internal programs were outlined. With regard to structure, participating programs varied from a single class or weeklong seminar to an 18-month program (NCHL, 2014). The most cited objective was talent development, which consisted of developing physician leaders "with the right capabilities" (p. 25) or "skills that will help lead and participate in collaborations" (p. 26).

An internal program included in the NCHL (2014) study was the leadership development program at the Cleveland Clinic. The Cleveland Clinic program was targeted to department or division chairs and selected administrators. The topics centered on health management, the method of delivery was primarily didactic, and outcomes consisted of business plans. After 13

iterations of courses offered over 14 years, 61% of the 49 business plans were implemented, cost was reduced in comparison to utilizing external programs (p. 4), and the organization benefited through "enhanced organizational effectiveness" (Stoller, Berkowitz, & Bailin, 2007, p. 5) of implemented business plans (Christensen & Stoller, 2016). Cullum (2016) utilized grounded theory to study the perceptions of a physician leadership development program in Georgia. An intriguing finding was that the 10 participants did not "feel like leaders" because they lacked the necessary skills or education. Furthermore, they stated that they were trained to be problem solvers and did not see the value in leadership development programs (Cullum, 2016).

External programs are those offered by organizations such as the AAPL (2017). Although robust offerings are provided in various formats (e.g., online), along with certification, the Cleveland Clinic noted the cost-prohibitive nature of professional organization programs as rationale for internal programs that would benefit the organization through course outcomes such as business plans (Stoller et al., 2007).

Initial implications of developing physician leadership in CME. The findings showed an increase in developmental programs in CME and professional practice from 27 in 2009 (AAMC, 2009) to 57 in 2014 (NCHL, 2014). The NCHL (2014) noted that competencies and capabilities were the most frequently cited objectives, followed by team building, networking, and organizational development. These could be interpreted as focusing on the leader, others, and system. These areas aligned with the three general areas (leader, social/collective, and context/system) discussed in the initial implications of historical leadership approaches and theories.

The emphasis of the leadership development program at the Cleveland Clinic was on outcomes, such as business plans, over other aspects such as nature or physician leadership

identity. Cullum (2016) found that physicians perceived themselves as unqualified and identified themselves as problem solvers, which influenced negative perceptions about leadership development. Specifically, the idea that the concept of feeling like a leader was perceived as incongruent with physician leadership development is curious and could merit investigation.

Implications for Future Study

Implications of Historical Leadership Approaches and Theories

Stogdill (1974) stated that, even with the breadth of research, there is not an "integrated understanding of leadership" (Rost, 1993, p. 4). Nearly 20 years later, Rost (1993) affirmed that leadership is still inadequately understood. What is known from the historical literature is the emphasis on the (a) leader, (b) social/collective, and (c) context/system. In the industrial era paradigm, leadership was defined as qualities or abilities emanating from the leader to the follower. In the post-industrial era paradigm, leadership was defined as created by leader, follower, context, and system.

What was not evident in the literature were definitions of leadership from followers. As suggested by Rost (1993), investigating leadership's "essential nature" (p. 5) would broaden leadership beyond attributes, behaviors, or even processes. Leadership is complex; an inductive approach may assist in exploring its nature. Furthermore, investigating leadership from the perspective of followers would provide a new perspective on leadership that is not present in the informing literature. Table 4 summarizes what is known, gaps, and implications identified in Rost's (1993) era paradigms for historical leadership approaches and theories.

Table 4

Historical Leadership Approaches and Theories: What is Known, Gaps, and Implications

Era paradigm	What is known	Gaps	Implications
Industrial	Focus on leader, outcomes, directed leadership Quantitative and deductive inquiry	Inductive inquiry Nature	Leadership is revealed Investigative nature Perspectives from nonleaders
Postindustrial	Relationships Shared leadership roles Complexity Transformation Leadership is created Mixed investigation	Understanding the essential nature of leadership	Leadership evolved in complexity, constructed, and multidimensional Investigate nature

Implications of Defining Physician Leadership in Medical Education

Four significant themes were identified from exploring the literature on definitions of physician leadership in the three contexts of medical education. Physician leadership was defined as (a) academic or clinical (AAMC, 2016; Detsky, 2011); (b) in relation to skills or outcomes (Clyne et al., 2015; Webb et al., 2014); (c) as influenced by context, specialty, or role (Mulholland, 2015; Oandasan et al., 2013; Serio & Epperly, 2006); and (d) primarily from the perspectives of physicians in leadership roles (Lobas, 2006; Nicol et al., 2014; Pettit, 2015).

The previous definitions of physician leadership across the three contexts of medical education reflected the industrial era paradigm, as well as the overarching regularities or themes of academic or clinical leadership that illuminated contextual limitations. Another theme was the recurrence of skills and outcomes over developing others. This communicated the consistent elevation of the leader over the context, culture, or members of the organization.

Academic leadership was primarily framed in terms of research and education (Fairchild et al., 2004; Lobas, 2006). Clinical leadership emphasized the patient or the health care team. A study by Nicol et al. (2014) and Howieson and Thiagrajah's (2011) meta review were helpful in understanding how physician leadership was conceptualized within the clinical context. The literature on how physician leadership is defined across medical education pointed to the importance of context and the physician's role (Pettit, 2015; Pregitzer, 2014), which contributed to definitions, or understandings, of physician leadership. A summary of what is known, gaps, and implications from each context is presented in Table 5.

Table 5

How Physician Leadership is Defined: What is Known, Gaps, and Implications

Context	What is known	Gaps	Implications
Undergraduate	Focus on skills, outcomes, and qualities	Definitions from nonleaders Lack of data on nature and identity	Understanding leadership is desired due to future roles Need for education, and other perspectives
Graduate	Focus on skills and outcomes Importance of context, role, and career stage Academically defined	Context, role, and career stage impact lack of unified understanding Nonleader studies	Influence of context, role, career stage, and academics on definitions Lack of perspectives from nonleaders
Continuing	Organization and specialties defined leadership Awareness of context Clinically defined	Perspectives from nonleaders	Lack of perspectives from nonleaders Cognizant of context Clinically focused

Implications of Developing Physician Leadership in Medical Education

The literature on how physician leadership is developed in UME, GME, and CME highlighted several implications. First, a larger body of literature exists on leadership

development and future study is needed with regard to defining physician leadership (Frich et al., 2014; NCHL, 2014; Stoller, 2008; Webb et al., 2014).

Second, the literature in UME suggests that developing content and approaches to developing physician leadership are desired but contextual limitations and an overreliance on formal approaches, such as the lecture-based approach, overshadow informal approaches (Neeley et al., 2017). Future studies could focus on the impact of informal approaches and the environment on physician leadership development.

Third, a significant finding in GME was the limited developmental opportunities for resident physicians who do not hold leadership positions (Frich et al., 2014; NCHL, 2014; Pettit, 2015). Kuo et al. (2010) reinforced this by stating that leadership education for resident physicians is generally assumed to occur "on the job for the select few who naturally achieve key leadership positions" (p. 1603). Opportunities that existed focused on formal approaches such as lectures (Frich et al., 2014) and quantitative evaluation methods. In the context of GME, resident physicians who do not hold leadership positions appear to be understudied.

Fourth, CME offerings for physician leadership development were noted by Stoller (2008), AAMC (2009), NCHL (2014), and Cullum (2016). Frich et al. (2014), Stoller (2008), and NCHL (2014) studies did not account adequately for various contexts such as private practice, hospital, or specialty. The NCHL (2014) outlined knowledge and competencies for physician leaders but context was not addressed sufficiently. Although it could be inferred that contextual understanding is covered in such areas as "systems thinking" (p. 19), the reviewed literature was unclear. Cullum's (2016) recent study highlighted a potential disconnect within the literature with regard to physician identity and development, as well as defining physician leadership. Physician leadership development may be incongruent with physicians' various

definitions of physician leadership (e.g., problem solving). The literature in CME echoed the importance of context and broadening the participant pool to those who are not in official leadership positions. However, an implication for study would be to examine the disconnect noted by Cullum (2016) about how physicians define physician leadership over outcomes and traditional understandings of leadership as outcomes skill development (AAPL, 2017; Dine et al., 2011). What is known, gaps, and implications in CME are summarized in Table 6.

Table 6

How Physician Leadership is Developed: What is Known, Gaps, and Implications

Context	What is known	Gaps	Implications
Undergraduate	Formal approaches (e.g., lecture) Use of joint degree programs Focus on skill development	Informal: (a) mentoring and other cocurricular options, (b) environment	Investigate informal approaches and environment
Graduate	Formal approaches for those in leadership roles Evaluation was primarily quantitative	Programming for nonleader resident physicians largely absent	Investigate the lack of perspective from, and programming for non-leader resident physicians
Continuing	Internal and external programming increased Formal programming focused on leader, collective, and context Emphasis on outcomes	Lack of study of informal approaches and environment, identity, nature, perceptions of leadership	Investigate nonleader physicians, context, nature, and perceptions of leadership

Chapter Summary

The purpose of this integrative literature review was to synthesize literature on what is known about historical leadership approaches and theories, as well as what is known about how physician leadership is defined and developed within the three contexts of medical education.

The goal of this inquiry was to reach an understanding of the construct of physician leadership in medical education, as well as a new perspective meriting research.

More than 30 years after Burns (1978) stated that the "essence" (p. 1) of leadership was not well understood, Swanwick and McKimm (2011) also attested to the elusive nature of physician leadership in medical education. The deductive studies of historical leadership approaches and theories, as well as focusing on the individual, collective, or the context/system, were largely mirrored in medical education and the focus on the leader was pervasive. Context and role were frequently mentioned but not adequately addressed. The literature suggested that physician leadership in medical education has overarching thematic definitions (e.g., academic) but varies based on aspects such as context, role, and specialty. Influences from the industrial era paradigm were prevalent and quantitative methods dominated inquiry and evaluation.

Dine et al. (2011) noted the extensive general literature on leadership but what is largely unknown is definitions specific to physicians within medical settings. The growing body of literature on physician leadership illuminates the proliferation of literature on developmental approaches (Frich et al., 2014; NCHL, 2014; Webb et al., 2014) but lacks clear understanding of the nature of physician leadership or definitions of physician leadership in medical education. It was also clear that studies on those who are not in leadership roles (e.g., resident physicians) were absent (Kuo et al., 2010; Pettit, 2015).

Souba (2004a) stated, "How we think about leadership matters a lot. It matters because our implicit leadership theory affects how we exercise leadership, consciously or unconsciously, in our everyday lives" (p. 178). The reviewed literature implies a gap in how physician leadership is defined in relation to context, role, and specialty. What is not known is defining, or understanding, the nature of physician leadership from the perspectives and lived experiences of

those who are not in leadership roles (Kuo et al., 2010; Pettit, 2015). Exploring the "essential nature" (Rost, 1993, p. 5) of physician leadership from the viewpoint of an understudied population, such as resident physicians, would provide a new perspective on physician leadership, thereby informing approaches to development and enactment.

CHAPTER 3

METHODOLOGY AND METHODS

This chapter contains a discussion of the methodology and methods that guided this study. First, the purpose and research question are restated to anchor the study. Next, I describe the inquiry paradigm, fundamental questions, research design, and rationale to build toward selecting a methodology. Justification for the selected methodology and specific approach follow before outlining methods for site and participant selection, data collection, and data analysis. Last, quality criteria and my perspective and positionality are discussed.

Study Purpose and Research Question

The purpose of this study was to explore the nature of physician leadership for family medicine resident physicians from their descriptions of physician leadership through lived experiences in GME. The lack of literature on the phenomenon of physician leadership in medical education is disturbing in light of a growing need for defining physician leadership and developing physician leaders (Dine et al., 2011). The extant literature was weighted toward the perspectives and experiences of those in official leadership roles in medical education (Kuo et al., 2010; Pettit, 2015). Investigating the perspective of an underrepresented population such as nonleader resident physicians offers a new perspective in the educationally critical context (Cooke et al., 2010) of GME and deepens understanding of the phenomenon of physician leadership.

The central research question for this study was, *How do family medicine resident physicians describe and experience the nature of physician leadership?* The central research question in a study points to design, inquiry paradigm, methodology, and methods (Creswell, 2014; Crotty, 1998). Furthermore, qualitative research questions are open, "evolving, and

nondirectional . . . start[ing] with a word as 'what' or 'how' rather than 'why'" (Creswell, 2007, p. 107). The central research question in this study was framed with *how*, pointing to an open and exploratory focus, rather than an explanatory (e.g., *why*) focus. Before describing the research design, it is essential to ground this study within an inquiry paradigm by discussing my philosophical stance and explicating the philosophical underpinnings that influenced and informed the research process.

Inquiry Paradigm

The guiding inquiry paradigm for a study can be viewed as "a basic set of beliefs that guides action" (Guba, 1990, p. 17) or philosophical stance (Denzin & Lincoln, 2011) that informs such aspects as research questions, positionality, or interpretations associated with methodology and methods. It is necessary for researchers to be explicit about their philosophical stance as assumptions associated with the stance are brought into the research process. Thus, I discuss my philosophical stance within the constructivist inquiry paradigm that outlines assumptions that guided this research process. Some qualitative researchers use the terms *constructivist* and *interpretivist* interchangeably (Creswell, 2014), while others define them separately (Schwandt, 1998). Merriam and Tisdell (2015) maintained that all qualitative research is interpretive; when utilizing the term *constructivist*, I refer to the assumptions of the constructivist paradigm as described by Guba (1990) and Guba and Lincoln (1994).

Fundamental Paradigmatic Questions

Guba and Lincoln (1994) stated that three fundamental paradigmatic questions summarize the philosophical stance of a researcher and the paradigm from which the study is situated. These questions are ontological, epistemological, and methodological (Guba, 1990): (a) What is the nature of reality (ontological)? (b) What is the nature of knowledge (epistemological)? and (c) How should the inquirer attain knowledge (methodological)? An

overview of how each question is answered through grounding in the constructivist inquiry paradigm and how they informed this study is offered below.

The ontological question. Ontology inquires about the nature of reality. The constructivist paradigm posits a relativist reality that states that there is not a singular reality but rather multiple realities that are "socially and experientially based, local and specific, dependent for their form and content on the persons who hold them" (Guba, 1990, p. 27). Schwandt (1998) clarified an important nuance within this paradigm by stating that realities are "sociohistorically relative" (p. 243) and bound by aspects such as sociohistorical context. Reality, and what is known about it, is constructed through "lived experiences" (Denzin & Lincoln, 2011, p. 102). Therefore, this fundamental paradigmatic question informed this study by recognizing and elevating the multiple constructed realities of the resident physicians through their lived experiences of the phenomenon of physician leadership in the context of GME. Answering this question from the constructivist paradigm also posits that an assumption of this study is that the nature of physician leadership is relative to sociohistorical context rather than a singular constant. In short, *a* relative nature pertaining to the participants rather than *the* generalizable nature of physician leadership is constructed through this study.

The epistemological question. The next fundamental question is a question of what makes for knowledge of that reality, or epistemology. The constructivist paradigm supports an interactive and subjectivist approach (Guba, 1990; Guba & Lincoln, 1994). Guba (1990) described epistemology as interactive because the researcher is the instrument of inquiry (Guba & Lincoln, 1994) and knowledge is constructed, not discovered (Scwandt, 1998) between the researcher and the participants. Thus, knowledge of reality is subjectively shaped by the researcher and the participants. These assumptions aligned with the purpose and research

question for this study in that the interactions and embeddedness of the family medicine residents in GME influence their lived experiences and constructions of physician leadership. Thus, in this study, I position myself as the primary research instrument to interactively construct, along with the resident physicians, what is known of, and about, physician leadership.

The methodological question. This question seeks to determine the process of inquiry, that is, how one ought to go about acquiring knowledge of the lived reality. Guba and Lincoln (1994) posited that the answer to this question is based on how the two previous questions (i.e., ontological, epistemological) are answered. Answering this third fundamental question is the focus of this chapter and is clarified by Guba (1990), who described the methodologies of the constructivist paradigm as hermeneutic and dialectical, "individual constructions are elicited and refined hermeneutically, and compared and contrasted dialectically, with the aim of generating one (or a few) constructions on which there is substantial consensus" (p. 27). The researcher is positioned close to the researched, research is conducted in natural settings, and the goal of the selected methodology is aligned with constructing what is known between the researcher and the participants (Creswell, 2007; Guba, 1990). This methodological stance informed this study in that I was the main instrument of inquiry, as posited above in the answer to the epistemological question. The research was conducted in laboratory-free settings and the resident physicians were included in co-constructing a description of a nature of physician leadership.

Informing the Study

From the brief examination of the three paradigmatic questions, the constructivist paradigm supports (a) the ontological position of multiple and sociohistorically relative (Schwandt, 1998) constructed realities, (b) the epistemological position of constructing what is known through an interactive and subjective process between the researcher and the participants,

and (c) the methodological position of identifying the researcher as the key research instrument located close to the participants in natural settings to co-construct what is jointly known.

Exploring the nature of physician leadership for family medicine resident physicians by investigating their descriptions of physician leadership through lived experiences in GME aligns with the constructivist paradigm. Specifically, this study aligns with the constructivist paradigm by upholding the multiple realities of the resident physicians and situating the researcher close to the resident physicians in natural settings to co-construct *a* sociohistorically relative nature of the phenomenon of physician leadership. As a result, this study was located in the constructivist paradigm, which, in turn, governed choices of design, methodology, and methods.

Research Design and Rationale

Building on the purpose, research question, and governing constructivist paradigm, I selected a qualitative research design. Research designs can be qualitative, quantitative, mixed, or multiple; they inform methodologies to investigate phenomena (Creswell, 2014). For example, a researcher studying physician leadership who is aligned with the postpositivist paradigm may select a quantitative nonexperimental correlational design and collect data by surveying a large sample of participants. Conversely, a researcher aligned with the constructivist paradigm, as is the case with this study, may select a qualitative phenomenological design and collect data by interviewing a small number of participants. The research design guides the research process through choices of methodology and methods to address the research question: *How do family medicine resident physicians describe and experience the nature of physician leadership?* I discuss qualitative research below to outline design guidelines and rationale that informed this investigation of physician leadership.

Denzin and Lincoln (2011) summarized qualitative research as primarily (a) naturalistic by locating "the observer in the world" (p. 3) to study interactively phenomena in natural

settings, and (b) interpretive by making sense of the meaning that people ascribe to phenomena. Characteristics of qualitative research include its inductive process and focus on "rich description" (Merriam & Tisdell, 2015, p. 17). What is known is not perceived as factually objective, but rather subjectively embedded within the perspectives of the knower (Guba & Lincoln, 1994). The subjective aspect of what is known in qualitative research is critical as this study was designed to capture rich subjective descriptions of how family medicine resident physicians understand physician leadership from lived experiences in GME.

Another characteristic of qualitative research is that the researcher is the primary instrument to collect and analyze data (Merriam & Tisdell, 2015). The researcher as the human research instrument was important to this study as this role highlighted close proximity to, and interactive relationship with, the resident physicians to co-construct a nature of physician leadership.

The last characteristic of qualitative research is the emphasis on emergence. The emergent characteristic of qualitative research is important to note because qualitative research does not encourage a "tightly prescribed" (Creswell, 2007, p. 39) plan but recognizes that methods may shift, or emerge, during the research process to accommodate collection and analysis of rich data. In short, qualitative design guides the investigation of the rich depth of phenomena. The following section describes methodologies that were considered for this study and provides justification for the selected methodology and specific approach to carry out this investigation.

Methodologies Considered

Governed by the constructivist inquiry paradigm and guided by qualitative design, various methodologies were considered in determining how to conduct a study of physician leadership. Patton (2015) and Creswell (2007, 2014) described qualitative methodologies such

as grounded theory, narrative, ethnography, case study, and phenomenology that could be utilized for this study. Grounded theory was considered due to its focus on the meaning and description of experience. A key difference was that grounded theory emphasizes the generation of a theory or, at very least, a theoretical framework. The purpose of this study and research question did not point to production of theory as an outcome. Narrative research draws from the field of humanities and focuses on stories emanating from the lives of the participants and the researcher (Creswell, 2014). Ethnography emphasizes the study of such aspects like behaviors and language in natural settings over long durations of time (Creswell, 2014). Both narrative and ethnographic research have merit for emphasis on collaborative storytelling or understanding behavior and language. However, my central research question does not suggest a focus on storytelling or behaviors but rather internal, and cognitive, aspects that contribute to describing the nature and experiences of physician leadership.

Case study includes analysis of a bounded system which could be helpful to a context such as a residency program in GME. One way to determine whether a case study is warranted is whether the researcher can "fence in" (Merriam & Tisdell, 2015, p. 38) what is being studied. Constructions of physician leadership may be unique to the resident physician but could be grounded in lived experiences of a residency program or contextually (e.g., hospital) and situationally (e.g., conversation) relative to where physician leadership is enacted. Fencing in may be problematic as descriptions of physician leadership may transcend local contexts (e.g., clinic, hospital); therefore, case study methodology was not selected.

Phenomenology focuses on shared aspects of how people describe phenomena. The shared aspects constitute the nature or "essence" (Moustakas, 1994, p. 55) of a phenomenon in phenomenology. Halling (2002) stated that, "through its exploration of situated human

consciousness, phenomenology can help to make sense in psychological and human terms of some of the findings of traditional research, which are typically presented in statistical language" (p. 20). Thus, with the purpose and research question for this study focusing on exploring the nature of the phenomenon of physician leadership from descriptions by family medicine resident physicians through lived experiences in GME and guided by the governing constructivist inquiry paradigm and qualitative design, I selected phenomenology as the most suitable methodology to frame this investigation. Rooted in philosophy, phenomenology can be defined as a philosophy, methodology, and a set of methods (Merriam & Tisdell, 2015; Patton, 2015). Phenomenology as a philosophy and methodology are discussed below before identifying a specific methodological approach and set of methods for this study.

Phenomenology

Phenomenology is a method to illuminate the core of phenomena as experienced by participants. Van Manen (1990) defined phenomenology as searching "for the very nature of a phenomenon, for that which makes a some-'thing' what it is—and without which it could not be what it is" (p. 10). Creswell (2007) stated that phenomenological studies describe "the essence of the experience of the phenomenon" (p. 77). While outlining the philosophical roots of phenomenology and the two main methodological variations below, I build support for a methodological approach that aligned with the purpose and central research question of the study.

Phenomenology as a Philosophy

The founding of phenomenology as a philosophy is attributed to Edmund Husserl (Moran, 2000). According to Patton (2015), Husserl's basic assumption was that people can know only what they experience. A significant nuance in Husserl's philosophy is the focus on consciousness to address the epistemological question about the nature of knowledge (Vagle,

2014). Husserl elevated directed consciousness to connect the subject to the object, or phenomenon, through lived experiences (Merriam & Tisdell, 2015). In this study, when a resident physician (subject) encounters the phenomenon of physician leadership (object), such as through an interaction with a physician leader, a subjective understanding about physician leadership is constructed in the mind of that resident physician.

Husserl's transcendental philosophy was known for focusing on how essential structures of phenomena present themselves in a person's consciousness and influenced other philosophers, such as Martin Heidegger (Smith, 2013; Van Manen, 2017). In contrast to Husserl, Heidegger focused less on epistemology and consciousness and more on ontology and meaning (Holloway & Galvin, 2017). Vagle (2014) stated that Heidegger's orientation toward being (ontology) created an interpretive, or hermeneutic, relationship between the subject and object. Thus, it is not consciousness that connects the person to phenomena but rather the person's existence in the world (Van Manen, 1990). In reference to this study, Heidegger's hermeneutic philosophy would infer an interpretive focus on *being* a physician leader as what connects the resident physician (subject) to physician leadership (object).

Husserl and Heidegger's respective transcendental and hermeneutic philosophies are important to examine as they influence divergent philosophical branches and phenomenological methodologies. Based on the purpose and central research question (How do family medicine resident physicians describe and experience the nature of physician leadership?), the focus of this study was not on the lived experiences of resident physicians in formal leadership roles but rather their descriptions of physician leadership through lived experiences in GME. The following subsections present justification for use of the methodological approach in this study.

Phenomenology as a Methodology

There are two main branches of phenomenological methodology, one based in Husserl's transcendental philosophy and the other in Heidegger's hermeneutic philosophy. Transcendental, or Husserlian, phenomenology emphasizes epistemology (nature of knowledge) and the researcher suspending or "bracketing" (Patton, 2015, p. 575) prior interpretations of phenomena in order to stay close to the participants' descriptions of phenomena. Hermeneutic phenomenology, in contrast, highlights ontology (nature of reality) through participants' existence in the world, along with elevating the researcher's lived experience and interpretations.

Vagle (2014) distinguished the two main branches of phenomenological methodology through the propositions *of* and *in*. *Of* (transcendental) is the intentional directed relationship between the person (resident physician) and the phenomenon (physician leadership). The nature or essence of a phenomenon is constructed in directed consciousness, directly thinking, through lived experiences (in this case, GME). Methodologies based on Husserl are descriptive and focus on participant descriptions. *In* (hermeneutic) refers to the intersubjective relationship between the person (resident physician) and the phenomenon (physician leadership). Therefore, the meaning of a physician leadership is interpreted from the resident physician being in a leadership position. Methodologies based on Heidegger are interpretive as the researcher's lived experience and interpretations share focus with participants.

Based on this brief examination of the philosophical roots of descriptive and interpretive phenomenology, I selected descriptive phenomenology as the methodological approach that was best suited for this study. The following subsection discusses rationale for selecting descriptive phenomenology and does not expand on interpretive phenomenology. The following subsections describe descriptive phenomenological methodology, as well as the two core components of epoche and bracketing.

Descriptive phenomenology. The philosophical roots of transcendental philosophy in descriptive phenomenology aligned more with the purpose of this research to explore the nature of physician leadership through descriptions of resident physicians through lived experiences in GME. By recognizing and suspending my prior interpretations about physician leadership through bracketing, I could enhance the focus on the resident physician's descriptions. Selection of descriptive phenomenology as the methodological approach was also supported through the central research question: *How do family medicine resident physicians describe and experience the nature of physician leadership?* This question points to a directed relationship between the subject (resident physician) and the object (physician leadership). It is critical to note that meaning in descriptive phenomenology is epistemologically focused as it is crafted internally in consciousness (Moustakas, 1994), directed at the object, and explicated through description. The directed relationship is also an important distinction because resident physicians are not in official leadership roles but rather focusing on their descriptions of the nature of physician leadership as nonleaders. Thus, descriptive phenomenology emphasizes constructing a nature or essence of physician leadership from resident physicians' descriptions that are grounded in their lived experiences in GME.

Epoche and bracketing. The critical aspects of epoche (identifying prior interpretations) and bracketing (suspending prior interpretations) in descriptive phenomenology are rooted in Husserl's transcendental philosophy, which influence the process of conducting descriptive phenomenological research. First, epoche charges the researcher to identify prior interpretations (i.e., assumptions, biases). Second, once interpretations of a phenomenon become apparent, the researcher intentionally suspends, or brackets, these prior interpretations in order to focus on the phenomenon as described by participants (Moerer-Urdahl & Creswell, 2004). Important to

descriptive phenomenological research, epoche and bracketing are often perceived as striving for objectivity by restraining the interpretive role of the researcher (Merriam & Tisdell, 2015). To counter claims of objectivity, Giorgi (2012) stated that, in descriptive phenomenology, "the psychological analyses we perform are interpretations. They are psychological interpretations of life-world events that are broader than psychological understandings we bring to them. However, these analyses are done by means of a descriptive method" (p. 8). Moustakas (1994) also noted that epoche does not seek to eliminate prior interpretations in support of objectivity; rather, epoche assists the researcher with increasing awareness and transparency. The phenomenological researcher increases awareness of prior interpretations in order to be fully present, and focused on, the lived experiences of the participants.

The perspective of increasing awareness and transparency of the researcher's prior interpretations parallels Finlay and Molano-Fisher's (2008) "critical self-awareness" (p. 17). Critical self-awareness requires the researcher to be meticulously open about prior interpretations in an effort to raise self-awareness and enhance transparency (Nelms, 2015). Therefore, descriptive phenomenology can be viewed as being transparent about the researcher's prior interpretations and interpretive role but focused on descriptions by participants. In this study, and as the key research instrument, it was important to critically examine my prior interpretations through epoche and bracketing in order to focus on the descriptions by participants. The role of a reflexive journal for documenting epoche and bracketing is discussed in the section on quality criteria after addressing the selected methods for this study.

Methods

The following subsections detail the methods applied to select the site and participants, as well as the plan for collecting, analyzing, and reporting data. Data collection consisted of two rounds of one-on-one semistructured interviews of family medicine resident physicians from two

family medicine residency programs in a southwestern state in the United States, as well as a round of member checking with each participant after the first interview. The first interview explored lived experiences of the resident physicians with regard to physician leadership through questions about interactions with formal physician leaders based on their roles as nonleader resident physicians, the context of GME, and the specialty of family medicine. The second interview was designed to gather feedback from the resident physicians about how a cross-case synthesis statement about physician leadership constructed from data analysis reflected their experience and understanding of physician leadership.

The process of data analysis was informed by Moustakas (1994) and Colaizzi (1978). By integrating methods of data analysis, I sought to provide a descriptive process rooted in Husserl's transcendental philosophy through Moustakas (1994) and to incorporate Colaizzi's (1978) methods, which are frequently utilized in the nursing field and specifically support returning to participants for feedback on data analysis. The quality criteria of trustworthiness and authenticity are discussed after the description of data analysis to establish methods for ensuring a methodologically sound study. Figure 3 illustrates the methods used to conduct this study.

Site and Participant Selection

Site. Participants were recruited from two family medicine residency programs in a southwestern U.S. state associated with a public university system (Appendix A). The sites were selected based on close physical proximity and access based on my professional role in the college of medicine. The rationale for recruiting participants from two family medicine residency programs was predicated on the importance of the context of GME to the training of physicians and the primary care specialty of family medicine to health care (ACGME, 2014; Hofer et al., 2011). GME is an "essential dimension" (ACGME, 2017b, p. 1) and time of

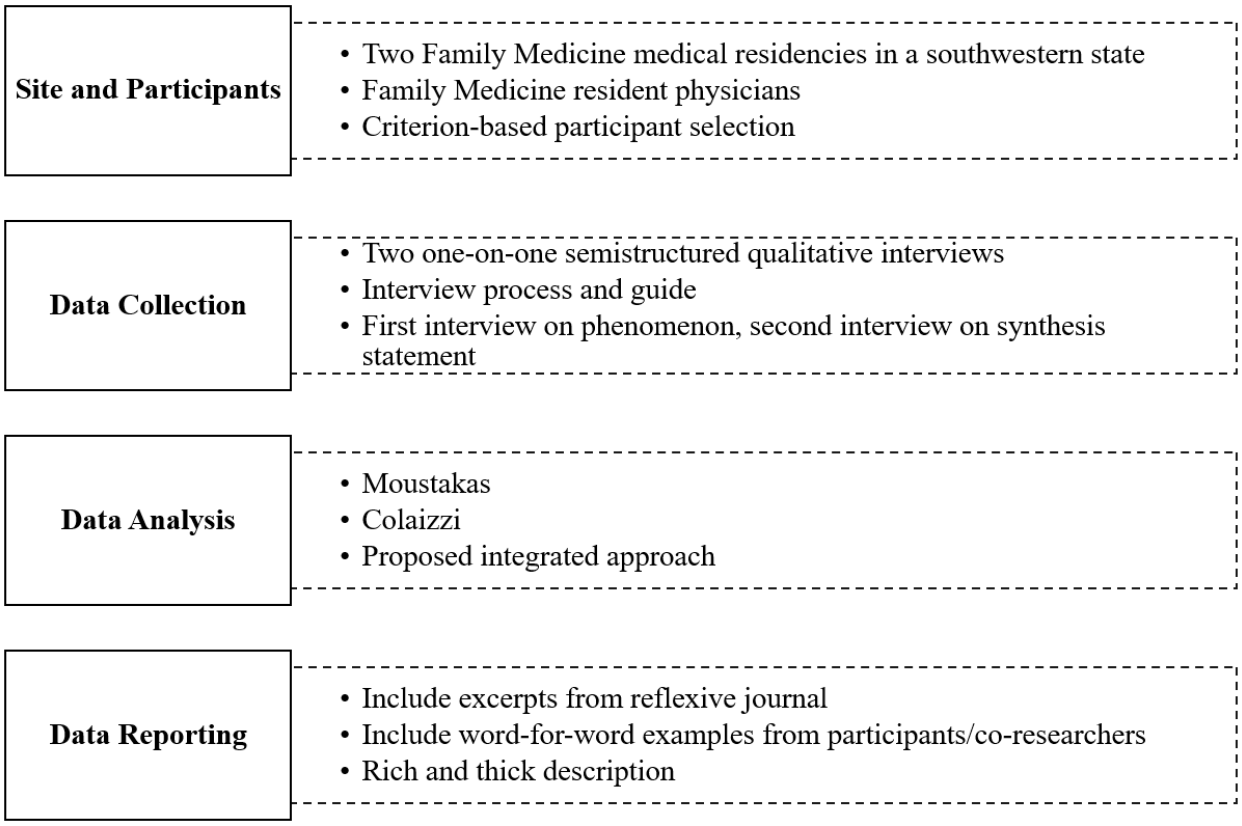

Figure 3. Overview of methods utilized for this descriptive phenomenological study.

significant development for resident physicians due to "teaching, team leadership and teamwork, and the nature of the resident's role in patient care" (Cooke et al., 2010, p. 31). GME also bridges UME and CME by placing resident physicians in an advanced educational role as student and supervised health care provider (Ackerly et al., 2011). Family medicine physicians are referred to as entry points to the health care system (Blumenthal et al., 2012). Thus, studying family physician resident physicians was an opportunity to investigate the phenomenon of physician leadership from the perspective of those who serve as entry points to the health care system.

Participant selection. Criterion-based purposeful participant selection (Patton, 2015) was utilized in this study with three governing criteria. In consultation with a physician at an

AMC in a southwestern state, it was determined that participants must (a) be resident physician in the medical specialty of family medicine, (b) not hold formal leadership roles in a medical residency program, and (c) have completed at least 1 year of GME in a family medicine medical residency program. The rationale for these criteria was to ensure that participants were family medicine resident physicians and not in formal leadership roles (i.e., nonleaders), since the descriptive phenomenological approach was predicated on descriptions of nonleader resident physicians. The final criterion ensured that the participants had completed their first year in GME, which is considered a "forge of professional formation" (Cooke et al., 2010, p. 239) due to adjusting to such aspects as new responsibilities, expectations, work hours, and supervision of physicians (Dare, Fancourt, Robinson, Wilkinson, & Bagg, 2009). Requiring completion of at least 1 year in GME allowed time for lived experiences of physician leadership from which to draw rich data.

Purposeful participant selection is a strategy utilized in qualitative research to identify participants who can "inform an understanding of the research problem and central phenomenon in the study" (Creswell, 2007, p. 125). Purposeful participant selection seeks "information rich" (Patton, 2002, p. 230) data to illuminate the depth of a phenomenon. Creswell (2007) advised that criterion-based participant selection works well with phenomenological studies to ensure that participants have experienced the phenomenon. Thus, the stated criteria aided in selecting participants who could provide rich insight into the phenomenon of physician leadership.

Recruitment and informed consent. First, this study was vetted by the Institutional Review Board (IRB) at CSU and the public university associated with the sites to ensure that standards for human subjects research were met. Based on human subjects exemption criteria, this study qualified as exempt under Category 2 (iii) IRB (#00010468 or 00000202; CSU,

2018a). This exemption was based on (a) minimal risk to participants, and any person discussed in data collection, through maintaining anonymity by utilizing pseudonyms; and (b) no perceived risk for liability (criminal, civil) or damage to employability as participants were not asked risk-prone questions or asked to disclose names of formal leaders (CSU, 2018b).

After approval by both IRBs and the organization affiliated with one of the medical residency programs, I worked with administrators of the identified residency programs to send an email to the resident physicians informing them of the study, inclusion criteria, and ethical measures to ensure confidentiality of data. Once participants were recruited based on the selection criteria and self-selected by responding to the email, I secured informed consent for in-person interviews prior to scheduling the interviews by sending participants a document created from a template provided by the Office of Research Integrity and Compliance Review at CSU (CSU, 2018d). If interviewing over the phone or other digital means (e.g., Skype), I secured informed consent through reading a verbal consent form from CSU immediately prior to the first interview. The informed consent documents detailed measures to protect participant anonymity through use of pseudonyms as well as (a) the purpose of the study, (b) the rationale for data collection, (c) how the data would be used, (d) what would be asked, (e) confidentiality of data (e.g., audio recordings, transcriptions, pseudonym key), and (g) any potential risks or benefits from participating (Patton, 2015). Locations, times, and means (e.g., Skype, telephone) for data collection were determined based on confidentiality and convenience. Recognizing time constraints, participants who completed all requirements of the study received a $100 Visa gift card, either emailed or physically sent to a location of their choosing.

Total participants. The purpose of this exploratory study on the phenomenon of physician leadership pointed to selecting information-rich participants with lived experiences

that were “illuminative, that is, they offer useful manifestations of the phenomenon of interest . . . aimed at insight about the phenomenon, not empirical generalization from a sample to a population” (Patton, 2002, p. 40). With regard to the number of participants for a descriptive phenomenological study, there is an absence of definitive rules in phenomenological inquiry (Creswell, 2014). The extant literature noted that the number of participants in phenomenological studies ranged from two (Klenke, 2016) or three (Giorgi, 1975; Nelms, 2015), up to 25 (Polkinghorne, 1989). Creswell (2014) stated that the number of participants in phenomenological studies typically ranged from 3 to 10.

Based on the purpose of the study and phenomenological literature, the target total of participants was three to eight. However, the total number of participants was guided by Lincoln and Guba’s (1985) notion of redundancy. Redundancy, or data saturation, suggests that participant selection ceases when no new information arises (Patton, 2015). Not setting the total participants supports redundancy (saturation) and reflects the constructivist paradigm through recruiting participants until the data are determined to be saturated with repetitive aspects of resident physicians’ understanding of physician leadership through lived experiences in GME (Lincoln & Guba, 1985). To this end, it is important to reiterate that qualitative design, specifically pertinent to participant selection, is “flexible and emergent” (Patton, 2002, p. 246) in order to facilitate gathering thick, rich, and in-depth data.

In summary, the chosen method for sites and participant selection was intended to recruit three to eight family medicine resident physicians within the context of GME who could provide rich data on physician leadership. Once the resident physicians met the criteria and self-selected to participate, they completed the physical informed consent document or provided verbal

consent. Informed consent was secured prior to collecting and analyzing data, as described below.

Data Collection

In qualitative inquiry, the researcher is considered to be the key instrument (Guba & Lincoln, 1994) to collect and analyze data (Guba, 1990; Merriam & Tisdell, 2015). This subsection outlines the chosen method of collecting data for this study, which included two rounds of qualitative one-on-one interviews and member checking by email after the first interview, assisted by a semistructured data collection guide.

