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**FIRST AND FOREMOST, PHYSICIANS: THE CLINICAL VERSUS
MANAGERIAL IDENTITIES OF PHYSICIAN LEADERS**

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ABSTRACT

Physicians – commonly promoted into administrative and managerial roles in U.S. hospitals on the basis of clinical expertise – often lack the skills, training or inclination to “lead.” In response to calls for more “professional” leadership in U.S. health care institutions, several studies have sought to identify factors associated with effective physician leadership – but we know little about how physician managers themselves construe their roles. Phenomenological interviews with physicians at three organizational levels in a typical U.S. urban hospital reveal vivid differences in how they understand and value managerial versus clinical roles, claim and/or grant leadership status, and identify as (or with) physician managers on individual, relational and organizational basis. Results suggest the need for change in how health care organizations frame and promote physician leadership. Understanding physicians’ attitudes and biases about being managers and appreciation for the strength of their primary identity as physicians should provoke health care boards and leaders to consider new approaches to selecting, training and rewarding physician managers.

Key words: Identity; physician management; leadership; role; professionalism; self-categorization

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INTRODUCTION

The U.S. health care industry, long recognized as “convoluted, expensive and often deeply dissatisfying to consumers,” is in crisis (Christensen, Bohmer, & Kenagy, 2000), and cries for change at both system (Shortell, Gillies, & Devers, 1995; Weber & Joshi, 2000; Ferlie & Shortell, 2001) and leadership (Schwartz & Pogge, 2000; Kahn, 2003; Stoller, 2008) levels are increasingly strident. The need for more “professional” leadership has been argued (Leatt & Porter 2003) as hospitals, in particular, struggle to reinvent themselves (Shortell et al., 1995) and transition into better run, more profitable organizations.

Physicians have long assumed leadership roles in hospitals, often as full time administrators or as full time clinicians with part time managerial duties (Reinertsen, 1998; Schwartz & Pogge, 2000). While some have argued that industry challenges demand more physician leadership (Stoller, Berkowitz, & Bailin, 2007), others have observed that physicians, often promoted into administrative roles on the basis of clinical expertise but lacking qualities necessary for effective organizational leadership (Lobas, 2006; Stoller, 2008; Taylor, Taylor, & Stoller, 2008; Weston et al., 2008), “have not been great leaders” (Porter, 2008: 1).

While several studies in recent years have sought to identify factors that promote effective physician leadership (Lane & Ross, 1998; Lobas, 2006; Chaudry, Jain, McKenzie, & Schwartz, 2008; Stoller, 2008; Taylor et al., 2008), there has been limited focus on understanding how physician leaders themselves construe their roles.

To address this gap, a qualitative study was undertaken. Semi-structured interviews with 25 physicians in four hospitals within a single health care organization in the southeastern United States were conducted to understand how physicians in leadership roles

understand and enact them. Participants included physician administrators, physician managers, and physicians. Our findings suggest that identity, at individual, relational and organizational levels has significant impact on how physicians understand and enact leadership, and that acceptance of a dual identity may be advantageous for success as a physician leader. Our results may be useful to decision makers in hospitals and other health care contexts challenged with the selection and assignment of physician-leadership. Our findings may also contribute useful insights to the growing niche literature on physician administrators and physician managers by providing a better understanding of physician managerial self-construal.

LITERATURE REVIEW

Despite marked changes in the organization of many US hospitals in recent years to address rising costs and the need for increased productivity (Aiken, Clarke, & Sloane, 2000), many long embedded institutional and structural features endure. Considering the transformation in health care in the past several decades – and increasing calls for more of it – research on institutional features of hospitals has been remarkably limited (Kinston, 1983). While cost pressures have considerably reduced middle management staffing in many hospitals, for example, traditional management approaches prevail. The leadership and management structure of hospitals have long and typically included a mix of lay and clinical professionals. Their interaction points to a variety of issues related to “inter-professional behavior” such as authority, hierarchy autonomy and rivalry (Kinston, 1983). The first two relate to hospital structure and environment and the latter to human resource roles.

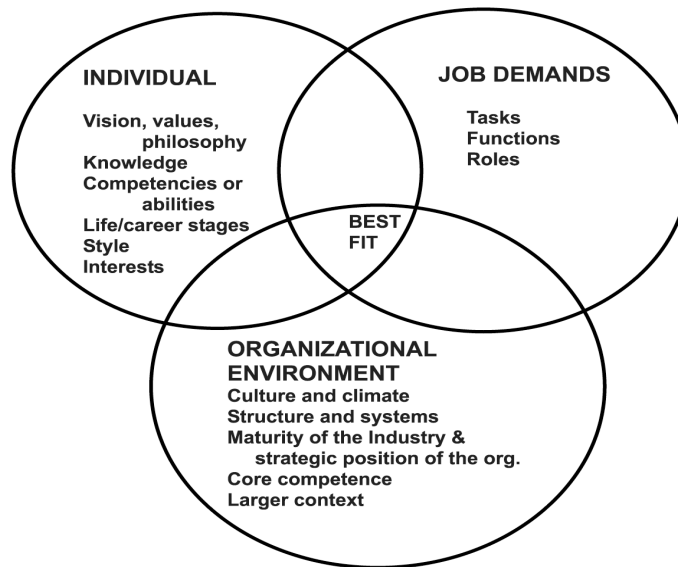
Both environment and job role are key components of Boyatzis’ Contingency Theory of Action and Job Performance (1982), which predicts organizational performance as

