Healer Vs Leader –Determinants & Deterrents of Clinician Leadership in Indian Healthcare

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Clinician leadership is important for quality healthcare delivery, but does it collide with the image of a healer? This study explores different leadership styles of doctors and contextual factors causing it in a corporate, private hospital in South India. Managerial Grid questionnaire and Semi-structured interviews are used to elicit data. Thematic Analysis is used to interpret Semi-structured interview data. It is found that a few position holders are exhibiting appropriate style while most of them are exhibiting styles that are incompatible with their job description. The deterrents identified in the study prevent the healer to become a leader. At the same time, these deterrents also prevent the healers to reconcile with the growing importance of clinical leadership.

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Introduction

Leadership is known to exist since ages, with a tremendous influence on human performance across different sectors. Yet, it remains pretty much of a 'black box' because its inner working cannot be precisely spelled out or defined.

Let us examine the healthcare sector as a case-in-point. According to Daly, Jackson et al (2014), in the developed world, hospital care is often threatened by dynamic consumer demands, workforce challenges, financial constraints, increasing demand for access to care, patient-centric mandates, and issues relating to quality and safety standards of healthcare. Physicians/Doctors, who are masters within healthcare, should balance changes in the industry along with new demands to effectively lead teams. Long established leadership beliefs now stand to change for physicians and other healthcare professionals as team based approach is becoming more necessary to be effective. What may have worked in the past may not be successful today, thus, changes in leadership styles calls for a study. While Yukl (2012) asserts that good

leadership is becoming increasingly obvious within healthcare, Mcphee, et al (2013) found that effective governance is a critical means for managing hospitals and these findings laid the foundation for leadership in hospital settings.

Decentralized structures, and team approaches should be fostered.

Given that India is experiencing 22-25 % growth in medical tourism and the industry doubled its size from April 2017 (US$ 3 billion) to 2018 (US$ 6 billion), it is however essential that physicians and other healthcare professionals don the role of leaders besides healers (IBEF, 2019). New laws and regulations in the healthcare industry characterized by care coordination and payment models, novel methods of treatments to patients, and the capacity to work together is making team-based leadership styles necessary to be effective. To embrace these changes, leaders in healthcare need to focus on relationships (La Bier, 2014) and empathetic listening (Riordan, 2014). To achieve this, decentralized structures, and team approaches should be fostered through new work designs enabling executives to exercise informed judgements.

Very little is known about how medical leaders lead.

The question to ponder here is : do great doctors become great leaders too? Since leadership in healthcare began vigorously moving towards teams, the question crystallizes: does the image of a leader collide with the image of a healer? Siriwardena (2006) and Smith et al (2012) highlighted the importance of effective clinical leadership to ensure a high-quality healthcare system, but, very little is known about how medical leaders lead.

Background

For the present study, the leadership context is clinical integration, which calls for linking of physician and hospital efforts to achieve common healthcare delivery goals based on meta-leadership. The idea is collaborative problem-solving because problem solving and decision-making calls for facts and facts do not concentrate at one place. It follows a continuum from known to unknown. To know the ambiguities and factors facilitating/hindering the decision-making and problem-solving that clinician leaders face, it is essential to assess the leadership styles and explore the context of the leadership.

A formal discussion between the author and the Managing Director (MD) of a 30-year-old premier corporate hospital in a South Indian city highlighted the need to assess the leadership styles followed by the healthcare professionals to promote team leadership style given the above changes in the environment. The author was asked to use Managerial Grid by the hospital management. Therefore, the present study assesses the leadership styles and presents it through theoretical inputs and supplements it with practical recommendations.

Profile of the Hospital under Study

The hospital belongs to private sector and is a trendsetter in bringing medicare of international standards within the reach of every individual. It has 50 super specialties under one roof. This hospital is unique for its best doctors, paramedical staff and services, and nurses, state-of-art infrastructure which can match world class equipment, personal care to each and every patient, treating every employee as a family member and providing utmost value for money to every patient. The golden rules of the hospital are: 'customer/patient comes first', 'doctors are the best managers', 'demand value for money', and 'uncompromising service quality'.