Qualitative interview. I selected the qualitative interview as the method for collecting data for this study. Patton (2002) described the qualitative interview as entering "into the other person's perspective . . . to find out what is in and on someone else's mind" (p. 341). Holloway and Galvin (2017) added that the interview in phenomenological research aims "to facilitate the participant so that they provide rich descriptions of the phenomenon through examples from everyday life and their own experience" (p. 233). Thus, the decision to utilize the qualitative interview was predicated on drawing out rich descriptions of family medicine resident physicians' lived experiences in GME of physician leadership, while also serving as the primary method of data collection in phenomenological studies (Creswell, 2014; Holloway & Galvin, 2017; Merriam & Tisdell, 2015; Patton, 2002).

Moustakas (1994) offered approaches to phenomenological interviews: (a) building rapport, (b) participant reflection on experiences with the phenomenon, and (c) utilizing a data collection guide. The data collection guide, informed by Moustakas's (1994) approaches noted above, is discussed following the interview process for this study.

Interview process. I conducted two rounds of one-one-one semistructured, interviews. The first interview engaged the family medicine resident physicians in questions about the

phenomenon of physician leadership through lived experiences in GME with regard to their roles as nonleader resident physicians, the context of GME, and the specialty of family medicine to evoke "a comprehensive account of the person's experience of the phenomenon" (Moustakas, 1994, p. 114). The first interview was framed by questions that were developed utilizing thematic regularities in the informing literature. The first interview provided the data for analysis and construction of a cross-case synthesis statement (Colaizzi, 1978) about physician leadership for participating resident physicians. In addition, an in-case synthesis statement constructed from the first interview with each participant was returned to the participant after the first interview to member check the construction of data. The second interview inquired about this cross-case synthesis statement and how it reflected the resident physicians' experience and understanding of physician leadership. Feedback from the second interview was utilized to refine the cross-case synthesis statement (Abalos, Rivera, Locsin, & Schoenhofer, 2016; Colaizzi, 1978; Sanders, 2003). Interview questions were not limited to the guide; probing follow-up questions were asked (Merriam & Tisdell, 2015). The estimated duration for the first interview was 30 to 60 minutes. Based on the focus of the second interview on the cross-case synthesis statement, the estimated duration was 15 to 45 minutes. Each interview was transcribed and analyzed before interviewing subsequent participants for the first round of interviews; this was not required for the second round of interviews because they were designed solely to collect feedback. It was important to collect feedback from all participants before refining the cross-case synthesis statement to maintain the original constructed statement before any modification. The data collection guide and estimated interview durations were selected based on the assumption that the availability of resident physicians was limited and that the data

collection guide would assist in balancing an exploration of the phenomenon with the time limitations of the participants.

Both rounds of interviews were audio recorded and then transcribed into a word processing program by a professional transcription service. For the purpose of confidentiality, any digital files associated with the study (e.g., transcriptions) were housed in a secure location and protected through use of encryption and password access. The audio recordings will be destroyed at the completion of the study and transcripts will be stored securely for at least 3 years, as mandated by federal regulations (CSU, 2018c).

Data collection guide. Based on Moustakas's (1994) approach to phenomenological research, I developed a draft data collection guide (Appendix B) consisting of open-ended questions to evoke an exhaustive description of the lived experiences of physician leadership by participating resident physicians. In addition, Weick's (1995) social sensemaking property and thematic regularities from the informing literature on physician leadership informed the development of interview questions. I selected Weick's (1995) social property, as stated in Chapter 2, based on the importance of interactions and experiences among others, the culture, and the organization with regard to informing understanding of a phenomenon (Helms et al., 2010). Moreover, Weick's (1995) property aligned with the thematic regularities of role, context, and specialty (Mulholland, 2015; Oandasan et al., 2013; Pettit, 2015; Pregitzer, 2014) underscored in the informing literature. In short, the data collection guide aided in collecting data to be analyzed through an integrated approach based on Moustakas (1994) and Colaizzi (1978) and detailed below.

Data Analysis

The following subsections detail the approach to data analysis. Holloway and Galvin (2017) suggested that data analysis in phenomenology "aims to uncover and produce a

description of the lived experience" (p. 228). Thus, I discuss Moustakas's (1994) and Colaizzi's (1978) approaches to the descriptive phenomenological data analysis (Table 7) before outlining the integrated approach that was synthesized from these two researchers.

Table 7

Moustakas's and Colaizzi's Approaches to Data Analysis

Moustakas		Colaizzi	
Step	Process	Stage	Process
Epoche	Surface prior interpretations	Protocols	Iterative review of descriptions
Phenomenolog-ical reduction	Bracket prior interpretations Textural themes and description	Extracting significant statements	Extract pertinent statements
Imaginative variation	Structural themes and description	Formulated meanings	Group statements into meaning units
Synthesis	Construct shared textural-structural description	Clusters of themes	Group meaning units into themes
		Exhaustive description	Construct cumulative description
		Identification of fundamental structure	Distill cumulative description into statement
		Returning to the participants	Ask participants about findings

Note. Adapted from (a) "Psychological Research as the Phenomenologist Views It," by P. F. Colaizzi, 1978, pp. 48-71 in R. Vale & M. King (Eds.), *Existential-Phenomenological Alternatives for Psychology,* New York, NY: Oxford University Press; (b) *Qualitative Research in Nursing and Health care* (4th ed.), by L. Holloway & K. Galvin, 2017, New York, NY: Wiley; (c) *Qualitative Research in the Study of Leadership,* by K. Klenke, 2016, Bingley, UK: Emerald Group; and (d) *Phenomenological Research Methods,* by C. Moustakas, 1994, Thousand Oaks, CA: Sage.

Moustakas. Moustakas (1994) offered a descriptive approach to phenomenological inquiry and data analysis grounded in Husserl's transcendental philosophy (Creswell, 2014; Merriam & Tisdell, 2015; Patton, 2015). Moustakas's (1994) approach includes the steps of (a) epoche, (b), phenomenological reduction (c) imaginative variation, and (d) synthesis.

Prior to organizing and analyzing data, the first step of epoche requires the researcher to identify prior interpretations to enhance transparency and focus on the phenomenon as described by participants (Holloway & Galvin, 2017), otherwise known by Moustakas (1994) as "co-researchers" (p. 34) who join in the research process to construct an understanding of the phenomenon; the terms are used interchangeably in this study. Epoche appeals to roots in transcendental philosophy by encouraging the researcher to remain open to the phenomenon and to see it "freshly, as if for the first time" (Moustakas, 1994, p. 34). For example, a researcher might identify an assumption that physicians who have formal leadership roles in GME utilize authoritative approaches to physician leadership when educating resident physicians.

Next, phenomenological reduction calls for bracketing interpretations named in epoche to increase the researcher's focus on the "the essence of the experience" (Merriam & Tisdell, 2015, p. 27) as described by the participants before organizing and analyzing data. Horizontalization (Moustakas, 1994) is the process of organization by first laying out the data for examination (Merriam & Tisdell, 2015). Word-for-word statements from the transcripts pertaining to the phenomenon ("horizons"; Moustakas, 1994, p. 91), are separated from irrelevant, repetitive, or overlapping statements. The remaining statements are the "invariant constituents" (Moustakas, 1994, p. 97) of an experience and analyzed by clustering into textural themes. These textural themes constitute the *what* of an experience, or what occurred, with a phenomenon and contribute to constructing a textural description. The textural description constitutes an

experience and includes aspects such as "feelings, examples, ideas, situations" (Moustakas, 1994, p. 47). For instance, a resident physician might describe an interaction with a residency program director in which the textural theme of empowerment is constructed. Empowerment is then utilized to construct the textural description for that resident physician.

In the third step of imaginative variation, the researcher continues to analyze the data. For example, the researcher views the interaction with the program director as described in the textural (what) description from various perspectives to "seek possible meanings through the utilization of imagination" (Moustakas, 1994, p. 97). To accomplish this, various aspects of the textural description such as context, thoughts, and causation are considered. From these aspects, structural themes are constructed that illuminate the "underlying and precipitating factors that account for what is being experienced" (Moustakas, 1994, p. 98). In other words, structural themes are *how* a phenomenon was experienced by the resident physician. These structural themes then contribute to the structural description of an experience. Continuing the example, a structural theme of increased responsibilities given to the resident physician may be identified in terms of what contributed to how that resident physician experienced empowerment with regard to physician leadership. Therefore, the theme of increased responsibilities would contribute to the construction of the structural description. Individual textural and structural descriptions were constructed for remaining participants.

The last step of synthesis combines the individual textural (what) and structural (structural) descriptions for the resident physician into a shared textural-structural statement of an essence, or a nature, of physician leadership for that resident physician (Moustakas, 1994). Although Husserl (1931) inferred universality of essence, Moustakas (1994) stated that essence should not be considered universal but rather shared aspects located "at a particular time and

place" (p. 100) and from the vantage point of the researcher. In the current study, and in agreement with the governing constructivist paradigm, the nature of physician leadership was regarded as sociohistorically relative to lived experiences in the family medicine residency program within the context of GME. Individual textural (what)-structural (how) statements for all participants informed an overall textural-structural (nature) statement representing shared aspects as experienced by the group (Moustakas, 1994).

Although Moustakas's (1994) phenomenological process and data analysis are grounded in Husserlian descriptive phenomenology through emphasis on epoche and bracketing, I perceived that participant input as co-researchers in data analysis was lacking. Therefore, I sought data analysis strategies to complement Moustakas (1994) that aligned with descriptive phenomenology and agreed with my philosophical position in the constructivist paradigm. Based on the reviewed literature and advice from an expert in the field of medical education (W. W. Souba, personal communication, March 7, 2017), phenomenological literature in the health care field of nursing was examined for methods of data analysis to complement Moustakas (1994). Colaizzi's (1978) stages of data analysis were selected because they were cited by Moustakas (1994), aligned with descriptive phenomenology (Dowling & Cooney, 2012; Nelms, 2015), frequently used in phenomenological studies in nursing (Dowling & Cooney, 2012; Norlyk & Harder, 2010; Phillips-Pula, Strunk, & Pickler, 2011) and in agreement with the constructivist paradigm in co-constructing what is known by returning to participants for input on data analysis (Holloway & Galvin, 2017).

Colaizzi. Colaizzi's (1978) stages of data analysis consist of (a) protocols, (b) extracting significant statements, (c) formulated meanings, (d) clusters of themes, (e) exhaustive

description, (f) identification of the fundamental structure of the data, and (g) returning to the participants (Holloway & Galvin, 2017; Sanders, 2003).

The first stage, protocols, involves line-by-line iterative review of participant descriptions to increase familiarity (Colaizzi, 1978; Sanders, 2003) and grasp "the fullness of the experience as described by each participant" (Abalos et al., 2016, p. 22). In the extracting significant statements stage, the researcher extracts "phrases or sentences that directly pertain to the investigated phenomenon" (Colaizzi, 1978, p. 59) from each transcript. Next, formulated meanings consist of the researcher taking an interpretive "leap" (Colaizzi, 1978, p. 59) by grouping statements into general (Edward & Welch, 2011) meaning units for each participant. The purpose is to acquire a sense of the meaning (Sanders, 2003) and aspects shared in the statements by individual participants. It is important in this stage to ensure that meaning units adhere to participant descriptions by returning to the interview transcripts, as well as bracketing prior interpretations (Colaizzi, 1978; Sanders, 2003).

The fourth stage, clusters of themes, includes grouping the aggregate meaning units from all participants into themes according to shared aspects (Colaizzi, 1978; Sanders, 2003). An exhaustive description of the investigated phenomenon by all participants is written in the next stage, which includes the themes and word-for-word examples extracted from the transcripts. The identification of the fundamental structure stage involves synthesizing the exhaustive descriptions into a statement or the "essential structure" (Holloway & Galvin, 2017, p. 234) of the phenomenon. The essential structure consists of the shared aspects of what and how the phenomenon was experienced by the participants as a group. Last, returning to the participants consists of returning the statements to the participants for feedback regarding how the statements represent their experiences and understanding of the phenomenon (Sanders, 2003).

Integrated approach to data analysis. Moustakas's (1994) and Colaizzi's (1978) approaches to data analysis are grounded in Husserlian descriptive phenomenology through (a) emphasizing transparency and setting aside prior interpretations; (b) adhering to the descriptions by participants; and (c) synthesizing an essence, nature, or "essential structure" (Holloway & Galvin, 2017, p. 234) of a phenomenon. Based on Moustakas (1994) and Colaizzi (1978), the stages of data analysis applied in this study are shown in Figure 1: (a) familiarization, (b) extraction, (c) unitization, (d) thematic clustering and descriptions, (e) integrating descriptions, (f) synthesis, and (g) confirmation.

After the first interview, the first four stages are completed for that participant before member checking an in-case synthesis statement with that participant and interviewing subsequent participants. Once all participants complete the first interview and the first four stages, data are integrated and synthesized through cross-case analysis from all participants in the next two stages. A cross-case synthesis statement about physician leadership constructed in the penultimate stage is returned to the participants for feedback in the final stage.

Epoche and bracketing, respectively identified as critical self-awareness and suspension in this study, are essential aspects of descriptive phenomenology (Colaizzi, 1978; Holloway & Galvin, 2017; Moustakas, 1994). Although they occur early in the research process as preparation "for deriving new knowledge" (Moustakas, 1994, p. 85), returning to these aspects throughout the research process helps to ensure awareness, transparency, and adherence to the descriptions by participants (Colaizzi, 1978). I utilized a reflexive journal (Lincoln & Guba, 1986) to document critical self-awareness through identifying situations, people, or issues related to physician leadership and suspended interpretations emerging prior to and throughout the data

analysis stages described below. Thus, my first submission of critical awareness and suspension in my reflexive journal occurs prior to data analysis.

In addition to the reflexive journal, I documented research decisions in a research journal (Abalos et al., 2016). The research journal is separate from the reflexive journal in that memos in the research journal capture research decisions such as rationale for sufficient familiarity with transcripts and audio recordings rather than critical awareness and suspension. It is important to note that both the reflexive journal and the research journal were submitted to the dissertation committee chair throughout the process for peer review and auditing to assist with construction of a sound study (Lincoln & Guba, 1986, 2013). However, specific instances of peer review are noted in the subsection titled Trustworthiness.

Familiarization. The first stage of data analysis, familiarization, involves iteratively reviewing (Colaizzi, 1978) a transcript from the first interview with a resident physician, or co-researcher, to become familiar with their understanding of physician leadership from lived experiences in GME and to "get a sense of the whole" (Holloway & Galvin, 2017, p. 233). As suggested by Sanders (2003), I reviewed audio recordings of interviews to aid in understanding the fullness of their experience. Emerging interpretations were recorded in the reflexive journal to assist with critical awareness and suspension. The number of reviews of a transcript and audio recording was based on sufficient familiarity with a participant's lived experience (Sanders, 2003). As stated in the research journal, sufficient familiarity ranged from two to three reviews of a participant's transcript and audio recording.

Extraction. In the second stage I returned to the reflexive journal and noted interpretations that may have surfaced during familiarization and suspended them before extracting "phrases or sentences that directly pertain to the investigated phenomenon" (Colaizzi,

1978, p. 59) from the resident physician's transcript. This stage was identified by Moustakas (1994) as *horizontalization* but in this study it is defined as *extraction*.

The transcript was uploaded to a spreadsheet format in the online software program GoogleSheets (2019), secured with password protection, and identified as the full transcript tab. Word-for-word statements about physician leadership were listed along with the location in the transcript (e.g., Response 1). Questions and responses were then removed to focus solely on the participant's responses in the participant responses tab. Participant responses that pertained to the phenomenon of physician leadership (Colaizzi, 1978) were highlighted in red in the extraction tab. For example, Beth stated that physician leadership is about "working to further a goal" (Participant B, 2019, R6). If a statement had more than one relevant aspect, the statement was split into multiple spreadsheet rows, while maintaining the response number in the full list of statements tab. Next, the statements were reviewed and irrelevant, repetitive, or overlapping statements were set aside in the analyzed list of statements tab.

The remaining statements constituted the data for further analysis (Moustakas, 1994). In keeping with the assumption of the researcher being the key research instrument in qualitative inquiry, I was aware that software does not replace the researcher as the key research instrument to drive analysis. Rather, software merely aids with organizing the data for subsequent analysis (Patton, 2015) and enables secured access from multiple locations to assist with frequent return to the data to immerse myself in the lived experiences of the participants. Manually manipulating statements was used in conjunction with software and was specifically utilized to facilitate the stages of *integrating descriptions* and *synthesis*.

Unitization. Formulating meaning units is characteristic of the third stage, *unitization*. In this stage, digital index cards (using the secure digital software SuperNotecard

(SuperNotecard.com, 2019) were used to group the remaining word-for-word statements extracted from the transcripts into general meaning units, based on shared aspects identified between statements (Edward & Welch, 2011; Moustakas, 1994). Colaizzi (1978) noted the first interpretive "leap" (Colaizzi, 1978, p. 59) inherent to this stage occurs when the researcher groups statements based on the shared aspects. The analyzed statements were copied onto digital note cards and secured with a password. This method enabled manual manipulation of the note cards and allowed me to immerse myself in the data from various locations.

Moustakas (1994) and Colaizzi (1978) supported basing the interpretation of how shared aspects should be grouped by grounding decisions in the participant descriptions; therefore, it was important that I return to each participant's interview transcript to review data just prior to and following a statement. To complete this stage, I read through the note cards twice to continue to familiarize myself with the participant's lived experience of physician leadership before grouping them into meaning units. Rationale for constructed meaning units and themes listed in the thematic clustering and descriptions stage was documented in the research journal.

Thematic clustering and descriptions. The next stage of analysis involved clustering meaning units from the digital index cards drawn from the resident physician's transcript into textural (Moustakas, 1994) themes, or shared aspects about what was experienced in terms of the phenomenon of physician leadership. To complete this stage, I first read through the note cards again, titled each note card with the meaning of the text, and then grouped the note cards based on shared aspects. Textural themes included such aspects as feelings, ideas, and situations that constitute an experience of physician leadership. I utilized these textural themes, along with word-for-word examples extracted from the transcripts (Moustakas, 1994) to write a textural description of what was experienced. The purpose was to be drawn into *what* was experienced

by the resident physician with regard to physician leadership. A participant's textural description was noted in the research journal and in the textural description tab in GoogleSheets.

The second interpretive leap included various perspectives on the resident physician's textural description, defined by Moustakas (1994) as imaginative variation. The purpose of various perspectives on the textural description was to draw out structural themes, or shared aspects, regarding how physician leadership was experienced. To draw out structural themes, I considered such factors as context, feelings, thoughts, relationships, roles, and potential causes of the experience (Moustakas, 1994). Considering these factors assists with identifying structural themes "that account for what is being experienced" (Moustakas, 1994, p. 98). Structural themes from the textural description aid, and are included in, writing a structural description of *how* physician leadership was experienced by the resident physician. A participant's structural description was noted in the research journal and in the structural description tab in GoogleSheets. After the structural description was written, the textural and structural descriptions were reviewed and synthesized into an in-case textural-structural statement for that participant. A participant's textural-structural statement was noted in the research journal and in the textural-structural statement tab in GoogleSheets.

For the first round of member checking, I emailed to each participant his or her individual textural-structural statement for feedback to confirm an accurate representation of the participant's understanding of physician leadership through lived experiences in GME as described in the interview (Holloway & Galvin, 2017). Feedback from the participant, or co-researcher, and decisions regarding impact on the textural-structural in-case statement were noted in the research journal.

Once the textural (what) description, structural (how) description, and the textural-structural (nature) in-case statement were crafted for a participant, the stages of familiarization through thematic clustering and descriptions were repeated for remaining participants. Textural and structural statements, along with the textural-structural in-case statements, were constructed separately for each participant to highlight individual understanding through lived experiences before looking at shared aspects across participants in integrating descriptions and synthesis.

Integrating descriptions. After constructing individual textural (what) and structural (how) descriptions for each participant, and member checking synthesized individual textural-structural (nature) statements, I conducted the same process for all data to determine shared aspects across participants (Colaizzi, 1978; Edward & Welch, 2011). In agreement with MacTaggart (2018), Moustakas (1994) did not define a process for integrating descriptions. Colaizzi (1978) nor provide an explanation of how to integrate descriptions, stating only that it should occur. Abalos et al. (2016) stated that the "fifth and sixth steps in Colaizzi's method of analysis are integrating the results of the investigated topic into an exhaustive description and identifying its fundamental structure" (p. 22).

The absence of a structured process allowed flexibility and aligned with qualitative inquiry to support the researcher as the instrument of inquiry. Therefore, in keeping with the constructivist paradigm, the chosen research design, and combined analysis process based on Moustakas (1994) and Colaizzi (1978), I utilized the entirety of the data set across participants for analysis and construction of shared textural and structural descriptions, integrating the themes from all participants.

I exercised discipline to stay close to each participant's descriptions by continuing to note emerging interpretations in the reflexive journal and documenting research decisions (e.g.,

textural themes rationale) in the research journal. This stage integrated aspects of *what* and *how* physician leadership was experienced by all participants through lived experiences in GME, denoting what was shared by participants through constructing one shared textural description and one shared structural description. The respective shared textural and structural descriptions were synthesized in the next stage, synthesis.

Synthesis. Once the shared textural (what) and structural (how) descriptions for all participants were completed, these shared descriptions informed cross-case analysis and a shared textural-structural (nature) cross-case synthesis statement about physician leadership (Colaizzi, 1978). For reference, the length of synthesis statements in the reviewed literature ranged from one to nine paragraphs (Edward & Welch, 2011; Moustakas, 1994; Sanders, 2003). To accomplish constructing a shared textural-structural cross-case statement, and adhering to Colaizzi (1978), I first reviewed the shared textural and structural descriptions (Moustakas, 1994). I then reviewed the shared textural meaning units, as well as shared textural and structural themes, while reflecting on their respective rationales and seeking to determine the emerging narrative. The rationale for the cross-case textural-structural statement was documented in the research journal. The cross-case synthesis statement represents the group as a whole (Moustakas, 1994). The statement helped me to understand how the participants understood the nature of physician leadership. It is important to note that the synthesis statement should not be considered universal but rather shared aspects drawn from "a particular time and place from the vantage point of an individual" (Moustakas, 1994, p. 100).

Confirmation. The last stage in Colaizzi's (1978) method included returning to participants to confirm findings as the second round of member checking, this time on the synthesized, and co-constructed, cross-case (nature) statement. I followed Colaizzi's (1978)

method by submitting the cross-case synthesis statement to the participants in the final stage of confirmation through a second interview and refining the statement based on feedback. Questions in the second interview were detailed in the data collection guide and focused on the synthesis statement as it reflected the participants' experiences of physician leadership (Abalos et al., 2016; Wojnar & Swanson, 2007). Holloway and Galvin (2017) and Sanders (2003) suggested seeking input from participants in earlier stages, as individual descriptions were considered to be "more recognizable for them to comment" (Holloway & Galvin, 2017, p. 234). Conversely, Colaizzi (1978) and Abalos et al. (2016) encouraged input on the cross-case synthesis statement from participants as the final stage. To enable co-construction of individual and shared understandings of physician leadership, both perspectives on member checking were included in this study. I gathered feedback on individual textural-structural synthesized in-case statements in the stage of thematic clustering and descriptions; I also gathered feedback on shared understandings through the cross-case synthesis statement in the final stage of confirmation. Member checking in the final stage of synthesis allowed participants to learn from other perspectives by reviewing a synthesized statement rather than limiting the review to their respective individual statements. Research decisions on the impact of feedback on the final version of the cross-case textural-structural statement were logged in the research journal.

In summary, critical awareness and suspension of prior, or emerging, interpretations were noted in the reflexive journal, whereas research decisions were documented in the research journal. I iteratively examined the resident physicians' lived experiences of physician leadership in GME through their transcripts and audio recordings in the first stage of familiarization. Word-for-word statements were extracted from the interview transcripts and organized based on shared aspects, respectively, in extraction and unitization. Thematic clustering and descriptions

involved clustering the units into textural themes (what), crafting a textural description, and then drawing out structural themes (how) from the textural description to construct a structural description. Individual textural and structural descriptions were synthesized into individual textural-structural in-case statements and emailed back to the participants. Combining the individual textural and structural descriptions into one shared textural description and one shared structural description for all participants constituted integrating descriptions. The entire data set for all participants was analyzed and constructed into a single cross-case synthesis (nature) statement about the phenomenon of physician leadership in the synthesis stage. Confirmation involved a second interview with the participants about the cross-case synthesis statement. Feedback from the second interview informed the final cross-case statement regarding how the participating resident physicians understood the nature of physician leadership from their lived experiences in GME.

Data Reporting

Along with outlining an approach to data analysis, reporting the data is a critical aspect of phenomenology to illuminate the depth and complexity of phenomena (Halling, 2002; Holloway & Galvin, 2017). Strategies to assist with data reporting are detailed below.

Reporting of data is a key component to the descriptive phenomenological process (Finlay, 2009, 2015; Halling, 2002). Similar to the perspective that research methods should consider the potential audience of the research (Creswell, 2014), Finlay (2015), and Halling (2002) supported the approach that data reporting in phenomenology should also be cognizant of the audience. Therefore, (a) I included pertinent excerpts from critical self-awareness and suspension from my reflexive journal, (b) I established an audit trail (Lincoln & Guba, 1986) to document research decisions (Creswell, 2014) in a research journal, and (c) I incorporated visual representations to report significant statements and themes (Colaizzi, 1978; Creswell, 2007).

It is also important in phenomenological inquiry to produce "richly descriptive" (Merriam & Tisdell, 2015, p. 37) data to bring the audience into the lived experiences of the participants and to convey "what it is for someone to experience that" (Polkinghorne, 1989, p. 46). With the intent to draw the audience into the lived experiences of the participants, not only did the individual and cross-case synthesis statements and subsequent findings adhere to the accounts of participants in agreement with descriptive phenomenology; I also included word-for-word examples to craft a rich and thick description (Creswell, 2007). It is important to reiterate that the cross-case synthesis statement of the essence, or nature, of physician leadership should not be considered universal but should be considered as shared aspects drawn from "a particular time and place from the vantage point of an individual" (Moustakas, 1994, p. 100). Over all, one goal of data reporting is to present a phenomenological study that offers an organized, critically transparent, and richly naturalistic (Lincoln & Guba, 1986) exploration of a shared nature of the phenomenon of physician leadership.

Quality Criteria

To address concerns regarding quality in qualitative/naturalistic and constructivist inquiry, Lincoln and Guba (1985, 1986) proposed the criteria of trustworthiness and authenticity. Trustworthiness includes (a) credibility, (b) transferability, (c) dependability, and (d) confirmability (Lincoln & Guba, 2013; Nelms, 2015). Authenticity includes (a) fairness, (b), ontological, (c) educative, (d) catalytic, and (e) tactical, seeking to enhance the quality of the study. Trustworthiness and authenticity are listed in Table 8, along with strategies to satisfy each criterion outlined in the following subsections.

Trustworthiness

Credibility. This criterion refers to confidence in the data and interpretations in a study (Lincoln & Guba, 2013) and "how research findings match reality" (Merriam & Tisdell, 2015,

Table 8

The Quality Criteria of Trustworthiness and Authenticity

Criterion	Strategies
	Trustworthiness
Credibility	Peer review, member checking
Transferability	Word-for-word examples, thick description
Dependability	Audit trail in research journal
Confirmability	Critical awareness and suspension in reflexive journal, disclose perspective and positionality
	Authenticity
Fairness	Informed consent, member checking, audit
Ontological	Disclosing perspective and positionality, reflexive journal, participant feedback
Educative	Review cross-case synthesis statement, include pertinent literature
Catalytic	Semistructured interviews, returning to cross-case synthesis statement, voice of underrepresented population
Tactical	Inclusive posture of inquirer, participants as co-researchers

p. 242). However, an assumption of the constructivist paradigm is that there are multiple realities. Matching findings with reality is unveiling not a singular reality but rather the multiple realities of the participants, which is perceived as not fully attainable (Merriam & Tisdell, 2015). Thus, trustworthiness suggests determining whether the findings are credible based on the data.

Peer review and member checking are two strategies to ensure credibility (Lincoln & Guba, 2013). Peer review involves submitting data to a professional peer to determine whether the findings are based on the data and to "keep the inquirer honest" (Lincoln & Guba 1986, p. 19). I submitted my reflexive journal to the dissertation committee chair prior to (a) the first round of interviews, (b) data analysis, and (c) the second round of interviews, and (d) after the

construction of the final cross-case synthesis statement. I also submitted my research journal periodically to test construction of meaning units and themes in data analysis, such as in the stage of unitization. Member checking seeks feedback from participants regarding findings (Lincoln & Guba, 2013; Patton, 2015). In this study, member checking was conducted in the fourth (thematic clustering and descriptions) and final (confirmation) stages of data analysis. As an example of member checking, I returned the cross-case synthesis statement to participants in the last stage of data analysis and refined it based on participant feedback. Peer review and member checking in two stages of analysis served as two specific actions to address the criterion of credibility.

Transferability. Transferability is the relevance of findings to different contexts or participants (Lincoln & Guba, 2013). Transferability points to extrapolating findings from a study that could be relevant to other settings. "Extrapolations are modest speculations on the likely applicability of findings to other situations under similar, but not identical, conditions" (Patton, 2002, p. 584). The determinant of relevance in transferability lies with "those who want to apply the findings and interpretations" (Lincoln & Guba, 2013, p. 104). A detailed account of participants' lived experiences of a phenomenon is essential for determining transferability; a common strategy is rich and thick description (Merriam & Tisdell, 2015). This strategy requires a meticulous presentation of the context, participants, and findings. In this study, criterion-based participant selection and an interview guide were utilized in data collection. Including word-for-word examples from participants' transcripts in data analysis, the final statement, and reporting enhanced transferability through providing rich and "thick description" (Lincoln & Guba, 1986, p. 19) and elevated the lived experiences of participants.

Dependability. Meticulous presentation of context, participants, and findings, along with word-for-word examples from transcripts, promotes transferability but also folds into dependability through helping external audiences to assess whether the results and data are consistent. The trustworthiness criterion of dependability is concerned with "whether the results are consistent with the data collected" (Merriam & Tisdell, 2015, p. 251). This perspective suggests that the external audience also determines that the results make sense, or are dependable, based on the data, not whether the findings could be replicated. I utilized a research journal to capture memos relating to data collection, analysis, and findings (Lincoln & Guba, 1986, 2013). These memos served as a trail of research decisions and noted aspects such as data collection, construction of meaning units, and decisions on clustering themes; they were submitted to the dissertation chair or designee for auditing. In short, the audit trail assisted with illustrating how I came to the results of the study.

Confirmability. Confirmability is "how the findings and interpretations are a result of a dependable process of inquiry as well as data collection" (Lincoln & Guba, 2013, p. 105). Strategies such as a reflexive journal are designed to satisfy confirmability (Lincoln & Guba, 2013; Patton, 2002). The reflexive journal is a powerful tool for a descriptive phenomenological study because it is a "means for coming to know the human as instrument, and for bringing to light prior constructions" (Lincoln & Guba, 2013, p. 57). By returning to the reflexive journal to document critical awareness of prior interpretations and suspension, I intended to confirm a dependable process that could be reviewed by peers.

Authenticity

Trustworthiness parallels the criteria of rigor in conventional paradigms (Lincoln & Guba, 1986). Due to constructivist assumptions (e.g., multiple realities, constructed knowledge), authenticity was developed as quality criteria specifically suited for naturalistic inquiry (Guba &

Lincoln, 1994; Lincoln & Guba, 1986; Patton, 2002). The authenticity criteria are (a) fairness, (b), ontological, (c) educative, (d) catalytic, and (e) tactical, defined below, along with strategies aimed at meeting each criterion.

Fairness. The overarching goal of fairness in authenticity is to offer a "balanced view that presents all constructions and the values that undergird them" (Lincoln & Guba, 1986, p. 20). Fairness is achieved through such strategies as informed consent, member checking, and auditing (Lincoln & Guba, 2013). Informed consent (physical or verbal) was secured prior to conducting interviews but was reaffirmed specifically prior to the second interview (Lincoln & Guba, 1986). Member checking was detailed in the previous subsection on trustworthiness. I constructed shared individual textural and structural descriptions in the fourth stage (thematic clustering and descriptions), which was specifically designed to satisfy fairness. My reflexive and research journals were submitted for review.

Ontological. The first criterion is that of ontological authenticity. This criterion seeks to determine the extent to which participants, including the inquirer, have become more informed about their own constructions (Guba, 1990; Lincoln & Guba, 1986). Strategies to satisfy this criterion included disclosing perspective and positionality, insight into the researcher's own growth, and reflection on final constructions (Lincoln & Guba, 2013). I satisfied ontological authenticity by first detailing my perspective and positionality below but also verbally to the participants. My reflexive journal documented reflections on the research process, alongside critical awareness of and suspension of prior interpretations. Second, returning the individual textural-structural statements and the cross-case synthesis statement to the participants offered them the opportunity to reflect on the co-constructions.

Educative. Educative authenticity is intended to ensure that all stakeholders are "'educated' in the variety of perspectives and value systems that exist" (Lincoln & Guba, 1986, p. 23). I addressed educative authenticity through taking the constructed cross-case synthesis statement back to participants during the second interview in the last stage of data analysis (confirmation), not only for review but also for feedback to serve as evidence of this criterion (Lincoln & Guba, 2013). The cross-case synthesis statement was crafted from the data from all participants; therefore, participants had an opportunity to learn from each other, rather than being limited in feedback solely on their own descriptions. The findings were informed by data from the participants but also including pertinent literature to develop a more "complex construction" (Lincoln & Guba, 1986, p. 23) of the nature of physician leadership.

Catalytic. Determining the degree to which action, defined as "clarifying focus on an issue, moving to eliminate or ameliorate the problem, sharpening values" (Lincoln & Guba, 2013, p. 70), is influenced is referred to as catalytic authenticity. Approaches to satisfying this criterion include crafting a joint construction, final report to participants, and practical applications (Lincoln & Guba, 2013). I satisfied catalytic authenticity by (a) semistructured interviews that allowed participants to help in directing dialogue, and (b) returning the cross-case synthesis statement to participants for feedback. The findings offered a voice to resident physicians, an underrepresented population in the literature on physician leadership.

Tactical. The last criterion is tactical authenticity, which serves to assess whether the study empowers participants and the inquirer (Lincoln & Guba, 1986). Tactical authenticity is accomplished by engaging participants in the research process. I met this criterion by engaging participants with an inclusive posture that identified them as participants who helped to shape the research process through semistructured interviews and feedback on the cross-case synthesis

statement. The criterion was also met through open-ended interview questions that promoted "dialectical conversations" (Lincoln & Guba, 2013, p. 71), in addition to feedback that informed the final cross-case synthesis statement.

The quality criteria discussed above were intended to enhance the study. By utilizing strategies to satisfy trustworthiness and authenticity, I offered a dependable and fair study that is informative not only to the participants but also to my own understanding of and the literature on physician leadership.

Researcher's Perspective and Positionality

As the primary instrument for data collection and analysis, it is important for me to disclose any assumptions and biases that may have affected the study (Merriam & Tisdell, 2015). I am a male who has served in such positions in UME as Coordinator, Director, and Assistant Professor at nonprofit and for-profit medical schools since 2009. I currently serve as faculty and administrator in a college of medicine at a public university. From teaching leadership theory to collaborating with various academic and administrative departments, I interface with physicians from various specialties and leadership roles. Based on my experience in working in UME, an assumption was made that physician leadership is a complex and contextually sensitive phenomenon. Through the literature, conversations, and professional conferences, I hold a bias that, although physician leadership is a topic that surfaces repeatedly, it does not appear to be adequately understood within medical education, as the literature points back to historical approaches and theories from other fields or sectors (e.g., corporate).

After completion of a graduate degree in higher education administration in 2009, I served in an offshore international medical school. Serving in a joint faculty and administrative role provided opportunities to interact with physician leaders from various countries and at various levels of leadership. Following this opportunity, I assumed a director-level position at a

medical school in the central United States, which placed me on the administrative side of operations; however, I continued to serve with faculty on various committees and initiatives.

During my time as a director, I had an encounter with a surgeon who was well known in the region for excellent surgical skills and who was eventually appointed chair of an academic department. Our initial interactions were cordial and eventually became friendly as I stopped by his office unannounced to socialize or to discuss administrative issues. One afternoon in late spring, I dropped by his office to discuss administrative issues. Our conversation turned to the topic of physician leadership and how he defined it. In a soft, yet commanding, voice he eloquently stated that leadership is about taking charge and directing others toward a goal. His articulate and concise response communicated a firm conviction and allegiance to his interpretation. From interactions such as this, I questioned whether physician leadership could be more complex and could vary according to contexts, such as a classroom in medical school, a clinic in a residency program, or an operating room. Conversations with other physicians highlighted more egalitarian approaches to physician leadership and supported my curiosity.

I am the spouse of a female family medicine physician who graduated from medical residency in 2018. Thus, I also consider myself an outsider because I do not know what it means to be a resident physician. Her experience in GME prompted my exploration of the family medicine specialty. Her making meaning of her lived experience as a medical student and resident physician also informed my perspective of medical education and physician leadership. In short, my initial understanding of being a resident physician and physician leadership in GME was filtered through the lens of her lived experience.

My professional career and my spouse provided insider and outsider status with regard to medical education and physician leadership. In reference to data collection, I recognize that

serving on faculty at a college of medicine may be perceived as a power dynamic with the participants. However, to resolve this, I disclosed my professional role and communicated the division between my roles as faculty, administrator, and doctoral student. My perspective was also influenced by the constructivist paradigm. I recognize that realities, including my own, are constructed (Guba, 1990) and sociohistorically relative (Schwandt, 1998); therefore, it is important to view this study as exploratory rather than definitive.

I acknowledge that my various roles in reference to medical education afforded me insider and outsider perspectives and shaped my assumptions about physician leadership. These roles provided an opportunity to gain insight into the structures, norms, and behaviors of faculty, administrators, resident physicians, and medical students in the field of medical education. The value of my roles is that I had the opportunity to view physician leadership being enacted by various people in formal leadership positions and to engage leaders in dialogue about physician leadership. Therefore, my professional roles and as a spouse of a physician situated me well to study the phenomenon of physician leadership by engaging the various perspectives from which physician leadership is enacted or understood.

Chapter Summary

This chapter described the research purpose, central question, inquiry paradigm, design, methodology, methodological approach, and methods to conduct the study. The purpose of the study was to explore the nature of physician leadership for family medicine resident physicians from lived experiences in GME. To accomplish this purpose and address the research question, I (a) situated this study in the constructivist paradigm, (b) selected a qualitative design utilizing two rounds of semistructured interviews to collect data, (c) identified phenomenology as the methodology and descriptive phenomenology as the methodological approach, and (d) constructed an integrated approach to data analysis based on Moustakas (1994) and Colaizzi

(1978). To address quality issues, trustworthiness and authenticity criteria were applied. Detailing my perspective and positionality served to establish a critically aware and transparent attitude for the research process and was in agreement with qualitative research and descriptive phenomenology.