occurring when individual capabilities are a close fit with both. The capabilities of physicians center on technical skills and clinical training – but competence in organizational management, it has been argued, is also required (Kindig & Lastiri-Quiros, 1989; Brooke, Jr., Hudak, Finstuen, & Trounson, 1998; Lane & Ross. 1998; Schwartz & Pogge. 2000; Lobas. 2006; Stoller. 2008). An obvious tension between these two roles, however, is recognized. Physicians’ performance as leaders may be compromised as they are prepared to excel as “solo performers” (Reinertsen, 1998: 833) and to “take charge” in clinical settings (Hall, 2005: 191) and have training focused less on relationships and more on action (Reese & Sontag, 2001). Boyatzis’ Contingency Theory model, although not intended to address the physician/manager dilemma, helps to frame the issues associated with it. The model demonstrates the intersection of organizational and individual factors and job demands where a “best fit” identifies a field of optimum job performance. These three factors offer a framework for thinking about the tension between physician and leadership roles.

FIGURE 1

Boyatzis (1982) Theory of Action and Job Performance

(best fit (maximum performance, stimulation, and commitment) = area of maximum overlap or integration)



Boyatzis' contends that congruence between any two components of the model will increase the chance of effective performance, while inconsistency between any two will have the opposite effect (Boyatzis, 1982). If job demands conflict with the organizational environment (e.g. culture, climate, structure and systems, etc.), for example, employees will feel pressured and job performance may suffer. While performance is heightened when any two components of the model are in congruence, it is maximized when all three are in sync (Boyatzis, 1982).

Hospitals have unique organizational environments and Lobas (2006) points to the impact of their environment and structure on performance. Organizational structure, a “manifestation of powerful institutional rules which function as highly relational myths that are binding on particular organizations (Meyer & Rowan, 1977: 343), is a “blueprint” (ibid: 342) for activities (ibid: 342) within them. Structures beget titles, roles and responsibilities.

Hospitals, once small organizations founded and run by physicians, are more commonly now large, complex, bureaucratic and professionally managed. Many of the current administrative problems of hospitals lie in their transitional state (Lentz, 1957) as restructuring and re-engineering in response to competitive imperatives to cut costs and increase productivity exacerbate (Aiken et al., 2000). Lentz (1957) notes that the social role of hospitals, their economic features and their internal structures are in flux. A vestige of traditional hospital structure – the extra-clinical managerial role of physicians – however, persists in most institutions. Physicians often assume part or full time roles as department chairs, committee members, directors, etc. Many of these roles are linked with clinical departments or special health care functions that operate somewhat separately from the larger

organization (Lobas, 2006). But hospitals are today challenged to transform from rigid and divided hierarchies into flexible and collaborative networked communities (Bate, 2000).

Physician executives can play a part in this transformation by serving as bridges or boundary-spanners, speaking the language of and relating to both administration and clinicians (Sherrill, 2000). Hall (2005) notes the challenge when members of different professional groups attempt to collaborate, as they have different cognitive maps which develop as a condition of their professionalism. Friedson (1985) observed that physician administrators ideally “balance the necessity to carry out the collective ends of the governing board [or] firm against the needs and desires of those who do the medical work, thereby buffering the practice of medicine against the political and economic pressures of the environment” and in doing so, foster teamwork between physicians and administration.

But, as Bate (2000) has argued, transforming hospitals into networked communities can only be accomplished if there are “dramatic changes in culture, relationships and skills, all of which have to be addressed as part of an overall organization development effort.” Relationships and skills are part of the individual factors in Boyatzis’ job performance model, which, he argues, may be a central factor in how an individual adapts to roles and responsibilities, especially within the constraints of the organizational environment.

Membership within various groups, such as work groups, organizations, and as members of a profession, defines individuals’ identification of themselves (Tajfel & Turner, 1985; Ashforth & Mael, 1989). This act of social identification assists the physicians in placing themselves (and others) into categories of classification within their environment and separating themselves as physicians from certain ‘others’ in the organization.

According to Larson, the focus upon the uniqueness and specialization of the role exaggerates the ‘dignity’ of the profession (Larson, 1979: 490), forming the professional self. The individual, in this case the physician, adopts an identity focused on the primary function (of diagnosing and treating patients), which is given a superior priority and distinction. Larson observes that professionals are “locked in by their vocational choice, by the particular mystique of each profession, and by their whole sense of social identity” (ibid: 490). While physicians/managers/administrators are all members of the greater organization and health care community, they see themselves as in terms of their profession, which ‘confines the professional’ to that primary identity (Larson, 1979).

This classification process is thought to occur as physicians move through their training when they are not only learning how to become a physician and care for patients, but are also being socialized into a profession and assuming their identity as a physician (Hall, 2005). Individuals assign themselves to a classification for emotional value (Tajfel, 1974) which is predicated on the respect that they receive (Ashforth & Mael, 1989). When they then shift into roles of physician-leadership, the majority hold on to their primary identity of physician (Montgomery, 2001). The ‘value’ of their identity lies in their expertise as a physician, which has been reinforced through their professional group.

This process of self-categorization accentuates the similarities of those belonging to the same category and the differences of those in different categories (Turner, 1985). Thus, people are depersonalized and construed as in-group and out-group members (Hogg, Terry, & White, 1995). As physicians adopt a universal persona, depersonalization is *not a negation* of identity. Instead, the individual changes the perception of his/her identity to that of the group he/she identifies with (Hogg et al., 1995). As a result of self-categorization,

individuals create prototypes to represent social groups. These prototypes are defined by the greatest similarities between group members, focusing on the positive attributes of members, as well as the differences that set the group apart from others (Hogg & Terry, 2000).