Objectives

Given the above, the objectives of the study are to:

Assess the present leadership styles of healthcare executives at all levels.

Explore the determinants and deterrents causing/affecting the leadership style.

Recommend guidelines and interventions that should be adopted to reach the appropriate style.

Scope of the Study

The study is conducted on healthcare executives across levels in a single corporate hospital. In this study, the term '*healthcare executive'* means doctors holding a senior managerial role as well as non-doctors playing an administrative role in a clinical setting. In the hospital under study, it is observed that doctors play two leadership roles: (i) a senior clinician with responsibility for supervising a clinical team delivering patient care, and (ii) as part of the managerial structure of the healthcare organization. The doctor may use different leadership skills in these two roles, and here, only the non-clinical role is examined.

Sample Size & Sampling

Stratified random sampling is used and a sample of 100 respondents is chosen from all levels of clinical and non-clinical executives, i.e., from Junior Executive to General Manager and all Physicians, i.e., from Residents to Consultants.

Research Instrument & Data Collection

In-depth semi-structured interviews and Managerial Grid Questionnaire with 50 items are administered. The questionnaire was piloted prior to distribution. Secondary data is obtained from research papers, job profiles of the incumbents, and health sector reports.

Semi-structured interviews were verbal and face-to-face but recorded with respondents' permission. It had many aspects broadly relating to three main questions viz.,

1. What is the context for leadership for physicians to be leaders within health systems?

2. How do physicians make a transition into leadership roles? Is it a conscious decision or is it dictated?

3. What are the perceived benefits and drawbacks of being a physician leader within health systems?

All the respondents were requested to attend two half-day sessions in the hospital premises to learn about the study. Questionnaires were administered during the same time followed by semi-structured interviews; informed consent was obtained in writing. Thematic Analysis is used to derive insights from semi-structured interview data.

Data Computation & Analysis

Managerial Grid Questionnaire was administered and percentages were drawn. Table 1 consists of grouping based on organizational hierarchy and Table 2 was prepared with 6 columns, viz., Designation, Country club, Team, Task, Impoverished, and Middle Road indicating different categories of employees in different styles. Table 2 serves as a basis for further qualitative analysis coupled with information from interviews and job profiles. Job profiles were compared with the leadership style they were following in order to assess its efficacy and compatibility.

Table 1 Grouping based on Organizational Hierarchy

Group	Designations Covered
I	General Manager – Dy. General Manager, Consultant, Dy. Medical Superintendent, Resident Medical Officer, Sr. Manager
II	Manager, Assistant Manager, Junior Consultant, Senior Medical Officer, Chief Medical Officer
III	Senior Registrar, Registrar, Senior Resident
IV	Executives, Chief Technologists, Engineers, Physiotherapists
V	Resident, Junior Registrar

The responses elicited from semi-structured interviews were categorized into 9 broad themes using thematic analysis in three steps, viz., (a) Iterative Review (b) Design Analysis and (c) Design Synthesis. Analysis is through the transcription, along with the repeated listening of interviews for a deeper understanding of what the respondents described. The key themes began to emerge even before thematic analysis began. Points of discomfort were expressed by the respondents with respect to donning the leadership role, the subordinates' behavior, the culture of the organization and so on for managing their condition as well as opinions and experiences of the transitional role. But, the author avoided personal interpretations of the motivation behind the responses and also evidences displayed by the respondents. Only, data in the form of direct evidence, such as a quote, or an action is used and written on separate slips of paper and is pasted on the author's desk. Reference to the interview is done using a code (e.g P01). The slips are then grouped, and sorted into various themes.

Limitations

Questionnaire was too simple for the respondent to place himself under Team Style whether real/unreal, thus, the session led to copying and chatting despite author's appeals to work seriously and independently. Questionnaires are administered at a stretch in a group, therefore, focusing/ probing were not possible; some respondents answered it perfunctorily calling this exercise a farce. Sole reliance on job profiles vis-à-vis unstructured interviews and then comparing it with leadership styles probably led to bias; the hospital authorities didn't permit the researcher to use the plotted managerial grid for public use.