CHAPTER 4

THE NATURE OF PHYSICIAN LEADERSHIP

FOR SIX RESIDENT PHYSICIANS

This chapter presents the findings of this study on the nature of physician leadership as described by, and co-constructed with, the six participating family medicine resident physicians. Part I outlines individual descriptions of the nature of physician leadership. Next, textural descriptions, or *what* was experienced, with regard to physician leadership are stated, followed by structural descriptions of *how* physician leadership was experienced. Textural (what)-structural (how) synthesis descriptions are utilized to construct the nature of physician leadership from the sociohistorically (Schwandt, 1998) relative perspective of each participant as stated in textural-structural (nature) statements depicted in Figure 4.

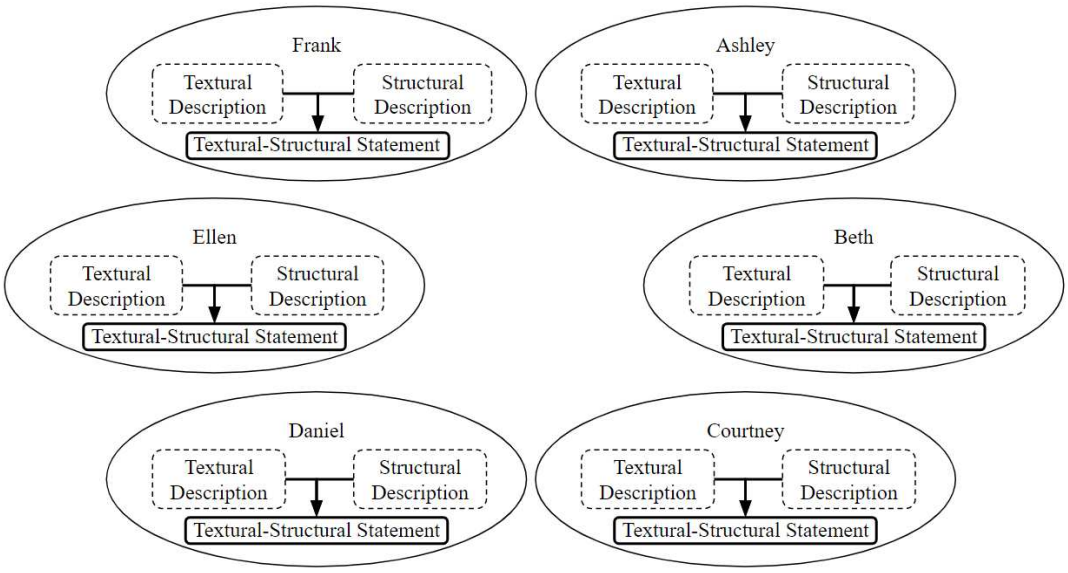

Figure 4. Individual descriptions and statements of physician leadership.

Part II presents respective composite, or shared, textural and structural descriptions that were constructed based on analysis of the entirety of the data set and informed by shared aspects from each participant's individual textural (what) and structural (how) descriptions in Part I. To address the central research question for the study (*How do family medicine resident physicians describe and experience the nature of physician leadership?*), a shared textural-structural (nature) cross-case synthesis statement is constructed across the data as shown in Figure 5.

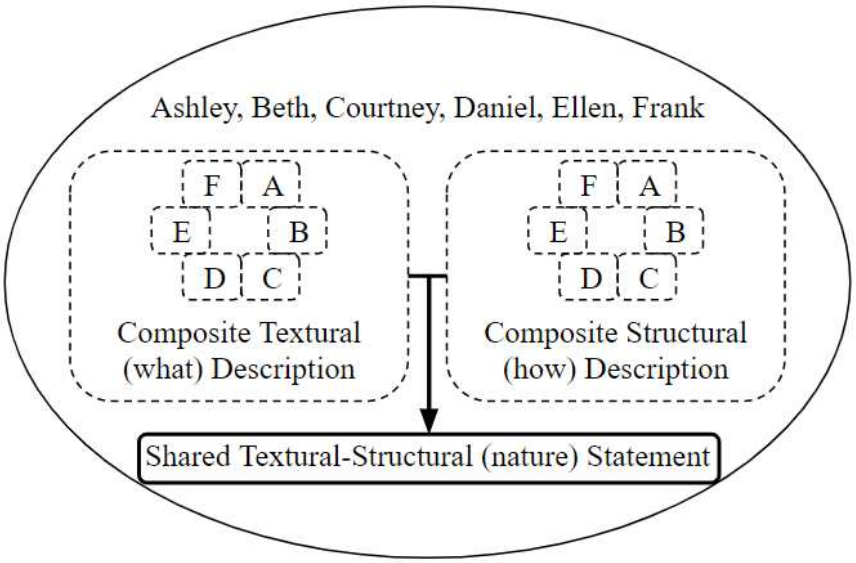

Figure 5. Composite descriptions and shared textural-structural statement.

This co-constructed textural-structural synthesis statement details the *nature*, or "essential structure" (Holloway & Galvin, 2017, p. 234), of physician leadership as perceived by participants at "a particular time and place from the vantage point of an individual" (Moustakas, 1994, p. 100). Visual representations are utilized in alignment with MacTaggart (2018) and Senge (2006) to support the findings presented in this chapter. However, the visual representations are utilized to depict findings rather than to guide analysis. The participants were assigned the following designations and pseudonyms: (a) Participant A for Ashley, (b)

Participant B for Beth, (c) Participant C for Courtney, (d) Participant D for Daniel, (e) Participant E for Ellen, and (f) Participant F for Frank. The designation of "participant" in citations enabled auditing to track statements back to the spreadsheet response line, noted with an "R" instead of a page number in the transcript.

Part I: Individual Descriptions of the Nature of Physician Leadership

Focusing on the individual descriptions of the phenomenon of physician leadership through the lived experiences of the participants in GME aligns with the guiding constructivist paradigm by upholding the multiple realities of the participants (Guba, 1990; Schwandt, 1998). Although at the time of data collection, the participants were situated in a medical residency within the larger educational context of GME for their training, they also drew on prior experiences to inform their descriptions. The participants (a) were family medicine resident physicians engaged in the medical specialty of family medicine, (b) did not hold formal leadership roles (i.e., nonleaders) in their respective residency programs (e.g., chief resident), and (c) had completed at least 1 year of GME in their residency programs.

Individual descriptions are presented in this chapter utilizing the participants' pseudonyms as stated above, which were selected to protect anonymity and mitigate risk. At the time of the first interview, Ashley and Daniel were in medical residency. At the time of the second interview, both had graduated from medical residency. They were included in this study because the questions for the second interview focused on how their individual textural-structural (nature) statements, constructed from data collected during the first interview, did or did not resonate with their understanding of physician leadership.

In reporting the findings, I first describe the lived experiences of each participant through individual textural (what) and structural (how) descriptions. To conclude each participant's

section, the nature of physician leadership, as described through in-case textural-structural (nature) synthesis statement, is presented.

Ashley

Ashley had served in leadership roles prior to medical residency, including President of her high school class. She did not elaborate on this experience, but mentioned a time during high school at church when a preacher stated that not everyone can be leaders. "I thought I was a leader until I realized I didn't have all those qualities that I think a leader should have" (Participant A, 2019, R10). Ashley initially framed her lived experience of physician leadership prior to medical residency as skills that she did not naturally have. However, her role as a nonleader resident physician afforded her opportunities to learn from formal leaders. Her textural description of physician leadership follows the subsection on analysis.

Analysis. It is important to discuss the analysis process to aid with describing Ashley's perspective of physician leadership. Applying an integrated approach to data analysis based on Colaizzi (1978) and Moustakas (1994), for Ashley's data and all of the participants, resulted in constructing five textural (what) themes, as shown in Figure 6, from the interview with Ashley.

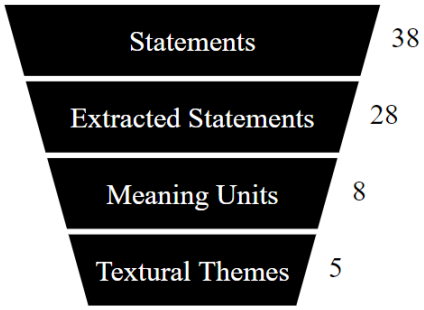

Figure 6. Analysis process and totals for each stage toward a textural description for Ashley.

To arrive at Ashley's textural (what) themes, I first pasted the transcribed first interview into a secured online spreadsheet (i.e., GoogleSheets) and extracted "phrases or sentences that directly pertain to the investigated phenomenon" (Colaizzi, 1978, p. 59). To determine whether a phrase or sentence pertained to the phenomenon, I followed Colaizzi (1978), Moustakas (1994), and MacTaggart (2018) and asked whether content (a) was directly relevant to describing physician leadership as experienced by the participant, and (b) helped me to understand physician leadership as experienced by the participant. For example, Ashley stated, "I think of leadership as being able to like influence others, I guess" (Participant A, 2019, R2).

Thirty-eight statements were identified from the transcript. Irrelevant, repetitive, or overlapping statements were set aside. This part of the analysis process resulted in 28 extracted statements for further analysis. These 28 extracted statements were copied and pasted onto individual digital note cards in the online software platform SuperNotecard (SuperNotecard.com, 2019) and secured with a password. SuperNotecard enabled me to move the note cards on a screen and label them. After reading through the note cards twice, I constructed eight meaning units (Table 9) based on shared aspects among the extracted statements (Edward & Welch, 2011; Moustakas, 1994). The meaning units constructed were (a) behaviors, (b) important to know right now, (c) influence, (d) knowledgeable, (e) perception, (f) specialties, (g) traits, and (h) role. After another iteration of reading the note cards, five textural themes were constructed: specialty-based variances, actions, abilities, personal characteristics, and physician's role.

The ensuing eight meaning units were grouped based on shared aspects from among the extracted statements. For example, the behaviors meaning unit was constructed based on aspects within the statement that spoke to the behaviors of leaders, such as showing care by asking how the participant was doing or by following up on a request without the participant asking.

Table 9

Meaning Units and Textural Themes From Ashley's First Interview

Meaning units	Inform →	Textural themes
Role Perception		Physician's role
Specialties		Specialty-based variances
Influence Traits Perception Important to know right now		Personal characteristics
Behaviors Role Perception		Actions
Influence Knowledgeable		Abilities

These meaning units were also not categorically confined to a textural (what) theme; there was some crossover between constructed themes. For example, Ashley spoke about a physician in a formal role as a leader who "makes decisions, people who obviously I mean lead another group of people" (Participant A, 2019 R2) but also the role of a physician as an informal leader due to their desire to help peers. Although role is described in both instances, the focus is on a formal role versus specific altruistic actions that shape a perceived role; thus, the overlap among meaning units and connection between textural themes.

I grouped the eight meaning units into five textural (what) thematic clusters, or themes: (a) physician's role, (b) specialty-based variances, (c) personal characteristics, (d) actions, and (e) abilities. For specialty-based variances, I observed that Ashley noted variations in her perceptions of the leadership capabilities/perceptions between specialties such as family

medicine or surgery. She also spoke of specific actions by the chief resident. For abilities, Ashley spoke of various abilities, such as seeing other perspectives, or being knowledgeable. Last, for physician's role, Ashley spoke about perceptions of those in formal authority above her, as well as her general perspective of the physician's role prior to, and while in, residency.

Textural (what) description. Ashley's textural description and inherent textural themes are visually presented in Figure 7. This description discusses what was experienced by Ashley with regard to physician leadership.

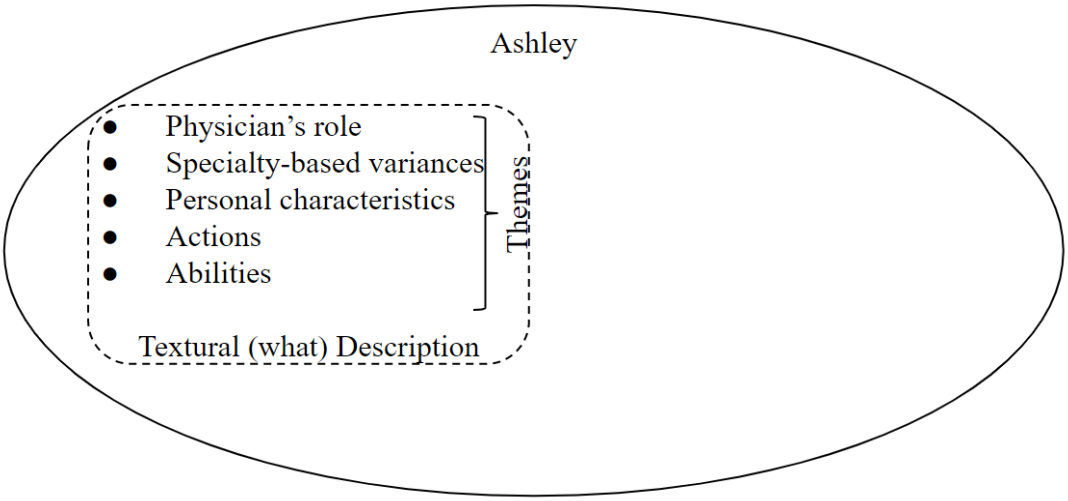

Figure 7. Ashley's textural (what) themes constituting her textural description.

After engaging Ashley in a reflective exercise about previous examples of leadership, Ashley stated that she had "always thought of leadership as just like the people who make decisions" (Participant A, 2019, R2). Her perspective of the authoritative physician's role and decision-making aspect were echoed in descriptions of how physicians are leaders to their peers when assuming formal roles, such as running a hospital or political advocacy. Conversely,

Ashley stated that a physician is also a leader to patients "because of the position that I [she] hold[s] with patients" (Participant A, 2019, R22).

Ashley was keenly aware of specialty-based variances in ways in which physicians lead. "Surgery just comes to mind, as being more of an aggressive, and certainly thicker-skinned, able to take more criticism, if you will, than I guess family medicine" (Participant A, 2019, R52). These variances were more fluid than definitive. Personal characteristics of physician leaders, such as sense of authority and likeability, were marks of what Ashley considered as good leadership. The actions and abilities of physician leaders particularly influenced Ashley's understanding of physician leadership to peers and patients. The authentic actions of physician leaders communicated care to her.

In relation to peers, Ashley said, "The simple fact that we want to be felt we're cared about, and that we're heard. Those here are the leaders that are the people above me that have made the biggest influence on me" (Participant A, 2019, R28).

Ashley focused on knowledge and influence as abilities. Whether knowledgeable of an aspect of medicine, other perspectives regarding organizational decisions or an idea, knowledge affected a physician's ability to influence others. "And so I just think of people who are leaders, like they're able to influence through, whether you know hopefully not popularity, but sometimes it is popularity. And sometimes it's knowledge" (Participant A, 2019, R12).

Structural (how) description. The structural description outlines how a phenomenon was experienced. Moustakas (1994) described the themes that constitute the structural description as the "underlying and precipitating factors that account for what is being experienced" (Moustakas, 1994, p. 98). In reviewing Ashley's transcript, textural (what) themes, and textural description, the structural (how) themes that were constructed from the textural

description and reflected *how* she experienced physician leadership. Ashley's experience of physician leadership was bound by the structural themes of (a) patient experiences, (b) peer influence, and (c) rotations in residency. These themes were constructed from the comments about being a leader to patients and showing care to patients based on role modeling. Also, prior experiences with rotations in residency informed her perspective of other specialties.

The following is Ashley's structural (how) description (Figure 8). This description discusses how physician leadership was experienced by Ashley.

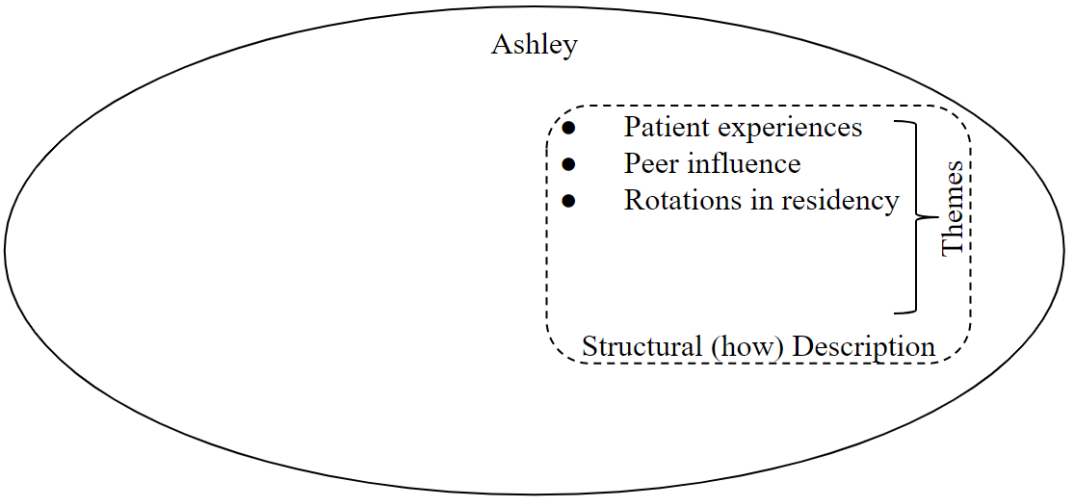

Figure 8. Ashley's structural (how) themes constituting her structural description.

Ashley reiterated the impact of patient experiences to her understanding of leadership. Her ability as a physician to affect the patient's well-being was particularly powerful—specifically, the desire of one patient to wait until Ashley was in the clinic to seek care for a broken arm. She spoke about the importance of peer influences in showing care to her which, in turn, she attributed to her emphasis on showing care to patients. The care shown to Ashley by peers was reciprocated by Ashley to peers and patients. Through specialty rotations in residency,

Ashley constructed an understanding of how physicians, or settings, may differ. She also crafted a perspective of physician leadership to aid her in determining what settings and with what types of physician leaders she was most comfortable.

Textural-structural (nature) statement. Holloway and Galvin (2017) defined the textural-structural statement as a statement that describes the "essential structure" (p. 234) of a phenomenon. Moustakas (1994) referred to this description as "essence" (p. 55), or in this study, the *nature*. In short, the textural-structural (nature) statement integrates the *what* and the *how* the phenomenon of physician leadership was experienced by Ashley.

To construct each participant's textural-structural statement, I reviewed the participant's textural and structural descriptions and themes in the online software and in the research journal. I noted rationale for the construction of the textural-structural statement in my research journal. For example, what was apparent for Ashley was her understanding of physician leadership derived more from peers and patients than physician leaders in formal roles. This perspective could be based on Ashley's negative experiences with leaders in formal roles. Ashley's textural (what) and structural (how) themes that assisted with constructing her textural-structural (nature) statement are displayed in Figure 9.

The following is Ashley's textural-structural (nature) statement. From Ashley's lived experience, she noted that peers and patients influenced her description of physician leadership. Authentic actions, perceived abilities, and personal characteristics of Ashley's peers offered insight into what a leader does and who a leader is. For example, Ashley stated that, when upper-level peers in roles of authority (e.g., chief residents) displayed authentic care about who the resident physicians are and their input, the leader figure is perceived to be invested in Ashley's personal well-being and perspective.

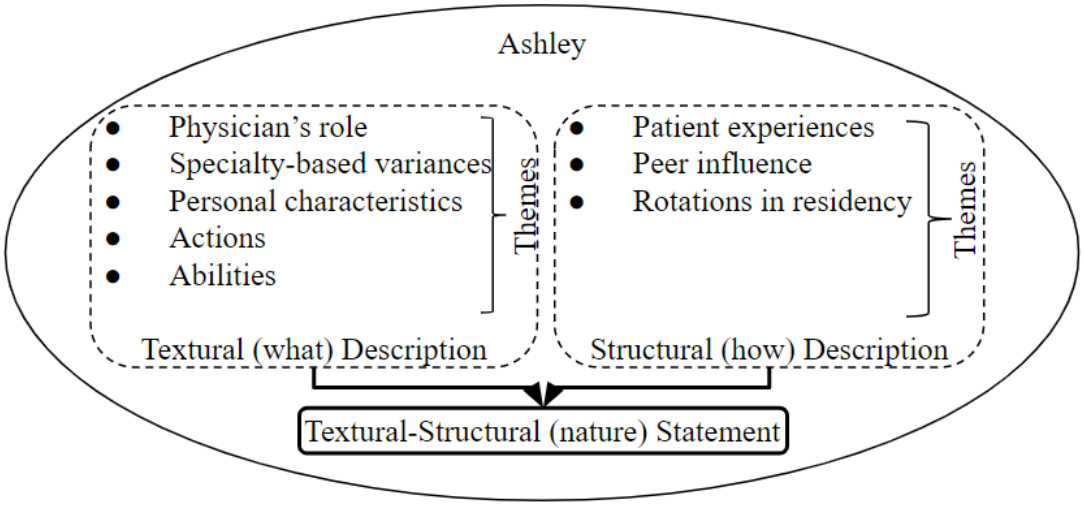

Figure 9. Ashley's textural and structural themes constituting her textural-structural statement.

> They didn't just say "I'm always available," they didn't say "Hey, my door is always open," because that's very commonly said amongst leaders, "My door is always open, come in any time." But when you went into that door, so to speak, it felt like they were engaged and cared about what I was telling them. (Participant A, 2019, R14)

Personal characteristics, such as knowledge of such aspects as, but not limited to, clinical topics or issues, are pivotal because the clinical knowledge influenced Ashley and others to abide by the leadership of that physician leader.

Ashley said that, when peers in formal roles have the ability to balance a sense of authority with likability, they are more effective. Moreover, through patient experiences, Ashley is aware that the physician's de facto role of directing patient care, is not fully considered but is recognized:

> I mean, you can broadly speak, and I definitely had an understanding of this before I came to medicine, that just by being a physician, before I was ever a doctor, you like revered doctors as this, you know, like every doctor is technically a leader, because to each of their patients. (Participant A, 2019, R20)

By rotating through specialties in residency, Ashley was made more aware of specialty-based variances in ways that people lead. "If I compare surgery, and I compare pediatrics, the

personality types are very different" (Participant A, 2019, R50). These experiences assisted Ashley with not only deriving an understanding of what settings are more comfortable for her but also what types of leaders she might respond well to, as well as how physician leadership might be perceived by those she considers to be physician leaders.

Reflecting on Ashley's lived experience of physician leadership as described above in the preceding statement, she had a primarily negative perception of those in formal leadership roles. Due to this emerging aspect, it was important in my role as the research instrument to become critically aware of my prior interpretations before and during analysis. One of those prior interpretations, retrieved from my reflexive journal entry on March 22, 2019, included my prior perception about physicians in formal leadership roles:

> Prior to constructing the textural description for Participant A, it is important that I name a previous perception about physician leaders. My previous perception is that they [physician leaders] do not understand, or rarely have experience with, effective leadership. In my view, they are oftentimes thrust into positions of leadership based on willingness or skill-based power in that they are perceived to be excellent at something (e.g., pathology) and therefore they must be a good leader in a different realm (e.g., department head in academia).

Although this was a prior interpretation, I named it to enhance critical awareness of my interpretations and assumptions.

Beth

Prior to Beth's time as a second-year resident physician, she served as Vice-President of a student organization in medical school and competed in beauty pageants. She noted that, in her role in beauty pageants, she was responsible for selecting a charity and advocating on the charity's behalf. She selected a charity that served children and stated that this experience in particular helped her to understand leadership and working with various personalities:

> I mean, within the individuals in which I'd interact with at different levels, so people in much higher positions than me, different backgrounds than me, there's just this sense,

> you know, having to learn and understand those individuals in a way in which you can really collaborate. (Participant B, 2019, R12)

Beth also mentioned a specific faculty member in medical school who advocated for rural medicine. This faculty member was a fervent champion for rural health and encouraged Beth to pursue additional education to enhance her understanding of various populations in rural health care that she might serve as a physician. Beth described her experiences in beauty pageants and medical school as informing her perception of physician leadership.

Analysis. Analyzing Beth's data resulted in four themes constructed from 33 statements, 25 extracted statements, and six meaning units, as shown in Figure 10.

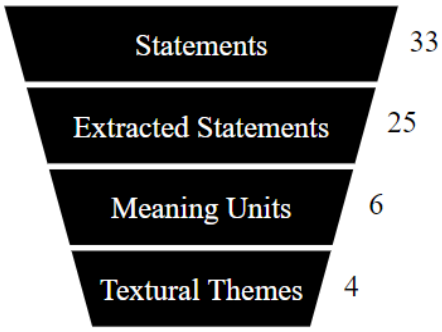

Figure 10. Totals for each component of analysis toward a textural description for Beth.

The constructed textural (what) meaning units were (a) advocating, (b) care, (c) transparency, (d) trustworthy, (e) understanding followers, and (f) understanding of leadership. The six meaning units informing the four textural (what) themes are shown in Table 10. Examples of how the meaning units and themes were constructed are provided below.

For example, the advocating meaning unit was constructed based on Beth's description of a former formal leader exhibiting the characteristic of advocacy for a type of focus in family medicine (i.e., rural). Transparency was a unit as Beth discussed the importance of transparency

Table 10

Meaning Units and Textural Themes From Beth's First Interview

Meaning units	Inform →	Textural theme
Advocating Care Trustworthy Understanding of leadership		Patients
Advocating Understanding of leadership		Profession
Understanding of leadership Transparency Trustworthy		Being
Advocating Transparency Trustworthy Understanding followers Understanding of leadership		Knowing

in leadership as she did not feel, from lived experiences in GME, that those in formal leadership roles above her were transparent. Care was constructed based on the quality of care being exhibited by physicians to patients.

An example of meaning units crossing textural themes for Beth related to advocating. First, she stated, "I feel like family physicians are often the ones that are advocating very strongly for their patients" (Participant B, 2019, R58). Beth noted that family medicine physicians should advocate for the medical profession, specifically family medicine, by championing resources to rural areas. She shared that physician leadership is about the physician leader hearing and valuing followers. "I personally just feel like I'm not heard, and so I feel like that's been one of the experiences that's really pushed me to be like this is what I view leadership as" (Participant B, 2019, R46).

Beth's four textural (what) themes are (a) the patients, (b) the profession, (c) being, and (d) knowing. Beth described physician leadership as caring for patients, whether one on one or advocating for the patient's best interests. The physician sacrifices to care for their patients. When describing physician leadership with regard to the profession, Beth spoke specifically about advocating for the profession, whether that is rural medicine or the overall specialty of family medicine. This focus was heavily grounded in experiences in medical school and interactions with a formal leader. Beth also spoke about passion and the need to be heard in residency as influencing her description of physician leadership. For Beth, physician leadership was reflected in phrases and statements about *being* transparent, being someone who values followers, is trustworthy, or is a leader who can develop a sense of camaraderie among peers. Knowing what physician leadership is was described primarily in terms of situations. Feeling that she was not heard influenced her understanding of physician leadership in knowing that a leader is someone who hears and values followers. Other aspects included knowing goals, knowing followers, and knowing the expectations of followers.

Textural (what) description. The following is Beth's textural description. This description discusses what was experienced by Beth with regard to physician leadership. The themes informing Beth's textural description are depicted in Figure 11.

As with Ashley and subsequent participants, I asked Beth to engage in a reflective exercise, which is described in the data collection guide (Appendix B). After doing so, Beth described physician leadership with regard to patients, the profession, being a physician leader, and knowing about physician leadership. She also described physician leadership in terms of caring for patients and advocating on their behalf. "I feel like family physicians are often the ones that are advocating very strongly for their patients" (Participant B, 2019, R58). This care

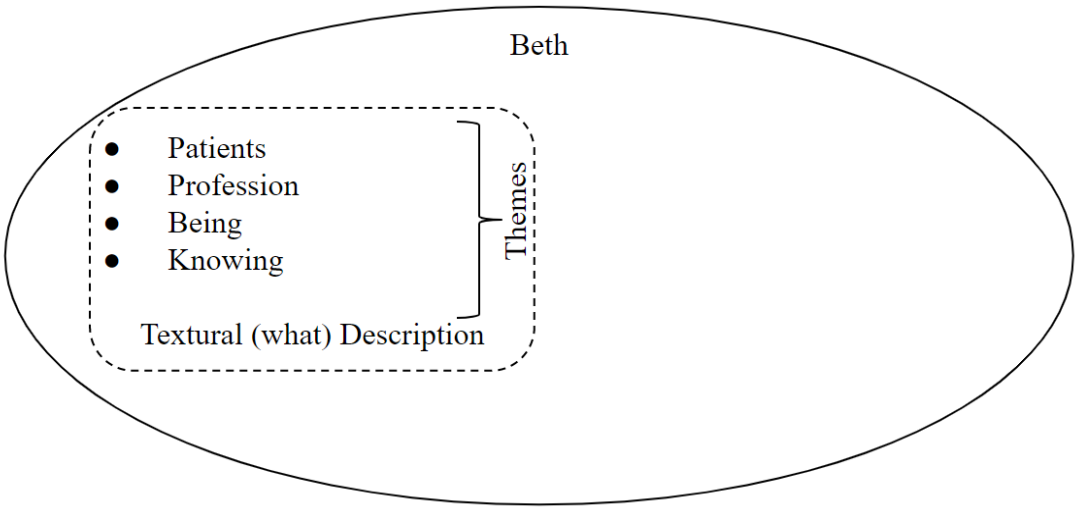

Figure 11. Beth's textural (what) themes constituting her textural description.

and advocacy aided in building trust with the patient. When asked about the care and physician leadership, Beth responded,

> So I think there's just that innate leadership quality with the understanding that we're going into this profession because we want to help people, we want to take care of people, and we're willing to sacrifice a lot to do that. (Participant B, 2019, R64)

Regarding the specialty of family medicine, Beth recalled an experience with a faculty physician in medical school who advocated for rural medicine. She described the impact of this faculty physician on her perspective of physician leadership as the physician was passionate. She commented, "Passion is a big part of leadership, because you cannot be a leader if you're not passionate about what you're leading" (Participant B, 2019, R50). In addition, Beth reported that she had felt unheard through her experiences in GME and therefore advocated for changes to policy. Advocating on behalf of the patients and the profession is important to Beth. "A true leadership role is advocating on behalf of what you believe in order to further improve the specific career you're a part of, whether it be medicine or accounting" (Participant B, 2019, R14).

Beth also emphasized aspects of a physician leader. To Beth, being a physician leader meant being someone who had integrity, was trustworthy, was transparent, and could develop a sense of camaraderie among followers. According to Beth, building trust occurred partly through being transparent and having integrity.

> Those things are so important, and I think that's why I feel like transparency is so important, because we don't want to feel like we weren't considered in the decision-making, because we should be a part of that. We don't want to feel like we're just an afterthought, and it's not going to affect us, because it does affect us. (Participant B, 2019, R36)

Transparency builds trust, which Beth considered to be critical "because you want those people in which you're leading to understand why you're making decisions" (Participant B, 2019, R18).

Beth described physician leadership in terms of knowing about specific aspects of leadership. For example, she stated that physician leadership is about knowing how to handle certain situations, knowing expectations and goals, and knowing the followers. Beth focused on understanding followers; she commented, "One of the biggest things is understanding the population in which you're trying to lead, right? Because not everybody may have the same viewpoints in regards to what they perceive a leader to be" (Participant B, 2019, R36). Knowing these viewpoints and expectations helps physician leaders to lead effectively. "There's just this sense, you know, having to learn and understand those individuals in a way in which you can really collaborate" (Participant B, 2019, R12).

Structural (how) description. Aligning with the integrated approach to data analysis, and as with all participants, I returned to Beth's transcript, textural (what) description, and textural themes to construct structural themes for a structural (how) description.

The first structural (how) theme constructed from Beth's textural description was the impact of a formal leader who was a faculty physician in medical school/UME. This faculty physician appeared to influence her in many aspects regarding advocating and being transparent.

Beth's current lived experience in GME also appeared to contribute to feelings of not being heard and a lack of transparency, thus cultivating feelings of being devalued—the second structural theme. The formal leader in UME and not being valued were Beth's two structural themes. The following is Beth's structural description. This description discusses how physician leadership was experienced by Beth (Figure 12).

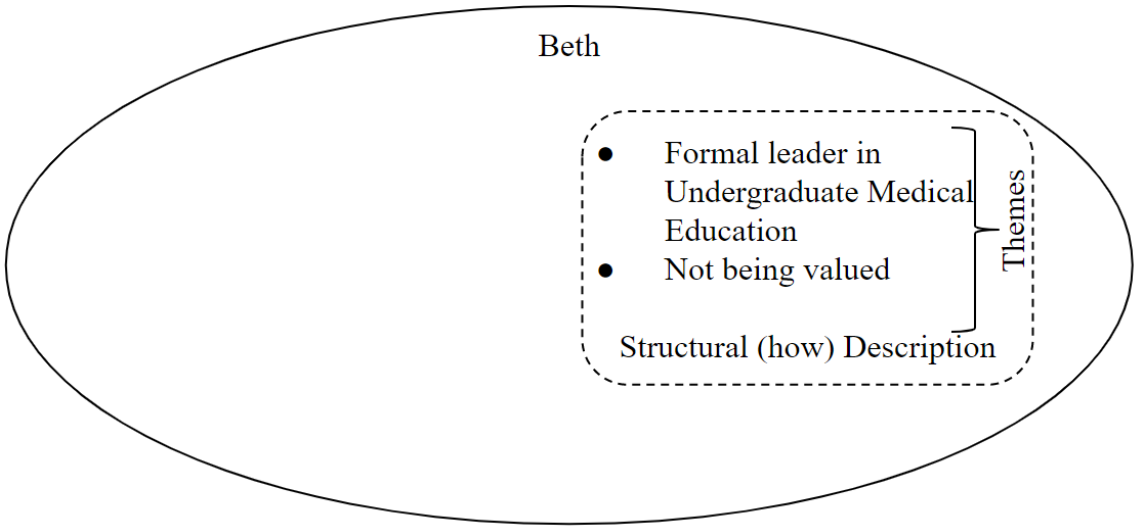

Figure 12. Beth's structural (how) themes constituting her structural description.

Through Beth's lived experience with a formal leader in UME, it was evident that advocating was an aspect of physician leadership. Observing a faculty physician advocate for funding, or other resources, influenced how Beth constructed her idea of physician leadership.

> He kept on fighting for what he believed was necessary in trying to train us to become the best rural physicians we could be going forward, and to fill these gaps in care in these rural areas. And I feel like that's something that really stood out to me in a true leadership role, is advocating on behalf of what you believe in. (Participant B, 2019, R14)

In GME, Beth experienced feelings of not being valued as she felt that her voice was not heard. Whether it was from the lack of transparency from formal leaders or a lack of

communication about aspects of the program that influenced her and her colleagues, Beth felt strongly about the importance of followers feeling valued.

> I personally just feel like I'm not heard, and so I feel like that's been one of the experiences that's really pushed me to be like this is what I view leadership as . . . and that's kind of why I guess I view the leadership aspect so strongly on the transparency aspect of things. (Participant B, R46)

Textural-structural (nature) statement. Evident in Beth's understanding of physician leadership was that it was largely influenced by her perspective on advocating and camaraderie. These perspectives were connected to the faculty physician in UME, as well as lack of transparency on the part of those in formal leadership roles in medical residency. Role models appeared to heavily influence Beth's perceptions. Figure 13 illustrates the textural (what) and structural (how) themes constituting Beth's textural-structural (nature) statement. Following Figure 13 is Beth's textural-structural statement.

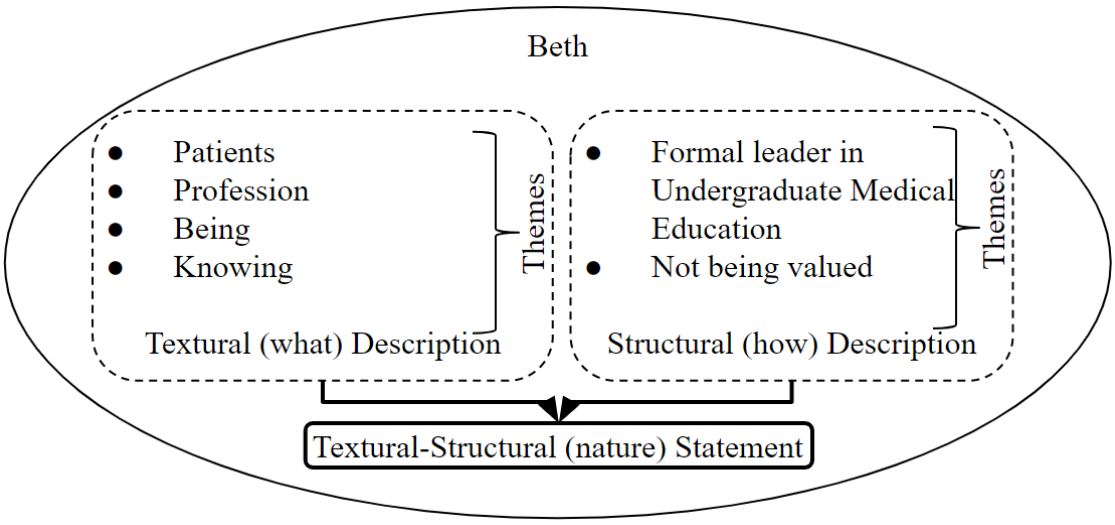

Figure 13. Beth's textural and structural themes constituting her textural-structural statement.

Beth emphasized advocating on behalf of patients and the profession as aspects of physician leadership. This belief was grounded in lived experiences with a formal leader in

medical school, as well as her current lived experience in medical residency. Beth said that her medical specialty is often the first to interact with patients. Due to this interaction, they "are often the ones that are advocating very strongly for their patients" (Participant B, 2019, R58) to coordinate future care. This focus on advocacy did not end with patients, as Beth's position was to advocate for the profession, or for aspects of family medicine such as rural medicine. The formal leader in UME's passion and belief in rural medicine were evident to Beth and influenced her understanding of physician leadership. "A true leadership role is advocating on behalf of what you believe in order to further improve the specific career you're a part of, whether it be medicine or accounting" (Participant B, 2019, R14).

Her lived experience in medical residency contributed to feelings of not being valued. Whether it was through a lack of transparency regarding changes that resulted in her and her fellow resident physicians not feeling heard, Beth felt that being valued assisted with building trust and contributed to a sense of integrity among the formal physician leaders. Beth also emphasized aspects of a physician leader, such as integrity, trustworthiness, transparency, and a sense of camaraderie among followers.

Beth focused on the variability in enacting physician leadership based on such aspects as the situation, goals, and expectations of the followers. Knowing followers is critical to collaboration and success in physician leadership. "One of the biggest things is understanding the population in which you're trying to lead, right? Because not everybody may have the same viewpoints in regards to what they perceive a leader to be" (Participant B, 2019, R36). Knowing these viewpoints and expectations helps physician leaders to lead effectively and contributed to Beth's description of physician leadership.

During her interview, Beth spoke strongly about advocating and camaraderie with peers. Her emphasis on leaders understanding their followers was influenced by her perception of her physician leaders in GME not understanding her or others in her residency program. This was an important aspect for my reflection, as I am in a position of leadership in the field of medicine. Beth did not suggest any changes to her individual textural-structural (nature) statement.

Courtney

When Courtney was asked to reflect on her experiences that informed her understanding of physician leadership, she initially discussed the summers she had spent employed at a summer camp. A significant aspect of that experience for Courtney was the emphasis on a servant-like approach to leadership.