As professionals, not only are physicians then confined to a professional group that excludes others, but there is reluctance to become subordinate to those outside of their group (Bate, 2000). This may extend to their view of their own peers, as physicians accept leadership roles and are expected to support organizational goals, which may be different than their own as clinicians. As a result of their professionalization, physicians themselves impact the organization by influencing the perception of the roles – including those of physician leaders – within it.

Social identity theory does not specifically address ‘roles,’ but does set out “to explain individuals’ role-related behaviors” (Hogg et al., 1995). Through a series of reflexive social interactions, individuals acquire meaning; thus clarifying their own roles as well as the roles of others (Burke & Reitzes, 1981). As physicians adopt their own role identity, they interact with other physicians, nurses, administrators and professionals within the organization, developing self-meaning and definition through their actions and the social structure. The role of physician, or administrator, then creates a norm for behavior as an incumbent of that role, and in turn “the self as a structure of role-identities... operate(s) as a social force, affecting the structure of society by affecting behavior in important ways” (Callero, 1985: 203, citing Rosenberg, 1981).

Also important for consideration, is the view from identity theory that role-identities are hierarchically positioned, thus having differing effects upon behavior (Callero, 1985; Hogg et al., 1995). This phenomenon, explained as ‘identity salience may, we conjectured,

affect physician behavior when a second role identity (“manager”) is added to a clinician’s behavioral repertoire.

Informed by literatures on identity formation and enactment, organizational roles and environments and physicians in leadership roles, we sought to increase understanding on how physicians perceive themselves and enact their roles as managers and administrators in institutions under increasing pressure to professionalize and a sector challenged to transform. We adopted a grounded approach.

METHODS

Methodological Approach

Qualitative research allows us to explore “the world of participants, to see the world from their perspective and in doing so make discoveries that will contribute to the development of empirical knowledge” (Corbin & Strauss, 2007: 16). This study is a naturalistic inquiry with a grounded theory approach (Glaser & Strauss, 1977; Charmaz, 2006; Corbin & Strauss, 2007). As such, our goal was purposeful interaction with the data by systematic and rigorous analysis to generate a theory that derives from it (Glaser & Strauss, 1977) – one fitting within the context and not able to “...be completely refuted by more data or replaced by another theory” (Glaser & Strauss, 1977).

Employing a comparative methodology of data collection and analysis, including the construction of analytic codes for the data and its categorization based on emergent ideas and themes that are not preconceived and logically deduced hypotheses (Glaser & Strauss, 1977; Charmaz, 2006) is a fundamental characteristic of grounded theory. This allows for the generation of theory that is inductively developed throughout the process. Our data analysis techniques are summarized below.

Sample

Our sample consisted of 25 physicians in four hospitals within a single health care organization in the southeastern United States. Participants included seven physician administrators who no longer practiced clinically and held full time administrator roles within the health care organization either during the time of the interview or within the last five years, 12 physician managers who were full time physicians but also held an organizational leadership role as either a department chair or president of staff at one of the four hospitals in the sample, and six practicing physicians who did not hold a leadership role in the health care organization. All of the current physician administrators in the health care system that hosted the research were included in the sample plus two recently retired physician administrators. Participating physicians and physician managers represented several specialties including radiology, cardiology, orthopedics, pulmonary medicine, as well as surgical specialties. Two of the physicians were women and twenty-three were men. The sample was intended to ensure collection of adequate data to support our inquiry (see sample summary, Appendix A).

Data Collection

Interviews were conducted during a two-month period from August to September 2010. 25 semi-structured interviews of approximately one-hour were conducted, twenty face-to-face at a location of the participant's choosing and five by telephone. All interviews were digitally recorded and professionally transcribed.

We conducted critical incident interviews (also called behavior event interviews) (Boyatzis, 1982; McClelland, 1998), during which participants provided narrative responses to open ended questions. Respondents were first asked to describe their personal and

professional backgrounds. We then asked the administrators to describe in rich detail both a typical and an atypical day in their current (or most recent) role as an administrator. The physician managers and physician were then asked to talk about someone they felt was an outstanding leader and describe a time that they witnessed outstanding leadership. Next, the physician managers and physicians were asked to recall a specific time in the last 12 months in which s/he felt particularly effective within his/her role as a physician (see Interview Protocol, Appendix B) and, subsequently, to describe a specific time when s/he felt less effective. All respondents, including the administrators, were then asked to recall a specific time in the last 12 months in which they were particularly effective as organizational leaders. Finally, we asked the interviewee to recall a specific time when s/he felt less effective as an organizational leader. Extensive probes were used to encourage detail.

Data Analysis

Data analysis began immediately following the first interview. We listened to each recorded interview and read each interview transcript several times. The interviews were then “open-coded,” a rigorous procedure involving line by line scrutiny of each transcript to identify fragments of text (referred to as “codable moments,” (Boyatzis, 1998) that might have significance. During this process, we identified approximately 1500 fragments that were then manually sorted and labeled into 25 categories with similar fragments from previously open-coded transcripts.

During the second phase of coding, axial coding, the code categories were refined as relationships among them became apparent, and ideas and themes emerged (Corbin & Strauss, 2007). During this coding phase, we turned to the literature to inform these ideas and themes as we narrowed our 25 categories into 8 key categories for further study.

In the final phase of coding, some categories were observed to unify around central themes (Corbin & Strauss, 1990) that form the basis of our findings. Thematic analysis was used for encoding qualitative information by perceiving and interpreting patterns and themes present in the data (Boyatzis, 1998). Moving between the data, field notes and the literature, three key findings emerged.