Health Sector in India

Healthcare industry comprises hospitals, clinical trials, outsourcing, telemedicine, medical tourism, health insurance, medical devices, and equipment. Weberg (2012) asserted that healthcare organizations (HCOs), with hospitals at the forefront, are large and complex contemporary organizations, owing to their advanced procedures and different resources.

Table 2 The Table of Executives Following Different Styles

Designation	Team	Country Club	Impoverished	Task	Middle Road
Consultants	5	3	-	-	-
Residents	7	6	-	2	-
Sr. Executives	2	-	-	-	-
General Managers	1	1	-	-	-
Sr. Managers	1	-	-	-	-
DGM	1	-	-	-	-
Jr. Consultants	2	-	-	-	-
Asst. Managers	2	4	-	-	-
Sr. Medical Officers	2	1	-	2	-
CMO	2	-	-	-	-
Managers	2	-	-	-	-
DNS	1	-	-	-	-
Sr. Resident	6	4	2	-	-
Registrar	3	-	-	-	-
Sr. Registrar	1	-	1	-	-
Jr. Registrar	2	2	1	-	-
Executive	3	4	-	-	-
Jr. Executive	1	4	2	-	-
Sr. Engineer	1	-	-	-	-
Engineer	1	-	-	-	-
Jr. Engineer	2	-	-	-	-
MSW	1	-	-	-	-
Trainee Physiotherapist	1	1	-	-	-
Physiotherapist	-	-	3	-	-
Chief Physiotherapist	-	1	1	-	-
Chief Technologist	-	1	-	-	-
Dy. Medical Superintendence	-	1	-	-	-
Total	50	35	10	4	1

In India, healthcare delivery system is provided by public and private agencies. The government/public healthcare system is limited with secondary and tertiary care institutions in key cities and rural areas providing basic healthcare facilities through primary healthcare centers (PHCs); the private healthcare system provides majority of secondary, tertiary and quaternary care institutions with a major concentration in metros, tier I and tier II cities.

Given the brisk changes with new laws and regulations, both in private and public sectors, government's role changed from provider to payer of the financial risk protection coverage to the margina-lized. For instance, The Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PMJAY), is the largest government funded healthcare program targeting more than 500 million beneficiaries. Private sector accounts for almost 74% of the country's total healthcare expenditure. Telemedicine is a fast-emerging trend in India; major hospitals such as Apollo, AIIMS, and Narayana Hrudayalaya have adopted telemedicine services and entered into a number of public-private partnerships (PPP). Further, India is a preferred destination for medical tourism. India's competitive advantage lies in its large pool of well-trained medical professionals.

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Healthcare organization's (HCO) performance depends on knowledge, skills, and personal incentives of human resources (Storey & Holti, 2013; Dinh et al, 2014). A consistent leadership is thus needed to achieve high performance to enhance employees' capabilities to improve the quality of care and outcomes. (Baker, 2011; McDermott, et al, 2013). Then, what constitutes leadership?

Leadership

Leadership means many things. However, the essentials of leadership remain the same to all leaders. Due to the variation in the skills required, roles played, functions performed, issues tackled, and the relationships promoted, different leaders have different perceptions of leadership. Therefore, Warren Bennis (1959) said that there are multiple definitions of leadership but no universal definition. Many definitions have evolved over a period of time. but Karmel (1978) said that there cannot be one single definition accommodating so many variations. There are some commonalities underlying all conceptualizations viz., (1) leadership is a process, (2) leadership entails influence, (3) leadership occurs within a group and (4) leadership involves shared goals or visions according to Schreuder et al., (2011). Many theoretical models of leadership (Adair, 1973; Hernandez et al., 2011; Northouse, 2012), emerged subsequently, attempting to find whether leadership connects with innate characteristics or behavior or actions of the leader. But, Dr. Marcus, in his speech said that leaders in hospitals are unprepared for their roles mostly (Kling, 2020).