> If the person is like "No, this is important, here's why it's important, and I'll do it with you to show you how important it is," it makes a huge kind of difference in the way that you perceive the leaders. The way that you're like willing to go the extra mile for those people, if they're willing to also work alongside you when you need the help, like it makes it more of a teamwork. (Participant C, 2019, R8)

Courtney described her understanding of servant leadership, which was particularly insightful with regard to how this type of leadership can influence the followers and teamwork.

Analysis. Following the same integrated data analysis process, I constructed six textural (what) themes from 31 statements, 26 extracted statements, and 10 meaning units (Figure 14).

The meaning units were (a) being, (b) compassion, (c) emotional intelligence, (d) focus, (e) humanizing, (f) modeling leadership, (g) role, (h) skills, (i) specialty-based leadership styles, and (j) valuing followers. The meaning units that were utilized to inform and create the textural themes are discussed following Table 11.

The being meaning unit was constructed based on participant Courtney's description of physician leaders being open to the followers/ unique experiences and perspectives, as well as

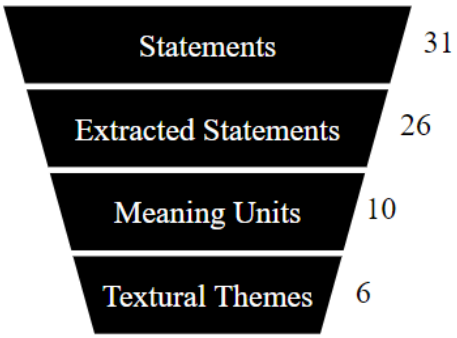

Figure 14. Totals for each component of analysis toward a textural description for Courtney.

Table 11

Meaning Units and Textural Themes From Courtney's First Interview

Meaning units	Inform →	Textural theme
Valuing followers Being Humanizing		Valuing followers
Emotional intelligence Valuing followers Humanizing		Emotional intelligence
Valuing followers Humanizing		Humanizing the experience
Skills Focus Being Compassion		Leader attributes
Modeling leadership		Role modeling
Role Specialty-based leadership styles		Miscellaneous

being passionate about leading in general. Compassion was grouped based on Courtney's description of how family medicine physicians tend to care about the whole patient and not just treat and move on. Emotional intelligence was constructed based on comments about family

medicine physicians being more emotionally attuned to patients or intelligence of emotions and the need for resident physicians to process experiences. Focus was created based on a comment about the focus of a physician leader being on the resident physician's development or to just get work done. Humanizing was constructed based on multiple comments about physician leaders humanizing the experience of medicine by valuing followers' experiences and giving them a voice. Modeling leadership was based on multiple comments about leaders walking alongside followers or resident physicians to explain why something is important. Role was based on a comment about the role of the resident physician and being able to see the systemic aspects of medicine. Skills were in reference to specific skills (e.g., visionary, logistical). Specialty-based leadership styles were constructed based on comments about the family medicine specialty drawing more emotionally attuned physicians, whereas other specialties tend to draw other personalities. The valuing followers unit was grouped based on multiple comments about how resident physicians needed to feel heard, to have their perspectives valued, to have their experiences respected, and to be included in the process of care.

An example of one meaning unit that crossed over for Courtney was humanizing. First, she described how a physician leader humanizes a situation by listening "where you feel heard, where you feel understood. Maybe that's not going to change anything specifically, but it humanizes the whole situation" (Participant C, 2019, R20). Next, Courtney used an example of a patient dying and remarked that the physician leader can humanize the situation by showing emotion. For Courtney, a lack of emotion about a patient dying exemplified an emotionally absent leader and disconnect between patients, as well as with the resident physicians. A physician leader can also communicate valuing the resident physicians by humanizing the

resident physician's daily struggles. "Hey, I recognize that residency is not easy" (Participant C, 2019, R20).

Courtney's textural (what) themes are (a) valuing followers, (b) emotional intelligence, (c) humanizing the experience, (d) leader attributes; (e) role modeling, and (f) miscellaneous. The theme of valuing followers was constructed based on meaning units that described aspects of what Courtney had experienced. The components entail, but are not limited to, feelings of inclusion when physician leaders take time to allow her to process a situation, recognize that all resident physicians do not process each situation the same, and understanding how decisions can affect followers. The emotional intelligence theme was constructed based on comments about physician leaders being more attuned to emotions or the specialty of family medicine drawing resident physicians who are naturally more attuned to emotions.

Humanizing the experience was created based on comments about physician leaders recognizing the difficult aspects of medicine and the resident physician's experience, which assisted with humanizing the experience of GME. According to Courtney, she felt more human and not just a machine to deliver a product. Leader attributes consisted of comments about what Courtney thought physician leaders should be, or have, or be able to do. For example, physician leaders should be a mix of visionary and logistical, if not both. Role modeling consisted of comments about the physician leader sharing the workload with the resident physician, being alongside that person and helping the person to understand the rationale for action rather than authoritatively directing action. The theme of miscellaneous included comments about the role of a resident physician offers insight into the health care system and specialties, drawing out, and even replicating, certain types of leaders within specialties. The following is Courtney's textural

(what) description. This description discusses what was experienced by Courtney with regard to physician leadership and is displayed in Figure 15, along with the informing themes.

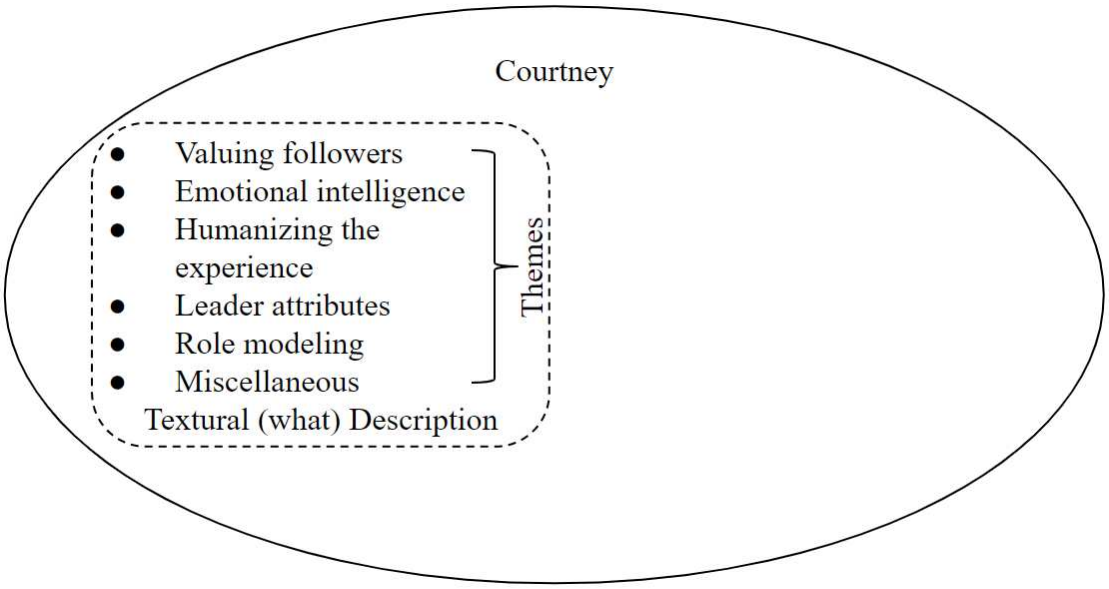

Figure 15. Courtney's textural (what) themes constituting her textural description.

Textural (what) description. After Courtney's reflective exercise, I asked her questions about her lived experience with formal leaders and how she would describe physician leadership. In particular, Courtney emphasized valuing followers, emotional intelligence, humanizing the experience, leader attributes, and role modeling. Courtney described the difficulty of being a resident physician with long hours and effort. She stated that when "leaders sort of like recognize that and sit down and have a conversation with you about how you're doing or how you feel about whatever it is . . . I feel like that has been a positive for me" (Participant C, 2019, R20). When formal physician leaders also take time to listen to Courtney, or other residents, and recognize their perspectives, she felt understood and valued. However, it was important to Courtney that physician leaders recognize not only the importance of valuing followers (e.g.,

resident physicians); she also said that each person should be looked at as an individual. "If you treat everyone just how you would want to be treated, a lot of times that can be a bad thing to not recognize that different people need different things" (Participant C, 2019, R28). Feelings of inclusion, value, and uniqueness contribute to Courtney's sense of purpose in GME.

Another aspect of Courtney's lived experience was the importance of emotions. She described how emotions are often not valued when trudging through the daily difficulties of clinical care, such as a dying patient. "It's an important thing that is brushed over in medicine, and it's looked at as, you know, weak if you can't just kind of like push through the emotions and keep taking care of patients" (Participant C, 2019, R30). Courtney maintained that, when physicians do not engage their emotions about patients, there is a disconnect in medical care. She also identified a disconnect with physician leaders and resident physicians when there are no visible signs of compassion for the resident physicians' experiences and perspectives. The emotional intelligence of a physician leader was important to Courtney and may attract physicians to the specialty of family medicine. To Courtney, the ability of physicians in family medicine to "relate on an emotional level more with patients a lot of times" (Participant C, 2019, R40) lends a broader perspective of patient care by considering other factors in care (e.g., home life, diet). Breaking bad news about a terminal illness or informing a family member about a death can lead physicians to build "emotional walls" (Participant C, 2019, R28) become emotionally paralyzed by the difficulty of care. Courtney noted that the rigorous daily work of a family medicine physician can often lead to dehumanizing patients or other physicians.

In Courtney's experience, a positive physician leader is one who recognizes the stress of being a family medicine physician and is "willing to cross that kind of uncomfortable bridge to meet the person and say, 'Hey, I recognize this is hard'" (Participant C, 2019, R28), rather than

expecting that everyone will process the work of a physician in the same way. Crossing that uncomfortable bridge humanizes the experience of being a resident physician for Courtney. Courtney focused on the importance of emotions and briefly contrasted the attributes of those whom she considered to physician leaders. One type of physician leader focused on the number of procedures to be performed or patients to be seen to meet preset metrics. The other type of physician leader understood those metrics but also emphasized the emotional and mental health of the followers. To Courtney, the passion for investing in the well-being of resident physicians should coincide with the ability to direct care.

Courtney expanded on the importance of role modeling to describe how she understands physician leadership. She related a story about a time when she was a medical student and a first-year family medicine resident physician told her how he dealt with the difficulty of processing a patient's death: "Everyone experiences it different, and I don't know the answer to that question. But I can tell you what I do; I make a point to learn something from every patient" (Participant C, 2019, R30). This frank response folded into other comments about the importance of those in formal leadership roles being willing to be open and work alongside her.

> And you felt as like someone who is actually, you're peers with them, but they're above you in this leadership totem pole, you know. You felt like if someone was kind of serving alongside you, doing the work alongside you, while kind of being the leader, it was just a lot easier to relate to them as your leader, a lot easier to understand why you were being told to do X, or why you were being told not to do this other thing. (Participant C, 2019, R8)

The ability of a physician leader to work alongside Courtney contributed to her efficacy as a physician, as well as her perception of that physician leader.

Structural (how) description. Two structural themes were constructed from the textural description: (a) role modeling, and (b) devaluing followers. When discussing valuing, emotional intelligence, humanizing, and attributes, it appeared that Courtney was discussing the behaviors

of role models and the impact of their actions on her and other resident physicians. The following is Courtney's structural (how) description. This description discusses how physician leadership was experienced by Courtney (Figure 16).

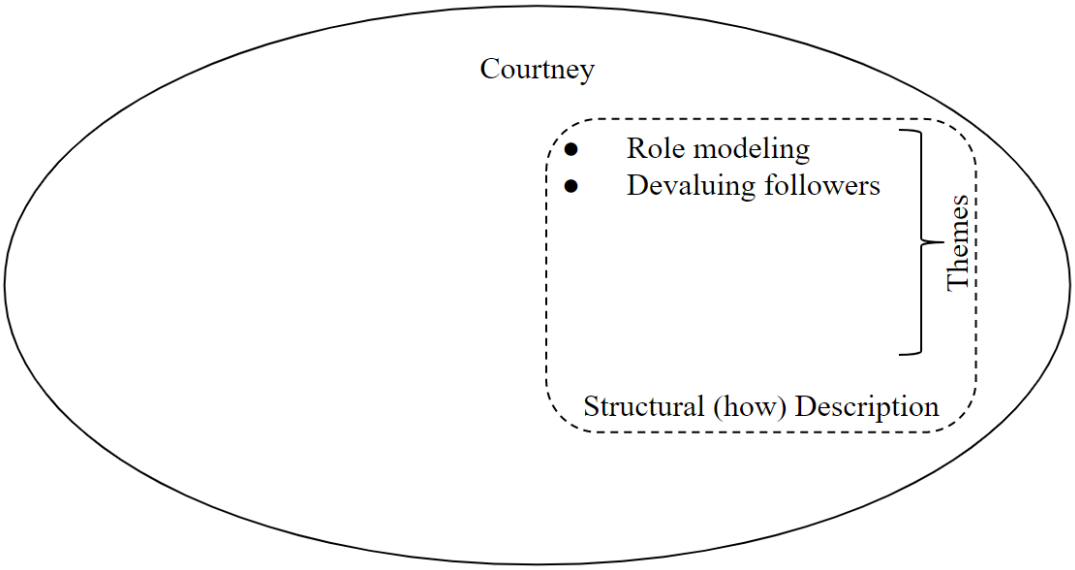

Figure 16. Courtney's structural (how) themes constituting her structural description.

Courtney encountered physician leaders who role modeled aspects of physician leadership that Courtney gleaned, as well as aspects that did not contribute to what Courtney considered to be a good physician leader. One experience was as a medical student with a first-year resident physician who took time to communicate how he dealt with the death of a patient. When physician leaders took time to invest in her experience and perspective, she felt valued. On the other hand, when physicians do not engage emotions regarding their patients or the resident physicians, Courtney perceived them as disconnected and poor examples of physician leadership.

Another aspect that was important to Courtney was valuing followers. However, Courtney focused on this aspect through general examples about not feeling valued in decisions by the administration. For example, she stated,

> And so I think there have been some things in our residency specifically where I've seen the leadership get really into these big ideas and these big changes, and not really thinking about the impact of those things, and how those things will actually play out and be enacted. (Participant C, 2019, R16)

Courtney contended that, when resident physicians are not considered in the effects of decisions, they are devalued. When a physician leader listens to Courtney and engages her emotions, she feels heard and valued and the situation is humanized:

> When a leader is willing to sit here and let you say, "Hey, this, what you're doing, what you've done frustrates me" and actually have like an open genuine conversation about those feelings or those thoughts, where you feel heard, where you feel understood. Maybe that's not going to change anything specifically, but it humanizes the whole situation. (Participant C, 2019, R20)

Textural-structural (nature) statement. Valuing and role modeling were important because they contributed to Courtney and others feeling valued. Humanization was experienced through how formal leaders had the emotional intelligence to help Courtney process a patient death. This aspect points to the attributes of a physician leader. Through these attributes, Courtney felt valued and humanized. Courtney's textural (what) and structural (how) themes, which inform the respective descriptions and her textural-structural (nature) are displayed in Figure 17.

Courtney's description of physician leadership focused on the importance of role modeling in GME. Courtney told a story of when she was a medical student and a first-year family medicine resident physician told her how he dealt with the difficulty of processing a patient's death. This experience had an impact on Courtney as it communicated to her that the physician leader was willing to be open and vulnerable and share his perspective. "Everyone

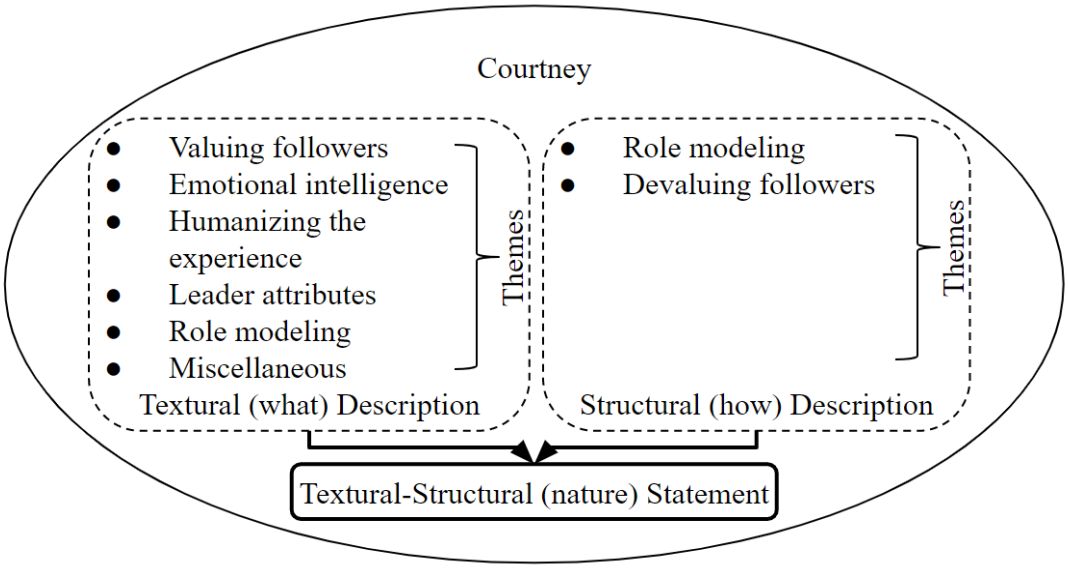

Figure 17. Courtney's textural and structural themes constituting her textural-structural statement.

experiences it different, and I don't know the answer to that question. But I can tell you what I do, I make a point to learn something from every patient" (Participant C, 2019, R30). In a way, that physician leader's vulnerability was a form of showing Courtney the importance of emotionally processing difficult experiences in family medicine. Through his example, he modeled learning something from every patient.

According to Courtney, through those in formal leadership roles acknowledging the difficulty of medical residency by being "willing to cross that kind of uncomfortable bridge to meet the person and say, 'Hey, I recognize this is hard'" (Participant C, 2019, R28), the experience of being a resident physician was humanized. This humanization is important because it helped Courtney to feel more like a human and less like a "robot" (Participant C, 2019, R32) to meet performance metrics. Courtney also recognized that delivering daily care as a family medicine physician is strenuous and can often have negative side effects. Through such aspects as breaking bad news about a terminal illness or sharing that a love one died can lead

physicians to put up “emotional walls” (Participant C, 2019, R28) to keep moving forward and not be emotionally paralyzed. The realization of the impact of the daily duties of a family medicine physician influenced Courtney’s focus on the emotional intelligence of physician leaders, in addition to leader attributes such as passion and providing direction. Courtney stated that when “leaders sort of like recognize that and sit down and have a conversation with you about how you’re doing or how you feel about whatever it is . . . I feel like that has been a positive for me” (Participant C, 2019, R20). While Courtney recognized that this is what she needs from a physician leader to feel valued, she also recognized that not all resident physicians may feel the same. The physician leader must be emotionally intelligent and account for various emotional needs. “If you treat everyone just how you would want to be treated, a lot of times that can be a bad thing to not recognize that different people need different things” (Participant C, 2019, R28).

Along with role modeling, Courtney emphasized the importance of recognizing when followers have been devalued. She said that she feels devalued when decisions are made that affect the residents and their voices are not considered.

> And so I think there have been some things in our residency specifically where I’ve seen the leadership get really into these big ideas and these big changes, and not really thinking about the impact of those things, and how those things will actually play out and be enacted. (Participant C, 2019, R16)

However, when physician leaders take the time to invest in her well-being, perspective, and emotions, Courtney feels valued, and she suggested that other followers will feel valued, as well. Courtney stated that, when physician leaders took time to invest in her personally, “You felt like if someone was kind of serving alongside you, doing the work alongside you, while kind of being the leader, it was just a lot easier to relate to them as your leader” (Participant C, 2019,

R8). Service by the physician leader alongside Courtney also contributed to her sense of purpose and perception of the efficacy of that physician leader.

Courtney's interview alluded to her prior interpretations regarding the role of emotions to physicians. Specifically, her use of phrases such as "cog in a wheel" (Participant C, 2019, R22) or "replaceable" (R22) stirred emotions from my own experience as a faculty member and administrator in UME. I documented, in my reflexive journal entry of March 25, 2019, my perception that more experienced physicians often disregard emotions.

> In my experience many seasoned physicians I have encountered coming from the clinical settings often appear callous to feelings and regard them as not objective or something less than desired. Although this was my experience, not all seasoned physicians may be like that.

Courtney did not change the textural-structural statement. As recorded in my April 30, 2019 research journal entry, she stated, "I think the write-up summarizes my thoughts well."

Daniel

Daniel was a third-year resident at the time of the first interview, with 1 year of experience in the surgical specialty. When asked via videoconference (e.g., Skype) to reflect on experiences that had informed his perception of physician leadership, he described his experience in graduate school working in a laboratory. In graduate school, Daniel's advisor was also the principal investigator (PI) and his supervisor. Due to these roles and the size of the laboratory, Daniel interacted with his advisor/PI/supervisor multiple times each day. Daniel highlighted the autonomy that he was given to run experiments, review journal articles, and propose research protocols. Daniel was direct and concise in his answers.

Analysis. The analysis process for Daniel resulted in three textural (what) themes from 27 statements, 23 extracted statements, and six meaning units, as displayed in Figure 18.

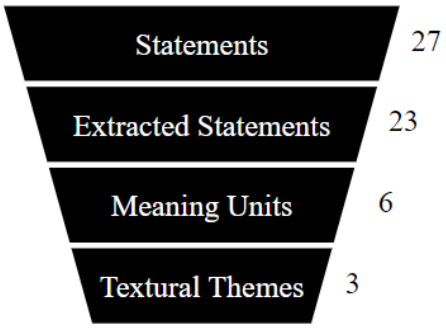

Figure 18. Totals for each component of analysis toward a textural description for Daniel.

Daniel's meaning units are (a) accessibility, (b) behavior, (c) examples of bad leadership, (d) preference, (e) role, and (f) specialty. The textural (what) themes informed by the constructed meaning units are shown in Table 12 and discussed in the text following.

Table 12

Meaning Units and Textural Themes From Daniel's First Interview

Meaning units	Inform →	Textural theme
Behavior Role Specialty Accessibility		Behaviors
Role Preference Examples of bad leadership Specialty Behavior		Personal preference
Specialty Behavior Accessibility		Context

The accessibility meaning unit was based on Daniel's description of the accessibility of leaders (e.g., program director) in family medicine as compared to surgery. Next, the behavior

meaning unit grouped statements about the actions of physician leaders that informed Daniel's understanding of leadership. An example was giving Daniel autonomy but also being a guide. Daniel also described leadership as sacrificial and drew on how previous peers had failed to act. The examples of bad leadership meaning unit described specific behaviors interpreted by Daniel as not being helpful, or being a bad leader. The preference meaning unit was constructed based on statements about how Daniel described physician leadership, or what stood out, based on personal preference or personality. Daniel appreciated autonomy and highlighted autonomous examples. The role meaning unit described aspects such as the physician leader's role to facilitate learning through guided autonomy. It appeared that these statements could be linked to personal preference as Daniel definitively correlated examples from his environment to all employee environments. The specialty meaning unit illustrated statements about contextual differences between the surgery and family medicine medical specialties.

An example of a meaning unit crossing over between textural themes was with regard to specialty. Daniel spent a year as resident in another specialty and had the unique experience to draw comparisons between specialties. For example, he first compared access to the program directors. The program director in the family medicine residency was open and accessible, whereas the other program director was not. Daniel stated that, as a resident physician in the other specialty, "You pretty much do what your attending says without question . . . and I feel like those two environments are a little different" (Participant D, 2019, R34). With regard to family medicine, Daniel suggested that this specialty is

> a lot more family-oriented, to where your boss, even though they are your boss, they're also your colleague, and they for the most part make you feel that way. . . . I was also there to learn and to be a part of a team, rather than just to do someone's bidding. (Participant D, 2019, R64)

Daniel's three textural (what) themes are (a) behaviors, (b) personal preference, and (c) context. The behaviors theme was constructed based on meaning units that described aspects of what Daniel experienced. Such components included, but were not limited to, formal leaders giving Daniel autonomy through work in a laboratory, which influenced his perceptions of similar behaviors in residency. The program director would tell Daniel to "figure it out" and would guide Daniel but not hold his hand. Learning from nonsacrificial behaviors of informal leaders (e.g., upper-level peers) influenced Daniel's understanding of behaving in sacrificial ways to show value of lower-level peers. The personal preference theme was based on comments about how Daniel's personality influenced his perception of the nature of physician leadership. Daniel stated that he liked to bend the rules a little and to be somewhat autonomous. Being authoritatively directed affected purpose and did not assist with this learning.

The final textural theme of context included statements about differences between the surgery specialty and the family medicine specialty. In the surgery specialty, leadership was more authoritative and hierarchical as the specialty may call for it, especially when someone is "cut open." The name *family medicine* denoted a more egalitarian approach. Furthermore, the context of medical residency (GME) is a context in which residents should be able to "learn while doing" (Participant D, 2019, R38). Figure 19 displays the textural (what) themes that informed Daniel's textural description, which is stated after the figure.

Textural (what) description. After Daniel's reflective exercise, and following the interview protocol, I asked him questions about his lived experience with formal leaders and how he would describe physician leadership. Specifically, the themes that were constructed from Daniel's experience were behaviors, personal preference, and context.

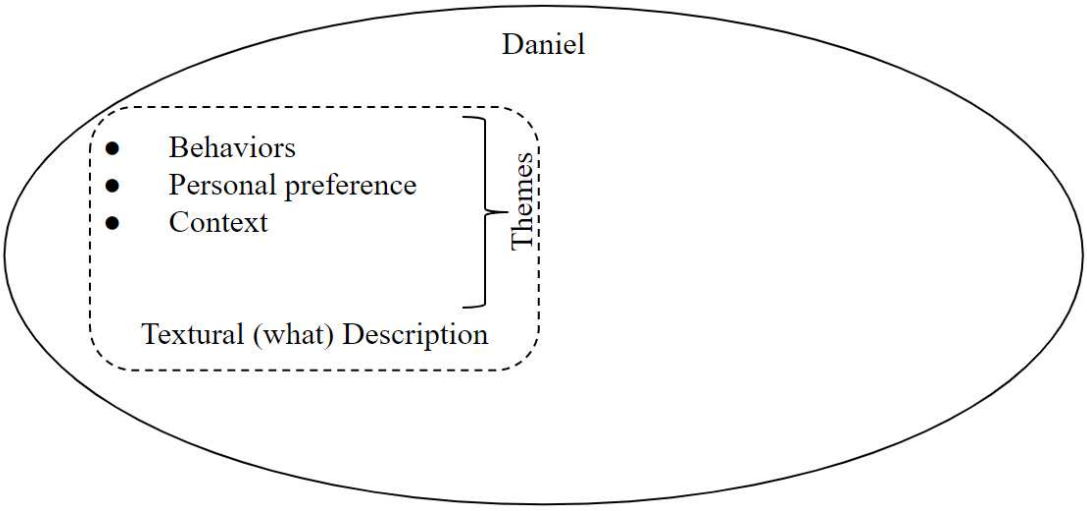

Figure 19. Daniel's textural (what) themes constituting his textural description.

Daniel first described experiences in college with a supervisor who gave him a task to review research articles and determine a research protocol. Daniel was given autonomy to make some initial decisions about the protocol and to o do' I will guide you but not hold your bring forward to his supervisor. Likewise, in medical residency, his program director displayed similar behavior by stating, "You figure it out what you're going to do; I will guide you, but not hold your hand the whole way" (Participant D, 2019, R30). To Daniel, this behavior inculcated a sense of guided autonomy in that he knew that his supervisor in college and program director in medical residency would give him freedom to learn individually but would also be available to assist by providing resources to determine next steps. Conversely, another supervising physician's authoritative behavior in medical residency "stripped" (Participant D, 2019, R30) Daniel of his autonomy and had an impact on his sense of purpose. "It didn't allow me to make my own decisions. It was more I am a machine who is being controlled by someone else to do what they want to do anyway, so my purpose here is kind of minimal" (Participant D, 2019, R30). Daniel mentioned that he had his family medicine program director's telephone number

and felt free to call him. This experience contrasted to a previous experience in the surgery specialty in which he also had the program director's number. "I had this phone number, but you would never ever call your program director, or if you did, it better be an emergency" (Participant D, 2019, R34). To Daniel, the accessibility of his current program director in family medicine reinforced support.

Throughout Daniel's interview, he described physician leadership in relation to personal likes and dislikes. When asked how he would define physician leadership, he defined it as the person who establishes the goal(s) and the "person who is guiding me toward an end goal" (Participant D, 2019, R16). Daniel's comments resonated with the guided autonomy behavior from his supervisor and program director as it appealed to his personal preference. "I just like to have some freedom to make my own decisions and choices" (Participant D, 2019, R26). With regard to dislikes, he described prior situations with senior resident physicians who had stated that they wanted to finish work early and appeared to disregard the junior resident physicians' life situations. Daniel stated that, when he was informally supervising junior resident physicians, it was important to him to support them by allowing them to finish work early.

Daniel recognized that a personal preference about physician leadership included sacrifice. Daniel's personal preference for physician leadership aligned with his current program director. "I mean I can only go by what I feel, and I just feel like [current program director]'s way that he approached things was a lot more my style the way that I learn better" (Participant D, 2019, R60).

The final theme that surfaced during Daniel's interview was context. In the surgical specialty, a person might be on the operating table "cut open" (Participant D, 2019, R34); therefore, "You pretty much do what your attending says without question" (Participant D, 2019,

R34), as many things could go wrong in a situation like that. To Daniel, hierarchy is probably necessary in situations such as an operating room, as well as in the overall surgical specialty, because certain situations are more suited for more hierarchical approaches. Conversely, in family medicine, the context is more collegial in that the supervising physician might be in a role of authority but also perceived as a colleague. The overall context of medical residency, or GME, is, to Daniel, a context that should promote learning.

> Residency is not a "do as you're told" more than it is a "learn while doing." So you should be able to make mistakes, albeit mistakes that shouldn't affect patient care. But you should be allowed to make mistakes, make decisions, even if they're wrong, and then have them corrected later or in some capacity learning about them. (Participant D, 2019, R38)

The context of GME and the specialty of family medicine informed Daniel's understanding of physician leadership. Leadership may be enacted differently based on the specific context (e.g., clinic) and/or the overall aspect of medicine practiced in that specialty.

Structural (how) description. Daniel emphasized his preference for autonomy and alluded to his personality. Specialty was also discussed in reference to how physician leadership could be perceived. The specialty context could drive the type of leadership enacted. This perspective influenced Daniel's interpretation and the structural description. The structural (how) themes present in Daniel's textural (what) description are (a) personality, and (b) specialty based. These structural themes are displayed in Figure 20.

Daniel encountered supervisors or leaders who displayed behaviors that provided him a sense of guided autonomy. Medical residency is a "learn while doing" (Participant D, 2019, R38) context for Daniel; therefore, he communicated the importance of experiential learning rather than authoritative direction. Admittedly, Daniel stated that his perspective on guided autonomy was most likely due to his personality. "I just feel like [current program director]'s

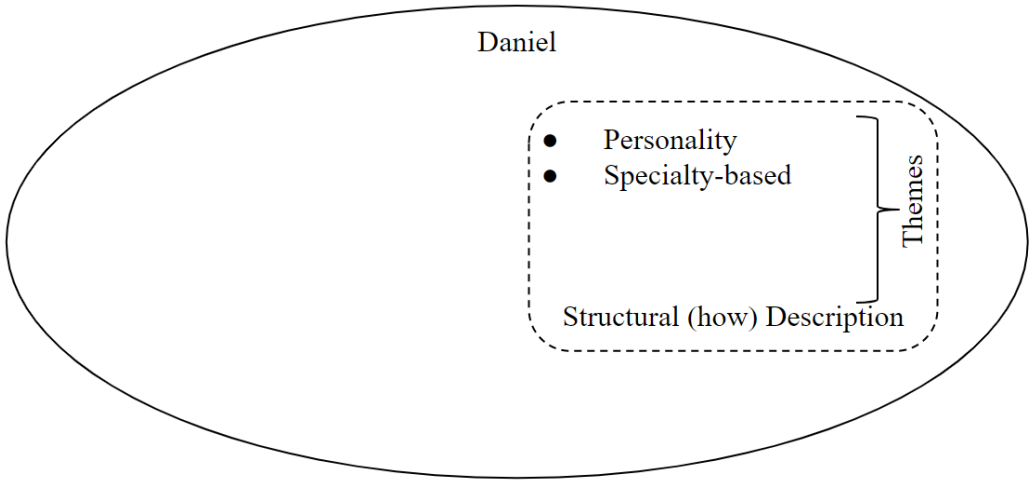

Figure 20. Daniel's structural (how) themes constituting his structural description.

way that he approached things was a lot more my style and the way that I learn better than other people" (Participant D, 2019, R60). It was through Daniel's, and his program director's, personality that Daniel described the nature of physician leadership.

Daniel contrasted the specialties of surgery and family medicine to explain how he understood physician leadership as potentially specialty based. Beyond the technical differences between surgical medicine and family medicine, Daniel stated,

> I feel like those two environments are a little different, because in surgery, there's so many things that can go wrong very quickly, especially an open case where you have someone's body physically cut open. Whereas if you're dealing with medicine, things can go by a lot slower, and you don't have to worry about the expediency of correcting something as fast as you can. (Participant D, 2019, R34)

Daniel also described the specialty of family medicine as more family oriented and collegial. He further described the ability to view his program director and supervisors as colleagues. Through the personality of those in supervisory roles and specialty-based nuances, Daniel described physician leadership as guided, sacrificial, and collegial.

Textural-structural (nature) statement. The behaviors, personal preferences, and context accounted for how Daniel described physician leadership. For example, he experienced

the behavior and personality of the current program director but also experienced his own personal preference within the context of family medicine or surgery. Moreover, he focused on the personalities of formal leaders, as well as the contexts, to explain how he understood physician leadership. Daniel's textural (what) and structural (how) themes informing his descriptions and textural-structural (nature) statement are displayed in Figure 21.

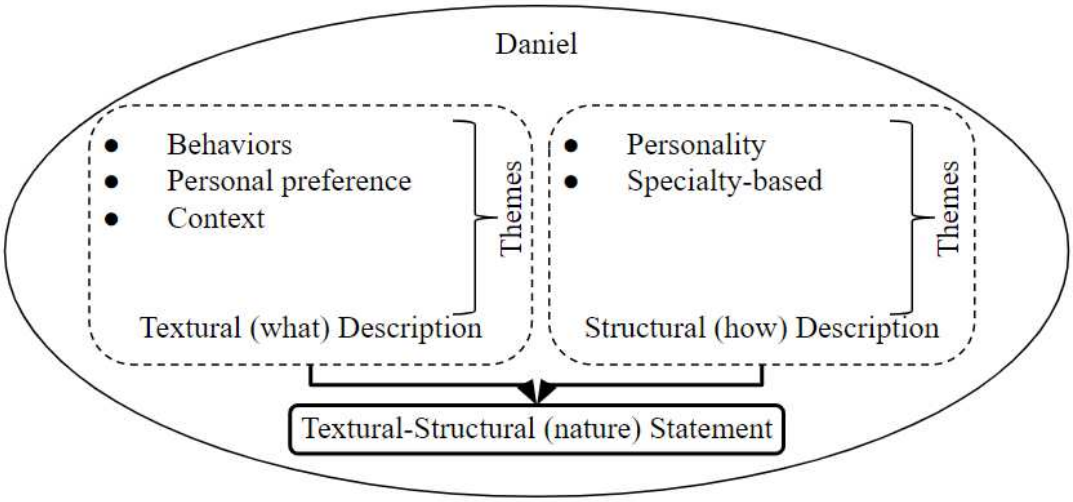

Figure 21. Daniel's textural and structural themes constituting his textural-structural statement.

Daniel's description of physician leadership emphasized the behaviors and personality of those in formal and informal leadership roles. Daniel described a situation prior to medical residency in which he was given autonomy to review research articles to determine a research protocol. In medical residency, he also described the family medicine program director's approach to clinical care. "You figure it out what you're going to do, I will guide you, but not hold your hand the whole way" (Participant D, 2019, R30). To Daniel, behaviors such as these inculcated a sense of guided autonomy.

Physician leadership as guided autonomy resonated with Daniel, as it appealed to his way of learning. "I just feel like [family medicine program director's] way that he approached things was a lot more my style and the way that I learn" (Participant D, 2019, R60). Furthermore, Daniel's personal preference is to "have some freedom to make my own decisions and choices" (Participant D, 2019, R26). This personal preference was evident in the way that Daniel described surgery as compared to family medicine.

> As a surgery intern or resident, you pretty much do what your attending says without question. So this kind of reflects the attending I talked about previously, about you're kind of a robot, you're just there to do what their bidding is. (Participant D, 2019, R34)

Stripping Daniel of autonomy negatively affected his sense of purpose. "It was more I am a machine who is being controlled by someone else to do what they want to do anyway, so my purpose here is kind of minimal" (Participant D, 2019, R30). The context of surgery also promoted a strict hierarchy, whereas family medicine was more egalitarian. For example, a first-year surgery resident would not even think of talking to a third-, fourth-, or fifth-year resident without talking to a second-year resident first. "So it's just this long drawn-out game of telephone until you get to the actual person who is going to be the one to make the ultimate decision anyway" (Participant D, 2019, R66). Conversely, in family medicine, a clinical decision can be made by the first-year resident physician and the attending physician.

In the context of medical residency, Daniel perceived physician leadership to be about facilitating learning by resident physicians. "You should be allowed to make mistakes, make decisions, even if they're wrong, and then have them corrected later or in some capacity learning about them" (Participant D, 2019, R38). As Daniel understands the context of medical residency, he also understood physician leadership to be about guided autonomy, which also involved sacrifice. Sacrifice could be the supervising physician relinquishing control of a degree

of clinical decisions by passing it to the resident physician or caring for junior resident physicians by allowing them to go home early and possibly sacrificing overall productivity.

> It was just one of those things, like it's a small olive branch or something I can give them that I couldn't do otherwise. And something I learned from the mistakes of prior residents, that being willing to give up a few things yourself in order to [make] your team happier. (Participant D, 2019, R48)

To Daniel, physician leadership is contextually bound but, over all, promotes autonomy. The physician leader guides toward an end goal, whether it is clinical care or increasing team satisfaction and productivity.

Daniel's videoconference interview was direct and concise. Furthermore, his ability to compare and contrast two specialties was helpful in illuminating his textural theme of context. One prior interpretation that I suspended prior to Daniel's interview was that I perceived family medicine physicians to be inclined toward teams, whereas other specialties, such as surgery, might be inclined toward hierarchy and power. Although this aspect was evident in Daniel's descriptions, I needed to set it aside in order to view Daniel's lived experience "freshly, as if for the first time" (Moustakas, 1994, p. 34). Daniel had no changes to make to the textural-structural statement. On July 24, 2019, he responded, "This looks great, Mike."

Ellen

Ellen was a second-year resident physician who was interviewed via telephone. She did not describe prior experiences in leadership roles but rather disclosed prior perceptions of physician leaders that were influenced by her experience in medical education:

> When I was looking back on it and thinking of physician leadership, I was thinking more of people who are in the higher-up levels, your program director, your CFO, your kind of just like clerkship directors, who were more involved in "the traditional leadership roles" . . . during residency and medical school. That definition has definitely changed now. (Participant E, 2019, R10)

Analysis. Analyzing Ellen's data resulted in four textural themes from 45 statements, 36 extracted statements, and eight meaning units, as displayed in Figure 22.