FINDINGS

Our data revealed distinctions in the individual, relational and organizational identity of physicians situated at three organizational levels in a typical U.S urban hospital, illustrating how physicians, physician (part-time) managers and physician (full-time) administrators internalized their organizational roles, how and the extent to which those roles were recognized and appreciated by others, and how and the degree to which all three sets of physicians identified with the larger organization in which they were situated. The data demonstrated distinct differences in how these professionals self-construed their roles and identities. While the self-concepts of members of all three groups as clinical practitioners were strikingly similar and uniformly robust, the relational and organizational identities of physician (part-time) managers versus physician (full-time) administrators, contrasted considerably. These findings may have implications for both individual and institutional performance.

Finding 1: Hospital Affiliated Doctors, Regardless of Organizational Role, Status or Title, Self-Construe, First and Foremost as Physicians

Our findings corroborate previous research that has emphasized the strong professional identity projected by physicians. The physician identity of all of our respondents, irrespective of organizational role, was strongly internalized, with all three

groups strongly self-categorized as clinicians. “Being” a physician was expressed as the defining characteristic of these individuals, differentiating them from others in their professional and social worlds and enabling them, as described by one respondent as “being able to do anything.” Whether full-time practitioner, practitioner/part-time manager or physician/ full-time administrator, all respondents described their profession as central to their social identity – persisting even when the individual reduced or ceased active practice. At all levels and in all roles, physicians construe themselves and their colleagues as a closed and enduring social group.

TABLE 1
Representative Quotes: Strong Identity as Physician

Physicians	<i>“I mean, that’s what we do as doctors, and it’s a nice feeling when you see somebody, and you diagnose the problem, and... you’re there and you take care of them.”</i>
Part Time Physician Managers	<i>“...we [doctors] think that since we’re good at one thing, we’re good at a lot of different things.”</i>
	<i>“[doctors think they] can tile your roof, do your floor, balance your checkbook, invent calculus again.”</i>
Full Time Physician Administrators	<i>“[Being a doctor], it’s in your soul. And I think to be an effective physician executive you have to have that engrained.”</i>
	<i>“I never had any other interest other than becoming a doctor going back to probably age four or five.”</i>

Finding 2: The Extent to which Physician/Part-Time Managers and Full-Time Physician Administrators Internalize Their Managerial Roles Differs Starkly

2.a. While strongly internalizing their physician identity, physician/part-time managers fail to project a strong managerial identity. Our physician/manager respondents emphasized their clinician – but subordinated their leader – self-concept. Their narratives demonstrated robust identification with physicians in their immediate practice and with those in their hospital workgroup (i.e. the department with which their practice was associated), but

identification with the larger organization was demonstrably weak. Physician/part-time managers, consequently, prioritized their physician, practice and workgroup roles and subjugated their organizational roles and responsibilities. Many respondents actually denigrated their managerial roles, suggesting that failure to internalize them was purposeful. One physician manager, for example, struggled to recall his title, asking “*What am I? Vice-something...*” Another, eager to clarify that his leadership role was involuntary, explained “*a lot of these things sort of get thrust upon you as time goes on.*” Throughout our interviews, we found evidence that physicians assumed managerial roles reluctantly and, largely, as an unappreciated “duty.” Another physician manager explained that leadership roles are “*handed like a hot potato to everybody,*” and one, asked to describe his role responded, “*I have [a] nominal title as executive director of...[something] ... [but] ... I have no idea [what that means].*”

2.b. Physician/ full-time administrators internalized both clinician and manager self-concepts. In contrast to part-time managers, all of our seven boundary-crossing physician full-time administrators revealed internalized identities as both clinicians and executives. Although no longer practicing medicine, all of them continued to self-identify as physicians, suggesting, in fact, a causal connection between that identity and effectiveness in their new roles as administrators. In explaining the importance of being a physician, one administrator offered, “*If I hadn’t been a physician and couldn’t talk doctor and think doctor around those tables, I couldn’t have carried [the meetings with the medical staff] off at all.*” Another administrator explained that he believed that it was vital that all physician administrators were not only doctors, but had ample clinical experience as they moved into their roles in administration. Physician/administrators construed their current administrative

roles as constituting “bridges” or conduits between two levels of their hospitals’ hierarchically structured systems and described deftly switching identities as situations and contexts mandated. As one explained, *“You have to straddle the fence. That means you are both. You are a physician and you believe and think like a physician, and that’s part of your morals and your ethic. And on the other hand, you have this whole body of knowledge, and this whole set of relationships, and the way you do things over here, which is administration... it’s my executive hat over here. And as I say, you can’t jump across the fence, you have to be solidly planted on both sides at once.”* It is not only one’s knowledge and training as a physician that is imperative, but also his/her experience “being” a physician that allows a physician administrator to relate to the physicians he/she advises. *“I think,”* one administrator confided, *“that because I [was] a practicing physician, I am sensitive to... [how] physicians think.”*

In addition to thinking like physicians, the administrators also realize that it is important how they present themselves to members of this tightly formed social group of physicians - even when it comes to appearance. As one explained, *“It’s as simple a thing., If I’m interacting with doctors, I don’t wear a suit. I’ll wear a sport coat or a golf shirt. Because if I show up in a suit, I’m a suit.”* The administrators embrace a dual identity and have mastered distinct behavioral repertoires associated with each..