In the present hospital, clinical leaders take long term decisions to develop, to adapt to the environment and to sustain. The catch point is that these decisions are taken with and without factual information and these conditions are inescapable. While some facts are scientific and evidence-based, others are gut and intuition based creating an "illusion of knowing" while the facts are non-existent. (Marcus & McNulty, 2019). What style do they follow?

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The concept of leadership 'style' emerged through studies by Lewin, Lippitt and White (Lewin et al., 1939) wherein three styles were identified, viz., authoritarian, democratic and laissez-faire, and demonstrated that leadership style had a profound effect on group productivity and interactions with other group members and the leader. Barrow (1976) asserted that leadership behavior and flexibility are causal determinants of job performance and is substantiated by Howell and Avolio (1991) that leadership styles are power predictors of organizational effectiveness. Others have recognized the importance of situational factors, with the concept of a leader 'choosing' a style appropriate to the context (Tannenbaum & Schmidt, 1973; Hersey & Blanchard, 1993).

Leadership in Health Care

The above are relevant to different sectors, roles and contexts. However, studies have revealed that most of the problems of healthcare systems are also due to poor communication and leadership as per Weberg (2012) and Vaghee & Yavari (2013) just like in any other sector. But the above definitions don't encompass the activities, processes, and roles of the healthcare sector. Smith et al (2012) found that most leadership studies have been conducted in developed countries and mostly outside healthcare industry. Ryan and Tipu (2013) said that management of HCOs in developing countries, is not adequately studied. (Kling, 2020) in his compilation of speeches highlighted that hospitals and medical systems are complex, nonlinear organizations, which are subjected to change in the form of mergers, closures, financial policies, floods of patients during emergencies, or pandemics.

Poor leadership in HCOs is likely to lead to escalation of costs, reduced efficiency and effectiveness, employee dissatisfaction, culminating into lower patient satisfaction; appropriate leadership alone would improve all the above. Resource allocation is a major challenge to almost all HCOs across the world because, besides profit making, it has to fulfil objectives of service to humanity with quality healthcare. To achieve this, capacity to work together is essential. However, in the context of healthcare, the importance of engaging doctors in leadership roles is acceptable and is a growing fact as per Ham (2003); Darzi (2008) Swanwick and McKimm (2011) and Kumar and Khiljee (2013) because deficiencies in medical leadership can have an injurious effect on patient care (The King's Fund, 2011).

Having an excellent leader in a HCO is not just essential, but vital, to link various departments/ units.

Schwartz and Tumblin (2002) found that historically it was perceived that transactional approaches prevailed among medical leaders, adequately supported by organizational structure and culture. Later, transformational style was perceived as more effective. However, studies by Xiragasar et al. (2005); Horwitz et al (2008) Palmer et al (2008) concluded that the perception of these two styles as being mutually exclusive is not only over-simplified but also the optimal approach to train successful medical leaders has not been established. Schyve (2009) defined clinical leadership as the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives. This is substantiated by meta-leadership whose focus is to create a culture where individuals are working together to help one another succeed (Marcus et al, 2006). A leader must understand and be aware of his subordinates' ambitions and try to use them for the good of the organization. In a nutshell, having an excellent leader in a HCO is not just essential, but vital, to link various departments/units (Schyve, 2009). For the present study, Schyve's (2009) definition is used.

Managerial Grid

The Managerial Grid was developed by Blake and Mouton in 1962 (fig.1) and it is based on two dimensions, viz., concern for people/relationships and concern for result/production each of which has a range from 0 to 9. Five types of leaders emerge when one looks at the extreme quadrants of the grid, namely, Impoverished management style (1.1), Country club management style (1.9), Task management style (9.1), Team management style (9,9), Middle-of-the-Road style (5,5) as depicted below:

Managerial Grid Findings

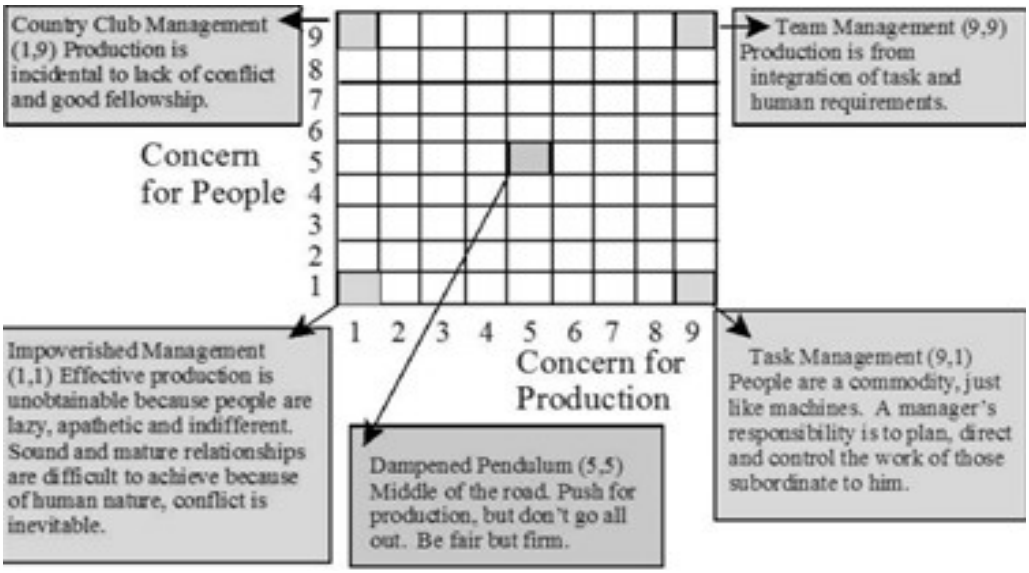
The entire sample of 100 is divided into 5 groups according to organizational hierarchy i.e., Group I, II, III, IV, and V. The details are as given in Table 1.

A majority of the healthcare executives irrespective of their job description follow the Team style of leadership.

In this study, it is found that a few position holders are exhibiting appropriate style while most of them are exhibiting styles that are incompatible with their job profile (Table 2). For instance, a majority of the healthcare executives irrespective of their job description follow the Team style of leadership. The role played by each position vis-à-vis the leadership styles is as follows:

Deputy Medical Superintendent is exhibiting country club-style which appears to be incompatible with the role. It involves responsibility to maintain the quality of patient care as laid down by the hospital, communicating information

Fig.1 The Managerial Grid



Source: Blake & Mouton (1962)

Table 3 Leadership Styles Being Followed by Different Groups

Leadership style →Group↓	Team	Country Club	Task	Impoverished
I	16%	15%	0	
II	22%	15%	50%	
III	20%	15%	0	30%
IV	24%	30%	0	60%
V	18%	25%	50%	10%
Total	100%	100%	100%	100%

or decisions from the board to the medical staff, day-to-day decisions at the hospital for medical management, enforce staff rules and discipline regarding doctors, bring all information to the board if any senior doctor is required to be censured, leave management, budget screening for medical staff and associated departments. The job incumbent should be a good communicator as well as a keen information seeker. The position holder is expected to display implicit trust in people, rely on high relationship orientation as well as task orientation. The job incumbent should be a team leader.

Deputy Nursing Superintendent is following team style which is compatible with the job description which involves more supervision, change, problem-solving, coordination with different departments, etc.

Sr. Resident, Jr. Resident, Registrar, Sr. Registrar, CMO, and Sr. Medi-

cal Officer are exhibiting different styles: 53% are exhibiting Team style; 27% are exhibiting Country club style; 9% are exhibiting Impoverished style, 9% are exhibiting Task style and 1% is using middle road. Their jobs involve writing case sheets as soon as they arrive into the ward, monitoring and noting the condition of the patient on the progress sheet and reviewing treatment chart after discussing with the consultant. Clear instructions should be given to the nursing staff regarding the investigations and plan of treatment. All the investigation reports must be entered into the mass investigation chart. A detailed review and reporting of patients' condition is to be made once in three days and any other jobs as assigned as per the exigencies of the work of the hospital. In this category, those exhibiting country club and impoverished styles appear to be incompatible with their job descriptions. These positions require analytical and technical skills. They should be alert, with sharp thinking and should have an urge to continuously upgrade their knowledge. Thus, these positions require Task orientation rather than a country club or impoverished style or a blend of task/team styles is advisable.

