Physician Leaders' Perspectives About Balancing Clinical and Leadership Responsibilities

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ABSTRACT

Objectives: Physician leaders represent diverse career interests, clinical specialties, and leadership types. Despite the perceived value of their clinical perspectives, little is known about how physician leaders balance patient care and leadership responsibilities or how that balance varies by clinical specialty or leadership type. We conducted what is to our knowledge the first survey evaluating physician leaders' perspectives about these issues.

Study Design: Web-based survey administered September 2017 to February 2018 among physician leaders from the 22 health systems cited in the 2016-2018 U.S. News & World Report Best Hospitals Honor Rolls.

Methods: Respondents were asked questions regarding their participation in patient care. We described our findings using percentages and χ^2 tests to compare categorical variables across leadership type (executive, educational, clinical) and clinical specialty (procedural, nonprocedural, supportive).

Results: Of 447 leaders contacted, 53% responded to our survey. Of those, 84% reported some degree of participation in patient care (69%, 90%, and 85% of executive, educational, and clinical leaders, respectively; $P = .001$); most (74%) spent no more than a quarter of their time on patient care, and they often achieved a balance that they deemed optimal (74%). Proceduralists were more likely to spend over a quarter of their time on patient care and less likely to achieve an optimal balance.

Conclusions: Although most physician leaders engage in some degree of patient care, the balance that they achieve varies by clinical specialty and leadership type. These findings provide insight for health care organizations seeking to engage and optimize physician leadership amid ongoing health care transformation.

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American health care continues to undergo significant transformation. Changes in health policy[1]; consolidation among providers, payers, and other stakeholders[2,3]; and trends in value-based payment[4] have placed an emphasis on accountability in health care delivery. These changes underscore the potential value of physician leadership,[5] which has been associated with improvements in operational efficiency,[6] value, and outcomes.[7-9] These dynamics have led to increased organizational interest in physicians with leadership skills[10,11] and growing numbers of physicians seeking leadership training.[12,13]

Importantly, physicians pursue leadership careers for different reasons[14]: Some seek administrative opportunities (eg, health system medical director) whereas others desire leadership in specific clinical (eg, service line chief) or academic (eg, department chair) areas. Variation also exists in each of these categories. For instance, some medical directors focus on specific projects or topic areas (eg, a certain hospital unit, an infection control program) whereas others focus on topics that cut across teams and units (eg, value-based care, population health).

Different leadership paths require different skill sets.[14] For instance, medical directors of clinical units benefit from change management and process improvement skills needed to drive daily operations. Physicians with leadership in cross-cutting topics such as population health must be proficient in policy analysis, data synthesis, and change management.

Despite this diversity, a common thread is that physicians' first-hand patient care experience lends them unique leadership perspective[15-17] that can be highly valuable to themselves and their organizations. For example, a physician who maintains an active clinical practice may have greater credibility

among clinicians whom they lead, or a physician can inform organizational contracting using their clinical perspective to balance financial and operational considerations. Conversely, the time and energy needed to maintain a clinical practice can siphon attention away from leadership work, with impacts on administrative capacity and potential leadership efficacy.[18] All physician leaders face the task of balancing clinical and leadership responsibilities.[19,20]

Despite these dynamics and the possibility that they vary by type of leadership role and clinical specialty, little is known about physician leaders' perspectives on balancing clinical and leadership responsibilities. Therefore, we conducted what is to our knowledge the first survey capturing these perspectives.

METHODS

Survey Population

We conducted a web-based survey and followed approaches used in prior work by sampling physician leaders from the 22 hospitals cited at least once in the *U.S. News & World Report* Best Hospitals Honor Roll from 2016 to 2018.[7,21-23] For each institution, we reviewed online content descriptions of its executive leadership teams and respective departmental websites to identify the names and contact information of the individuals who possessed a medical degree (MD or DO) and filled a position in 1 of the following categories of leadership types: executive (CEOs, vice presidents, and other health system executives), educational (medical school deans and academic department chairs), and clinical (internal medicine division or clinical service line chiefs). Division chiefs were limited to internal medicine division chiefs to promote consistency in use of title and scope of leadership responsibilities. Where online leadership information was limited (1 hospital), we followed an approach used in prior work by initiating email outreach to identify all eligible leaders.[7] Individuals filling multiple leadership roles were assigned to 1 category (executive, if relevant, followed by academic and clinical, in that order). Retirees were excluded. This yielded a sample of 447 potential participants (average of 20.3 leaders per institution).