Finding 3: Physician/Full Time Administrators – But Not Physician/Part-Time Managers – Perceived Their Managerial Roles to be Positively Recognized by Others and to be Organizationally Endorsed

3.a. Physician managers did not perceive their managerial roles to be valued by peers or to be formally endorsed by their organizations. Physicians who had adopted a part-

time managerial role, even if they felt the job was necessary and believed that “*someone had to do it,*” viewed it as a “*cross to bear*” that was “*their turn*” to assume. Few acknowledged it as either a personal or professional opportunity for self-enhancement or associated it with merit or status. One physician noted that his leadership role was “*not anywhere near a real job. It’s just a thing.*” Many lamented that it tapped personal and professional time and pointed out that it was an uncompensated undertaking: “*I wasn’t really going to get paid for it or anything like that.*” Managers recognized that their managerial roles were temporary and understood relational risks associated with them. Incumbents reported discomfort when required to deal with human resource problems involving peers – suggesting conflict between physician and managerial identities. One physician manager noted, “*[Managing] is very hard for specialists, and even surgeons, because of the disciplinary action they have to play. Their referral sources are coming from the various people they’re disciplining and monitoring, so it’s a tough position.*” Consequently, managers felt motivated to advance organizational issues and programs of potential benefit to themselves and their peers, but reluctant to pursue those perceived to be controversial or bearing reputational risk. Their clear affiliation was to their peer group of fellow physicians rather than to organizational goals and objectives. One physician manager described his reason for accepting management roles was personal development: “*I think it’s a realization that you’re a better physician to be on top of your game [in understanding the business issues].*” Another shared that the economy had an impact upon his decision to accept a post: “*We’re in a very tough economic time... my feeling is... I’m going to help myself or my practice.*”

3b. Physician/full time administrators perceive their managerial roles to be respected by others and to be formally endorsed by their organizations. Full time physician

administrators expressed allegiance to their staff and followers. *“My role here is pretty much to work with the medical staff. I’m the kind of liaison...servant leader, so to speak, to the medical staff and administration to help them govern themselves.”* Administrators are recognized as physicians and respected for their clinical knowledge but also respected as leaders that guide physicians and physician managers in the organization. One administrator described his role as *“...helping [the physicians] understand why the hospital has to do what it has to do to protect it as a community resource and meeting the needs of the community and how that interacts and affects what they do.”* Administrators perceive their roles as respected by their peers and strongly appreciated and endorsed by the organization.

Administrators revealed an interest in serving a greater *“community purpose”* than was possible when they were practicing clinicians. *“It was my belief that I could contribute as much, if not more, to the wider community that the hospital served by paying attention to a more global thing, rather than just the 2,000, 2,500, patients that I was trying to take care of [as a physician].”*

DISCUSSION

Despite transitioning into part time management or full time leadership roles, all of the physicians in our sample retained a strong primary identity as physicians. According to social identity theory, the characteristics of a social category in which one positions oneself (in this case “physician”), *fundamentally* defines the self (Hogg, 1992, 1993; Hogg & Abrams, 1988; Tajfel & Turner, 1979). Consequently, members of socially constructed social groups often see themselves and co-members in an accentuated or exaggerated way (Hogg et al., 1995), as the interview excerpts in Table 1 vividly reveal. In self-categorizing as

physicians, our respondents identified as members of an exclusive group of professionals – an elite “tribe” as aptly described by one physician administrator.

Physician managers are full time clinicians with part-time managerial duties that can include actions and decisions involving peers. Peers, however, relate to physician managers as “tribe” members – not as managers. DeRue and Ashford (2010) observe that, “if a person claims leadership in a setting but others do not reinforce that claim with supportive grants...leadership identity construction (is) insufficient for a leader-follower relationship to emerge.” Our data suggest that physician managers, far from actively “claiming” leadership and purposefully constructing a leadership identity, denigrate their managerial roles and, in so doing, fortify peers’ trivial interpretations of those roles. This behavior, firmly footed in strong physician identity, results in a deficit of both physician manager leadership and physician-to-physician manager followership – and most certainly undermines organizational effectiveness.

Consistent with their strong physician identity, physician managers reported discomfort with correcting or disciplining peers, even when they judged the behavior of a peer to be unprofessional or threatening to the institution. Physician managers prized – and feared jeopardizing – their relationships with fellow clinicians.

Physicians assuming part time management roles also understood the cost of time spent on those roles and the opportunity loss to their clinical practices. Attention deflected to managerial duties, they reported, taxes physician partners who must then “pick up the slack.” Our respondents also revealed feeling ill-equipped to handle managerial responsibilities due to lack of training and/or experience. Physician managers revealed struggling with “business

issues,” especially financial matters, and the majority referenced human resource skill deficiencies.

Contrarily, physician administrators – former physicians who have transitioned from clinician to full time managerial roles – view themselves and are viewed by others unambiguously as both physicians and organizational leaders, demonstrating the two roles are, indeed, compatible. Unlike part-time physician managers, physician administrators hold official, collectively endorsed, and thus legitimized, organizational roles. Physician managers, on the other hand, function as managers temporarily, reluctantly, and without collective endorsement. Quinn (1996) observed that leadership is a “state of being” and, consequently, one can be recognized as a leader without holding an official role within an organization. This suggests that physician managers, could, even without organizational endorsement, independently assume a “state” of leadership and successfully assemble a followership. Our data, however, suggests few are so inclined.

Physician disinclination to manage may be attributable, in part, to organization failure to frame, endorse and appropriately reward management roles. Our respondents described the managerial role as tedious, unfulfilling and sometimes onerous (as when involving the enforcement of rules and regulations on peers). Rarely, the physicians revealed, were they asked to champion new ideas, lead change and inspire others to achieve goals. If and when they did attempt to support innovation, they were met with challenges and a lack of support from both their peers as well as administrators. Our results indicate the need for deliberate reframing of the physician manager role and purposeful organizational endorsement and legitimization of it.