62% of the *Consultants* are exhibiting Team style while 38% of them are exhibiting Country club-style which is not apt. Consultants need analytical, technical, social, and good liaison skills. They should be planners and coordinators of departmental activities; alongside is innovativeness with continuous upgradation of knowledge. They should be team leaders.

*General Manager (Finance and Accounts) i*s exhibiting Country club style of functioning which appears to be undesirable as this job requires analytical, technical, planning, financial allocation, negotiating, conceptual skills and objectivity. Job incumbent needs to be thoroughly informed about matters concerning finance, accounts, and budgets; should be a good communicator also. Given the above, the incumbent should be a task leader.

Manager (Accounts) and Assistant Manager (Accounts) are exhibiting team styles but their roles call for more task orientation as it involves billing procedures, salary disbursements, working capital management, audit and fixation of tariffs, etc. *Sr. Executive (Secretarial)* is exhibiting team style, which satisfies the needs of the job description. But this position needs task style. *Internal Auditor* is exhibiting team style but it requires more task orientation as qualities like discipline, vigilance, alertness, and commitment are needed. The job involves checking/verifying daily credit bills and income statement of main and branch offices, checking records and accounts, auditing on operation theatre house/machine utilization, handling idle capacity and time, auditing on In-Patient and Out-Patient discounts, and Manpower, and audit annual hospital budgets.

General Manager (Operations) is exhibiting team style which is compatible with the job description. *Manager, Assistant Manager and Executive (Front Office)* are exhibiting team style

which is desirable for this position. *Assistant Manager (Corporate Relations)* is exhibiting country club style of functioning which is not at all suitable for this position as per the job description. 60% of the executives (Corporate Relations) are exhibiting country club style and 40% of them are exhibiting team style. Since these positions are directly responsible for the enrichment of the organization, the job incumbents should be team leaders with patience, dynamism, communication, interpersonal and social skills, and objectivity.

Chief Physiotherapist is exhibiting a country club style of functioning which is desirable, but the task part shouldn't be forgotten. Most Physiotherapists are showing an impoverished style of functioning which is not all desirable because they should have to deal with different kinds of patients and it needs a lot of patience and they have to coordinate with different medical departments for the smooth running of departmental activities. They need to exhibit country-club style while the task part shouldn't be ignored

Sr. Engineer (Bio-Medical) is exhibiting team style, which is most desirable as per the job description. *Engineer and Junior Engineer (Maintenance)* are exhibiting a team style of functioning which suits the job description. *Assistant Manager (Materials)* is exhibiting a country club style which is not at all desirable as this position is quality based. They should be well disciplined and committed with good communication and social skills. Thus, team style is advisable for this position or some shades of task style is desirable too.

Style of leadership is inconsistent with the amount of control exerted by an individual executive.

Discussion: The central idea of this study is the diagnosis of volatility that leadership is simplistic and more intractable. While leaders play an enormous role in the survival and sustenance of an organization, most research has overrated the leader's personality in an attempt to understand and define leadership. It is observed in the present study that the style of leadership is inconsistent with the amount of control exerted by an individual executive. Also, leadership styles, as responded is effective under certain conditions and not under others. For instance, where a manager needs to exhibit high relationship orientation he is being a task leader and his response to the questionnaire also indicates task style. In this case, envisioning without appropriate interpersonal relations led to poor enactment of vision. The job profiles of the respondents do not prescribe a fairly consistent leadership style as they are working in a more docile operating environment. Therefore, it involves only giving and taking directions (instruction oriented). Instruction oriented style of communication is mostly emanating from position power or hard power; both rewards and sanctions are through this style only.

Semi-structured Interviews

The respondents were questioned to explore the context and culture of lead-

ership in the organization. The responses are as follows:

Although respondents varied in their decision-making authority and consultative tendency, virtually everyone showed evidence of some or the other leadership styles. Organizational culture, context, individual propensity, and "style history" emerged during the interviews as important factors in determining the use of leadership styles by medical leaders.