Survey Design

Respondents were asked what amount of time they currently spend on direct patient care, defined as serving as a physician of record or consultant on a clinical service (**eAppendix A** [eAppendices available at **ajmc.com**]). They were also asked about the optimal amount of time that they believed someone in their leadership position should spend on direct patient care to be an effective leader; the minimum amount of time someone in their clinical specialty needs to spend on direct patient care to be a safe, effective clinician; and whether they would increase or decrease their participation in patient care. Physicians participating in patient care were asked if it influences their performance in their leadership role and, if so, how. Those not currently involved in direct patient care were asked why they no longer practice. Additional questions confirmed leaders' leadership type, clinical specialty, and years in clinical practice.

Survey Administration

After pretesting among 32 physician leaders (which led to the addition of 1 question about number of years participating in patient care), the survey was sent to eligible respondents between September 19, 2017, and February 5, 2018. Recipients received up to 6 reminders to complete the survey. The protocol was deemed exempt by the University of Pennsylvania Institutional Review Board (protocol No. 827375). Respondents were not financially compensated for their participation.

Statistical Analysis

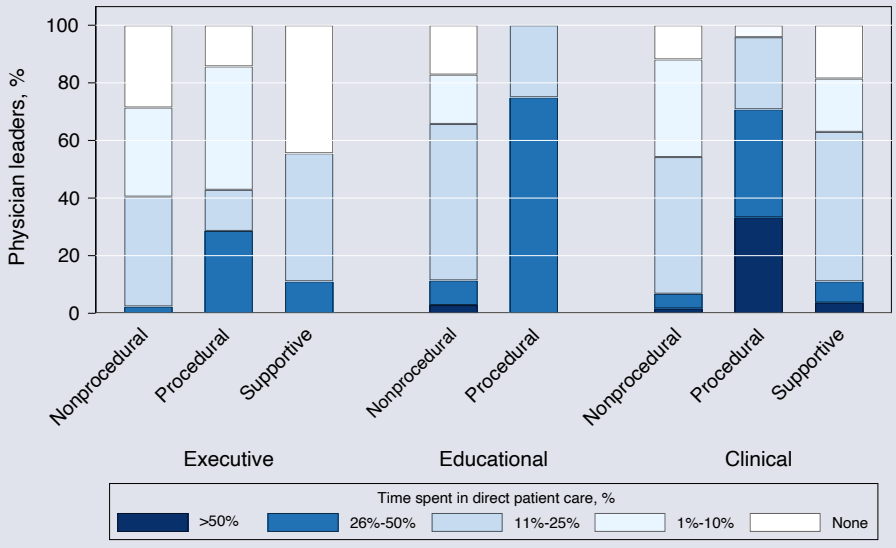
Leaders' clinical specialties were categorized according to the nature of their primary patient care responsibilities as procedural (obstetrics-gynecology, ophthalmology, surgery, urology), nonprocedural (emergency medicine, dermatology, family medicine, internal medicine, neurology, pediatrics, physical medicine and rehabilitation, psychiatry), or supportive (anesthesiology, pathology, radiology, radiation oncology).

We used several definitions to describe respondents' perceptions about balance between clinical and leadership responsibilities. We defined balance as optimal (those spending an amount on patient care equivalent to the amount they deemed optimal from a leadership standpoint) or nonoptimal (all other situations). Among the latter group, we identified individuals for whom clinical burden (spending more time on patient care than was optimal from a leadership standpoint) contributed to nonoptimal balance. Additionally, we defined the feasibility of balancing leadership and clinical responsibilities as infeasible (if the optimal amount of time on patient care from a leadership perspective was less than the amount needed to maintain clinical competence) or feasible (all other situations). We used χ^2 tests to compare categorical variables. All tests of significance were 2-tailed and deemed significant at $\alpha = .05$. All analyses were performed using Stata version 15.1 (StataCorp).