In a 2010 paper exploring leadership from an identity perspective, DeRue and Ashford asked, “What are the relational and social processes involved in coming to see oneself, and being seen by others, as a leader?” Noting a trend in viewing leadership less as something “prescribed because of one’s position in an organizational hierarchy” (ibid: 627), these authors argue it is, rather, a mutual influence process among individuals – a socially constructed and reciprocal relationship between leaders and followers that is co-created and mutually reinforced. DeRue and Ashford offer new insights on existing theory on social identity by emphasizing the process of claiming and granting, by which leader (and follower) identity is generated. They argue that leadership identity must be “internalized”, i.e. a person must incorporate being a leader as a “sub-identity.” Thereafter, the person must be seen by others as a leader, i.e. leadership must be “relationally recognized.” Finally, leadership must, the authors argue, be “collectively endorsed” and legitimated by the broader organization.

The full time administrators in our sample, but not the part time physician managers, satisfied each of these three leadership identity construction requirements. Administrators retained their physician identity but willingly incorporated their executive status as a sub-identity. In keeping with DeRue and Ashford’s theory that “leadership identity will be stronger to the extent that it is relationally recognized,” (2010: 629) the executive status of physician administrators was perceived by them to be accepted, and respected, by physician peers and others in the organization. Administrators sensed strong and visible organizational endorsement of their roles, perceived their opinions and ideas to be respected and sought after and felt recognized as contributors to the success of the organization. Administrators reported actively “claiming” and being reciprocally “granted” leadership. DeRue and Ashford theorized that claiming and granting tactics vary on two basic dimensions:

verbal/nonverbal and direct/indirect. We saw evidence of physician administrators using both. As one administrator informed us, for example, he varies his attire depending on his institutional audience – suits for meetings with non-physician management and a more casual sports coat for meetings with physicians. How he presents himself, this administrator understood, affects how his “claims” may be received and whether they are reinforced with a supportive “grant.” While administrators may no longer be officially part of the ‘tribe,’ they are still able to make use of the categorical connection as a member of the same professional group (*physician*), when enacting their role and embracing their identity as leaders.

Contrarily, physician managers strongly resisted a manager identity – often to the extent of deriding the role. Physician managers also expressed sensitivity about the trivial perceptions of their roles by peers – both they and fellow physicians considered it as an unavoidable “duty” that was not highly valued by the organization. Contrary to DeRue and Ashford’s understanding of the relational construction of identity taking place through ‘claims’ and ‘grants,’ (2010: 631), physician managers avoided ‘claiming’ their leadership title, even admitting that they didn’t know their title, or had “a nominal title” or had “no idea” what their title meant. DeRue and Ashford argue that a reinforcing grant is essential to the identity construction process, but physician manager peers (practicing physicians) did not provide them. Neither did physician managers perceive they had not been granted the power necessary to lead or to gain the support of peers.

DeRue and Ashford’s conception of identity as relational and collective (2010) is reminiscent of Giddens’ case for the ‘mutual dependence of structure and agents’ (1979: 69). “The concept of structuration involves that of the duality of structure, which relates to the fundamentally recursive character of social life and expresses the mutual dependence of

structure and agency” (Giddens, 1979: 69). Giddens argues that the “individual is a reflexive agent, connecting reflexivity with positioning and co-presence” (Giddens, 1986: 162). The construction of an identity is therefore dependent upon both the stability of the social structure, and the ever-changing fluidity of the individual interacting within the social environment – i.e. “the individual and society are mutually constitutive” (Howard, 1994: 210). Giddens further contends that structure “is always both enabling and constraining,” with “structure” defined as “rules and resources” (Giddens, 1986: 169). As the physician leader moves within his/her environment, reflexivity (defined by Giddens as both action as well as knowledge and meaning), impacts him/her in the creation of identity and relationships (Giddens & Pierson, 1998).