Leaders, in the study, do strongly share a seemingly inexhaustible and a visible commitment to better ways and believe deeply that the hospital's future is dependent on change. However, in reality, they perceive that situations are not flexible to exert adequate leadership; also trust in this organization was mostly gauged by the presence/lack of respect expressed by each party for the other. This point is substantiated by Marcus' speech (Kling, 2020)), as individual leaders in hospitals are always at logger heads with each other given their bloated egos which become an impediment to collaborative problem-solving. For instance, during interviews, executives have highlighted that there is a lot of indiscipline, ill-defined work culture, lack of recognition, lack of need-based training, and dissatisfaction levels which prevents them from envisioning; the operating environment is frustrating and deters individuals from being a visionary, influencer, and a motivator.

It was observed that physicians are disinclined to undertake leadership roles due to the extra administrative burdens; while a few of them expressed their fear of failure in assuming this role given the patients' workload. Also, respondents said that there is no training regarding leadership execution. This shows a lack of preparedness for the role amongst the physicians and they are usually satisfied with their technical prowess for which they are qualified. Though physicians are scientifically trained, they do not study business and finance courses. Thus, administrative burdens of independent practice can create time management challenges, juggle with the complexities of leading-managing, with very little time to practice medicine. But once, physicians choose to practice medicine as well as leadership, a high level of commitment to both causes favorable results, asserts Hoff and Mandel (2001).

Doctors complained about improper pay structure leading to high dissatisfaction. Pay structures are non-competitive and non-uniform. Another grievance is that promotion and salary are based on years of service and not on performance, which made it impossible for managers to hold staff accountable. At this point, they scoffed at the very idea of leadership and its effectiveness. As physicians, they spend much of their careers immersed in clinical practice, thus, leadership qualities are not always identified. However, management's role in fostering/investing in leadership development is hazy. These people also complained about the non-cooperative environment and monotonous work practices. Some of them were disinterested in filling-up the questionnaire and they mocked that these kinds of studies are a

sham and serve no purpose. On probing, they responded that they know the 'insider' things more than the researcher. Given an opportunity, they are likely to erupt to vent their frustrations and grievances. On probing, it is noticed that 'knowing what to do but constrained by context' is a major factor for on-the-job frustration.

Management's role in fostering/investing in leadership development is hazy.

To authenticate the above deterrents, the author ended up with some conversations with the frontline staff. Frontline workers said that their managers don't respond to their work needs such as essential drugs, medical supplies, equipment and infrastructure needed for quality service delivery. They attributed this behavior to hospital managers having other priorities. This creates frustration and demotivation. When the author cross verified this with the managers, they admitted that the complaints were true and replied that they were constrained by the context. Frontline staff also said that monitoring mostly involved finding faults than guiding. They substantiated that the procurement procedure contributed to bureaucratic bottlenecks that slowed down decision making, project implementation, and the acquisition of equipment, tools, and supplies, to meet workers and their hospitals' needs. Given the centralized decision making, hospital managers' power to address needs for infrastructure, equipment, tools, medicines and other supplies is constrained. The non-clinical leaders express their grief that their awareness about in-house clinical practices and processes is severely skewed because there is no formal channel of communication between clinical and non-clinical leaders. The collaboration appears far from a panacea. Given their centrality in inpatient care, physicians have extensive knowledge about the 'core business' of caring for human beings, but the infrastructure and support needed comes from the non-clinical leaders. This point gets ignored/missed most of the time.

Another noticeable thing is that most respondents reported as 'team leaders'. However, from their interviews, it is observed that they either want to be team leaders or the responses may just be perfunctory. Thus, the author could sense some 'unconscious conspiracy' which involves undermining one's vision. On the contrary, in response to their deterrent, hospital managers adopted a variety of coping strategies often within a transactional leadership style. However, they juggled between leadership styles. Unfortunately, neither there is a mentor to follow nor is there any encouragement to exert leadership.