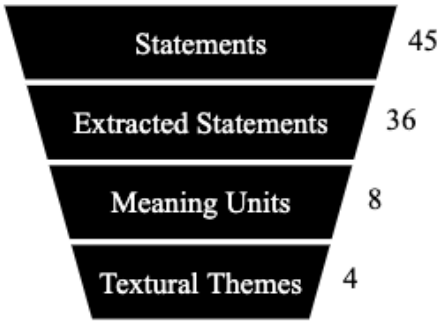

Figure 22. Totals for each component of analysis toward a textural description for Ellen.

Ellen's meaning units include (a) action-oriented, (b) environment, (c) humanitarian, (d) influence, (e) informal leadership, (f) prior perceptions, (g) supportive, and (h) valuing. The meaning units which assisted with construction of four textural themes are listed in Table 13.

The action-oriented meaning unit was constructed based on Ellen's descriptions of a physician who took action in the community without a formal role. For the environment meaning unit, descriptions of a formal leader's ability to craft an environment, as perceived by Ellen, drew her to that program. The humanitarian unit described aspects of formal or informal leaders who served the local community. Influence was constructed from descriptions such as the observation that formal leaders authoritatively directing residents was not influential.

The informal leadership unit grouped statements that discussed how physician leaders were leaders due to their actions regardless of role. Prior perception grouped statements about perceptions of leadership prior to medical residency. The supportive unit collated statements about Ellen feeling supported by formal leaders, as well as Ellen guiding or supporting more junior resident physicians and/or medical students. The valuing meaning unit grouped

statements about such aspects as formal leaders (e.g., chief residents, program directors) listening to the other residents and acting on their behalf, which communicated value.

Table 13

Meaning Units and Textural Themes From Ellen's First Interview

Meaning units	Inform →	Textural theme
Prior perceptions Supportive Influence Environment		Supportive
Action oriented Humanitarian Informal leadership Supportive Valuing		Take action
Prior perceptions Informal leadership Humanitarian Action oriented		Informally influential
Valuing Influence Environment		Foster culture

Ellen described influence of physician leadership in two ways. First, she stated that physician leaders who dictate actions are not supportive or inspiring. "I'm going to tell you to do this, because I don't think that's very inspiring for other residents or students to learn from" (Participant E, 2019, R36). Conversely, Ellen discussed how she perceived Program Directors as influencing the culture of programs when she was applying for residency training. She wanted someone who believed in work-life balance and listened to resident physicians.

Ellen's textural (what) themes are (a) supportive, (b) take action, (c) informally influential, and (d) foster culture. The supportive theme ensured that patients were doing well or that junior physicians or even medical students were doing well. Ellen spoke about how they could help young medical students to start out well and assist them with their education. She also stated specifically that she viewed physician leadership as more supportive with regard to patients, peers, and other physicians. The take action theme was constructed based on comments regarding how Ellen saw physicians, whom she may have considered leaders, take action to serve their local communities. Moreover, the chief residents told residents to come with a solution rather than a complaint, noting that all they could do with a complaint was to listen. The informally influential theme was created based on statements about physicians who influenced Ellen by their actions in their local community, regardless of role. As a resident physician, Ellen did not realize that because she did not have a formal leadership title in the resident program did not mean that she was not perceived as a leader by other health care professionals. The theme of foster culture centered on statements about formal leaders who made Ellen feel valued, included, or listened to, thus fostering a culture. The following is Ellen's textural description. This description discusses what was experienced by Ellen with regard to physician leadership, as displayed in Figure 23, with textural (what) themes constituting the textural description.

Textural (what) description. After Ellen's reflective exercise, I asked her about experiences with formal leadership, to first think about examples prior to medical residency and then to reflect on examples of her experiences throughout residency. The themes that were constructed from Ellen's experience were supportive, take action, informally influential, and foster culture.

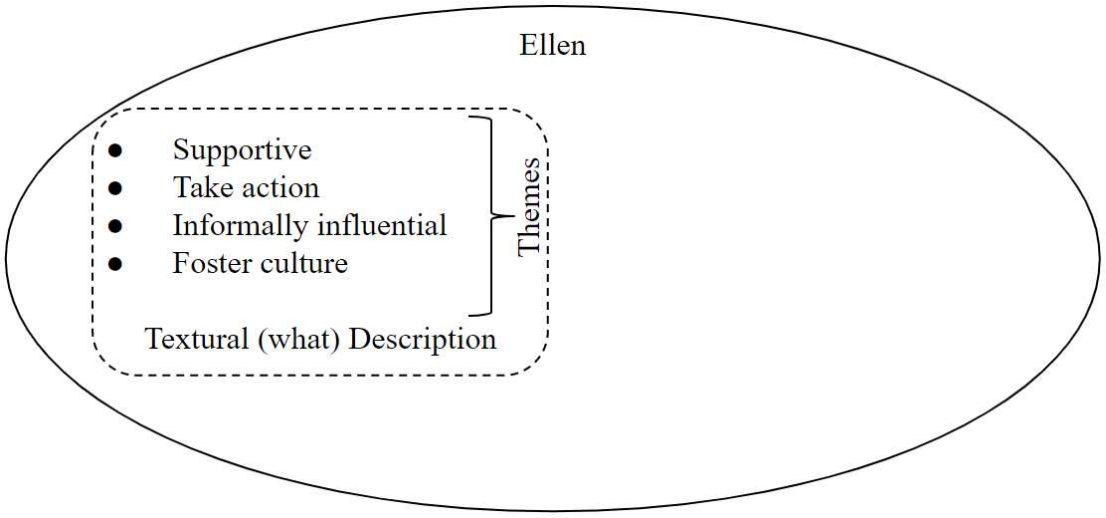

Figure 23. Ellen's textural (what) themes constituting her textural description.

Ellen started the interview by detailing perceptions of physician leadership as being a formal role and describing how medical residency had changed this perception. Ellen stated that she thought of physician leaders as those higher up or in "the traditional leadership roles" (Participant E, 2019, R10), such as program director or Chief Financial Officer, as well as physicians in the clinic who focus solely on patient care. Upon entering residency, Ellen became a part of a clinical team and, without her initially realizing it, led teams to take care of patients. As a third-year family medicine resident, Ellen viewed leadership as supportive in that she ensures that her "team is ahead of the game, and that they know what they need, and that I kind of help guide them toward that direction" (Participant E, 2019, R 36). She said that being supportive of patients and peers will inspire people to follow physician leaders.

Ellen focused on describing how a few physicians from her residency program took action to help patients, fellow physicians, and the local community. She stated that part of the role of the family physician is to advocate for the patient. This could occur by finding alternatives to costly medications, ensuring that the care provided by specialists is in the best

interest of the patient, or crafting policy that empowers residents to ensure the safety of their patients. Ellen stated that she observed senior physicians who saw a need for colon cancer screening in the community and did not wait for a formal role to take action but rather "reached out and made it happen for the community" (Participant E, 2019, R32). These physicians were influential through their informal roles.

One of the physicians whom Ellen mentioned continued to take informal action. "She kind of just reached out and kind of just helped patients, and then that's how she ended up getting into that role, which then tells us again that she didn't need that official leadership position" (Participant E, 2019, R32). From this example and others, Ellen described how her understanding of physician leadership had evolved from formal roles to being informally influential.

Ellen described that she was initially terrified when people referred to her as *Doctor* when she started medical residency. However, she felt that she had to make that cognitive shift and accept that she was a physician. She stated that leadership in her context is often more about informal influence rather than formal title or role.

Ellen perceived physician leaders to be those who, informally or formally, fostered culture. Ellen reflected on when she was interviewing at residency programs and stated that she was looking for a program director who was "reflective of what I wanted in a program, like someone who believed in work-life balance, someone who's like, "If you need this change, we'll make this change'" (Participant E, 2019, R20). She focused on the program director, other faculty physicians, and chief residents at her residency program and described how they fostered culture in her current program by not running the program authoritatively but rather by listening to input from the resident physicians, ensuring that the residents were healthy and enjoying

residency as much as possible. At a recent retreat, the formal leaders of the program questioned the resident physicians regarding what they wanted in the program and the type of applicants they should look for. To Ellen, these aspects helped to shape the culture of the program.

Structural (how) description. Ellen's structural themes are (a) role models, (b) medical residency, and (c) environment. Ellen focused on describing how physicians role modeled aspects that were either supportive or influential. For example, by taking action and helping a local community with colon cancer screenings, Ellen was inspired to see leadership through informal, rather than formal, roles. Also, the context of medical residency shaped Ellen's understanding of leadership. Prior to residency, Ellen had thought that leadership was about formal titles or roles. In residency, she entered a team atmosphere and had to lead patient care teams. She described the environment that formal and informal leaders created through taking action or communicating value by listening to the residents. The following is Ellen's structural (how) description. This description discusses how physician leadership was experienced by Ellen (Figure 24).

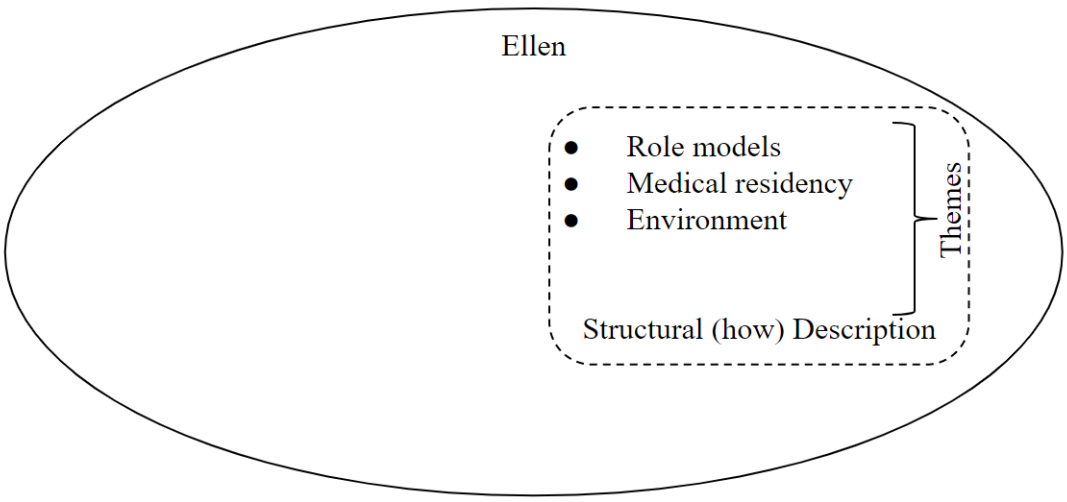

Figure 24. Ellen's structural (how) themes constituting her structural description.

From Ellen's experience in family medicine medical residency, she engaged with formal and informal leaders who served as role models that influenced her perception of physician leadership. Prior to medical residency, Ellen assumed that physician leadership was enacted by those in formal roles, such as a Program Director or Chief Financial Officer. Specifically, a few physicians who took action as informal leaders to provide health care for a local community, which resulted in formal roles communicated to Ellen the importance of influence:

> It just tells me how much more physicians can do, and not necessarily have to have that formal position. She kind of just reached out and kind of just helped patients, and then that's how she ended up getting into that role, which then tells us again that she didn't need that official leadership position. (Participant E, 2019, R32)

Ellen spoke of a supervising physician whom she had encountered when applying to the program; she said that the physician had helped to shape the culture of the program by valuing the voice and lived experience of the residents. For example, this supervising physician stated, "If you need this change, we'll make this change, we have the flexibility for us to do that here at our program" (Participant E, 2019, R20).

The context of medical residency appeared to influence how Ellen described physician leadership. She spoke about prior perceptions and contrasted them with experiences in residency where she was referred to as a doctor or being part of a clinical care team. "But now it's like, 'Oh no, you're a part of that team,' and you don't realize it, but you kind of run that team and have to take care of that patient" (Participant E, 2019, R12). The transition through residency from first year to third year, when senior physicians viewed the third-year resident physicians as colleagues, instilled a sense of ownership of informal leadership of resident physicians.

The environment that formal and informal leaders create influenced Ellen's perception of leadership. For example, the formal leaders espoused collaboration:

> "No, I'm not just telling you, you know, this isn't a drill sergeant telling you to do it, and you do it." It's like, "No, we want to hear your side of it so that we can make the

> program better, we can be better." And I think that is telling of a program in the leadership there. (Participant E, 2019, R20)

This example communicated to Ellen that the formal leaders were intentionally crafting an environment that was supportive and valued the resident physicians.

Textural-structural (nature) statement. From Ellen's transcript, it was apparent that she felt supported by informal and formal leaders who helped to develop a culture of support. This culture was attractive to Ellen, drew her to the medical residency program, and led to her overall satisfaction with the program. Through these role models, medical residency, and the overall environment, Ellen described her understanding of physician leadership. She took cues or was influenced, directly and indirectly, by environmental aspects or senior physicians. Ellen's textural (what) and structural (how) themes which guided construction of her textural-structural (nature) statement are depicted in Figure 25, followed by Ellen's textural-structural statement.

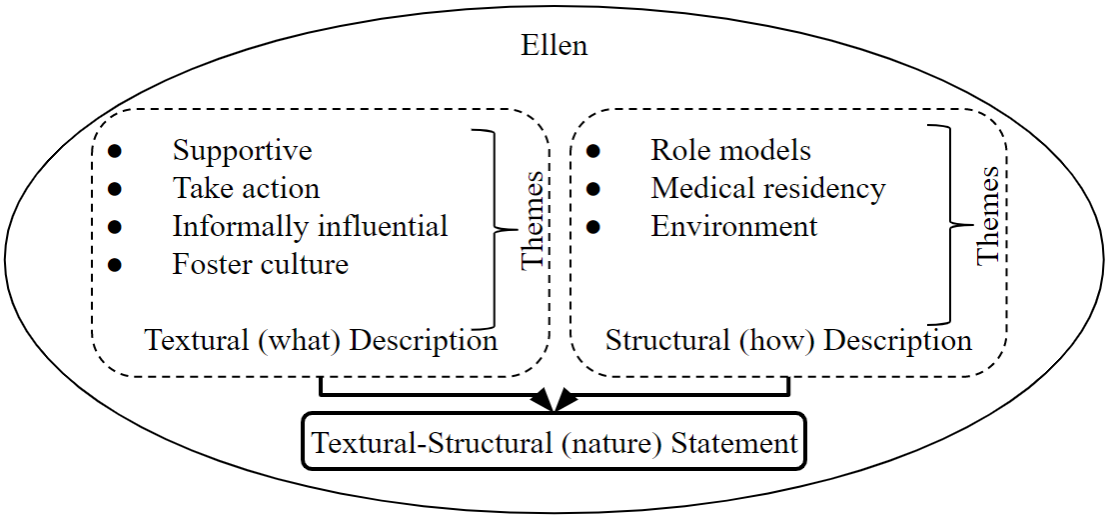

Figure 25. Ellen's textural and structural themes constituting her textural-structural statement.

Ellen highlighted how physicians acted directly or indirectly as role models by being supportive, taking action, being informally influential, and fostering culture. She also described

physicians who, without formal roles, took action to provide medical screenings. "It just tells me how much more physicians can do, and not necessarily have to have that formal position. She kind of just reached out and kind of just helped patients" (Participant E, 2019, R32). Although these physicians did not have formal leadership roles, they acted in ways that were informally influential to Ellen. "They just reached out and they made it happen for the people in the community" (Participant E, 2019, R32). The willingness to take action was also evident in Ellen's description of being a leader to patients.

Ellen discussed how family medicine physicians are on the front line of care. They are often the ones, unlike specialists who might solely focus on a specific aspect of care (e.g., heart, lungs), who can advocate for the safety and overall care of the patients. Ellen stated that, in day-to-day aspects such as care for a patient, resident physicians "make a decision on patient care; they're actually the team leader for that patient" (Participant E, 2019, R12).

Physicians who were in formal roles of leadership (e.g., program director, chief residents, faculty physicians) also influenced Ellen's understanding of physician leadership by being supportive through listening to the resident physicians or fostering a culture within the residency program. At a retreat, the program director and the chief resident had open conversations about the culture of the program and the type of applicants whom they should look to hire. Ellen reflected on when she was interviewing at residency programs and stated that she was looking for a program director who was "reflective of what I wanted in a program, like someone who believed in work-life balance" (Participant E, 2019, R20). The formal leaders in the program went out of their way to ensure that the resident physicians were enjoying medical residency and were mentally healthy.

The aspects of requesting feedback and looking after the resident physicians modeled physician leadership to Ellen and created a supportive environment in the context of medical residency. This role modeling informed Ellen's growth and understanding of physician leadership. With regard to medical students or more junior resident physicians whom she might lead, Ellen stated, "How I take it now as a resident in that role, like I do more a guide each year, like just guide the uprising students or residents just so that they can have that good learning time for them" (Participant E, 2019, R36). Through descriptions of her lived experience, Ellen grew from an understanding of physician leaders as holding formal roles to informal leadership roles. To Ellen, physician leadership is perceived as an overall

> supportive role, supporting our patients, supporting our co-residents, supporting our colleagues, but in a way that they kind of follow you. I don't think the traditional way of like "I tell you to do it, and you do it," that doesn't really work now. . . . I think physician leaders just kind of support, and then people generally follow along because they believe in that same goal setting and aspiration for it. So I think they follow the more supportive role. (Participant E, 2019, R48)

Ellen communicated that, prior to medical residency, she had thought little about physician leadership other than formal roles. Throughout my analysis, I needed to be critically aware of another prior assumption—that physicians do consider what physician leadership is prior to medical residency. Ellen did not make any changes to the textural-structural statement and stated on July 24, 2019, "I think the statement captured my understanding of physician leadership."

Frank

Frank was interviewed via telephone and, like Ellen, he thought of physician leadership prior to medical residency in terms of formal role or title. "My understanding for physician leadership is relatively vague. I don't believe I had any prior thoughts or opinions about what that meant. . . . I might have just thought of a title" (Participant F, 2019, R12). During the

interview, Frank spoke about an experience as a medical student when he was observing resident physicians. He described a supervising physician who challenged the resident physicians to think critically and empowered them to be self-reliant. He stated that the supervising physician "really empowered them to think for themselves, and I think that was eye-opening for me as far as what I want to do" (Participant F, 2019, R20). Frank is a second-year family medicine resident physician who disclosed that his time in medical residency had sparked interest in physician leadership, which led him to explore the topic on his own.

Analysis. Three textural themes were constructed based on 31 statements, 26 extracted statements, and five meaning units. This process is depicted in Figure 26.

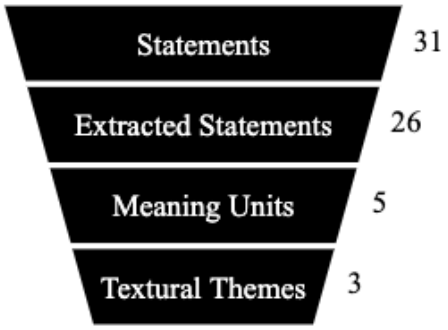

Figure 26. Totals for each component of analysis toward a textural description for Frank.

Frank's meaning units are (a) behaviors, (b) characteristics, (c) context, (d) culture, and (e) specialty. The meaning units and ensuing constructed textural (what) themes are listed in Table 14 and discussed subsequently.

The behaviors unit referred to the specific behaviors that Frank described. For example, Frank described how a more senior resident empowered or failed to empower through actions. The characteristic meaning unit was constructed based on descriptions of the leader behaving in

Table 14

Meaning Units and Textural Themes From Frank's First Interview

Meaning units	Inform →	Textural theme
Characteristics Behaviors Culture		Leader focused
Specialty Behaviors		Specialty
Context		Residency

specific ways. For example, Frank described physician leaders as behaving in empowering ways, such as encouraging residents to think critically or having the right attitude to garner student buy-in and foster culture. The context meaning unit was created by grouping statements on the context of GME. Frank spoke about the hierarchy in medical residency, as well as how his role in leadership had evolved in residency.

Frank used examples from the surgical and family medicine specialties. He spoke about an overall culture that was created by the characteristics and behaviors of the leader, which grouped statements under the culture meaning unit. The specialty meaning unit referred to specialty-specific comments regarding leadership. Frank spoke about how leadership in specialties may differ based on the specialty and specific outcomes (e.g., surgeries performed).

Frank's description of behaviors as they related to the leader and the specialty is an example of meaning units that cross over in the textural themes. First, Frank described how the physician leader should guide the resident physician and not be judgmental or aggressive, but act rather "in an empathic way" (Participant F, 2019, R24). This example was leader focused; however, Frank also described how physician leaders in surgery require their resident physicians

to perform a certain number of surgeries to become proficient. Conversely, Frank thought that physician leadership in family medicine was more about attitude than numbers.

Frank's textural (what) themes are (a) leader-focused, (b) specialty, and (c) residency. Frank experienced characteristics of leaders, or absence thereof, such as an overall attitude, empathy, or empowerment. Frank also experienced the culture of the context being created by such aspects as the characteristics and behaviors of the physician leaders, thus focusing on physician leaders or leader focused. The specialty theme was created from statements that discussed similarities and differences between the surgical and family medicine specialties. Family medicine was described as needing more broad and vague skill sets than surgical, which is more technical. Therefore, the leadership that Frank experienced was more difficult to solidify compared to his perceptions of the surgical specialty. Surgeons need to produce a surgery, whereas what family medicine physicians produce is less tangible. The residency theme was created based on comments regarding nuances within the realm of medical residency. Frank spoke about their roles evolving, being in the trenches, and the implicit/explicit hierarchy. The following is Frank's textural (what) description. This description discusses *what* was experienced by Frank with regard to physician leadership and is presented visually in Figure 27.

Textural (what) description. After Frank's reflective exercise, I asked him about his thoughts on physician leadership. He openly admitted that, thinking back on his education prior to medical school, he probably would have thought of leadership as a formal, titled, role. The themes that were constructed from Frank's experience were leader focused, specialty, and residency.

Much of Frank's description was leader focused in that he described aspects of the leader who would create a conducive learning environment or culture. For example, Frank stated that,

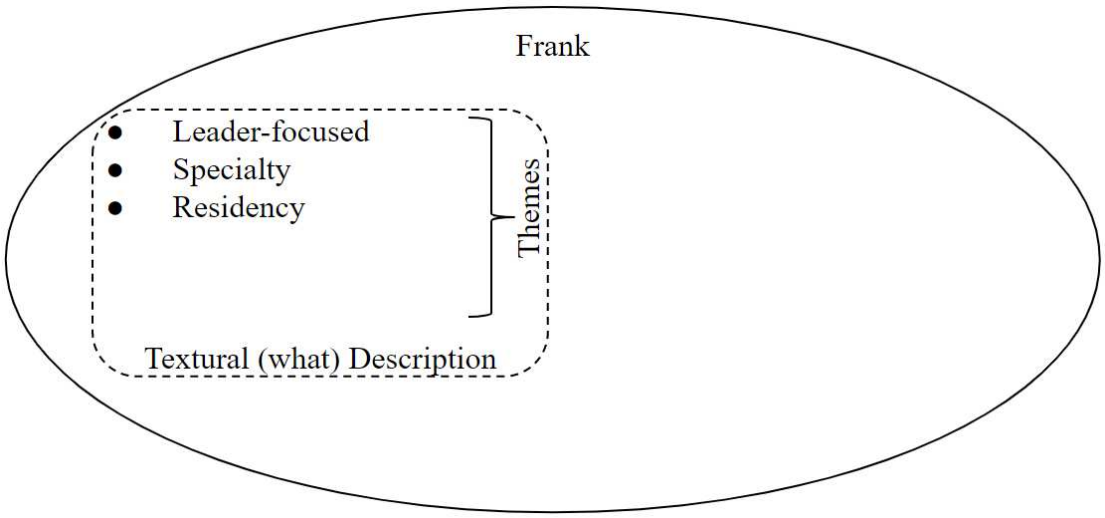

Figure 27. Frank's textural (what) themes constituting his textural description.

from his experience, physician leadership is "less so a position, it's more of an attitude, and how you generate a culture that's conducive to learning and also success, and empowering those working with you and underneath you to put them in a position to succeed" (Participant F, 2019, R18). Frank described a situation when he was a medical student that occurred with a senior physician who challenged the resident physicians to think more critically. This senior physician "really empowered them to think for themselves, and I think that was eye-opening for me as far as what I want to do" (Participant F, 2019, R20). Frank also stated that it was the attitude of those in leadership roles that cultivated an effective culture. Having a good attitude and displaying behaviors that empower and build trust were important to Frank and based on his experiences as a medical student but were inconsistent with experiences in medical residency. Frank mentioned that the leader should not only have the characteristics and behaviors to empower others but should also have insight into the follower' needs.

> You need to understand where your learner is far as strengths and weaknesses, as far as their goals, and as far as their comfortability with you and working within the team. If you can do that and identify those things, you can build a winning culture needed to put that learner in a position to succeed. (Participant F, 2019, R52)

Frank added that the leader must have a good attitude in order to create a positive environment for the person/learner to grow. The personhood of the leader appeared to be very important to Frank as he described many characteristics and behaviors that, from what he stated, would contribute to a culture within a residency program.

Drawing from examples in medical residency, Frank compared and contrasted the specialties of surgery and family medicine. When asked about physician leadership and whether the specialty influenced his perceptions, he described differences in outcomes between the two specialties. He noted that surgeons need to spend a certain number of hours in the operating room and complete a specific number of surgeries to develop successful techniques. In short, the completion of a surgery, to Frank, can be defined as success. Conversely, for family medicine, "It's more about attitude, it's less so about regimented numbers, I would say. So I think it's a little bit more vague and broad (Participant F, 2019, R48). For example, treating a patient in the family medicine specialty can be perceived less about technique. Frank said that, since success in family medicine is less clear, the characteristics and behaviors of the leader, such as attitude and empowerment, are important. The nuances between the specialties in terms of technique and definitions of success influence Frank's perception of physician leadership.

Frank highlighted the importance of the context of residency.

> [In residency,] you are in the trenches. You live within the hierarchy of the hospital. You are right there in the middle in the hierarchy between students and attendings. . . . You see the power transfer or power dynamics between physician to resident physician, and then you yourself live the power dynamic between yourself and the medical students. (Participant F, 2019, R38)

This hierarchy can, according to Frank, be difficult because resident physicians are at the bottom of the hospital hierarchy but often have responsibilities to lead teams, care for patients, and teach medical students. Frank perceived himself as a role model for medical students and tried to model characteristics and behaviors with regard to what he thinks a physician leader is. "So as a

leader myself, as a resident leader, leading medical students is what I mean, and being a role model to them, I've actively made strides to be positive with them" (Participant F, 2019, R40). Frank does not hold a formal role but perceived that his informal role with medical students makes him a leader to them.

Structural (how) description. Frank's structural (how) themes that were constructed from his textural (what) description were (a) role modeling, and (b) context (Figure 28). From Frank's textural description, he focused on examples in medical residency that did not match with his prior perception of physician leadership held in medical school. The role modeling that Frank saw in medical school and inconsistently observed in medical residency appeared to influence his perception of physician leadership and, thus, his behavior toward medical students. Through the specialty of family medicine and the context of medical residency, Frank perceived physician leadership to be different based on the practice involved in the specialty (e.g., surgical, outpatient), as well as the overall context of residency. Frank's structural description is presented below.

Based on Frank's lived experience in family medicine medical residency, he stated that he had encountered formal leaders who displayed characteristics and behaviors that matched a prior perception of physician leadership derived from experiences in medical school. Specifically, he observed a supervising physician who "really empowered them [resident physicians] to think for themselves, and I think that was eye opening for me as far as what I want to do" (Participant F, 2019, R20). Then Frank entered residency and "had certain expectations of what it meant to be a leader that would empower their residents. And I did get some of that, but I didn't get some of that, it has been hit or miss" (Participant F, 2019, R20).

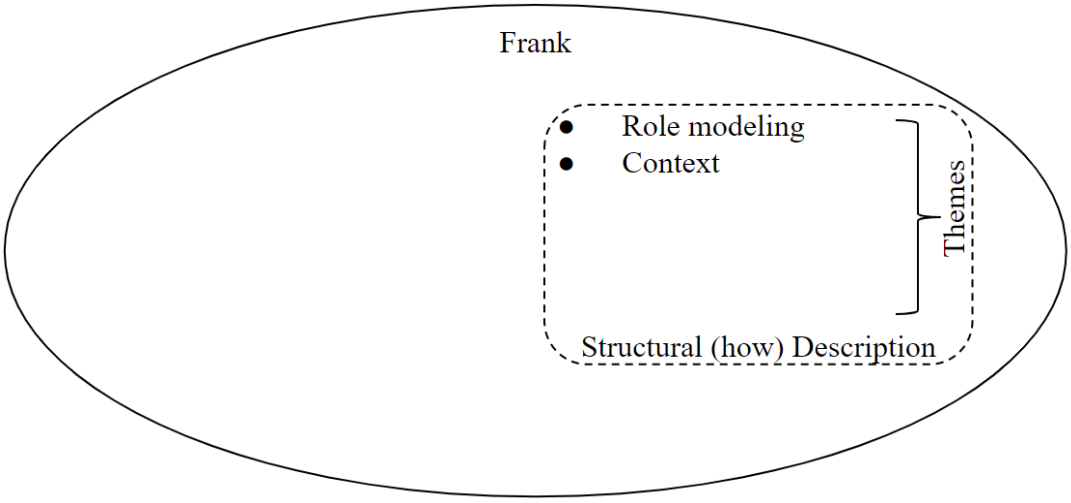

Figure 28. Frank's structural (how) themes constituting his structural description.

Frank perceived that the effective role models inculcated a productive culture. To Frank, effective role models foster such aspects as trust, empowerment, and autonomy. Ineffective role models did not hinder Frank's attitude; but rather encouraged him to learn more about physician leadership.

The context of medical residency helped to shaped Frank's understanding of physician leadership. Prior to medical residency, Frank perceived that he would have thought physician leadership was limited to a formal role or title. However, throughout residency, Frank has experienced the hierarchy of the hospital, which can be "tough" and have a "bad outcome" (Participant F, 2019, R44) if not navigated successfully. Frank's experience in GME communicated to him that he can also be an informal leader to medical students. For example, he tries to

> live more positively and spread that positivity around to the people around me. So as a leader myself, as a resident leader, leading medical students is what I mean, and being a role-model to them, I've actively made strides to be positive with them. (Participant F, 2019, R40)

While Frank admitted that a hierarchy embeds resident physicians in the trenches of clinical work and, between the power dynamics of senior physicians and medical students, Frank saw an opportunity to grow and improve himself as a physician and as a leader.

Textural-structural (nature) statement. Based on my textural and structural descriptions, Frank learned from effective and ineffective role models. The personhood of the role models (characteristics and behaviors) either helped to create a culture that empowered and built trust with others or did not. Frank said that the attitudes of the physician leaders were important. He perceived that physician leadership was different between specialties due to the type of work (e.g., surgical, clinical) and definitions of success (e.g., completed surgeries). Effective role modeling was important to Frank. Ineffective role modeling was also important, as it encouraged him to investigate what it meant to be a physician leader.

Frank said that he felt supported by informal and formal leaders who helped to develop a culture of support in his medical residency. Through role models, the context of GME, and the overall environment, Frank described his understanding of physician leadership. He took cues, directly and indirectly, from environmental aspects or those senior to himself. Frank's textural (what) and structural (how) themes that constitute his textural-structural (nature) statement are shown in Figure 29. Frank's textural-structural statement is stated below.

Frank's description of physician leadership was leader focused in that he centered on the personhood of the leader. He also emphasized the importance of the context of residency, as well as the differences between specialties such as surgery or family medicine. Moreover, Frank derived much of his perception of good leadership from effective and ineffective role models.

Frank admitted that, reflecting on his education prior to medical school, he probably would have thought of leadership as a formal titled role. He recalled an experience in medical

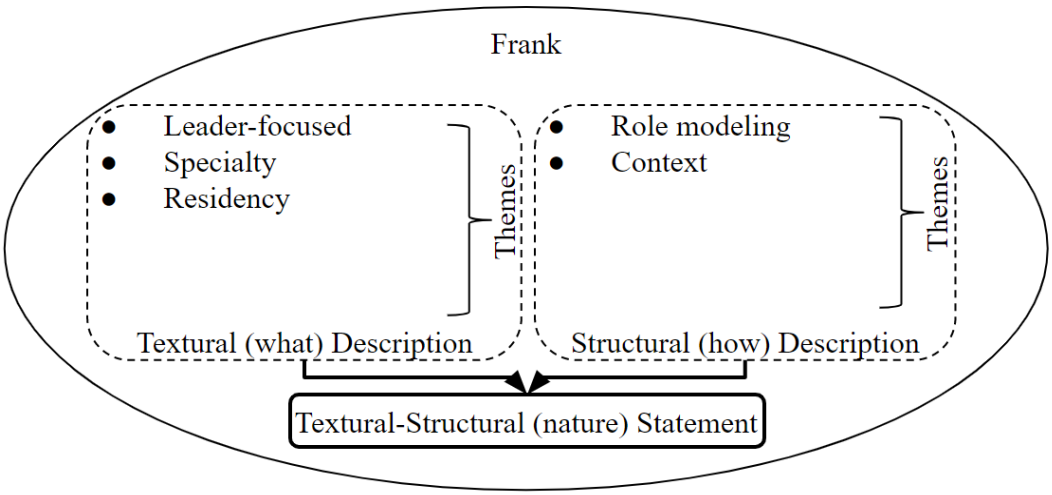

Figure 29. Frank's textural and structural themes constituting his textural-structural statement.

school in which he observed a supervising physician empower residents to think for themselves rather than just tell them what to do. "I think it that was really eye-opening for me as far as what I want to do" (Participant F, 2019, R20). As Frank described being in the trenches of clinical work and within the hierarchy of the hospital, he now perceived physician leadership "less so a position, it's more of an attitude, and how you generate a culture that's conducive to learning and also success, and empowering those working with you and underneath you to put them in a position to succeed" (Participant F, 2019, R18). According to Frank, effective physician leadership begins with the personhood of the leader; that is, it is leader focused. For example, when a physician leader has characteristics such as a positive attitude that empowers, behaves emphatically, and is insightful, that leader can build trust among followers as they feel that they can trust that the leader believes in them, gives them responsibilities rather than authoritatively dictating what to do, and is intentional about understanding their position. "If it's a positive culture, and you can tell the person is empathetic and cares for you, you will work harder and produce better results for someone who cares for you" (Participant F, 2019, R30). Conversely,

authoritative leaders are perceived by Frank as potentially toxic because they are perceived to be trying to overwork him and may lack connection with him and other followers, which contributes to a negative environment (Participant F, 2019, R30). To Frank, culture originates with, and is propagated by, the personhood of the leader.

The context of medical residency affirmed Frank's prior understanding of physician leadership as he had "expectations of what it meant to be a leader that would empower their residents. And I did get some of that, but I didn't get some of that, it has been hit or miss" (Participant F, 2019, R20). Through residency, Frank observed both effective and ineffective role models. He perceived that the effective role models instilled a positive culture through such aspects as trust, empowerment, and autonomy. The ineffective role models encouraged Frank to learn about physician leadership on his own.

Medical residency can be perceived as a long and difficult process for many reasons. To Frank, an effective temperament can differentiate those who leave medical residency as productive leaders and those who "crack under the pressure of this long process" (Participant F, 2019, R44). Frank stated that medical residency has many challenges, such as hospital hierarchies and power dynamics; however, the process has inspired Frank to change himself for the better. He realized that, even though he does not have a formal title, he has seen his responsibilities evolve to the point that he can also view himself as an informal leader. "As a leader myself, as a resident leader, leading medical students is what I mean, and being a role-model to them, I've actively made strides to be positive with them" (Participant F, 2019, R40).

Frank acknowledged that physician leadership may depend largely on the overall attitude of the physician leader who fosters a culture. However, he noted that leadership can also be influenced by variations in practice and outcomes between specialties. He described differences

in outcomes between surgery and family medicine. He stated that surgeons need to spend a certain number of hours in the operating room and complete a specific number of cases to develop successful techniques. According to Frank, the completion of a surgery can be defined as success. Conversely, for family medicine, "It's more about attitude, it's less so about regimented numbers, I would say. So I think it's a little bit more vague and broad" (Participant F, 2019, R48). For example, treating a patient in the family medicine specialty could be perceived to be less about technique and to require a somewhat different skill set (e.g., interpersonal). Frank discussed that, since success in family medicine is vague, the characteristics and behaviors of the leader, such as attitude and empowerment, are important.

Frank's telephone interview was particularly exhilarating. Although he was concise, he discussed aspects such as empathy, culture, and understanding followers, which were especially insightful points for reflection. Frank requested no changes to my textural-structural statement of his lived experience of physician leadership. On July 30, 2019, he responded, "Yes, that looks accurate. Thanks for your hard work. Look forward to hearing from you in the coming weeks."

Summary

The six resident physicians provided in-depth descriptions of how they perceived the nature of physician leadership from their lived experiences in GME. Although their time was limited, the participants were interested in discussing this topic. The process of reflecting and describing their perceptions proved educational to me and to the participants. In particular, when I asked Daniel about interactions that have informed his understanding of physician leadership, he reflected on sacrificial aspects. "Then I guess through our conversation, realizing that there's a lot more sacrifice to leadership than it is just being a leader in name" (Participant D, 2019, R68). Once I had analyzed the individual participants' data, I analyzed the data across

participants. Thus, the entire data set is depicted in my integrated data analysis stages of *integrating descriptions* and *synthesis* as discussed in Part II below.

Part II: Shared Description of the Nature of Physician Leadership

Both Colaizzi (1978) and Moustakas (1994) stated that individual descriptions inform a synthesis statement that captures the shared "essential structure" (Holloway & Galvin, 2017, p. 234) or "essence" (Moustakas, 1994, p. 55) of a phenomenon. Aligning with MacTaggart (2018), both Colaizzi (1978) and Moustakas (1994) did not define a process for integrating descriptions to construct a shared textural-structural (nature) synthesis statement. This allowed deference to myself as the instrument of inquiry (Guba & Lincoln, 1994). To integrate descriptions and construct a shared synthesis statement, I discuss the following in the subsequent sections: (a) redundancy, (b) integrated analysis, (c) shared textural (what) description, (d) shared structural (how) description, and (e) shared textural-structural (nature) synthesis statement.

Redundancy

The number of participants in this study was guided by the notion of redundancy (Lincoln & Guba, 1985). Redundancy suggests that recruiting participants can cease when no new information arises (Patton, 2015). The anticipated range of participants was three to eight. Not presetting a specific number of participants supported a "flexible and emergent" (Patton, 2002, p. 246) design and echoed the constructivist paradigm through recruiting participants until the data are determined to be saturated with repetitive aspects across participants (Lincoln & Guba, 1985). In total, I recruited three participants from one family medicine residency program and three from another. Both residency programs, and the participants, were located in the same southwestern state.