RESULTS

Of 447 eligible respondents, 53% returned complete (n = 233) or partial (n = 4) surveys. Nineteen percent of respondents were executive leaders, 58% were educational leaders, and 23% were clinical leaders. Executive leaders were more likely to come from nonprocedural clinical specialties (72% nonprocedural, 12% procedural, 16% supportive) relative to educational leaders (38% nonprocedural, 38% procedural, 24%

Figure. Participation in Direct Patient Care, by Leadership Type and Clinical Specialty[a]



[a]No educational leaders came from supportive specialties.

supportive). Clinical leaders were primarily nonprocedural (90% nonprocedural vs 10% procedural and 0% supportive) ($P<.001$). Compared with nonrespondents, respondents did not differ with respect to gender, geographic distribution, leadership type, or clinical specialty (**eAppendix B**).

Overall, 84% of physicians reported participating in direct patient care. The majority (96%) reported that doing so somewhat or greatly improved their performance as leaders. Respondents noted a number of ways in which this occurred, including increased credibility among those they lead (98%) and insight into "frontline" issues (96%) (**eAppendix C**). Only 3% of physician leaders believed that direct patient care somewhat diminished their performance, citing reasons such as decreased time for leadership responsibilities. Of respondents not participating in direct patient care, the most commonly endorsed reason was "insufficient time or energy to be an effective clinician" (78%). None reported expectations from leadership as a reason for not participating in patient care.

Balancing Clinical and Leadership Responsibilities

Among physicians participating in direct patient care, most reported spending no more than a quarter of their time on it (74%) and that spending less than a quarter of their time was optimal from a leadership standpoint (80%). The majority (74%) reported achieving an optimal balance, with 15% citing clinical burden as contributing to nonoptimal balance. Only 4% reported that balance between clinical and leadership responsibilities was infeasible.

Variation by Leadership Type

Perspectives varied by leadership type. Overall, executive leaders were less likely to participate in direct patient care (69%) relative to educational (90%) and clinical (85%) leaders ($P=.001$) (**Figure**). Among respondents participating in clinical care, executive leaders were also less likely to spend more than a quarter of their time on patient care or to believe that spending over a quarter of their time on patient care was optimal from a leadership standpoint (**Table**). In contrast, rates of optimal balance or clinical burden and the reported feasibility of balancing clinical and leadership responsibilities did not vary by leadership type.

Variation by Clinical Specialty

Participation in direct patient care varied by clinical specialty, ranging from 98% of leaders in procedural specialties to 82% of leaders in nonprocedural specialties and 76% of leaders in supportive specialties ($P=.002$) (Figure). The amount of and perceptions about time spent on patient care also varied by specialty type (Table). With regard to balance between clinical

and leadership responsibilities, leaders in procedural specialties were least likely to achieve optimal balance (61.0% vs 78.4% and 82.1%; $P = .028$) and most likely to report clinical burden (28.8% vs 9.9% and 7.1%; $P = .002$) relative to leaders from nonprocedural and supportive specialties, respectively.

DISCUSSION

To our knowledge, this study is the first to document physician leader perspectives about the balance between their clinical and leadership responsibilities. It has 2 key takeaways.

First, our results suggest that many physicians serving a range of leadership roles find it feasible to balance clinical and leadership responsibilities. That many leaders believed patient care aided them in fulfilling their leadership responsibilities is informative to both physician leaders and organizations seeking to foster physician leadership.[19,24] For these groups, it can be instructive to recognize that participation in patient care may be hampered more by insufficient time rather than external pressures or expectations.

Second, our findings suggest that fostering balance among physician leaders' clinical and leadership responsibilities is not a one-size-fits-all task. In particular, it is relevant that perspectives and features of balance varied across leadership type and clinical specialty.