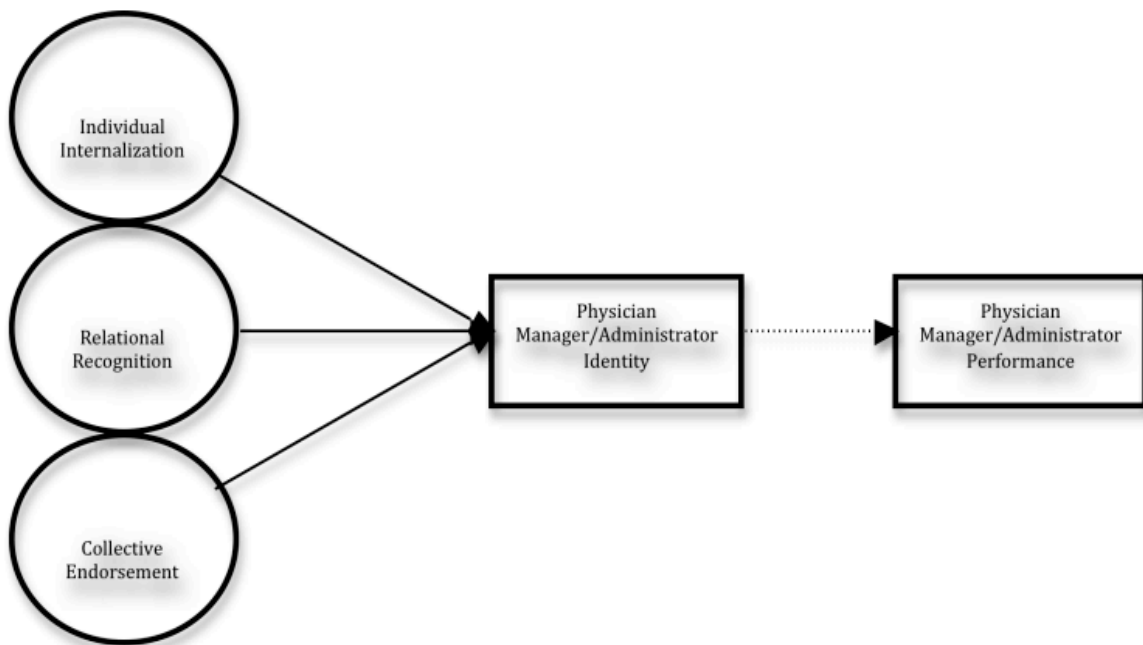
According to Ratner and Miller (2001), people act based upon self-interest, but they may also do so when motivated to “preserve a collective good” (Brewer & Gardner, 1996: 86). This may explain why some physician managers reluctantly accepted executive positions despite the absence of relational and organizational support for them. Several managers in our sample cited, for example, concern for the financial security of their own practices and, more generally, those of their “tribe” as a reason to serve in managerial posts. These physician managers endured temporary discomfort for a perceived reward for themselves and others within their social group. In stark contrast, physician administrators expressed altruistic motivations for their transition to full-time hospital leadership positions. Their revelations of commitment to the greater organizational goals of their institutions contrasted vividly with the self, and the interests of the “tribe” expressed by the part-time managers.

Our research revealed differences in how part time and full time physician executives view themselves and their roles – differences that should be of concern to hospital boards and

top management seeking superior institutional performance. Leaders cannot simply be “appointed” – rather they are socially constructed. Leadership must be both claimed and granted. Reciprocal claims and grants, “promote individual internalization of leader and follower identities and their relational recognition in group members’ roles and relationships” (DeRue & Ashford, 2010: 632). As others in the organization come to recognize and understand this emerging relational structure and pattern of influence, “the leadership identity becomes collectively endorsed in the broader organizational context” (ibid: 632).

Our data revealed self-identity construction as a key factor affecting physician manager performance. The narratives of our respondents revealed, as depicted in Figure 2 below, that role internationalization, relational recognition, and organizational endorsement are critical antecedents of leadership self-construal by physicians.

FIGURE 2
Physician Manager/Administrator Identity



Our data suggests that at the full-time hospital administrator level all three conditions are evident. At the part-time physician manager level, contrarily, all appear weak or nonexistent. These differences have clear implications. In a 2002 article, Dukerich, Golden and Shortell noted, “identity and identification may provide insights into some fundamental challenges of managerial life,” such as, “why some members of organizations regularly engage in cooperative behaviors... whereas others do not” (2002: 507). Hospitals might benefit by engaging in purposeful “identity work” to better frame the roles of physician managers and administrators, offering grants that stimulate relational recognition and collective endorsement of those roles. Identity work relates to “people being engaged in forming, repairing, maintaining, strengthening or revising” identities (Sveningsson & Alvesson, 2003: 1165).

Our findings imply the importance of frank recognition by top hospital management of the neutral to negative attitudes toward physician manager roles held not only by clinicians currently in those roles, but by the broader community of hospital affiliated physicians. The data recommends a conscious effort by management to address those attitudes by reforming and revising physician manager identity and reinforcing it as legitimate. Such effort, we conjecture, can strengthen physician managers construal of their roles, their beliefs about the value of their work, the time and effort they dedicate to it and, ultimately, their contribution to the organization.

LIMITATIONS

Although the physicians in our sample were affiliated with four community hospitals, all of them were part of a single not-for-profit health care system in one geographical locale. Including hospitals with different structures (e.g. for profit, not for profit, teaching, or

specialty) and in different U.S. regions may have produced different results. We limited our sample to physicians who held department chair or president of staff positions, although other physician manager jobs exist both in the health care system that supported our research, as well as in other health care organizations. A broader sample may have produced different results. Our methodological approach required respondents to recall past experiences and events and we recognize the potential effect of time on memory.

IMPLICATIONS FOR PRACTICE AND FUTURE RESEARCH

Our results have implications for both practice and future research. For the past two decades, the health care industry has been impacted by economic, legal, and structural changes that have altered the relationship between physicians and health care organizations (Zuckerman et al., 1998). Physician-leadership is attracting keen interest from both scholars and practitioners and can be expected to be an intensified research domain in the years ahead. Taylor, Taylor and Stoller (2009), for example, point to the need for specific research on physician leader training. Our own work points to a broader and more fundamental need – a modified mindset about the nature and value of physician leadership. A better understanding of physician beliefs and attitudes about leadership – as well as institutional impediments to it is wanting. Empirical work on organizational commitment to physician leadership and cultural acceptance of it are recommended. Replication of our study involving a broader selection of hospitals and a wider breadth of physician manager roles is indicated.

Our findings may be of interest to hospital administrators and boards seeking deeper commitment and higher performance from physician managers. Results suggest the need for change in how organizations frame and promote physician leadership. Understanding physicians' biases about being managers and appreciation for the strength of their primary

identity as physicians should provoke health care boards and leaders to consider new approaches to selecting, training and rewarding physician managers.