Guided by Lincoln and Guba's (1985; also Bowen, 2008; Patton, 2015) notion of redundancy, I reviewed the textural (what) descriptions, structural (how) descriptions, and textural-structural (nature) statements for all six participants. For example, four of the participants (Ashley, Beth, Courtney, and Ellen) noted attributes or characteristics of the physician leader as important. Ashley valued authentic communication. Beth noted the attributes care, integrity, trustworthy, and transparency of physician leaders that built trust between Beth and the formal physician leader. Courtney stated that emotional intelligence is important for physician leaders to understand how their followers are doing, as well as passion for investing in followers. Ellen described physician leadership as more of an inherent attitude of the physician leader than a specific position.

Three participants (Courtney, Ellen, and Frank) described role models as their path to feeling valued, devalued, empowered, and so forth. Courtney described how role modeling by physician leaders had influenced her perceptions of physician leadership. She also discussed how a physician leader processed the death of a patient. According to Courtney, the approach that the physician leader took in that situation cultivated a perception of equality with the physician leader. For Ellen, the role modeling by informal leaders who took initiative to help patients in the community communicated to her that physician leadership is not just about a formal role. Frank observed a senior physician who modeled empowering residents to think critically, which influenced his perception of what he wanted to do when he is in that role.

Based on this review, the following aspects were redundant and no new substantial information arose. The information provided by the participants was thick and rich; thus, redundancy (Bowen, 2008) occurred. I perceived that I could move to the next stage of analysis

(integrating descriptions). Financial resources to engage more participants were constrained, as well my overall timeline, which, according to Patton (2015), must be considered.

Integrated Analysis

In keeping with the constructivist paradigm, the research design, and integrated analysis process based on Moustakas (1994) and Colaizzi (1978), I utilized the entirety of the data set for analysis and construction of shared textural and structural descriptions. Reviewing meaning units, transcripts, in-case descriptions, and in-case textural-structural (nature) statements was important to ensure accurate understanding of the content (Colaizzi, 1978; Moustakas, 1994). The steps for integrated analysis in the stage of *integrating descriptions* follows.

First, I printed the textural (what) and structural (how) descriptions for each participant on individual pages and physically laid them on the floor. This approach aligned with the constructivist paradigm and allowed me to move back and forth physically among the descriptions to foster an understanding of parts and the whole of the lived experiences of physician leadership for each participant and across participants. This approach proved to be more effective than software (i.e., GoogleSheets, SuperNotecard). Manual manipulation of the individual descriptions acquainted me with their individual experiences before looking across the data for shared aspects. I also printed the pertinent statements from the full list of statements tab in GoogleSheets for each participant and cut them out so they could be manipulated manually.

Next, and following the same process with the individual descriptions, I read through the 205 statements for all participants twice and grouped them into textural (what) meaning units, then textural themes. I returned to the in-case textural descriptions to refresh understanding of what was experienced to guide cross-case analysis and returned to the transcript as needed to clarify contextual questions.

I first read each statement from Ashley, then sorted her statements to look for shared aspects, or meaning units. Once I had sorted Ashley's statements, I took the meaning units and placed them onto statements that shared the same, or similar, aspects for Beth. I made sure to be cognizant of statements that were singular as they might be repeated across participants. The iterative process was (a) sort Ashley, (b) sort Beth and include Ashley's meaning units and read back over the individual statements, (c) sort Courtney and include Ashley's and Beth's meaning units and read back over the individual statements from Ashley, Beth, and so forth. I proceeded to each subsequent participant until meaning units shared across participants remained. In keeping with Moustakas (1994), irrelevant, repetitive, or overlapping statements were set aside which resulted in 122 extracted statements as shown in Figure 30.

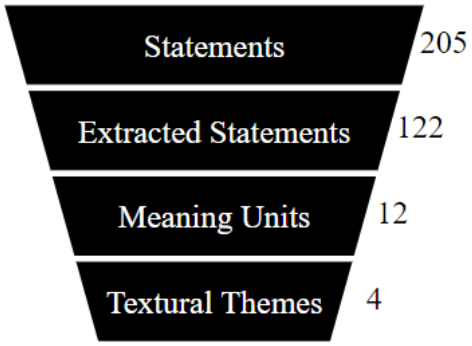

Figure 30. Totals for each component of analysis toward a shared textural description.

After reading through the 122 statements twice, and the first sorting noted above, I constructed 14 meaning units. I went back through the emerging meaning units and individual statements to ensure that no shared aspects were missed during the second sorting. I followed MacTaggart (2018) and identified the meaning units as shared if the majority identified something in their statement that was repeated across four of the six participants. I then

constructed six meaning units. I reviewed the meaning units to determine whether there were separate ideas within meaning units that were shared by four of the six participants.

In the third round of sorting, I constructed seven meaning units. The number of meaning units expanded during the fourth round of rereading and sorting. In this round, I determined that some meaning units should be divided based on disparate concepts. For example, I split the followers meaning unit into understanding followers and developing followers. Variance in specialties was split into specialty magnetization (i.e., drawn to a specialty) and specialty context. After the fourth round of sorting, I constructed 12 meaning units, as shown in Table 15.

Table 15

Textural Meaning Units and Statements From Each Participant

Textural meaning units	Statements	A	B	C	D	E	F
Specialty magnetization	5	1	0	2	1	1	0
Specialty context	10	1	0	1	1	2	5
Compassion	4	0	0	1	1	1	1
Advocates	8	0	3	1	1	3	0
Listening	8	2	2	2	0	2	0
Hierarchy	14	4	0	0	2	4	4
Leader influence	18	0	2	3	1	4	8
Understanding followers	8	1	4	1	0	1	1
Developing followers	12	2	3	4	0	2	1
Skills	8	5	1	1	1	0	0
Traits	15	6	6	2	1	0	0
Action oriented	12	1	0	0	5	5	1

I returned to the individual textural meaning units to determine whether the composite, or shared, meaning units reflected individual meaning units. I determined alignment based on similar concepts (e.g., understanding followers, modeling leadership) between individual and shared meaning units.

The next step involved reviewing the shared meaning units, in the same manner for individual meaning units, by asking questions such as (a) What are the units describing, and (b) are the units compatible with the participant's experience (MacTaggart, 2018; Moustakas 1994). Once done reviewing the note cards twice, I recorded my rationale for the shared textural meaning units as stated in the following subsection.

Shared meaning units rationale. The specialty magnetization meaning unit grouped statements addressing differences between family medicine and other specialties, personality variances (in general) between family medicine and other specialties, and unique aspects of family medicine that drew the resident physicians to that specialty. Next, the specialty context meaning unit collected statements addressing aspects to describe the context of family medicine. For example, some statements discussed how family medicine is not as rigid or dogmatic as other specialties, so the goals for training may not be uniform. In addition, the skill sets required of family medicine physicians may differ due to the point of care in which they interact with patients. The compassion meaning unit described how compassion of a leader was important and how it influenced the resident physician's desire to be compassionate toward others.

The advocates meaning unit grouped statements on how family medicine physicians, in general, advocate for others, such as advocating for patients to have access to a certain type of medication, rural health care, or a policy change to improve care for their patients. Advocating appeared to focus on the benefit to the patient, not necessarily to the benefit to resident

physicians. Statements about leaders listening to resident physicians were grouped into the listening meaning unit. Statements about the need to be heard were also grouped into this meaning unit. Next, the hierarchy meaning unit included statements about (but not limited to) (a) where resident physicians are in the hierarchy of the hospital, (b) pre-residency perceptions about hierarchy and leadership, and (c) the tangible ways in which resident physicians are treated within the hierarchy.

The leader influence meaning unit included statements about formal and informal leaders building a trusting culture through such actions, the inclusion of medical students and residents in making decisions, and the general attitude of leaders that helped to shape a culture. Statements about a general sense of camaraderie that resident physicians felt from the formal physician leader were also included. In addition, aspects leaders who served with followers exhibited collaboration and built a collaborative culture. Understanding followers collected statements about physician leaders, either showing that they are making efforts to understand their followers or the need for leaders to understand those who follow them. The developing followers unit also grouped statements about followers, but these statements focused on supporting followers (e.g., resident physicians) through behaviors that built trust, communication, and exhibited a sense of transparency.

The skills meaning unit grouped statements about specific aspects of physician leaders that enable them to lead, build culture, develop followers, and so forth. Such aspects included knowledgeable, goal oriented, and inspired (inspirational). Leader attributes grouped statements about the specific aspects of the physician leader that the resident physicians saw as reflecting physician leadership. Such aspects included but were not limited to patient, trustworthy, desire, and personality. The action-oriented meaning unit collected statements about how informal and

formal leaders took action to care for patients, their community, or the resident physicians. Their actions communicated care and fostered a sense of leadership. After discussing the rationale, I exported the note cards into outline format to look across the participants' experiences. The following subsection discusses the shared textural themes

Shared textural themes. After completing the fifth round of reading through the statements in their respective meaning units, I grouped the meaning units into four textural themes: (a) environment, (b) leader behaviors, (c) leader attributes, and (d) follower focused. Once the textural themes were identified, I uploaded the statements into SuperNotecard and arranged the individual statements into stated themes and meaning units, as shown in Table 16.

Shared textural (what) themes rationale. After reviewing the individual statements, meaning units, and thematic clusters, I determined alignment. Alignment was based on similar topics, as shown in Table 16 and in the list of meaning units and themes in-case descriptions and statements.

The environment textural theme grouped meaning units that addressed aspects of the specialty, hierarchy, or influence of the leader that influenced the participant's understanding of physician leadership. The leader behaviors theme grouped behaviors or actions of the leader, such as listening or advocating on behalf of peers, resident physicians, or the family medicine specialty. The leader attributes theme coalesced aspects such as skills or attributes (e.g., compassion) that were described as more internalized and similar to traits. The follower focused theme grouped meaning units around the physician leader understanding or developing followers. The shared textual (what) description follows.

Shared textural (what) description. From the data collected from six family medicine resident physician participants, I identified shared textural themes, or what was experienced,

Table 16

Textural Themes, Meaning Units, and Statements From Each Participant

Textural themes	Meaning units	*n*	A	B	C	D	E	F	Total
Environment	Specialty magnetization	5	1	0	2	1	1	0	47
	Specialty context	10	1	0	1	1	2	5	
	Hierarchy	14	4	0	0	2	4	4	
	Leader Influence	18	0	2	3	1	4	8	
Leader behaviors	Action oriented	12	1	0	0	5	5	1	28
	Listening	8	2	2	2	0	2	0	
	Advocates	8	0	3	1	1	3	0	
Leader attributes	Skills	8	5	1	1	1	0	0	27
	Traits	15	6	6	2	1	0	0	
	Compassion	4	0	0	1	1	1	1	
Follower focused	Understanding followers	8	1	4	1	0	1	1	20
	Developing followers	12	2	3	4	0	2	1	

Note. n = number of statements for the meaning unit. Total = number of statements for the theme.

with regard to the phenomenon of physician leadership through their lived experiences in GME (Figure 31). Although shared textural (what) themes were identified, it is important to reiterate that these themes are relative to the sociohistorical contexts of the participants and provide "insight about the phenomenon, not empirical generalization from a sample to a population" (Patton, 2002, p. 40). The quality criteria for this study places the onus on the audience to determine transferability, or relevance of findings, to other settings (Lincoln & Guba, 2013). To reiterate, the 12 meaning units were grouped into four thematic clusters or themes: (a) environment, (b) leader behaviors, (c) leader attributes, and (d) follower focused.

Environment. The environment in which the family medicine resident participants practice medicine is important to their growth as health care professionals and skilled primary

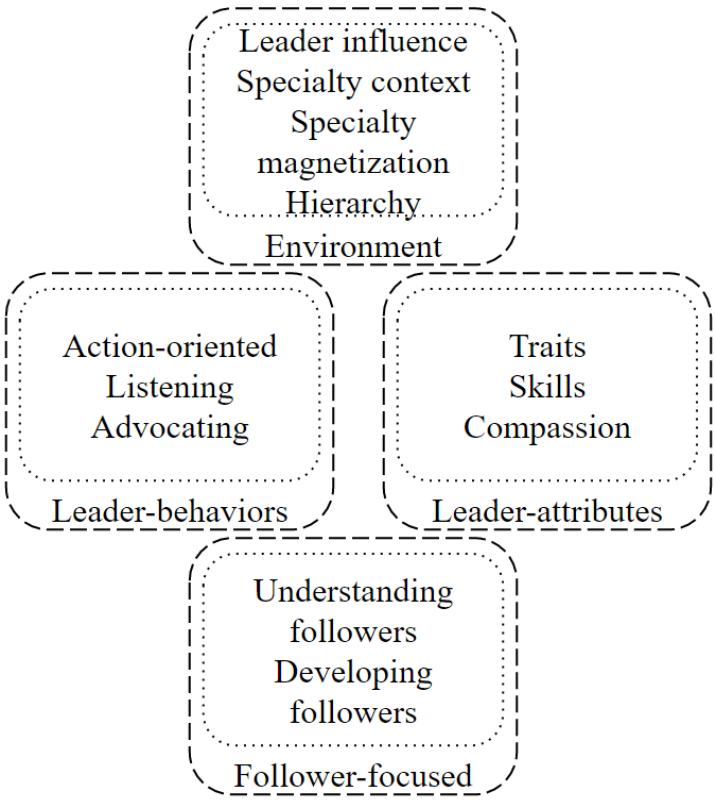

Figure 31. Shared textural (what) themes and meaning units for all participants.

care physicians. In the overall environment of medical residency, or GME, family medicine resident physicians encounter daily cross-examination of clinical knowledge, long working hours, acclimating to the complex administrative structures of the health care organization, documenting care in electronic health records software, and navigating health care policy, all while attempting to provide care to patients and learn what it means to be a physician. Frank stated that medical residency is "a long and arduous process . . . your knowledge and your confidence is constantly being tested, whether implicitly or explicitly, with learners questioning you, or nurses asking for orders, or patients asking for advice, you are constantly being tested" (Participant F, 2019, R44). With the various clinical and educational demands on resident

physicians, medical residency can be considered the "forge of professional formation" (Cooke et al., 2010, p. 239).

Leader influence. The participants described how formal (e.g., program director) and informal leaders, such as a respected upper-level resident, influenced their understandings of physician leadership. From those leaders who degrade to those who include the resident physicians and medical students in caring for patients, the participants described how these leaders either personified the culture or shaped the culture within the medical residency environment.

Personify culture. Ellen described how the program director of her residency exemplified what she was looking for when selecting a residency program. "I picked a program that the program director was kind of reflective of what I wanted in a program" (Participant E, 2019, R20). Ellen stated that she believed in balancing work and personal life and desired the opportunity to provide input into her education. She found a culture that reflected her values and was embodied by the Program Director. Beth described her chief residents as embodying "a sense of camaraderie, which I think is really important from a peer perspective of things" (Participant B, 2019, R26).

In the forge of professional formation, it is understandable that camaraderie through years of rigorous training is important to the resident physicians. Courtney and Frank said that, when leaders personified teamwork by serving alongside the participants, it made the leaders more relatable, which influenced them to work harder for their leaders. According to Courtney, the leaders embodied the teamwork that they wished to see in the resident physicians. Conversely, Frank noted that, when leaders are toxic, "you don't find any connection with this person, you're not going to feel [like] wanting to work" (Participant F, 2019, R30).

Shape culture. The participants spoke about how the leaders in their programs helped to shape culture through their attitudes. Ellen reflected on a retreat during her second year in which the Program Director, Chief Resident, and other resident physicians in her class engaged in a collaborative dialogue about the trajectory of their program and the type of people whom they wanted to admit to the program. To Ellen, this open attitude among the leaders was important and reinforced that the leaders were intentional about ensuring that they exhibited an inclusive attitude and "that the residents are like having a good time during residency" (Participant E, 2019, R16). Frank noted that the attitude of a leader either shapes a negative culture or helps to "generate a culture that's conducive to learning and also success, and empowering those working with you and underneath you to put them in a position to succeed" (Participant F, 2019, R 18). Daniel mentioned that, when he was a first-year resident on hospital service he "got shit on" (Participant D, 2019, R46), so it was important to him to have a leader who looked out for the resident physicians. Daniel desired to have a supportive attitude toward junior resident physicians and offer them concessions, such as going home early to take care of family.

Specialty context. The participants noted differences in context of specialties between family medicine and other specialties, such as surgery. These differences influenced how formal and informal leaders led the participants. For example, Ellen noted that in family medicine, physicians encounter patients upon entering the health care system and ensuring that they receive appropriate care, including from specialists if needed. Working with the patient to ensure future care, as well as with specialists and other health care providers engenders interpersonal skills that may differ from the skills that those in other specialties such as surgery. For Ashley, and there are exceptions, leaders in surgical specialties come across "as being more aggressive, and certainly thicker skinned" (Participant A, 2019, R52). Frank said that leaders in family medicine

focus more on attitude and interpersonal skills than on technical outcomes, such as the number of surgeries completed. Courtney added that those in surgical specialties tend to focus not as much on emotional skills but "probably more on this is what needs to be done, and get it done" (Participant C, 2019, R40). Daniel said that, when a patient is lying on the operating table, many things can go wrong and "you are there to do exactly what the physician who is in charge wants you to do" (Participant D, 2019, R 34).

In comparison to the specialty of surgery, Frank admitted that the exact skill set that he needs to develop in family medicine is less clear. For example, surgical resident physicians need repetitions and hours in the operating room to perfect techniques that may drive directed and manual-skills focused leadership. On the other hand, family medicine resident physicians interact with medical students and patients in a more interpersonal and less technique-driven setting, such as in an outpatient clinic. "I would say family medicine is not as dogmatic as surgical specialties because of the way their specialty is required to act as far as like what their training is, as far as skill sets they're learning" (Participant F, 2019, R48). Frank stated that, in comparison to surgical specialties, family medicine has a less regimented approach to leading, teaching, and creating an environment in which resident physicians can learn (Participant F, 2019, R48). The family medicine specialty interacts with patients on the front lines of health care and requires the participants to develop interpersonal rather than technical skills in order to work with other physicians and patients.

Specialty magnetization. In addition to the context of family medicine informing the type of leadership that may be displayed by formal and informal leaders, the participants indicated that the family medicine specialty seems to draw certain types of physicians. In general, Courtney suggested that the specialty of family medicine

> attracts more people who are interested in having relationships with their patients and stuff like that because they [family medicine physicians] care about you [patients], what's your job, what do you do, what's your family like, how's your home life? You know, you care about those sorts of questions a lot in family medicine. So I feel like there's . . . kind of my field of medicine tends to attract, I don't know, more . . . people who I think can relate on an emotional level more with patients a lot of times. (Participant C, 2019, R40)

Ashley and Daniel agreed that personality types appear different between specialties and that family medicine has more of a feel of being a family. Daniel expanded on the need to be a part of a team "rather than just do someone's bidding" (Participant D, 2019, R64), whereas Ellen focused on patient care and described a strong need to serve as a guide to help patients to get "what they want from their life at the end of the day" (Participant E, 2019, R46). Regardless of the aspects of specialty that drew each of the participants to family medicine, they described physician leadership in ways that reflected traits or characteristics (e.g., compassionate) that are important to the work of family medicine physicians.

Hierarchy. The hierarchy within the medical residency is visible, tangible, and difficult. The participants initially described physician leadership based on the hierarchical structure of medical residency. Daniel discussed the hierarchy in the resident program in which third-year residents supervise second- and first-year residents, as well as patients under their care. Ellen and Frank perceived the resident physician as the lowest person on the hospital totem pole.

> As a resident physician, you are in the trenches. You live within the hierarchy of the hospital. You are right there in the middle in the hierarchy between students and attendings. So day-to-day, you do live that hierarchy, and you see the power transfer or power dynamics between attending physician to resident physician, and then you yourself live the power dynamic between yourself and the medical students. (Participant F, 2019, R38)

Although it is difficult, the hierarchy of physician leadership was not surprising to the participants. They spoke about either having explicit perceptions of physician leaders as those in formal leadership roles who "make decisions" (Participant A, 2019, R2) or just implicit

assumptions about physician leaders being the physicians in "higher-up levels, your program director, your CFO, your kind of just like clerkship directors, people who were more involved in the traditional leadership roles" (Participant E, 2019, R10). While the participants readily acknowledged the hierarchy of the GME and clinical environments, they acknowledged but did not easily accept the hierarchy between professions (e.g., nursing, technicians) and even patients. For example, Ashley recognized that physicians are leaders to their patients but said that she did not fully process this hierarchical role. "That's a whole other kind of leader that I haven't really considered, or haven't really brought up, like that yes, every physician is a leader just simply to their patients" (Participant A, 2019, R 22). The hierarchical influence on the environment influenced how participants viewed physician leadership in their roles as resident physicians to those in formal roles above them or to their patients.

Leader behaviors. When describing the nature of physician leadership, the participants spoke at length about the behaviors of formal and informal leaders. They focused on physician leaders being (a) action-oriented, (b) listeners, and 3) advocates.

Action oriented. Ellen focused on the actions of informal leaders from her experience in medical residency. One of the physicians who did not hold a formal role in the program engaged in medical missionary work in other countries but also coordinated free clinics in the local community. Ellen said that the leader "just made it happen for the people in the community" (Participant E, 2019, R32). The initiative from this physician influenced Ellen's understanding of physician leadership. Daniel focused on a situation with his program director whom he consulted regarding a specific dosage issue and was advised to research the issue and teach the program director. To Daniel, the program director could have just told him the solution, but he had Daniel take action and research it himself. An action-oriented leader is very important to the

experience of medical education for Daniel. Furthermore, Daniel perceived that the nature of the environment requires action:

> The environment that we're in residency is not a "do as you're told" more than it is a "learn while doing." So you should be able to make mistakes, albeit mistakes that shouldn't affect patient care. But you should be allowed to make mistakes, make decisions, even if they're wrong, and then have them corrected later or in some capacity learning about them. Whereas without making some mistakes, you don't have anybody to learn from, you're a robot being told what to do. (Participant D, 2019, R38)

Daniel's experience with his program director influenced his understanding of physician leadership in that he realized that physician leadership involves intentional sacrifice. Just as Daniel's program director sacrificed clinical time, and possibly performance metrics, to help him learn, Daniel also described an experience as a third-year resident physician when he sacrificed time and assumed a larger workload so that resident physicians under his supervision could go home early. "I don't know, it made me feel like they felt like I appreciated the work that they did, and that they would continue to work hard for me, knowing that I'm willing to give up a few things myself" (Participant D, 2019, R52).

Ashley recalled an experience with the chief residents who did not just tell the other resident physicians they were available but made it a point to be available when they were needed. Specifically, Ellen described the situation with a physician who did not have a formal leadership role in the program until efforts to coordinate clinics in the local community were noticed and the physician was given a formal leadership role. "She just did it—because I guess that's how physicians fall into those [leadership] positions" (Participant E, 2019, R14). To these participants, physician leadership is action oriented.

Listening. One of the specific behaviors that the participants described as informing their understanding of physician leadership was listening. The participants arrived at this conclusion from various experiences. For example, Beth stated, "I personally just feel like I'm not heard,

and so I feel like that's been one of the experiences [medical residency] that's really pushed me to be like this is what I view leadership as" (Participant B, 2019, R46). Conversely, Ashley, Courtney, and Ellen all stated that the formal leaders of their program valued their input. "I think our program director has done really well about listening to the residents, and then also making sure that they are heard" (Participant E, 2019, R16).

The behavior of listening to the resident physicians influenced their perception of the leaders and of physician leadership in general. Courtney stated that, when her leaders take time to talk with her "and actually have like an open genuine conversation about those feelings or those thoughts, where you feel heard, where you feel understood. Maybe that's not going to change anything specifically, but it humanizes the whole situation" (Participant C, 2019, R20). Moreover, the act of listening made Ashley feel cared for and influenced how she acts toward patients. "And that's just a trickledown effect" (Participant A, 2019, R28). The responses from the participants about the behavior of listening were passionate, as the training in medical residency is rigorous and having leaders who take the time to acknowledge input speaks positively to the participants about their personal value.

Advocates. Another key aspect of the lived experiences of physician leadership was leaders who advocate for patients and the specialty of family medicine. Ellen, Courtney, and Beth perceived that, due to the role of the family medicine physician, a physician leader must advocate for the well-being of patients. For example, Ellen noted, "I think as family medicine physicians, we are the biggest advocate for our patients . . . for safety, and things that we would see on the first line that most of our specialist colleagues won't be able to see" (Participant E, 2019, 44). Courtney supported Ellen's perceptions and added that advocating for patients occurs because family medicine physicians look at other variables that affect the patient, such as

socioeconomic status, family dynamics, and access to medications. Courtney said that family medicine physicians advocate because "they tend to want to improve as much as they can of the person's life, not just kind of focused on treating this one thing" (Participant C, 2019, R40).

Beth discussed advocating on behalf of the family medicine specialty with regard to rural health care. She cited a formal leader in medical school who strongly believed in the rural health care component of family medicine. This leader's passion and dedication influenced Beth in broadening her understanding of physician leadership beyond patient care.

> He kept on fighting for what he believed was necessary in trying to train us to become the best rural physicians we could be going forward, and to fill these gaps in care in these rural areas. And I feel like that's something that really stood out to me in a true leadership role. (Participant B, 2019, R 14)

Leader attributes. In addition to describing behaviors of physician leaders that helped the participants to understand physician leadership, they examined attributes such as traits, skills, and compassion. These attributes framed participants' understanding of physician leadership.

Traits. According to Ashley, physician leaders are passionate, caring, and outgoing and have a sense of authority. "They're not easily like pushover kind of people" (Participant A, 2019, R4). Beth echoed Ashley's observation about passion and added that passion enables leadership to be sustainable. "Passion is a big part of leadership, because you cannot be a leader if you're not passionate about what you're leading" (Participant B, 2019, R50). Beth also stated that caring is innate to physician leadership in family medicine. "I think there's just that innate leadership quality with the understanding that we're going into this profession because we want to help people" (Participant B, 2019, R64).

Skills. Beyond innate traits, the participants spoke about specific skills displayed by physician leaders. Ashley and Beth spoke about physician leaders being knowledgeable about a topic, clinic issue, and so forth. This knowledge enabled physician leaders, in her experience, to

evaluate various perspectives on an issue and motivate others toward a goal. "I have looked at people who present an idea, and people can jump on board because they like have researched the idea, they're able to talk, you know, highly effective about such [an] idea" (Participant A, 2019, R12). Daniel added that knowledgeable physician leaders clearly define accessible goals. Courtney and Ashley also spoke about the skill of motivating others. To Courtney, motivating others was not only goal focused but also inspired a sense of purpose.

> That's something that gives us all a sense of purpose if we feel like we have something unique to offer wherever we go to work. Versus if you just feel like one of the masses, no one knows you or cares about you, you're just an employee, it's a very different feel. (Participant C, 2019, R22)

Compassion. Participants spoke consistently about the attribute of compassion. Whether it is compassion for fellow physicians, resident physicians in training, or patients, compassion was important to the participants.

> If you care about them [resident physicians] as people, and you genuinely want them to succeed and excel, you will put them in positions to excel. And you will guide them in a way that's not judgmental or aggressive, but in an empathetic way. (Participant F, 2019, R24)

Daniel's experience in sacrificing time off by allowing second- and first-year residents to go home early to be with family exemplified the compassion that he thought was important in physician leadership.

Ellen stated that she is more of a guide to younger resident physicians so they can have a good and effective time in medical residency. Although it was important to the participants, Courtney cited the difficult role of compassion in medicine.

> I think there's just, it's an important thing that is brushed over in medicine, and it's looked at as, you know, weak if you can't just kind of like push through the emotions and keep taking care of patients. But I think it's the opposite. I think that if you can sit there and watch someone die and not have a single emotion about it or feel anything, then you're kind of, you have a huge disconnect between your patients, you're not really like connecting with them in any way. (Participant C, 2019, R30)

The attributes that the participants cited centered on innate traits and skills that could be developed. Care and/or compassion was important to all participants and was influenced by family medicine physicians encountering patients as they enter the health care system.

Follower focused. In addition to physician leader behaviors and attributes, the participants discussed the importance of followers. The importance of the followers was categorized as (a) understanding followers, and (b) developing followers.

Understanding followers. Beth and Courtney emphasized that an important component of physician leadership is understanding followers. "I think one of the biggest things is understanding the population in which you're trying to lead, right? Because not everybody may have the same viewpoints in regards to what they perceive a leader to be" (Participant B, 2019, R36). Frank added that understanding followers is an important aspect of physician leadership because it helps the physician leader to identify strengths and weaknesses and to construct experiences that will help followers to succeed (Participant F, 2019, R52). Beth's noted that, when she felt that she was not understood by those in leadership, she felt like an "afterthought" (Participant B, 2019, R 36). With regard to more junior resident physicians, Ellen suggested that understanding resident physicians will help her to identify their needs and how best to guide them. Ashley discussed an interaction with a more senior resident physician who did not hold a formal leadership position but whose words influenced her experience. The resident physician took time to write an email to Ashley after one week of work in the hospital, noting what she did well and what she could work on, and observed that she Ashley did not complain. This experience encouraged her not to complain when leading other resident physicians.

Developing followers. Due to the rigors of medicine and stages of training, the participants also emphasized the importance of developing followers. However, they did not

discuss development in terms of clinical skills or technical competence but rather as personal development related to emotional health and trust. Courtney mentioned that, due to dealing with aspects of medicine such as terminal disease and death, it is important to her that physician leaders take time to invest in her development and well-being. "It becomes even more important that you focus on the emotional and mental health of your subordinates" (Participant, C, 2019, R28). Ashley commented that the physician leaders whom she admired were those who took time to reach out to her and make her feel included in her training. Frank said that, when physician leaders take time to make him feel included, he felt a sense of trust established between himself and the physician leader. Beth agreed and stated,

> I think one of the big things that residents want to see is transparency. I really think that's so important because we're working so hard behind the scenes, and we're striving for a specific type of training, trust is a really important part of leadership. (Participant B, 2019, R22)

The four shared textural themes of environment, leader behaviors, leader attributes, and follower focused were important to the participants. The shared structural themes and description are presented in the next section.

Shared Structural (How) Description

Analysis. To construct the shared structural (how) description, I reviewed the shared textural description twice, along with the individual structural descriptions, themes, and meaning units to ensure that the shared structural themes that were constructed from the shared, or composite, textural (what) description aligned with shared aspects of the individual experiences. Structural themes illuminate how a phenomenon was experienced by describing the "underlying and precipitating factors" (Moustakas, 1994, p. 98). Questions that informed the analysis of determining shared structural themes were (a) What themes are primarily consistent (at least four

of six) across the participants? and (b) What themes speak to how physician leadership was experienced?

Shared structural (how) themes rationale. Based on the identified individual structural themes and review of the shared textural description, two themes across participants were constructed: (a) proximity, and (b) context. After another review of the shared textural (what) description, I identified apprenticeship as the third structural (how) theme, depicted in Figure 32. These three themes are discussed thereafter.

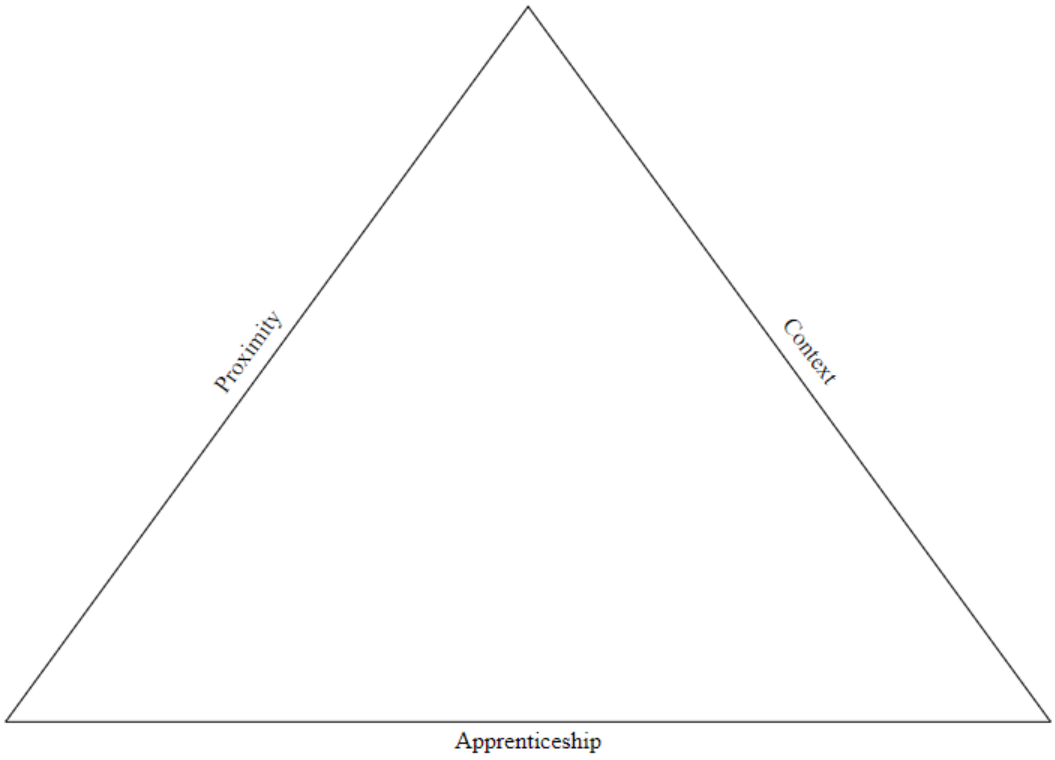

Figure 32. Shared structural (how) themes for all participants.

Proximity was identified as a shared structural theme based on descriptions of positive and negative experiences with physician leaders in family medicine during medical school or

from other specialties in which the participants had interacted. The proximity of the participants to physician leaders enabled them to formulate their descriptions of physician leadership. Context also was identified as a shared structural theme based on the participants' discussion of the overall context of GME and more specific contexts of medical specialties. Apprenticeship was the final shared structural theme as the participants described the hierarchical structure within their residency program, as well as other specialties and the hospital itself. The following is the shared structural (how) statement.

Proximity. Each of the participants spoke about formal and informal physician leaders with whom they had interacted in medical school or in medical residency. Beth and Frank spoke about physicians in medical school with whom they had interacted who had either advocated for rural health care or had challenged other resident physicians to think critically. Frank described the ability to observe a conversation between a more senior physician and other resident physicians as impactful:

> Now I was still a student, so I didn't have any formal duties. But just from my observation, this particular attending [senior physician] liked to challenge the residents to think more critically and empower them to think more critically, as opposed to just following orders and going about carrying out their marching orders and duties. Really empowered them to think for themselves, and I think that was eye-opening for me as far as what I want to do. (Participant F, 2019, R20)

The close proximity of Frank to this situation was formative to his experience and understanding of physician leadership.

Similarly, Ashley, Courtney, and Daniel described experiences in which close interactions, either formal (e.g., program director) or informal (e.g., third-year resident physician), were informative to their perceptions of physician leadership. Ashley described a situation with a chief resident who took time to interact with her and listen to her concerns. Courtney mentioned a resident physician from her experience in medical school who included

her in the care team for a patient. This resident physician helped Courtney to process her very first experience with a patient death, encouraging Courtney to reach out to the family and to take one thing away from that experience that she could implement in future care. Daniel's perception of physician leadership changed throughout his time in medical residency. "It definitely changed a little bit from my first, second, and third year just based on the people that I worked with" (Participant D, 2019, R46). As with the other participants, proximity to physician leaders enabled Daniel to cultivate an understanding of physician leadership.

Context. The overall context, or environment, of medical residency (GME) offered unique challenges to the participants. They encountered daily testing of their medical knowledge, long days, a range of medical specialties, health care bureaucracy, and policy, all while learning how, and what it means, to be a physician. Frank aptly stated that medical residency is a "long and arduous process" (Participant F, 2019, R 44) in which resident physicians are in the "trenches" (Participant F, 2019, R 38) of clinical care.

With regard to the more specific context, or specialty, Courtney stated that family medicine physicians "tend to care more about the whole person, the whole family, even their socioeconomic status, and how that's affecting their health" (Participant C, 2019, R40). This differed from other specialties, such as surgery, that may focus on more procedural aspects (i.e., surgeries). Beth said that physician leaders helped to shape the experience within the context of GME and the specialty of family medicine. For example, she cited her chief residents who exhibited a sense "of camaraderie, which I think is really important from a peer perspective of things" (Participant B, 2019, R26). Ashley reflected on her experiences with physician leaders from other specialties who appeared to her as more "aggressive, and certainly thicker skinned" (Participant A, 2019, R52) than the physician leaders with whom she interacted in family

medicine. Daniel reflected on time spent in the surgical specialty, where he could not speak to the attending physician until he spoke to resident physicians in descending order. Daniel said that this context in family medicine was more team oriented and he could bypass hierarchy and speak directly to the program director about a clinical concern. Ellen described family medicine physicians' encounters with patients and commented on the nature of those encounters influencing the type of skills that are needed (e.g., interpersonal or technical).

Apprenticeship. The final theme of apprenticeship was constructed from descriptions of the educational structure of medical residency. For example, Daniel described how he supervised second- and first-year residents. Due to his experience under previous supervising resident physicians, he opted to allow those whom he was supervising to go home early.

> So I wanted to be the person who would support that and I would say a couple of days of the week, at least one or two days a week to allow the residents to at least have some time off to go take care of family things. (Participant D, 2019, R48)

Frank stated that, based on his experience in the apprenticeship model under other resident physicians and senior physicians,

> As a resident physician, you are in the trenches. You live within the hierarchy of the hospital. You are right there in the middle in the hierarchy between students and attendings. So day-to-day, you do live that hierarchy, and you see the power transfer or power dynamics between attending physician to resident physician, and then you yourself live the power dynamic between yourself and the medical students. . . . Fortunately for me, I've come out of that [supervision by other resident physicians] wanting to change myself for the better and live more positively, and spread that positivity around to the people around me. So as a leader myself, as a resident leader, leading medical students is what I mean, and being a role-model to them, I've actively made strides to be positive with them. (Participant F, 2019, R 40)

In a different manner, Ellen spoke about her understanding that a physician leader should be supportive. Ashley and Beth mentioned that the physician leader in family medicine has an innate care quality for those whom they lead, as well as those for whom they provide care. It was specifically important to Beth that her physician leaders be transparent so she would feel

included in her training. Courtney identified that, in the apprentice relationship, it is important for physician leaders to "focus on the emotional and mental health of subordinates" (Participant, C, 2019, R28). The participants highlighted a strong apprentice-style relationship between themselves and their physician leaders in which they learned how to care for patients and what it means to be a physician by working side by side on a daily basis.

The three themes of proximity, context, and apprenticeship were integral to the lived experiences of physician leadership for the participants in this study. These themes helped to frame the participants' experiences and were the conditions in which physician leadership was experienced. The shared textural-structural synthesis (nature) statement describes the nature of physician leadership for the participant resident physicians.

Shared Textural-Structural (Nature) Synthesis Statement

A phenomenological study is intended to describe "the essence of the experience of the phenomenon" (Creswell, 2007, p. 77). The *nature*, or essence, of a phenomenon as referred to in this study is the "essential structure" (Holloway & Galvin, 2017, p. 234) of *what* and *how* the phenomenon of physician leadership was understood and experienced by the participating family medicine resident physicians through their lived experiences in GME. It is important to reiterate that *nature* does not suggest a singular perspective, or reality, of physician leadership; rather, it is relative to the participants of this study with regard to time, place, and perspective.