Thus, the deterrents affecting leadership execution could be placed under the following 9 broad themes, viz.,

(i) Lack of prior leadership education or training

(ii) Structural and situational obstacles

(iii) Lukewarm response by physicians to exert leadership

(iv) Lack of preparedness for leadership responsibilities

(v) Lack of influence and a voice in decision making

(vi) Lack of time for other causes

(vii) Frustrations with the amount of time needed to impact change

(viii) Difficulties in work/life balance

(ix) Difficulties in leadership and clinical balance

Thus, the above factors cause collision between the image of healer and the image of leaders and prevents them to reconcile with the growing importance of clinical leadership in healthcare industry. Thus, the importance of having the right leadership style matching the demands of the situation gets diluted. Under these circumstances, how to make great doctors into great leaders?

Conclusion & Recommendations

A changeover from a 'volume to value reimbursement methodology' (propounded by Patterson, 2015) shall generate an environment where novel ways of working together to maximize or maintain current revenue streams are essential for physicians and hospitals. However, the structural mismatch of Physicians and hospitals is the major obstacle to clinical integration. To elaborate, a hospital consists of many departments and individuals working together in a corporate environment; Physicians commonly work independently or within a small group often alienated from the corporate world. Bringing these two very different realities together is inherently complicated. It is to be understood that Physicians inherently possess characteristics such as '*no harm'*, '*work your best*', and so on which form a sound base for exerting leadership and makes clinical integration possible. To substantiate, Guthrie (1999) suggested that Physicians generally focus their energies more on problem-solving, innovation, listening to advice, decision making, strive for excellence, technology, and so on. Some Physicians engage in a good amount of research and publication, which in turn can nurture a sound base for knowledge leadership. Given the reforms in healthcare, Physicians can no longer afford to be Physicians alone; they need to be leaders too. Promoting/Investing in Physician leadership serves as an opportunity to reach other doctors who may be disinclined or even afraid to change.

The structural mismatch of Physicians and hospitals is the major obstacle to clinical integration.

At the center of this evolving high voltage scenario, the critical need for organization is to not only continually adapt to fluctuating demands, but also to revamp the organization culture and relook at managerial effectiveness. This change should render the largely centralized bureaucratic structure obsolete and develop favorable systems. A mere presence of a physician-hospital association does not ensure clinical integration; it is important to analyze underlying social cooperation and consortium between both

parties. Trust building, placing physicians in management roles and developing leadership competencies amongst physicians are some strategic initiatives to promote physician-hospital alignment. Noon (2016) asserts that trust is the basis for engaging and partnering with physicians.

The organization has to relax its hierarchical control systems and decentralize aggressively and introduce work designs enabling operations staff at all levels to exercise informed judgment. The culture needs to modify to a degree wherein participation and group collaboration should be held as central determinants to quality and effectiveness. Alongside, decentralization makes it much more difficult to maintain the notion that top officials are 'in control' than did its predecessors – the pyramidal centralized structure that is receding. Effective decentralization will remain a mirage if hospital managers are not provided with the necessary authority to deal with the daily challenges that hospitals face.

Usually, new forms of organization, are adopted to bail out of turbulent conditions of contemporary operating environments; they seek to replace obedience and obligation with commitment and personal involvement in work. The key to success in this setting is collaboration and participation rather than deployment and command. Asking members across levels to merge this into their work roles, amounts to a re-negotiation of authority relations. It requires recognition of the fundamental interdependence between leaders and followers to create an effective enterprise leadership. Shifting the focus for understanding leadership capacity from the leader's context is likely to stir up massive anxiety. In practice, this sort of reorientation questions the established modes of thinking and relating. When responsibility for leadership is distributed around the system, people have to relinquish some of the shared notions that they have developed for hierarchical authority systems. To achieve the above, team interventions, formal diagnostic group meetings, process consultation interventions, review of salary structure, review of training needs, and job and attitude surveys are recommended. In a nutshell, encouragement and mentorship from the hospital management is vital because transformation is a movement and not a mandate.

Encouragement and mentorship from the hospital management is vital because transformation is a movement and not a mandate.

Implication: The outcome of this study is useful for leadership training and organization development. This study adds nine themes to the very limited evidence base on factors influencing style used in medical leadership.

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