Poor balance—for instance, through infeasibility or the presence of clinical burden—can complicate physicians' abilities to effectively meet either clinical or leadership responsibilities, much less both simultaneously. The fact that the extent and nature of imbalance can vary is exemplified by our finding that leaders from procedural specialties were more likely to

Table. Variation in Physician Leader Perspectives and Practices Regarding the Balance of Clinical and Leadership Responsibilities

	Leadership type				Clinical specialties			
	Executive	Educational	Clinical	*P*	Nonprocedural	Procedural	Supportive	*P*
Nature of balance								
Leaders who spent >25% on patient care,[a] n (%)	4 (9.8%)	7 (21.2%)	41 (33.3%)	.009	9 (8.0%)	39 (66.1%)	4 (14.3%)	<.001
Leaders who believed spending >25% on patient care was optimal, n (%)	3 (5.2%)	5 (12.8%)	38 (28.6%)	<.001	6 (4.4%)	36 (60.0%)	4 (11.8%)	.001
Leaders who believed spending >25% on patient care was needed for clinical competency, n (%)	9 (15.5%)	4 (10.3%)	20 (15.0%)	.724	11 (8.1%)	19 (31.7%)	3 (8.8%)	<.001
Likelihood of achieving balance[a]								
Leaders who achieved optimal balance, n (%)	35 (85.4%)	33 (72.7%)	86 (70.5%)	.17	87 (78.4%)	36 (61.0%)	23 (82.1%)	.028
Leaders who reported being clinically burdened, n (%)	2 (4.9%)	6 (18.2%)	22 (18.0%)	.11	11 (9.9%)	17 (28.8%)	2 (7.1%)	.002
Leaders who perceived balance as infeasible, n (%)	3 (7.3%)	4 (3.0%)	1 (3.3%)	.50	4 (3.6%)	2 (3.4%)	2 (7.1%)	.67
Desires regarding balance								
Leaders who desired a decrease in patient care, n (%)	1 (1.7%)	9 (20.5%)	22 (16.4%)	.008	14 (10.2%)	16 (26.7%)	1 (2.9%)	.001

[a]Assessed among physician leaders currently engaged in direct patient care.

report nonoptimal balance and clinical burden compared with leaders from other specialties.

Organizations can use insights about variation in the extent and nature of imbalance to tailor responsibilities and expectations for different types of leaders. For instance, organizations may require greater participation in patient care among clinical leaders, for whom clinical practice has more immediate relevance, than for executive leaders, whose primary responsibilities are often nonclinical (eg, emphasis on finance or operations[25]) and more removed from those of frontline clinicians. That perceptions about the feasibility of achieving balance did not vary by clinical specialty or leadership type is reassuring and underscores the ability of physician leaders from a range of clinical specialties and leadership types to achieve optimal balance.

Limitations

First, the generalizability of our findings is limited by the 53% response rate. Second, although our study was descriptive in design and did not evaluate for associations between leadership behaviors and outcomes, the results represent useful early evidence that can be built upon in future work. Third, our sample of leaders may not be representative of the full breadth of physician leadership (eg, it may not capture mid-level leaders or those in other divisions not directly sampled in our study) or representative of physician leaders in all hospitals or health systems. However, we followed prior approaches in sampling leaders across a consistent set of leadership types among a group of institutions recognized for excellence across a set of clinical measures and outcomes.[7] Fourth, we were unable to evaluate the presence and extent of institutional requirements, expectations, and minimum standards for physician leaders regarding patient care responsibilities. These factors should be evaluated in future work. Fifth, our study assessed self-reported perspectives among physicians but not other factors that should be studied in future research, including perspectives among those in nonleadership roles or objective measures of success (eg, staff retention, operational performance).

CONCLUSIONS

Our study provides important early evidence about physician leaders' practices and perspectives balancing clinical and leadership responsibilities. Although most engage in some degree of direct patient care, what kind of balance they achieve varies by clinical specialty and leadership type. Collectively, our findings provide context and insight for health care organizations seeking to engage physician leaders from various backgrounds and optimize the value of their clinical perspectives amid ongoing health care transformation.