Shared textural-structural (nature) synthesis statement rationale. The shared textural (what) and structural (how) descriptions informed the following shared textural-structural (nature) cross-case synthesis statement. Specifically, the participants described such aspects as the influence of the physician leader to personify, or exemplify, a culture that shaped the environment. In addition, the behaviors (e.g., care, compassion, advocacy, understanding, developing followers) and personal attributes (e.g., outgoing, personable, authoritative) of the

physician leader were powerful influences in how the participants viewed physician leadership. This could also be shaped by the described apprenticeship style approach to GME that enables younger physicians to work side by side with senior physicians. They also spoke about differences between specialties with regard to types of physician leaders and clinical work. In their opinion, these differences attracted different types of leaders to different specialties and affected how physician leadership was enacted and how outcomes were sought.

The cross-case shared synthesis statement represents the group as a whole (Moustakas, 1994). Furthermore, the synthesis statement helps to understand how the participants described and experienced the nature of physician leadership. It is important to reiterate that the shared textural-structural (nature) synthesis statement should not be considered universal, but rather as shared aspects drawn from "a particular time and place from the vantage point of an individual" (Moustakas, 1994, p. 100).

After reviewing the transcripts from the second interview, I determined that I should change *outgoing* to *personable* to capture the nature of physician leadership as it was perceived by the participants. I also included the word *transparent* to appeal to the participants' perceptions of physician leaders being open to followers.

Figure 33 presents the shared textural-structural (nature) synthesis statement with structural (how) themes that bound the inherent textural (what) themes and meaning units. The textural-structural statement is stated following the figure.

Shared synthesis statement. Constructing an understanding of physician leadership is an important part of the educational process of medical residency. However, uniformly describing physician leadership is precarious as it can vary based on context (e.g., clinic, hospital), medical specialty, audience (e.g., patient, nurse), or even the background of the resident physician.

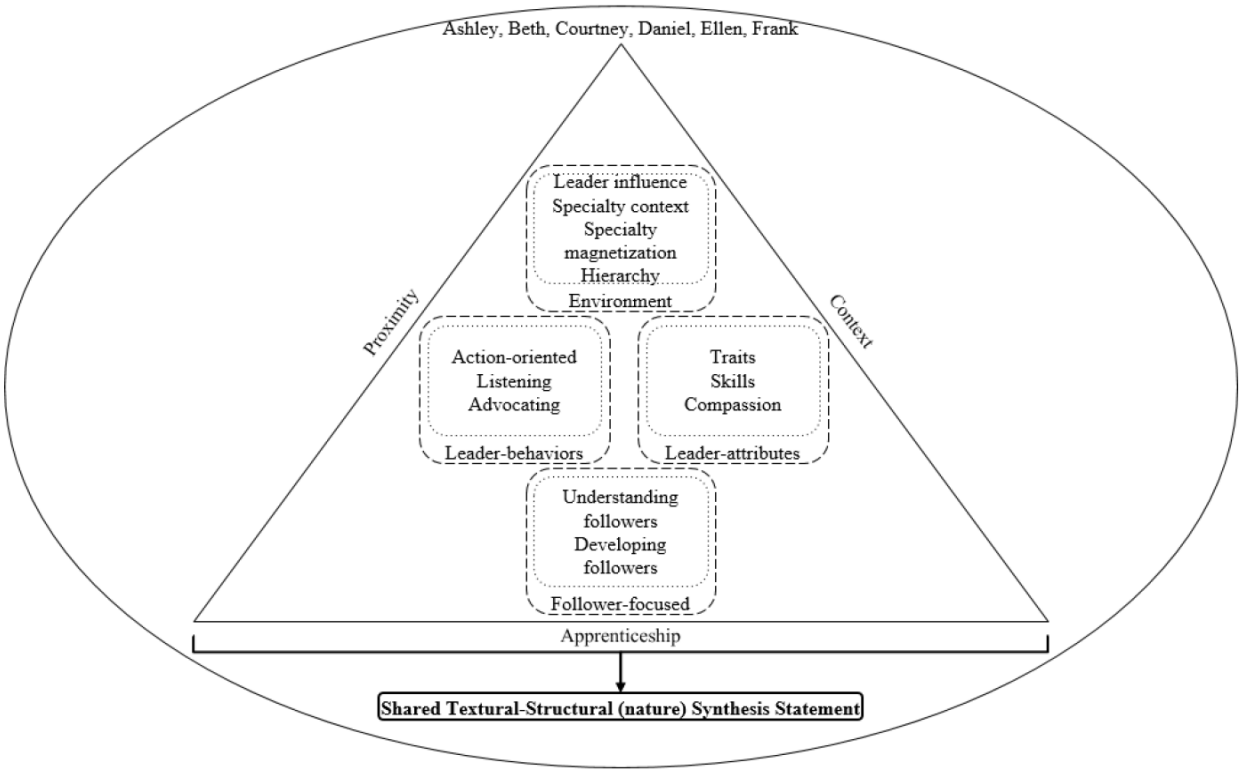

Figure 33. Shared textural-structural (nature) synthesis statement.

Although difficult to describe, behaviors and personal attributes of informal leaders (e.g., respected resident physician) and formal leaders (e.g., supervising physician) provided powerful anchors for residents to ground their descriptions of physician leadership.

The environment of medical residency is hierarchical and structured in an apprenticeship style in which resident physicians work in close proximity to other resident physicians and supervising physicians. This proximity allows resident physicians to decide, directly or indirectly, how to deliver care and what it means to lead other physicians or other health care professionals (e.g., nurses, technicians). Particularly important to the participants was how the physician leader treats those under supervision. For example, the participants engaged in daily rigorous clinical work side by side with more senior physicians. It is important to the resident physicians that their voices be heard and that these physician leaders take time to understand

them, as well as to invest intentionally in their personal and professional development. These aspects in particular enable resident physicians to feel a part of the clinical team and they add value to the medical residency program and the medical profession.

The nature of physician leadership is a combination of who a physician leader is and how the leader behaves, but it is tempered by the contexts in which leadership is enacted and how the leader treats those under supervision. Personal attributes of the physician leader such as personable, transparent, caring, knowledgeable, motivational, and inspiring purpose were important to the participants when describing physician leadership. Behaviors such as advocating for the resident physicians under their supervision, seeking cost-effective treatment for patients, ensuring appropriate care by specialists, or lobbying for the importance of family medicine speaks to the action-oriented temperament of physician leaders. For better or worse, physician leaders influence the types of practitioners that resident physicians become.

Answering the Central Research Question

The central research question for this study was, *How do family medicine resident physicians describe and experience the nature of physician leadership?* To answer this question, I presented the co-constructed shared textural-structural (nature) synthesis statement above. This statement was constructed across the data and informed by individual and shared findings of *what* and *how* physician leadership was experienced. In short, the local environment in which resident physicians practice medicine, the behaviors and attributes of the physician leaders, and a focus on the followers are what was experienced with regard to physician leadership. These textural (what) aspects were experienced through structural (how) means such as proximity to such physician leaders, the context of medical residency, and the apprenticeship-style approach to training in GME.

Chapter Summary

The intent of this chapter was to present "richly descriptive" (Merriam & Tisdell, 2015, p. 37) findings before offering conclusions and recommendations for practice, future research, and theorizing in Chapter 5. The shared synthesis (nature) statement was the result of analysis of the individual lived experiences and analysis across the participants' lived experiences. The six participating family medicine resident physicians provided deep insight into the phenomenon of physician leadership through their lived experiences in GME.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The focus of this chapter is to discuss conclusions and recommendations. The intent of this chapter is not to generalize but rather to inform practice, research, and theory through thick description and ensuing understanding. This chapter is structured first with a return to the quality criteria of trustworthiness and authenticity to support execution of a sound study before discussing relevant conclusions with regard to implications from the literature (i.e., role, context, specialty) reviewed in Chapter 2. Next, recommendations for practice, theorizing, and future research are presented, followed by advice and conclusions from reflections on my experience as a human research instrument.

To summarize the previous chapters, Chapter 1 presented the background, problem, purpose, and research question: *How do family medicine resident physicians describe and experience the nature of physician leadership?* Chapter 1 also provided an overview of the methodology, methods, and quality criteria before outlining the significance, conceptual framework, delimitations, limitations, and important terms. Chapter 2 was an integrative literature review that examined the historical literature on leadership since 1900, as well as the literature on physician leadership situated within the three contexts of medical education. Chapter 3 provided rationale for, and described, the guiding research paradigm, methodology, and methods for the study, which included an integrated approach to data analysis based on Moustakas (1994) and Colaizzi (1978). Chapter 4 presented the results of the analysis of findings to address the research question. Descriptions of the *what* and *how* of physician leadership as experienced by participating family medicine resident physicians informed a co-constructed synthesis, or "essence" (Moustakas, 1994, p. 55), statement.

Returning to Quality Criteria

As discussed in Chapter 3, Lincoln and Guba (1985, 1986) proposed the criteria of trustworthiness and authenticity to address concerns about the quality of research in qualitative/naturalistic and constructivist inquiry. Strategies to satisfy each criterion were also described in Chapter 3.

Trustworthiness

To satisfy credibility, I submitted my journals to my committee chair at multiple points throughout the research process. I also member checked (Lincoln & Guba, 2013) the in-case textural-structural (nature) statements and shared textural-structural cross-case synthesis statement with the participants in the fourth, and final, stage of data analysis. This approach allowed participants to serve as "co-researchers" (Moustakas, 1994, p. 34) by offering feedback at two specific points, which combined disparate views on the timing of member checking in phenomenological inquiry (Abalos et al., 2016; Colaizzi, 1978; Holloway & Galvin, 2017).

To enhance the relevance of findings to other contexts or populations, also known as transferability, I utilized criterion-based participant selection and a data collection guide in the data collection process. Specifically, word-for-word examples from participants in the individual (in-case) and shared (cross-case) descriptions described the lived experiences of the participants and offered rich and "thick description[s]" (Lincoln & Guba, 1986, p. 19) of participants' perceptions of the phenomenon of physician leadership.

I meticulously documented the research process in a research journal (Lincoln & Guba, 1986, 2013). The entries in this journal noted aspects such as data collection, analysis, rationale, and findings to serve as an audit trail (Merriam & Tisdell, 2015). The journal was organized by headings (e.g., Participant A) and aspect (e.g., textural meaning units rationale) to locate content

including, but not limited to, rationale or descriptions. Tables and pictures were also utilized to depict data analysis and to document the process.

For confirmability, I documented critical awareness and suspension of prior interpretations about physician leadership that arose through this study (Lincoln & Guba, 2013; Patton, 2002). I disclosed my perspective and positionality in Chapters 1 and 3 and to participants, as documented in the data collection guide (Appendix B) and transcripts.

Authenticity

The goal of fairness was achieved through informed consent and member checking to enable input from the participants as co-researchers. Submitting my journals to my chair for review also served to satisfy fairness.

Member checking and submitting journals back to the chair satisfied ontological authenticity. However, the intent of this criterion is to determine how the participants and the researcher are more informed about their own constructions of the phenomenon of physician leadership (Guba, 1990; Lincoln & Guba, 1986). Member checking provided participants an opportunity to reflect on constructions of their lived experiences. With regard to myself as researcher, in journal entry of July 21, 2019, I documented a prior interpretation about male physicians, which assisted me in becoming more informed about my own perceptions.

> Prior to this interview, I had some assumptions/prior interpretations about a male physician viewing physician leadership more about power, hierarchy, and delegation. I need to suspend this assumption/prior interpretation as this may not be how ALL male physicians perceive physician leadership. If I follow this perception, I could see influencing their description towards these aspects and I need to critically suspend this aspect to stay close to their description.

Beth, Courtney, and Frank stated that the process of discussing physician leadership helped them to become more aware of their own understandings of the phenomenon. For

example, in Beth's second interview she stated, "I think it definitely helped to bring light to the things that I find important" (Participant B, 2019, R20).

For educative authenticity, I returned the cross-case synthesis statement to participants for feedback during the second interview (Lincoln & Guba, 2013). The cross-case synthesis statement was constructed from the entire data set. Thus, participants had the opportunity to learn from each other rather than being limited to their own descriptions. Beth, Courtney, and Frank discussed the educational aspect of the interview process and the act of reviewing the final synthesis statement. Frank stated in his second interview,

> During my journey of residency and medical school, I really just self-reflect in my own head. And I have thoughts and conversations with other people, but I never put it down on paper. I think actually seeing the words and seeing it registering in mine back to you visually, through the words is actually pretty powerful. (Participant F, 2019, R6)

Beth commented in her second interview, "I think it helps to talk about it and try to understand it a little bit better and see other people's perspectives" (Participant B, 2019, R20). In addition, this chapter was informed by data from the participants but also integrated with pertinent literature to achieve a "complex construction" (Lincoln & Guba, 1986, p. 23) of a sociohistorically relative nature of physician leadership.

Catalytic authenticity refers to how the research process catalyzes action among participants. Catalytic authenticity was satisfied by (a) semistructured interviews, and (b) returning the cross-case synthesis statement to participants for feedback. Semistructured interviews enabled the participants to actively direct, or redirect, the conversations. The participants noted in their second interviews that the process of talking about physician leadership catalyzed reflection. In Ellen's second interview, when asked about her thoughts regarding voicing her perceptions about physician leadership through the interviews, she stated,

> It kind of gives me time to think about it. Even after our first interview where we talked about it, I even sat down afterwards and kind of had more time to think about it, and just

> kind of see where my role is at this point in my career, versus where my role could be later on in my career. (Participant E, 2019, R12)

During Ashley's second interview, she said, "I guess it just made me think about things that I don't necessarily reflect on a routine basis" (Participant A, 2019, R22). As the researcher, I stated in my journal entry of July 27, 2019,

> One interpretation that I also need to suspend is that how I define good understanding of something, say physician leadership, may be different than how they define it. For example, in the interviews I had to pull out information from time to time or restate information as a few of the participants noted that they had not really consciously thought of physician leadership before beyond a formal title or role.

On August 27, 2019, I stated,

> A frequent saying about leadership is, "it takes experience." . . . Rarely does the literature investigate *HOW* an/the experience is formative. Lived experiences could be an avenue for future research in physician leadership along with the importance of lived experience to leadership development.

Tactical authenticity refers to empowering participants, which echoes Moustakas's (1994) designation of participants as co-researchers for the purpose of empowerment. Tactical authenticity is accomplished by engaging participants in the research process. I satisfied this criterion by identifying participants as co-researchers who helped to shape the research process through "dialectical conversations" (Lincoln & Guba, 2013, p. 71) and construct final in-case textural (what)-structural (how) statements and cross-case (nature) synthesis statement.

Throughout the research process I was cognizant of the quality criteria of trustworthiness and authenticity to support the construction of a sound study. The secondary purpose was to produce a sound qualitative study for audiences with potentially dominant and alternative paradigms and designs other than constructivist and qualitative in the medical field. Thus, describing in detail how I satisfied quality criteria assisted in establishing a sound qualitative study before discussing relevant conclusions about the conceptual framework, role, context, and specialty in the following section.

Relevance of Findings to Implications From the Reviewed Literature

The literature that was reviewed for this study was approached conceptually rather than theoretically. As stated in Chapter 2, using a theoretical framework to guide phenomenological inquiry is contentious as framing a study with a theory is perceived as inhibiting broad exploration if utilized to sort data categorically (Creswell, 2014; Vagle, 2014). From my perspective, the reviewed phenomenological studies in health care were not sufficiently executed (Pettit, 2015; Pregitzer, 2014; Sorbello, 2010). Thus, I utilized a broad conceptual framework.

The first component of the conceptual framework includes Dugan's (2017) foundational leadership elements of definition and development. These elements were critical to include because (a) they are interconnected, and (b) they are influenced by assumptions about leadership (Heifetz, 2010). Dugan (2017) stated, "How people approach the development of leadership is a function of their formal and informal theoretical understandings of the construct" (p. 41). The second and third components were Rost's (1993) leadership era paradigms (industrial, post-industrial) and the three contexts of medical education (UME, GME, and CME).

The findings of this study were constructed from an in-depth examination of descriptions of the phenomenon of physician leadership by six resident physicians from the medical specialty of family medicine. The conceptual framework that delineated the focus and scope of the literature review resulted in implications related to (a) historical leadership approaches and theories, (b) defining physician leadership in medical education, and (c) developing physician leadership in medical education. These implications are revisited in the following subsections to discuss the relevance of findings from this study to implications derived from the reviewed literature.

Historical Leadership Approaches and Theories

The reviewed historical literature on leadership since 1900 (Rost, 1993) emphasized the progression of conceiving leadership based on the (a) leader, (b) social/collective, and (c) context/system. Leadership in the industrial era paradigm focused primarily on the leader (e.g., traits, behaviors) and actions were directed *to* followers. The leader who utilized a situational approach diagnosed situations and prescribed certain behaviors for followers. In this instance, the leader defined the nature of leadership required for the situation and acted as prescribed. Conversely, leadership in the post-industrial era paradigm did not focus solely on the leader but rather was conceptualized as a complex process *between* leader, follower, context, and system.

The relevance of this study to the historical leadership approaches and theories is that the progression in perceptions of physician leadership from *to* and *between* are mirrored in the lived experiences of the participants of this study. Ashley, Ellen, Daniel, and Frank expressed initial views of physician leadership that aligned with the industrial era paradigm. For example, prior to medical residency, these participants had conceived of leaders as those with formal titles or in "traditional [leadership] roles" (Participant E, 2019, R10), who "define the goals" (Participant D, 2019, R16) and "make decisions, people who obviously I mean lead another group of people. Usually they have a certain personality type" (Participant A, 2019, R2).

When the participants were asked how their roles as resident physicians in GME influenced their understanding of physician leadership (Appendix B), they described contrasting understandings of physician leadership. Ashley discussed a growing perception through medical residency of leadership roles beyond those that she had originally envisioned (e.g., Program Director). Courtney and Ellen spoke to physician leadership as understanding the culture of medicine, the meaning of being a physician, and working effectively with peers. Frank

encapsulated the progression from an industrial to post-industrial perceptions of physician leadership:

> What a leader means as far as physician leadership goes has changed between the time of residency training, and between prior to residency, and between now. It's less so a position, it's more of an attitude, and how you generate a culture that's conducive to learning and also success, and empowering those working with you and underneath you to put them in a position to succeed. (Participant F, 2019, R18)

Frank's description of the progression of his perception of how physician leadership had contributed to evolution found in historical leadership approaches and theories was echoed in the study by Oandasan et al. (2013). The researchers stated that "perspectives on leadership evolve throughout career stages" (p. 166), which suggested that perspectives of physician leadership evolve throughout a physician's career.

Over all, this study is relevant and contributes to the literature on historical approaches and theories with regard to the implications stated in the integrative literature review. First, the progression from leader to more complex understandings of physician leadership that may include the context, system, and culture is mirrored by the participants. Next, through exploring the nature of physician leadership, this study provokes examination of the development of perceptions in relation to followers.

There is a growing body of literature on leadership identity development (Komives, Longerbeam, Owen, Mainella, & Osteen, 2006) in higher education, as well as in health care (Koskiniemi, Vakkala, & Pietilainen, 2019). Rather than the identity development, the utility of exploring how perceptions, or cognitive schema, on physician leadership changes or develops may offer insight into the (a) interactions with followers, and (b) lived experiences of followers. Beth stated, "I think one of the biggest things is understanding the population in which you're trying to lead, right? Because not everybody may have the same viewpoints in regard to what they perceive a leader to be" (Participant B, 2019, R36).

Defining Physician Leadership in Medical Education

From the reviewed literature on physician leadership within the context of medical education (UME, GME, CME), physician leadership was defined broadly and definitions varied based on role, context, and specialty. For example, physician leadership was conceptualized primarily as academic or clinical (AAMC, 2016; Detsky, 2011) and predominantly discussed with regard to skills or outcomes (Webb et al., 2014). More important, and not surprising, those in formal leadership roles often defined physician leadership (Nicol et al., 2014; Pettit, 2015).

Although those in formal leadership roles primarily defined physician leadership in the literature (Lobas, 2006; Nicol et al., 2014; Pettit, 2015), this study is relevant to this finding as it promotes definition of leadership by those who may be identified in the medical education primarily as followers, or nonleaders. *Follower-focused* was a textural theme with two subthemes (understanding followers, developing followers) that were constructed as aspects shared by the participants. Followers in the field of medical education (i.e., resident physicians) to those higher in the hierarchical ladder (e.g., supervising physicians) in the context of GME may assume leadership roles in medical residency. Such leadership roles in medical residency might consist of leading other health care professionals on an interprofessional health care team (Jardine et al., 2015). For example, Ellen characterized the realization: "You don't realize it, but you kind of run that team and have to take care of that patient" (Participant E, 2019, R12). The literature reviewed in Chapter 2 did not address defining physician leadership with regard to the role of the resident physician leading an interprofessional health care team.

The relevance of inquiry on the definition of those not in formal leadership roles (nonleaders) and how they construct definitions of physician leadership is also a point for consideration, as many resident physicians are thrust into formal leadership roles after graduation. Ashley noted this interesting shift: "I'm a resident, but in 5 months I'm going to be

an attending physician, just like somebody who's been an attending physician for 20 years" (Participant A, 2019, 40). Daniel also highlighted this transition after graduating from medical residency: "After you graduate, you are the new boss, right . . . you're going to have a managerial position, but in medicine that's kind of the way it goes" (Participant D, 2019, R44).

Based on the reviewed literature, the perspective of the resident physician with regard to defining the phenomenon of physician leadership is not robust nor is it well articulated. For example, the reviewed literature (Howieson & Thiagrajah, 2011; Nicol et al., 2014) provided limited insight into a clinical definition of leadership, as opposed to an academic definition of leadership. The participants in this study did not delineate between the two nor provide another definition; rather, they addressed both definitions collectively.

Qualitative inquiry can aid in understanding phenomena such as physician leadership. This qualitative study contributes to the literature on defining physician leadership in medical education by acknowledging the voice of the underrepresented population of nonleader resident physicians who often assume leadership roles during, and after, medical residency. This study also offers insight into *how* the "long and arduous process" (Participant F, 2019, R44) of GME helps to construct definitions, or perceptions, of the nature of physician leadership.

Developing Physician Leadership in Medical Education

The primary delivery method for delivering leadership curricula in UME as documented in the study by Neeley et al. (2017) was formal mentoring (65.1%), which contrasted with earlier studies by Frich et al. (2014), who noted the use of didactic lectures (84%) in GME. The findings of this study are relevant to the literature on developing physician leadership in medical education in that the descriptions of physician leadership across the participants highlighted the importance of developmental relationships physician leaders in medical residency (Frich et al., 2014). Whether it was the ability of physician leaders to influence the culture of a medical

residency program or the behaviors of the leaders, the impact of the physician leaders through close proximity was described by the participants.

> When a leader is willing to sit here and let you say, "Hey, this, what you're doing, what you've done frustrates me" and actually have like an open genuine conversation about those feelings or those thoughts, where you feel heard, where you feel understood. Maybe that's not going to change anything specifically, but it humanizes the whole situation. (Participant C, 2019, R20)

Courtney's example indicates the importance of developmental relationships such as mentors. This study also reinforced findings by Neeley et al. (2017) that depicted the prominence of formal mentoring as a method for developing leadership.

This study supports the importance of developing physician leadership through developmental relationships. In addition, qualitative research design and phenomenological methodology offer a valuable approach to investigating *what* is derived from developmental relationships with physician leaders, as well as *how* these relationships are formative. In agreement with Halling (2002), phenomenology complements traditional research (i.e., statistical) by offering rich and deep understanding of a phenomenon. The body of reviewed literature was predominately quantitative. For example, in the study by Frich et al. (2014), 71% of evaluation designs for leadership development programs in GME were quantitative. Approaching developing physician leadership from a qualitative perspective, such as in this study, provides rich data to complement quantitative approaches.

This qualitative study adds to the extant literature by offering a deep and "richly descriptive" (Merriam & Tisdale, 2015, p. 17) phenomenological approach that explored the nature of physician leadership as described by family medicine resident physicians and as primarily experienced through GME. Focusing on nonleader resident physicians reframes physician leadership from a follower, or nonleader, perspective (i.e., resident physicians). Emphasizing the nonleader perspective offers a voice to the underrepresented and understudied

(Frich et al., 2014; NCHL, 2014; Pettit, 2015) population of resident physicians. A powerful catalyst and anchor for progression of perceptions of physician leadership was through relationships (i.e., mentoring, role models). The relevance of findings to gaps noted in the literature with regard to role, context, and specialty is discussed in the following sections.

Relevance of Findings to Role, Context, and Specialty

The extant literature pointed to variance in defining physician leadership based on role, context, and specialty (Mulholland, 2015; Oandasan et al., 2013; Serio & Epperly, 2006). These components informed the data collection guide and interviews. The interviews focused on exploring the nature of physician leadership through description. The following subsections discuss the findings of the study in relation to role, context, and specialty from a definition, rather than a developmental approaches perspective.

Role

The phenomenological study by Pettit (2015) offered skill-based definitions of physician leadership from the perspective of chief residents. As stated in Chapter 2, no literature was identified on defining physician leadership from the perspective of resident physicians who were not in the leadership roles (nonleaders).

Notably not sufficiently explored in the informing literature was the role of the resident physician in the hierarchy of clinical care. Daniel, Ellen, and Frank acknowledged their role as resident physician at the bottom of the clinical hierarchy. Not readily acknowledged, but alluded to, were the additional hierarchical layers below the resident physician, such as medical student and patient. "You yourself live the power dynamic between yourself and the medical students" (Participant F, 2019, R40). Ashley commented on her role as leader to her patients: "That's a whole other kind of leader that I haven't really considered, or haven't really brought up, like that yes, every physician is a leader just simply to their patients" (Participant A, 2019, R22).

The findings of this study suggest a hierarchical position for resident physicians between physician leaders (e.g., chief residents) and medical students or patients that was not evident in the reviewed literature. Kuo et al. (2010) acknowledged leadership training for resident physicians who "naturally achieve key leadership positions" (p. 1603) such as chief resident. However, this observation could infer that resident physicians who are not chief residents are not leaders. This inference also begs the question of who defines physician leadership. For example, and aligning with the study by Kuo et al. (2010), the supervising physician may define a resident physician as leader if that resident physician serves as chief resident. The nonleader resident physicians may then define their role as subservient and at the bottom of the hierarchy in relation to the Chief Resident and supervising physician. However, medical students who work with nonleader resident physicians may define the nonleader resident physician as a leader and themselves as subservient to the resident physician. With this said, the variability of defining physician leadership based on originating perspective (e.g., supervising physician, medical student, patient) is not addressed in the reviewed literature. The following section discusses the relevance of the findings of this study to the second component: context.

Context

The findings of this study reinforce the importance of context in describing physician leadership. Swanwick and McKimm (2011) suggested that "leadership is often described within the contexts in which it is exercised" (p. 23), which was echoed by the participants. The broad context of medical residency, or GME, is a "long and arduous process" (Participant F, 2019, R44) that tests the resident physician's knowledge, skills, and confidence through rigorous work hours and clinical responsibilities. Moreover, such aspects of medical residency as learning how to work within complex administrative structures of the health care organization or navigating

health are policy when documenting clinical care supported the view of overall context of GME as the "forge of professional practice" (Cooke et al., 2010, p. 239).

Although training in medical residency is rigorous, the relevance of the findings of this study relates to the influence of physician leaders on the lived experiences of resident physicians in GME. During Ellen's search for a medical residency program, she looked specifically for a program director who reflected what she desired in a residency program. The importance of finding a connection with the physician leader was critical to the participants, especially Frank, who stated, "If you don't find any connection with this person, you're not going to feel [like] wanting to work" (Participant F, 2019, R30).

The influence of physician leaders on the experience of medical residency was described with regard to interpersonal attributes, rather than managerial skills such as task orientation (Pettit, 2015) and team functioning (AAMC, 2014) as depicted in historical literature. For example, the participants noted attributes such as being inclusive, caring, and personable. In short, the rigor of the overall context of medical residency is strongly depicted in the informing literature but what is relevant from this study is the ability of the physician leaders to temper the rigor of GME through interpersonal attributes.

Specialty

In Chapter 2, contrasting definitions of physician leadership for the medical specialties of surgery and family medicine were provided. Mulholland (2015) defined leadership in surgery as skills such as advancing change or building teams, whereas Serio and Epperly (2006) highlighted cultural awareness in relation to leadership in family medicine. The participants in this study noted that, as a specialty, family medicine was more broadly focused on the whole person than in other specialties, such as surgery, which may be procedure based. The responsibilities or

outcomes of clinical care in each specialty accounted for different understandings of physician leadership. For example, Daniel, who had experience in both specialties, stated,

> You pretty much do what your attending says without question . . . in surgery, there's so many things that can go wrong very quickly, especially an open case where you have someone's body physically cut open. Whereas if you're dealing with [family] medicine, things can go by a lot slower, and you don't have to worry about the expediency of correcting something as fast as you can. (Participant D, 2019, R34)

Frank expanded on Daniel's observation by stating that family medicine is "more about attitude, it's less so about regimented numbers" (Participant F, 2019, R48). The setting of the family medicine specialty is with patients as they enter the health care system (e.g., outpatient clinic), whereas the surgical specialty occurs in more technical settings, such as an operating room; often occurring after that person has entered the health care system.

In short, the findings of this study reflect the definitional differences between specialties such as surgery and family medicine. This study highlights the aspects of each specialty that contribute to variations with regard to defining physician leadership. Aspects that contributed to variations included settings such as outpatient clinic versus operating room, attitude with patients versus technical surgical skills, and outcomes.

Summary

This section discussed the findings of this study in relation to the components of role, context, and specialty, which were identified as gaps in the informing literature. The role of the nonleader resident physician in the clinical care hierarchy as treated in the informing literature did not agree with the perceptions expressed by the participants, who acknowledge that they lead other health care professionals, medical students, and even patients. With regard to context, medical residency/GME is arduous; however, the participants highlighted the role of physician leaders to balance the challenge of this experience through interpersonal support. The informing

literature defined physician leadership differently based on specialty. The findings of this study aligned with the literature but expanded on aspects that inform definitional differences.

Recommendations for Practice, Future Research, and Theorizing

The participating resident physicians, also referred to as co-researchers (Moustakas, 1994, p. 34) in this study provided rich descriptions of their perspectives of physician leadership from the standpoint of nonleaders. In addition to the relevance of the findings to the reviewed literature, their descriptions informed recommendations for practice, future research, and theorizing, which are discussed in the following sections.

Practice

Since the late 1990s, attention to physician leadership in the field of medical education has increased (NCHL, 2014; Neeley et al., 2017). Physician leadership was suggested by Dine et al. (2011) to be "largely understudied" (p. 31) and to require attention due to the increasingly complex roles of physicians in the increasingly complex health care system (Neeley et al., 2017; Skochelak, 2010). This study resulted in the following recommendations for practice, including reframing the following in the context of GME: (a) the lived experience, (b) defining physician leadership, and (c) the development of physician leaders.

Reframing the lived experience of graduate medical education. As noted by Pettit (2015) and Kuo et al. (2010), leadership education for resident physicians is typically relegated to a few key individuals (e.g., Chief Residents) and often occurs "on the job" (p. 1603). Leadership education occurring on the job could also be interpreted as learning from experience. As an "essential dimension of transformation" (ACGME, 2017a, p. 1), the broad context of GME offers a fertile experience to cultivate physician leadership, as well as to develop relevant skills and competencies. For example, being in the "trenches" (Participant F, 2019, R40) of medical residency, and the hierarchy of the hospital, enabled Frank to observe the power dynamics

between resident and supervising physicians, as well as between resident physicians, other healthcare professionals, and the patients. Frank also noted that, throughout his time in residency, he was cognizant of the evolution of his knowledge and responsibilities, which included leading medical students. Interpersonal attributes helped to temper the rigorous experience of medical residency for Courtney. Courtney stated that open dialogue with physician leaders who recognize the difficulty of medical residency "humanize[d]" (Participant C, 2019, R20) the experience. Daniel commented that the environment in medical residency is "not a 'do as you're told' more than it is a 'learn while doing'" (Participant D, 2019, R38).

A practical recommendation for medical education is to invest in understanding the lived experiences of resident physicians (especially nonleaders) in medical residency as it relates to, or alongside, physician leadership. In the shared synthesis statement, I noted,

> The context of medical residency is hierarchical and structured in an apprenticeship style where resident physicians work in very close proximity with other resident physicians as well as supervising physicians. This proximity allows for resident physicians to gather directly, or indirectly, how to deliver care and what it means to lead other physicians or health care professionals (e.g., physician assistants, technicians).

In agreement with Jarvis-Selinger, Pratt, and Regher (2012), outcomes in medical education (UME, GME, and CME) should be reframed from technical competencies of clinical care to also include the professional identity formation of physicians. Professional identity formation in medical education is often discussed in relation to professionalism (Cruess, Cruess, Boudreau, Snell, & Steinert, 2014). However, the role of the lived experience of medical residency in the formation of the professional identity of resident physicians can offer critical information about *what* perceptions resident physicians are developing and *how* they are developing such perceptions about aspects such as clinical care, being a physician, and physician leadership. As cited by Dennick (2016), educational psychologist David Ausubel stated that "the most important factor influencing learning is what the learner already knows" (p. 200).

Understanding *what* resident physicians know about physician leadership and *how* they know it suggests a perspective that accounts for the cognitive constructions and lived experiences to assist with constructing individualized, or tailored, developmental approaches.

A practical approach to understanding perceptions of physician leadership grounded in the lived experience of GME is through the phenomenological methodology. In particular, descriptive phenomenology guided by the constructivist paradigm in this study offered a "richly descriptive" (Merriam & Tisdell, 2015, p. 37) approach to constructing perceptions of physician leadership. Understanding how the lived experience of GME is constructive to understanding physician leadership complements traditional quantitative measures that often evaluate formal didactic approaches (e.g., lectures) over informal approaches such as mentoring (Frich et al., 2014). Halling (2002) suggested that "phenomenology can help to make sense in psychological and human terms of some of the findings of traditional research, which are typically presented in statistical language" (p. 20). Developmental approaches guided by constructivism in GME provide an opportunity to build new knowledge about physician leadership from existing personal knowledge through experiences in GME.

While inquiring about the lived experience of GME, the participants in this study suggested tangible attributes for physician leaders to temper the rigor of medical residency such as being personable, transparent, caring, knowledgeable, motivational, and inspiring purpose. Along with reframing the lived experience of GME from technical competencies to professional/physician leadership formation, I recommend reframing the definition of the phenomenon of physician leadership, as discussed in the following section.

Reframing defining physician leadership in graduate medical education. The studies cited in Chapter 2 focused on defining physician leadership in GME from the voices of those in

formal leadership roles (e.g., chief resident, program director). The participants noted that, prior to medical residency, or upon matriculation, they primarily envisioned physician leadership as a formal leader such as chief resident or "people who are in the higher-up levels, your program director, your CFO [Chief Financial Officer], your kind of just like clerkship directors" (Participant E, 2019, R10). Both Ashley and Ellen spoke about other resident physicians or faculty physicians who were not in formal leadership roles but were influential to their understanding of physician leadership. Ashley described a nonleader third-year resident physician who sent her an email stating that she was excelling and suggesting what to improve. To Ashley, this was a formative interaction. Another example is Ellen's experience with nonleader physicians who took initiative to help the community, which communicated to Ellen that physician leadership is not synonymous with a formal role or title. "I think that, for me, it just tells me how much more physicians can do, and not necessarily have to have that formal position" (Participant E, 2019, R32).

Thus, a recommendation for those who are engaged in the practice of educating resident physicians in GME is to reframe *centralized* perceptions of physician leadership from those in formal roles or titles to a broader, and more *distributed*, understanding that may include those who do not hold formal roles or titles. Furthermore, defining physician leadership from the perspective of a formal role or title negates the educationally formative impact of other health care professionals, such as nonleader resident physicians, medical students, and nursing staff.

There is a growing body of literature on near-peer teaching (NPT), or peers teaching their peers, in UME with regard to academic and clerkship performance of the medical students (Knobloch, Ledford, Wilkes, & Saperstein, 2018). The literature on NPT points to the impact of medical students delivering NPT with regard to developing such skills as leadership and time

management (Lydon et al., 2017; Nimmons, Giny, & Rosenthal, 2019). Recognizing the growing prominence of educational approaches such as NPT and transposing this approach to the context of GME in relation to physician leadership suggests a more distributed view of physician leadership that includes nonleader peers. Such activities may be occurring organically but formalizing initiatives, such as near-peer mentoring between resident physicians, as identified by Jardine et al. (2015), reframes the location of leadership from those with formal titles or roles (centralized) to a distributed view that incorporates nonleader peers. A distributed understanding of physician leadership was exemplified by Ellen:

> I feel like as a third year right now, I've been more of a supporting role to make sure that my team is ahead of the game, and that they know what they need, and that I kind of help guide them towards that direction. I guess that's how I take it now as a resident in that role, like I do more of a guide each year, like just guide the uprising students or residents just so that they can have that good learning time for them. (Participant E, 2019, R36)

Reframing physician leadership from a centralized and formal perspective to a distributed and informal perspective could engage more members of the medical residency environment in the physician leadership development of resident physicians. Engaging more members of an environment also reinforces the importance of physician leadership to the lived experience of GME. The following section addresses reframing the development of physician leaders.

Reframing the development of physician leaders in graduate medical education. Blumenthal et al. (2012) and Jardine et al. (2015) noted the dearth of structured leadership programs in GME and suggested that the demands of clinical work may account for this absence. The approach that was often utilized, as identified by Frich et al. (2014), was lectures (84%). Lectures during the noon hour are a common educational approach in GME. In addition, the time dedicated to delivering content on physician leadership through lectures pales in comparison to time spent in clinical work in close proximity with peers and other physicians.

Therefore, those who direct development of physician leaders in GME could consider reframing educational approaches from largely formal and didactic to observation and role modeling to capitalize on the apprenticeship nature of GME and proximity to peers and other physicians. In particular, Frank noted the impact of observation and proximity.

> This particular attending liked to challenge the residents to think more critically and empower them to think more critically, as opposed to just following orders and going about carrying out their marching orders and duties. Really empowered them to think for themselves, and I think that was eye-opening for me as far as what I want to do. (Participant F, 2019, 20)

The AAMC (2006) emphasized the impact of conduct, or role modeling, as the "medium through which the [medical] profession perpetuates its standards and inculcates its ethical values" (p. 4). Baird, Soldanska, Anderson, and Miller (2012) found that dermatology resident physicians acquired leadership skills through observation (97%) or modeled behavior (90%). Reframing physician leadership development from the perspective of observation and role modeling has the potential to further distribute physician leadership development from centralized leaders to a broader responsibility within a residency program that reinforces the importance of conduct and role modeling. A broader responsibility for developing physician leadership also redirects emphasis from developing individual leadership skills, which may be contextually bound, to a culture of physician leadership that aligns with a growing sentiment in the literature that, "at some level, all physicians are considered leaders" (AAPL, 2017, para. 4).