APPENDIX A Representative Quotes

Representative Quotes, Finding 1: Strong Identity as Physician	
Physicians	<i>"I mean, that's what we do as doctors, and it's a nice feeling when you see somebody, and you diagnose the problem, and... you're there and you take care of them."</i>
Part time Physician Managers	<p><i>"So my effectiveness, primarily, is derived from that. Taking care of patients."</i></p> <p><i>"...we [doctors] think that since we're good at one thing, we're good at a lot of different things."</i></p> <p><i>"[doctors think they] can tile your roof, do your floor, balance your checkbook, invent calculus again."</i></p>
Full time Physician Administrators	<p><i>One administrator on how he views himself, "[as a] physician, patient advocate."</i></p> <p><i>"I wanted to be a physician since I was a teenager."</i></p> <p><i>"[Being a doctor], it's in your soul. And I think to be an effective physician executive you have to have that engrained."</i></p> <p><i>"I never had any other interest other than becoming a doctor going back to probably age four or five."</i></p>
Representative Quotes, Finding 2a: Physician Managers Failed to Embrace a Managerial Identity	
Part time Physician Managers	<p><i>"What am I? Vice-something..."</i></p> <p><i>"A lot of these things sort of get thrust upon you as time goes on."</i></p> <p><i>"[Leadership roles are] handed like a hot potato to everybody"</i></p> <p><i>"I have [a] nominal title as executive director of...[something]...[but]... I have no idea [what that means]."</i></p> <p><i>"I've always gotten leadership roles whether I like it or not, I guess."</i></p> <p><i>"Well, I'm chairman of [the department], and it was something that I kind of got pulled into."</i></p> <p><i>"Dealing with personnel, I find difficult."</i></p>

Representative Quotes, Finding 2b: Physician Administrators Identified as Physicians, but Accepted a Dual Identity as a Leader

Full time Physician Administrators

“If I hadn’t been a physician and couldn’t talk doctor and think doctor around those tables, I couldn’t have carried [the meetings with the medial staff] off at all.”

“You have to straddle the fence. That means you are both. You are a physician and you believe and think like a physician, and that’s part of your morals and your ethic. And on the other hand, you have this whole body of knowledge, and this whole set of relationships, and the way you do things over here, which is administrations... it’s my executive hat over here. And as I say, you can’t jump across the fence, you have to be solidly planted on both sides at once.”

“I think that because I [was] a practicing physician, I was sensitive to some of those issues and [how] physician think.”

“It’s as simple a thing as, if I’m interactive with doctors, I don’t wear a suit. I’ll wear a sport coat or a golf shirt. Because if I show up in a shit, I’m a suit.”

“I’m a kind of doctor on the ground on the administration side.”

Representative Quotes, Finding 3ba: Physician Managers Do Not Feel Legitimized by Followers and Collectively Endorsed by the Organization

Part time Physician Managers

“Someone had to do it.”

“It’s not anywhere near a real job. It’s just a thing.”

“I wasn’t really gonna get paid for it or anything like that.”

“It’s very hard for specialists, and even surgeons, because of the disciplinary action they have to play. Their referral sources are coming from the various people they’re disciplining and monitoring, so it’s a tough position.”

Representative Quotes, Finding 3b: Physician Administrators Do Feel Legitimized by Followers and Collectively Endorsed by the Organization

Full time Physician Administrators

“My role here is pretty much to work with the medical staff. I’m the kind of liaison...servant leader, so to speak, to the medical staff and administration to help them govern themselves.”

“[You are] helping [the physicians] understand why the hospital has to do what it has to do to protect it as a community resource and meeting the needs of the community and how that interacts and affects what they do.”

“It was my belief that I could contribute as much, if not more, to the wider community that the hospital served by paying attention to a more global thing, rather than just the 2,000, 2,500, patients that I was trying to take care of [as a physician].”

APPENDIX B

Interview Questions

1. Can you give me a short overview of your personal and professional background?
 - a. Can you tell me about your current role?
 - b. Can you tell me about what influenced you to become a physician?
 - c. Describe why this was a role / organization that appealed to you.
 - d. Can you tell me about any leadership roles that you currently hold or have held in the past?
 - i. What led you to take on these roles?
 - e. What are your past roles?

1. ADMINISTRATORS ONLY- Tell me about the day that you decided to stop practicing as a physician to become an administrator.

2. ADMINISTRATORS ONLY- Thinking back over the last few weeks, can you think of a day you would describe as 'typical'? Tell me about it.

3. ADMINISTRATORS ONLY- Could you now think back to a time over the last 12 months to a day that was atypical? Tell me about it.

4. PHYSICIAN MANAGERS AND PHYSICIANS ONLY- Can you think of someone that you feel is an outstanding leader. Can you tell me about that person?

5. PHYSICIAN MANAGERS AND PHYSICIANS ONLY- Can you tell me about a time that you experienced outstanding leadership?

6. PHYSICIAN MANAGERS AND PHYSICIANS ONLY- Tell me about a time in the last year or so that you felt effective in a specific experience as a practitioner?

7. PHYSICIAN MANAGERS AND PHYSICIANS ONLY- Can you tell me about a time in the last year or so that an interaction in dealing with others as a practitioner did not go so well?

8. Can you tell me about a time in the last year or so that you felt effective in a specific experience as a leader?

9. Can you tell me about a time in the last year or so that an interaction in dealing with others as a leader did not go so well?

Clarifying Questions (Pertaining to Questions 2-5)

- a. What led up to the event/situation?
- b. When did this happen?
- c. Who was involved?
- d. What did they say/do?
- e. What did you say/do?
- f. What were you thinking and how did you feel?
- g. What was the result?
- h. Is there anything else that you would like to share with me?

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