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eAppendix A. Physician Leader Survey

Confidential

Physician Leader Survey

Basic Information

Thank you for agreeing to share your thoughts and experiences on the impact of patient care in your role as a physician leader. This survey should take no more than 2 to 3 minutes to complete. No individuals will be identified in the reporting of results.

Please identify your current leadership role(s).

Please select all that apply

- ☐ President or CEO
- ☐ Executive Officer (ie. Chief Officer, Vice President)
- ☐ Medical School Dean
- ☐ Department Chair
- ☐ Service Line Chief
- ☐ Division Chief
- ☐ Other (describe below)

_____

(please describe)

Please select your clinical specialty.

- ◯ Anesthesiology
- ◯ Dermatology
- ◯ Emergency Medicine
- ◯ Family Medicine
- ◯ Internal Medicine
- ◯ Neurology
- ◯ Obstetrics and Gynecology
- ◯ Ophthalmology
- ◯ Pathology
- ◯ Pediatrics
- ◯ Physical Medicine & Rehabilitation
- ◯ Psychiatry
- ◯ Radiology
- ◯ Radiation Oncology
- ◯ Surgery
- ◯ Urology
- ◯ Other (please describe below)

_____

Clinical Practice

Do you currently participate in direct patient care (e.g., serving as physician of record or consultant on a clinical service)?

◯ Yes
◯ No

On an annual basis, what percentage of your time do you spend in direct patient care?

◯ 0%
◯ 1-10%
◯ 11-25%
◯ 26-50%
◯ 51-75%
◯ 76-100%

Clinical Practice

Please identify factors/reasons for why you do not currently participate in direct patient care.

Please select all that apply

☐ Insufficient time or energy to be an effective leader
☐ Insufficient time or energy to be an effective clinician
☐ Less interest in clinical medicine compared to other activities
☐ More interest in leadership compared to other activities
☐ Prohibitive expectations from your leadership supervisors
☐ Prohibitive expectations from your clinical supervisors
☐ Prohibitive expectations from those you lead
☐ Concern regarding state of clinical skills
☐ Other (describe below)

_____
(please describe)

If possible, how would you change the amount of time you spend on direct patient care?

◯ Significantly increase
◯ Slightly increase
◯ Neither increase nor decrease
◯ Slightly decrease
◯ Significantly decrease

In your opinion, how does your participation in direct patient care influence your performance in your leadership role?

◯ Greatly improves
◯ Somewhat improves
◯ Neither improves nor diminishes
◯ Somewhat diminishes
◯ Greatly diminishes

Direct Patient Care

How does your participation in direct patient care improve your performance in your leadership role?

Please select all that apply

☐ Increases confidence in your own clinical skills
☐ Increases your credibility among those being led
☐ Increases your insight into "frontline" issues in areas of responsibility
☐ Produces satisfaction among your supervisors
☐ Improves the quality of your communication with those being led
☐ Improves your ability to empathize with those being led
☐ Energizes or refreshes you to fulfill your leadership responsibilities
☐ Maintains your self-image as a physician
☐ Maintains others' image of you as a physician
☐ Other (describe below)

_____
(please describe other)

How does your participation in direct patient care diminish your performance in your leadership role?

Please select all that apply

☐ Decreases your time for leadership responsibilities
☐ Decreases the energy or "bandwidth" needed to grow in leadership role
☐ Creates internal conflict about pursuing clinical vs leadership excellence
☐ Creates dissatisfaction among your supervisors
☐ Signals that only partial focus on patient care is acceptable
☐ Signals that only partial focus on leadership is acceptable
☐ Increases perception that you are "micromanaging" those being led
☐ Increases concern about the safety or quality of patient care you provide
☐ Other (describe below)

_____
(please describe other)

In your opinion, what is the optimal percentage of time, on an annual basis, that a person in your current leadership role should spend on direct patient care in order to be an effective leader?

◯ 0%
◯ 1-10%
◯ 11-25%
◯ 26-50%
◯ 51-75%
◯ 76-100%

In your opinion, what is the minimum percentage of time, on an annual basis, that a person in your clinical specialty needs to spend on direct patient care in order to be a safe, effective clinician?