Reframing leadership development in GME from a centralized approach to a distributed approach should include structured reflection. A growing body of literature highlights the importance of reflection in physician leadership development. "Reflection is key to good medical practice. A reflective outlook raises consciousness, prompts movement from the routine of practice to its critical appraisal and drives change. It is central to appraisal and medical revalidation" (Moen & Prescott, 2016, p. 372). Beth, Courtney, and Frank discussed reflecting

on physician leadership. Frank stated in his second interview that he "self-reflect[s] in my own head. . . . I think actually seeing the words and seeing it registering in mine back to you visually, through the words is actually pretty powerful" (Participant F, 2019, R6). As previously used to highlight catalytic authenticity, when Ellen was questioned about her thoughts about voicing her perceptions of physician leadership, she aptly stated to illustrate the role of reflection,

> Even after our first interview where we talked about it, I even sat down afterwards and kind of had more time to think about it, and just kind of see where my role is at this point in my career, versus where my role could be later on in my career. (Participant E, 2019, R12)

Reflection offers the opportunity to self-analyze and self-regulate. If coupled with structured reflections that engage peers, supervisors, and even patients, as suggested by Moen and Prescott (2016), the results could prove informative to developing physician leaders in GME.

Jardine et al. (2015) noted the dearth of leadership training for resident physicians and suggested a uniform national leadership curriculum for GME. I disagree with this suggestion, as the literature reviewed for this study identified variations in definitions of physician leadership based on role (Detsky, 2011; Fairchild et al., 2004; Stoller, 2009), context (Clyne et al., 2015; Webb et al., 2014), and specialty (Mulholland, 2015; Serio & Epperly, 2006) that influenced development of physician leadership. The participants described specific differences between the surgical and family medicine specialties. Ashley reflected on her experiences with physician leaders from other specialties who appeared to her as being more "aggressive, and certainly thicker skinned" (Participant A, 2019, R52) than the physician leaders with whom she interacted in family medicine.

The outcomes of clinical care in each specialty could also infer contrasting understandings of physician leadership. Contextual flexibility with regard to medical specialties, or even settings, could reveal nuances within the specialties or settings that account for

definitional variation. Although shared aspects between specialties and settings may be evident, such as motivation or inspiring purpose, a national curriculum may pose multiple problems, such as approaches from a larger context like a hospital to a small physician-run clinic. Physician leadership in those contexts may differ based on, but not limited to, aspects like patient population, outcomes, and employees.

One problem noted in the literature on physician leadership is transposing approaches and theories from other sectors (e.g., corporate) to the medical profession and crafting generalizable developmental approaches. Taylor et al. (2008) reinforced the importance of the specialty context and challenged Crites, Ebert, and Schuster (2008), who stated that leadership education in medicine is not specific to business or health care. In agreement with Taylor et al. (2008) and Collins-Nakai (2006), "The solution does not lie in simply injecting a 'business' way of thinking into health care organizations" (p. 70), but rather accounting for contextual nuances between specialties and settings.

Based on the reviewed literature and findings from this study, I recommend reframing the lived experience of GME, physician leadership, and the development of physician leaders. Reframing could consist of a broader perspective of physician leadership development in GME that accounts for cognitive constructions based on lived experiences. Physician leadership could be reframed from a centralized perspective of those in formal leadership roles to a distributed perspective that engages peers (e.g., near-peer mentoring), utilizes observation and role modeling. In conjunction with observation and role modeling, reflection is a powerful tool to analyze cognitive constructions, observations, and interactions with role models. The focus on communal responsibility cultivates a climate within a medical residency program that reframes physician leadership as a collective, rather than a solo, endeavor.

Future Research

The purpose of this study was to explore the nature of physician leadership for family medicine resident physicians from their descriptions of the phenomenon of physician leadership through lived experiences in GME. The central research question was, *How do family medicine resident physicians describe and experience the nature of physician leadership?* This study suggested areas of future inquiry: the phenomenon of physician leadership, valuing the nonleader resident physician perspective, and the importance of role modeling.

The phenomenon of physician leadership. A larger body of literature exists on approaches to physician leadership development than on defining physician leadership. These subsections discuss areas of future research with regard to other specialties, sex, and career stage.

Specialties. Mulholland (2015) and Serio and Epperly (2006) highlighted the definitional differences of physician leadership between the medical specialties of surgery and family medicine. Context was a shared structural (how) theme for the participants of this study. The participants contrasted educational outcomes and behaviors of physicians in family medicine and other specialties. Although the scope and focus of this study was delimited to nonleader resident physicians in the specialty of family medicine, the question arises as to how nonleader resident physicians in other specialties (e.g., internal medicine) describe the nature of physician leadership. It is important to restate that the nature of physician leadership, as constructed through the integrated approach to data analysis (Colaizzi, 1978; Moustakas, 1994) from shared aspects across participants, is not intended to be generalizable. However, transferability of methods and findings could be relevant to other specialties in order to understand perceptions of nonleader resident physicians about physician leadership.

I recommend that future inquiry consider constructing the nature of physician leadership for nonleader resident physicians from additional medical specialties. This approach would offer

data sets to investigate the phenomenon of physician leadership across specialties. For example, a qualitative metasynthesis of descriptive phenomenological studies on nonleader resident physicians from various specialties could offer a broader understanding of the phenomenon of physician leadership in GME (Zimmer, 2006). Issues to consider regarding metasynthesis studies of phenomenological literature are discussed in health care (especially nursing) literature (Paterson, Thorne, Canam, & Jillings, 2001). However, the opportunity to construct shared aspects regarding the nature of physician leadership for nonleader resident physicians across medical specialties enhances the voice of the underrepresented population of nonleader resident physicians and offers insight into the phenomenon of physician leadership.

Sex. Criterion-based purposeful participant selection (Patton, 2015) was utilized to recruit participants. The criteria did not identify sex as a criterion but rather sought "information rich" (Patton, 2002, p. 230) participants who could "inform an understanding of the research problem and central phenomenon in the study" (Creswell, 2007, p. 125). Thus, recruiting participants and the findings of this study were also not differentiated based on sex.

In 2018, the AAMC stated that females (51.6%) matriculated into U.S. medical schools at a higher rate than males (48.3%; AAMC, 2018, p. 8). The overall number of matriculating female students increased 3.9% from 47.7% in 2008 to 51.6% in 2018, whereas males decreased 3.9 % from 52.2% to 48.3% over the same 10-year period. Female resident physicians account for 45.6% (Murphy, 2019) of resident physicians and about one third (Dall, Chakrabarti, Iacobucci, Hansari, & West, 2019, p. 45) of licensed physicians in the United States.

Based on these data, the number of female physicians matriculating through medical school, medical residency, and becoming licensed physicians has increased. Despite the increase in the number of females entering UME, GME, and constituting the physician workforce in

CME/professional practice, they are underrepresented in leadership roles in academic medicine (Rochon, Davidoff, & Levinson, 2016). Although rationale for such underrepresentation ranges from lacking role models, work-life balance, and sex bias (Rochon et al., 2016) understanding the lived experiences of physician leadership for female nonleader resident physicians in GME could be transferred to myriad applications of female medical students, resident physicians, and nonleader licensed physicians, as well as those in leadership roles.

The overall literature on physician leadership would benefit greatly from understanding the lived experiences of female physician leaders in academic leadership roles. For example, understanding *what* and *how* the culture or organizational structures impact the lived experiences of female physicians in leadership roles is an avenue for constructivist qualitative research to complement existing data from alternative paradigms and research designs (Murphy, 2019). Over all, providing insight into the lived experiences of females in academic or clinical medicine could contribute to constructing more inclusive cultures, systems, and practices across the contexts of medical education (UME, GME, CME) and possibly the profession.

Career stage. Oandasan et al. (2013) highlighted how understandings, or definitions, of physician leadership for physicians change based on career stage. Although potentially idiosyncratic to the context(s) study, the findings by Oandasan et al. (2013) posed the question of whether definitions of physician leadership change over a physician's education and/or career. As noted in the section on historical approaches and leadership theories, the perceptions of physician leadership changed for the resident physicians in this study during their time in medical residency. Prior to medical residency, Ellen perceived physician leaders as those higher up or in "the traditional leadership roles" (Participant E, 2019, R10), such as a program director or chief financial officer. Upon entering family medicine medical residency, Ellen quickly

realized that she was responsible for leading an interprofessional health care team. Daniel also stated that his perception of physician leadership "definitely changed a little bit from my first, second, and third year just based on the people that I worked with" (Participant D, 2019, R46).

Investigating change in perceptions with regard to career stage offers an opportunity to understand the growing complexity of physician leadership on a personal level, which is parallel with evolving complexity found in the historical literature on leadership and the literature on physician leadership in medical education. Identifying *what* about the understanding of physician leadership increases in complexity as well as *how* such understandings are informed by career stage would offer an avenue to determine the opportunities and challenges that are encountered at various career stages. For example, Oandasan et al. (2013) stated that early-career physicians perceived physician leadership as *receiving* mentoring, whereas late-career physicians perceived physician leadership as *delivering* mentoring and executing administrative responsibilities. Understanding the lived experiences of late-career physicians with regard to mentoring roles and administrative responsibilities would be informative to preparing early-career physicians.

Valuing the nonleader resident physician perspective. The reviewed literature displayed the lack of inquiry on how nonleader resident physicians define physician leadership, as well as developmental approaches. The extant literature focused on the subset of resident physicians who assume leadership roles (e.g., chief resident), thereby imparting value to those resident physicians and indirectly devaluing resident physicians who are not in formal roles, or nonleaders. However, both leader and nonleader resident physicians may oversee other healthcare professionals and medical students on interprofessional health care teams.

> Daily patient care is carried out by a team of physicians, nurses, care coordinators, pharmacists, social workers, nutritionists, physical and occupational therapists, and other

> health care allies. Residents often lead these activities, yet their ability to effectively lead teams often is not explicitly addressed in their curriculum and is rarely assessed in a formal manner. (Jardine et al., 2015, p. 307)

Through such roles on interprofessional health care teams, resident physicians impart value to the medical residency program and the academic medical center by such aspects as, but not limited to, the number of patients treated and the quality of care. Once resident physicians graduate medical residency, they often assume advanced clinical roles similar to "someone who's been in their physician role for 20-30 years" (Participant E, 2019, R38) and could serve in a formal leadership position for future resident physicians. The exponential value of nonleader resident physicians is logical but not explicitly highlighted in the literature.

Frich et al. (2014) observed that 13 of 45 residency programs studied included physician leadership development programs that were open to nonleader resident physicians. Considering that in 2019-2020 the total number of accredited programs in the United States was 11,723 (ACGME, 2019), the programs in the study by Frich et al. (2014) constituted a negligible fraction of overall available programs. Needless to say, the majority of literature on physician leadership in GME directs development, evaluation, inquiry, and ensuing value to resident physicians in formal leadership roles. I disagree with the limited focus on resident physicians in formal leadership roles, as this approach is directed at a micro subgroup rather than at the majority resident physician population who are nonleaders but will advance into leadership roles after medical residency. More research on nonleader resident physicians would assist in understanding this critically understudied population in medical education, thus imparting value and contributing to the knowledge base on physician leadership in GME.

The importance of role modeling. In a previous section I reframed the development of physician leaders in GME from directed at formal leaders as an individual, and centralized, developmental responsibility to a distributed responsibility within a residency program, thereby

reinforcing the importance of role modeling. Role modeling is perceived as a primary method for the medical profession to perpetuate its standards and ethical values (AAMC, 2006) and is often referred to as the "hidden curriculum" (Kenny, Mann, & MacLeod, 2003, p. 1204). Two structural themes of proximity and apprenticeship bound *how* the participating resident physicians experienced physician leadership.

The participants in this study described the impact of the physician leader on the types of practitioners that resident physicians become. The personal attributes and behaviors that physician leaders exhibit offered powerful anchors to describe physician leadership. The resident physicians also described the nature of physician leadership through the side-by-side relationship with formal leaders. They would learn how to care for patients, as well as what it meant to be a physician, by working in close proximity on a daily basis with formal leaders and/or role models. This study contributes to the expansive literature on role modeling as a method for developing physician leaders.

Kenny et al. (2003) documented the emerging literature on role modeling in medical education. Students and residents were identified recipients and senior physicians served as role models, which alluded to the reach of the role modeling relationship. Sternszus and Cruess (2016) stated, "Although much has been written on role modeling, more data are needed to support thinking on *how* individuals learn from role models" (p. 1257, emphasis added).

More research is needed to understand how the role modeling relationship is formative to the receiver (resident physicians), as well as to the deliverer (senior physicians). This line of inquiry would offer perspectives on the lived experiences of role modeling as they contribute to perceptions of physician leadership. Phenomenology offers an approach to understand physician

leadership with regard to the *what* and the *how* of the role modeling relationship for resident physicians and those they consider as role models.

In summary, and based on the findings of this study, future research could focus on the phenomenon of physician leadership, valuing the nonleader resident physician perspective, and the importance of role modeling. Conducting inquiry on what about medical specialties, sex, and career stage influences perceptions of physician leadership would be insightful. Furthermore, inquiry into the perceptions of nonleader resident physicians would contribute to a currently limited knowledge base on the majority of the resident physician population that is underrepresented in the literature. Role modeling in medical education received significant attention at the turn of the century (Kenny et al., 2003); however, more recent literature (Sternszus & Cruess, 2016) pointed to the necessity of additional research on how the role modeling relationship influences perceptions of receiver and deliverer. Research on role modeling from a phenomenological perspective would contribute to understanding *what* about, and *how*, role modeling influences perceptions about physician leadership.

Theorizing

Utilizing a theoretical framework is not a uniformly acceptable approach in phenomenological inquiry, nor was specific leadership theory (e.g., transformational) utilized to delineate the scope and focus of this study. It is important to state that the purpose of phenomenology is not to produce a theory. Grounded theory was considered for this study based on its focus on the meaning and description of experience, but a key outcome of grounded theory is generation of a theory; thus, it was not utilized. With this said, the findings on how family medicine resident physicians described the nature and the experiences of physician leadership revealed areas of potential theory formation related to cognition, behaviors, and the influence of a system.

Responsible leadership for performance theory, as originally proposed by Lynham (1998), suggested that leadership is environmentally focused, system serving, and focused on "interacting inputs, processes, outputs, and feedback wherein individuals and/or groups influence and/or act on behalf of specific individuals or groups of individuals to achieve shared goals" (Lynham & Chermack, 2006, p. 75). Lynham and Chermack (2006) stated that members of that system interpret and define leadership. This theory pointed to the individual and social constructions of leadership that could be beneficial to future theories on physician leadership by highlighting personal and systemic influences.

In addition to responsible leadership for performance theory, other theories, such as implicit leadership theory (ILT), as championed by Rush, Thomas, and Lord (1977), contribute the perspective of leadership progressing from internal attributes to relational processes and externally oriented systems. Implicit leadership theory highlights the importance of constructing cognitive schemas based on experience. "ILTs are social constructs that are largely shaped by individual's past interactions and unique personal experiences" (Shondrick, Dinh, & Lord, 2010, p. 963). Cognitive constructions about who the physician leader is, how that person behaves, and the influence of contexts or systems suggest future inquiry, or potential theory formation, around these areas that could contribute to the literature on physician leadership.

Although phenomenological research does not result in a theory, exploring the phenomenon of physician leadership through description grounded in lived experiences in GME offers valuable insight for the field of medical education in that "how people approach the development of leadership is a function of their formal and informal theoretical understandings of the construct" (Dugan, 2017, p. 41). Constructing theory on physician leadership within the broad context of GME would offer a foundation to produce developmental approaches that are

cognizant, or reflective, of such aspects as, but not limited to, contextual (e.g., clinic) or specialty-based nuances.

Reflections on My Experience as a Human Research Instrument

I began this chapter by returning to the quality criteria of trustworthiness and authenticity to reaffirm the quality of this study. Now it is important that I discuss reflections and advice on my experience as a human research instrument (Merriam & Tisdell, 2015).

Lincoln and Guba (1985) discussed seven characteristics of the human research instrument as drawn from an earlier work by Guba and Lincoln (1981): (a) responsiveness, (b) adaptability, (c) holistic emphasis, (d) knowledge base expansion, (e) processual immediacy, (f) opportunities for clarification and summarization, and (g) opportunity to explore atypical or idiosyncratic responses. These characteristics frame this reflection of the researcher as a human research instrument.

Characteristics of the Human Research Instrument

Lincoln and Guba (1985) noted that utilizing humans as research instruments is not novel. Such practices existed in the field of anthropology; however, qualitative/naturalistic inquiry must "learn and to profit from the experience" (p. 195) for a study to be trustworthy. This study was a formative experience and the characteristics discussed below guide reflections on my learning process as a human research instrument.

***Responsiveness*.** Lincoln and Guba (1985) defined responsiveness as responding "to all personal and environmental cues that exist" (p. 193). The first round of interviews with Ashley, Beth, and Courtney were conducted in person. The other first-round interviews and all second-round interviews were conducted via telephone or videoconference (e.g., Skype). I responded to behavioral cues more easily during the in-person or videoconference interviews than during the telephone interviews. For example, Ellen and I conducted the first round of interviews by

telephone. She had a rare day off and was running errands. At first, I perceived that she was out in public, as I could hear faint voices in the background. I initially thought that she was rushing the interview and was frustrated. However, I quickly reflected and realized that I needed to be grateful for the time that I was able to secure and continued with the interview. She was concise, which I could have interpreted as rushed, but her answers were substantive. I memoed in my reflexive journal, "I am excited to analyze her data."

I initiated this study with the assumption that resident physicians have very limited free time. This assumption was based on my wife completing medical residency and my experience with her schedule. Utilizing the semistructured data collection guide proved very helpful in balancing a focused interview with freedom to open a line of questioning. I did not change any of the questions; however, throughout the interviews I increasingly provided more of a preface to help the participants to understand the questions. I also progressively offered summaries of statements to ensure that I understood their responses. Future qualitative researchers conducting research on resident physicians should consider a semistructured data collection guide to balance free exploration while staying focused to honor the limited time of the resident physicians.

With regard to responsiveness for myself as the human research instrument, I realized throughout this process that phenomenological inquiry is deep and, at times, required that I sustain focused attention (e.g., cross-case analysis). On August 3, 2019, I wrote,

> I found that reading through the textural and structural statements is intensive and requires me to be fully attentive. Therefore, I am going to give myself at least 4 hours to one day to wait before the next reading. This will also allow time for reflection.

Future phenomenological researchers must account for the time and focus required to conduct phenomenological studies.

Adaptability. Human researchers as instrument are valuable with regard to adapting to such aspects as situations, context, and collection methods. "This ability to adapt to differing

contexts and different informational needs is a virtue that a paper and pencil text can never achieve" (Guba & Lincoln, 1981, p. 131). Upon reflection, I should have paid more attention to this characteristic. I initially required the interviews to be in person, with no gratitude attached to participation. In a memo from my research journal on May 6, 2019, I determined that I should adapt my collection methods to include telephone or videoconference (e.g., Skype), as well as a $100 gift card, previously included as of March 24, 2019, to show gratitude for completing the study. I understand that telephone or videoconference may be preferable approach for resident physicians over in-person collection methods.

With regard to data analysis, I anticipated utilizing secured online software (e.g., GoogleSheets, SuperNoteCard) to facilitate analysis across participants. However, I found the online software to limit moving from the parts (individual descriptions) to the whole (across descriptions). Thus, I printed the descriptions for each participant on individual pages and physically laid them on the floor. I found this approach more effective than utilizing online software. Manually manipulating the individual descriptions familiarized me with the individual experiences of the resident physicians before looking across their data for shared aspects. I printed the pertinent statements and cut them so they could be manually sorted.

Along with being cognizant of the work requirements for resident physicians and data analysis, I wanted to craft descriptions that accounted for the availability of resident physicians. On March 27, 2019, I noted,

> Since resident physicians tend to be extremely busy, with an average of 10-12 hour shifts, I have opted to try and construct the textural, structural, and textural-structural statements in no more than 4 paragraphs each so as to not lose the attention of the participant. This range is on the shorter end of one to nine paragraphs in the literature. (Edward & Welch, 2011; Moustakas, 1994; Sanders, 2003)

Crafting descriptions that were succinct but that embodied the lived experience of physician leadership for the resident physicians was time consuming. Significant time is required to conduct phenomenological inquiry and should be accounted for throughout the study.

Holistic emphasis. "The world of any phenomenon and its surrounding context are 'all of a piece'" (Guba & Lincoln, 1985, p. 194). In short, context is important when conducting qualitative/naturalistic inquiry. This aspect was difficult for me as I perceived a holistic emphasis at conflict with descriptive phenomenology. This perception arose from transcendental, or descriptive, phenomenology's emphasis on "bracketing" (Patton, 2015, p. 575) prior interpretations. Through the course of this study, I realized that holistic emphasis did not contradict descriptive phenomenology as the world of the phenomenon refers is in relation to the participants. I can be critically aware of, or bracket, my interpretations as evidenced in my reflexive journal and be attentive to the holistic context of the participants. This is demonstrated by expanding on Beth's, Courtney's, and Frank's descriptions of experiences that informed their understanding of leadership prior to medical residency. Beth discussed a faculty member in medical school who championed rural health care. Courtney spoke of time spent working in summer camps, whereas Frank related a situation with an attending physician when he was in medical school. These experiences where holistically formative for Beth, Courtney, and Frank. I neglected asking Ashley to expand on her experiences. However, I became more attentive to talking points like this, starting with Beth.

With regard to analysis, I asked questions such as (a) What are the units describing? and (b) Are they compatible with the participant's experience? (MacTaggart, 2018; Moustakas 1994) when reviewing the note cards for the meaning units. Analyzing across participants, and guided by MacTaggart (2018) for meaning units, questions that informed analysis of determining

individual and composite structural themes were (a) What themes are primarily consistent (4 out of 6) across the participants? and (b) What themes speak to *how* physician leadership was experienced? Such questions aided in crafting textural (what), structural (how), and the final shared textural-structural (nature) synthesis statement. These questions were helpful in viewing the data holistically and aided in refocusing analysis when it appeared to be overwhelming.

Knowledge base expansion. Guba and Lincoln (1981) described the domains of knowledge as propositional and tacit. Propositional knowledge includes hypotheses, statements, and assertions, whereas tacit knowledge includes "insights, apprehensions, and hunches" (Guba & Lincoln, 1981, p. 135). In short, moving from conscious (propositional) knowledge to unconscious (tacit) knowledge enables the human research instrument to be more effective. Moving from propositional and tacit knowledge is evident in my research and reflexive journals.

Accessibility of these journals was important. MacTaggart (2018) utilized a physical notebook to capture ideas and notes. I utilized GoogleDocs, which I could access from various locations. This enabled me to document prior interpretations or other aspects in real time, as well as return to the data in GoogleSheets frequently when large blocks of time were not available. Both were secured with a password. On September 14, 2019, I noted,

> Definitely feeling inundated with the experiences of the participants. So much to put together. What was a large help was physically moving around, and through, their lived experiences printed out on paper and/or cut into pieces. As much as I like the accessibility and organization of digital means, I can see why physically manipulating data is preferred. However, it is not feasible to bring note cards everywhere you go and continually lay them out for reflection. I did appreciate how secured online software allowed me to frequently emerge myself in the data . . . even if it was for a short time.

Reflecting on accessibility to expand my knowledge base, I realized that I needed to be flexible and to utilize discretion. For example, when deciding to incorporate software, I had to be cognizant of its utility (e.g., journaling, returning to the data) and limits (e.g., analysis across

participants). Software is controversial in phenomenological studies; however, I utilized it to organize the data and recognized its limits in analysis.

Processual immediacy. The human researcher as instrument has the ability, as described by Guba and Lincoln (1981), to "process data immediately upon acquisition, reorder it, change the direction of the inquiry based on it, generate hypotheses on the spot, and test them with the respondent or in the situation as they are created" (p. 136). I utilized a conceptual, rather than a theoretical, framework to guide this study. Descriptive phenomenological inquiry requires suspending prior interpretations (i.e., bracketing) to see the phenomenon "freshly as if for the first time" (Moustakas, 1994, p. 34). Thus, I attempted to suspend any potentially hypothesis-laden interpretations, as described below in a memo from April 20, 2019:

> Upon writing participant B's textural description, I recognized that a prior interpretation in that physicians often described physician leadership in regard to the patient or peers (e.g., participant A). This is evident in anecdotal sayings such as, "it's all about the patient" that I have come across in my experience. However, I need to be critically aware of this interpretation and see freshly participant B's description of their need to advocate for, and lead, the specialty of family medicine. I must be cautious as to not tunnel focus on patient and peers, but be attune to descriptions that emphasize broadening perspectives of physician leadership to move the profession forward.

Opportunities for clarification and summarization. As the human research instrument, I had the opportunity to provide feedback to participants in the form of summaries. This ensured that what I had heard from their descriptions was accurate. For example, when interviewing Ashley, I stated, "So what I heard from you was, different people "above" you may be in formal roles, . . . From what I'm hearing from you, that influenced how you are going about doing that with people" (Participant A, 2019, R29). This summarization occurred in the first interview; consciously and subconsciously, I incorporated this method in the following interviews. As a lecturer in a medical school, I often utilize this common pedagogical method to ensure a shared understanding. Reflecting on this method, I perceived that, when I summarized information to

participants, the participants felt heard. If I did not summarize something accurately, I framed the summary in such a manner to create a space where the participants were free to correct me, such as with Frank, who corrected my summary on medical culture.

Opportunity to explore atypical or idiosyncratic responses. Exploring responses from participants that are unique or idiosyncratic can provide a way to a "higher level of understanding than might otherwise be possible" (Lincoln & Guba, 1985, p. 194). A tangible approach utilized throughout the course of this study was to inquire about experiences, not solely about people, that had informed perceptions of physician leadership. Courtney is a prime example, as she discussed working at summer camps prior to medical residency. She described leaders who exhibited a servant attitude that influenced her understanding of physician leadership. I allowed free thinking about the phenomenon of physician leadership by stating, "Just whatever you think is important. You can stick to medicine if you feel like that's good, or you can branch out and talk about other aspects" (Participant C, 2019, R5). To an observer, discussing summer camp might not appear to be directly related to the phenomenon of physician leadership. However, through her description, it was evident that she appeared to carry a servant attitude of leadership into medical residency. If I had stated that she should limited her discussion to examples in medicine, I might not have received that rich and unique perspective.

Qualities of the Human Research Instrument

The desirable qualities of the human research instrument, as described by Guba and Lincoln (1981) are (a) empathy, (b) stress-regulating, and (c) attentive and curious. Following these qualities, I offer advice from my experience as a human research instrument.

Empathic. The quality of empathy is described as "the most applicable in any naturalistic study or evaluation" (p. 140). Empathy assists with human connection and can occur while conducting an interview or in the design of the study. With regard to interviewing, I often made

such comments as, “I know you’re very busy” (Participant A, 2019, R55) or “Thank you for your time” (Participant D, 2019, R69) or “There is no right or wrong answer” (Participant F, 2019, R15). Comments such as these and others displayed empathy for the time commitments of resident physicians and potentially lack of reflection on the phenomenon. I also perceived availability as an issue and adapted data collection methods to accommodate for the availability of the resident physicians, thus communicating empathy through the design of the study.

Stress-regulating. “Recognition that the fieldworker is subject to change is one of the more important realizations of social inquiry” (Guba & Lincoln, 1981, p. 141). Conducting an in-depth phenomenological study was difficult. Not only did it require significant time to conduct the two rounds of interviews; analyzing the data to identify themes, write descriptions, and integrate descriptions for individuals and across participants required dedication. I reflected on the rigorous analysis in a memo on September 26, 2019:

> This type of methodology and analysis is difficult. Granted, I do not have much to compare it but the level of mental attention to lived experiences and immersing myself in the data takes energy. . . . However, to analyze the data, I needed to set apart a significant amount of time to allow mental processing.

To mitigate the stress related to the amount of data to analyze, I was intentional about being attentive to my ability to focus. If focus waned, I took a break and stepped away from the data. It was my intent to honor the lived experiences and descriptions of the participants; therefore, I did not want to rush. When I became frustrated in recruiting participants, I sought guidance from colleagues and mentors. Their guidance aided in determining how to adapt the study to recruit participants with limited availability. Developing self-awareness and seeking assistance from others was key to moving the study forward.

Attentive and curious. The ability to be attentive and curious by becoming a good listener and inquiring about various viewpoints is important when investigating a phenomenon.

Guba and Lincoln (1981) stated that the inquirer must be curious about participants and must be "aware that information can come from unexpected quarters" (p. 142). This was most evident in the interview with Courtney and her discussion on summer camps prior to medical residency.

Becoming critically aware of my prior, or emerging, interpretations during the research process was key to being attentive to the phenomenon of physician leadership as described by the participants. For example, I reflected on my interview with Beth and became aware of a growing perception that, although she may not have reflected on the topic of physician leadership and, similar to other physicians I have encountered, she had strong opinions about knowing what it is. I had to set this perception aside so I could be attentive and curious as to what she was describing about her experience.

As I interviewed the participants, I also noticed improvement in my ability to identify statements that could lead to rich descriptive information. For example, in Frank's interview, I followed up a response to question with the following:

> I want to step back into a couple of words that you said. You said first, to start out with, attitude. You said it was less of a position, and more of a . . . the first thing you said, I believe, was attitude. Tell me a little bit more about that. Why did you focus on an attitude? Were there certain things that you saw in residency that made you think that this is more of an attitude? (Participant F, 2019, R21)

My ability to pick up on descriptive nuances was key to identifying aspects of the interview that merited further questioning. I perceived that picking up on verbal cues was easier when conducting the interview via telephone, as I had to be intentional about listening to what was said rather than observing behavioral cues when interviewing in person or through videoconference.

The journey of conducting a phenomenological study on an underrepresented population with regard to the topic of physician leadership was difficult, worthwhile, and exciting. I recall specific times when I was excited to analyze the data. For example, Ellen provided concise but thoughtful responses. Her ability to unpack the influence of informal leaders and her growing

understanding of her role on the interprofessional health care team was invigorating. I was excited to see aspects of the literature reflected in the descriptions given by the participants.

Conclusions from my experience as a human research instrument. Whether vigorously climbing the mountains of data or persistently trudging through the valleys of analysis, this study was a journey not only to explore the nature of physician leadership but also a journey with regard to serving as a human research instrument. From this journey, I concluded that I was changed with regard to time, commitment, and living the questions.

Conducting this study required a significant time commitment, about which I was previously naïve. I frequently redefined my understanding of time as I encountered delays with IRB approval and with recruiting participants. Not only did I need to be aware of the time requirements to conduct this study; I also needed to be aware of the time commitments of my participants. This awareness enabled me to move beyond my perceived best practice of in-person interviews to engage participants in telephone and videoconference interviews. Had I come to this realization earlier, I might have been able to recruit participants sooner.

Next, commitment was required to return frequently to the lived experiences of the participants. Allocating large portions of a day to focus on data analysis was difficult due to full-time employment and family responsibilities. Thus, incorporating secured digital means (e.g., GoogleSheets) enabled me to return to the data when I was available.

Being committed to conducting a sound study was key in the early stages of crafting an integrated approach to data analysis. Colleagues who utilized Moustakas's approach (1994) suggested that I review his approach. Moustakas's (1994) phenomenological process and data analysis are grounded in Husserlian descriptive phenomenology. However, I perceived that participant input as co-researchers in data analysis was not adequately addressed. Therefore, I

merged Moustakas's approach (1994) with Colaizzi's (1978) stages of data analysis to co-construct what is known by returning to participants for input on data analysis (Holloway & Galvin, 2017). Arriving at this point of integration was time intensive as I struggled to identify an ideal approach to analysis. This experience taught me the lesson about being committed to flexibility and the emergent nature of qualitative research.

Finally, I lived the questions of the study. By this, I refer to the central research question that evolved but also to questions raised in interviews, through analysis, or about myself. Such questions about myself included, "Can I do justice to the lived experience of the participants?" "Do I have the mental energy and stamina to continue?" and "Do I have the patience to keep waiting for participants?" All of these questions were critical to my journey as a human research instrument. What helped me in the journey through these questions varied from my chair, committee, and peers. However, a quote from a required textbook in undergraduate studies frequently echoed in my thoughts:

> Be patient toward all that is unsolved in your heart and try to love the questions themselves, like locked rooms and like books that are now written in a very foreign tongue. Do not now seek the answers, which cannot be given you because you would not be able to live them. And the point is, to live everything. Live the questions now. Perhaps you will then gradually, without noticing it, live along some distant day into the answer. (Rilke, 1993, p. 35)

Living the research question, the interview questions, and the personal questions that arose from this experience as a human research instrument are important to this study with regard to time and commitment, as well as to my role as the human research instrument.

I advise qualitative researchers to fully engage the questions raised throughout the research process but to allocate sufficient time to reflect on the questions that arise while being mindful of resources and deadlines. For example, I did not decide to alter my data collection method from in-person to telephone and videoconference interviews immediately. This decision

required time, investigating the literature, and discussing the approach with colleagues and mentors. Forcing answers to questions at the detriment of the paradigm, design, participants and topic is a disservice to the research process. The researcher should remain flexible and self-reflective, seek guidance from mentors and colleagues, and be intentional about learning about oneself as a qualitative researcher as much as what is gleaned from the findings.

Conclusion

Since the late 1990s, recent challenges facing health care, such as financial constraints and interprofessional health care teams (Morrison, Goldfarb, & Lanken, 2010; Orlando & Haytaian, 2012) have complicated the physician's role. The physician's role has evolved from solo practitioner in the late 19th century to team leader, team member (Morrison et al., 2012), and "manager and system architect" (Bohmer, 2004, para. 6) in the 20th and 21st centuries. In addition to the physician-patient relationship and teams, physicians can also manage private practices, supervise physician groups (Dickerman et al., 2018), and engage in the political arena (Snell et al., 2011). These factors, along with the growing sentiment that, "at some level, all physicians are considered leaders" (AAPL, 2017, para. 4), has strengthened the importance of defining physician leadership and developing physician leaders (Neeley et al., 2017).

The purpose of this study was to explore the nature of physician leadership for family medicine resident physicians from their descriptions of the phenomenon through lived experiences in GME. The research question was, *How do family medicine resident physicians describe and experience the nature of physician leadership*? Through a descriptive phenomenological methodology and an integrative phenomenological data analysis process framed by Moustakas (1994) and Colaizzi (1978), the participating family medicine resident physicians described the nature of physician leadership. The synthesis statement based on shared textural (what) and structural (how) data consisted of how the context of GME, specialty of

family medicine, and apprenticeship style relationship with formal and informal physician leaders contributed to their understanding of physician leadership. Although difficult to define uniformly, behaviors and personal attributes of informal and formal leaders offered critical anchors for the resident physicians to ground descriptions of physician leadership. Medical residency is hierarchical but more important than role or title to the participants is how the physician leader treats followers such as the resident physicians themselves. Ensuring that the voices of nonleader resident physicians are heard and that their experience in GME, which is the "forge of professional practice" (Cooke et al., 2010, p. 239), is critical. Listening to the voices of nonleader resident physicians is specifically critical to promoting the physician leadership development of future generations of resident physicians entering and practicing in the evolving landscape health care.

The focus of this chapter was to offer conclusions and recommendations based on the findings of this study. After a review of quality criteria to reinforce a sound study, implications from the reviewed literature were reviewed to make recommendations for future research. I reflected on my experience as a human research instrument and offered advice to future researchers. It is my hope that this dissertation provided insight into the lived experiences of six family medicine resident physicians as they described the phenomenon of physician leadership. I also hope that my study generates future inquiry on the elusive (Swanwick & McKimm, 2011) phenomenon of physician leadership.

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APPENDICES

Appendix A

Recruitment Email

Doctors,

Good day, my name is Michael Dewsnap and I am a doctoral student from Colorado State University (CSU) in the School of Education. As a part of the requirements for my doctoral degree at CSU, we are conducting a research study on physician leadership from the unique, and understudied, perspectives of Family Medicine resident physicians to inform the literature, theory, and practice on physician leadership. The title of our study is, "Exploring the Nature of Physician Leadership for Family Medicine Resident Physicians: A Phenomenological Study." The Principal Investigator is Susan A. Lynham, Ph.D. and I am the Co-Principal Investigator. We are hoping to learn from resident physicians who:

1. are in the medical specialty of Family Medicine,
2. do not hold formal leadership roles in a medical residency program, and
3. have completed at least one year of a Family Medicine medical residency program.

If you qualify, we would like to invite you to participate in two in-person interviews at times and locations that are convenient for you. The first interview explores your understanding of the nature of physician leadership as a resident physician not in a formal leadership role through experiences in graduate medical education (GME). The second interview occurs approximately one to two months after the first interview and asks for your feedback on a synthesized statement from combined interview data about physician leadership. The estimated duration is 30 to 60 minutes for the first interview and 15 to 45 minutes for the second interview. In addition, I will ask you to provide feedback via email on our analysis of your first interview.

Your participation in this research is voluntary; however, to express my gratitude for your participation, I will provide a $100 Visa gift card at the completion of the requirements for your participation in this study. If you decide to participate in this study, you may withdraw your consent and stop participation at any time without penalty but will not receive the $100 Visa gift card as you did not complete the requirements for this study. When we report and share the data, we will use pseudonyms as well as combine the data from all participants. Your personal information will not be attached to reported findings. There are no known risks or direct benefits to you, but we hope to gain more knowledge about the phenomenon of physician leadership.

If you meet the criteria and would like to participate or have any questions about the research, please contact the Co-Principal Investigator via email at michael.dewsnap@colostate.edu or phone at (503) 804-0956. If you have any questions about your rights as a volunteer, contact the CSU IRB at: ricro_irb@mail.colostate.edu; 970-491-1553.

Susan A. Lynham, Ph.D.
Associate Professor
CSU School of Education

Michael A. Dewsnap
Doctoral Candidate
CSU School of Education

Appendix B

Data Collection Guide

Exploring the nature of physician leadership for family medicine resident physicians: A phenomenological study

Participant:_____

Date: _____ Time: _____ Location: _____

Welcome and Introductions:

Round 1

- Casual conversation to build rapport.
- Disclose perspective and positionality.
- Reflection on experiences with the phenomenon of physician leadership.

Round 2

- Casual conversation to build rapport.
- Review synthesis statement.

Purpose and Consent:

- Review purpose of interview to learn about what physician leadership is through their lived experiences in graduate medical education (GME).
- Inform participant that interview will be audio recorded and transcribed.
- State that a synthesized statement about physician leadership for all co-researchers will be provided for reflection and feedback at the second interview.
- Have participant read and sign consent form.
- Reaffirm informed consent at second interview.

Interview Questions:

Round 1

1. Tell me about your experiences in residency with physician leaders in formal roles?
2. Describe a specific experience with a physician leader in a formal role and how this, and previous, experiences influenced your understanding of physician leadership?
3. How does your role as a resident physician influence your understanding of physician leadership?
4. How does the context of GME influence your understanding of physician leadership?
5. How does your specialty influence your understanding of physician leadership?

Round 2

1. Does the synthesis statement reflect your experiences with physician leadership?
2. Does the statement reflect your understanding of physician leadership?
3. Is there anything else you would like to add?