◯ 0%
◯ 1-10%
◯ 11-25%
◯ 26-50%
◯ 51-75%
◯ 76-100%

Since completing post-graduation training, how many years have you participated in at least some degree of direct patient care?

◯ None
◯ 1-5 years
◯ 6-10 years
◯ 11-15 years
◯ 16-20 years
◯ Over 20 years

After completing post-graduation training, how many years did you participate in at least some degree of direct patient care?

◯ None
◯ 1-5 years
◯ 6-10 years
◯ 11-15 years
◯ 16-20 years
◯ Over 20 years

How many years has it been since you last participated in any direct patient care?

◯ 1-5 years
◯ 6-10 years
◯ 11-15 years
◯ 16-20 years
◯ Over 20 years

Other Clinical Activities Not Involving Direct Patient Care

In your current role, do you participate in other clinical activities that do not involve direct patient care (e.g., teaching rounds, morning report)?

◯ Yes
◯ No

How many hours, on a monthly basis, do you generally spend on these activities?

◯ < 1 hour
◯ 1 hour
◯ 2-5 hours
◯ 6-10 hours
◯ >10 hours

Thank You

Thank you for completing this survey on physician leader participation in patient care. Your time and input is much appreciated. You will receive a summary of our findings at the completion of the study.

While not required, we also invite you to consider answering the following nine questions regarding your leadership style. Responses will be used to inform future study. To respond, select the most appropriate descriptor for each scenario below. Otherwise scroll to the bottom of the page to submit your survey.

	Not at all	Once in awhile	Sometimes	Fairly often	Frequently, if not always
I am effective at meeting others' job-related needs	○	○	○	○	○
I use methods of leadership that are satisfying to others	○	○	○	○	○
I get those I lead to do more than they expected to be able to do	○	○	○	○	○
I am effective at representing those I lead to higher authority	○	○	○	○	○
I work with others in a satisfactory way	○	○	○	○	○
I heighten the desire of those I lead to succeed	○	○	○	○	○
I am effective at meeting organizational requirements	○	○	○	○	○
I increase the willingness of those I lead to try harder	○	○	○	○	○
I lead a group that is effective	○	○	○	○	○

Thank you again for your participation.

eAppendix B. Characteristics of Respondents vs Non-Respondents

Characteristic	**Respondents**	**Non-Respondents**	**p-value**
Female Gender	15.2% (37)	16.7 (34)	0.68
Geographic Area			0.84
West	17.7% (43)	18.6% (38)	
Central	27.6% (67)	29.4% (60)	
East	54.7% (133)	52.0% (106)	
Leadership Type			0.16
Executive	19.8% (48)	22.1% (45)	
Educational	64.2% (156)	55.9% (114)	
Clinical	16.0% (39)	22.0% (45)	
Clinical Specialty Type			0.37
Non-Procedural	58.8% (143)	63.4% (128)	
Procedural	24.7% (60)	24.7% (50)	
Supportive	16.5% (40)	11.9% (24)	

eAppendix C. Perceptions of Positive Impact on Leadership Performance by Type of Clinical Specialty

How does your participation in direct patient care improve your performance in your leadership role? (respondents asked to select all that apply)					
	Respondents Endorsing (n=190)	**Non-Procedural Specialties (n=107)**	**Procedural Specialties (n=55)**	**Supportive Specialties (n=28)**	**p-value**
Increases confidence in your own clinical skills	45%	41%	47%	54%	0.45
Increases your credibility among those being led	98%	97%	100%	96%	0.42
Increases your insight into "frontline" issues in areas of responsibility	96%	93%	100%	96%	0.14
Produces satisfaction among your supervisors	21%	17%	31%	14%	0.074
Improves the quality of your communication with those being led	68%	61%	84%	68%	0.012
Improves your ability to empathize with those being led	89%	87%	91%	93%	0.58
Energizes or refreshes you to fulfill your leadership responsibilities	64%	66%	60%	64%	0.73
Maintains your self-image as a physician	76%	76%	78%	75%	0.93
Maintains others' image of you as a physician	72%	72%	75%	68%	0.81