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Characteristics and Philosophies of Family Physician Leaders: A Qualitative Investigation

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Abstract

Introduction: Supported by the Society of Teachers of Family Medicine Special Project Fund, the goal of this hypothesis-generating project was to better understand the characteristics and philosophies of family physicians who hold leadership positions within and beyond the specialty.

Methods: From July 2023 to May 2024, we conducted ten 1-hour semistructured interviews and one five-participant focus group with family physician leaders. Each transcript was analyzed by two researchers, who compiled codebooks. All researchers then met and reviewed the codebooks for all interviews, developing agreed-upon themes and subthemes through an iterative process.

Results: Our 15 interviewees described their careers in terms of personal influences and professional experiences. Identified career-related influences included personal traits, resources, identity, upbringing, and experiences. Interviewees agreed that family medicine training supported leadership preparation through the development of numerous competencies. Participants identified with multiple defined leadership philosophies, all of which reflected a resonant style.

Conclusions: Our findings suggest that no singular characteristics or philosophies are held by all family physician leaders. Identified themes center on collaborative, team-based leadership, which requires strong communication skills and relatability. Many identified themes converged on personal and professional development, as well as support, as essential to leadership growth.

Introduction

With their firsthand understanding of the challenges faced by their patients and a deep appreciation for adaptability and creating solutions, family physicians are needed at every level of leadership in medical education, health care systems, and government.[1,2] No single strict path or required personal characteristics exist for successful family physician leadership.[3] This project sought to explore characteristics and philosophies common to family physician leaders with the goal of better understanding commonalities and differences.

Methods

This study was conducted by representatives from the Deans Associated With Family Medicine Special Project Team of the Society of Teachers of Family Medicine (STFM) and supported with funding from the STFM Special Projects Fund. Participants were recruited via email or through the STFM Connect platform; 10 people responded and consented to participate in 1-hour, semistructured, and recorded Zoom interviews (Appendix 1). Five participants were recruited and recorded during a focus group at the 2023 STFM Conference on Medical Student Education. While anyone who self-identified as a family medicine leader was eligible for inclusion in the study, only physicians responded to our calls for participants. Transcripts of the focus group and interviews were generated using ClariVita. The study was determined to be exempt from review by the institutional review boards (IRBs) of Florida International University and the University of Central Florida, citing exemption category 2.

Thematic analysis of the personal narratives was done using the Braun and Clarke method for reflexive analysis.[4] Two independent raters coded the data for themes and subthemes; then the themes and subthemes were compared to the point of saturation. Disagreements were discussed with one to three additional reviewers using reflexive discussion, interrogation of different perspectives, and iterative refinement of themes until a consensus was reached.

Stoller's six leadership competencies in health care (technical skill and knowledge, health care systems knowledge, problem-solving skills, emotional intelligence, communication skills, and commitment to lifelong learning) were used as a framework for coding responses to the question "How has family medicine informed your leadership style?"[5] Participants' leadership philosophies were coded as resonant (visionary, coaching, affiliative, democratic) or dissonant (pacesetting, command and control) using Goleman et al's classification of leadership styles as a framework.[6]

Results

Participant Demographics

Of the 15 participants, 12 identified as being underrepresented in academic leadership due to their gender, race and ethnicity, or socioeconomic status. Three participants considered themselves underrepresented in academic medicine leadership because they were family physicians. Leaders used numerous titles to describe their identities, with most defining themselves by administrative rank, followed by personal identity. Some also defined themselves by their academic rank or clinical specialty. Additional self-descriptors included personal traits, approaches, and skills. The most cited personal traits were being driven, committed, and hardworking. Other traits mentioned include enthusiasm, honesty, humility, passion, creativity, optimism, thoughtfulness, inspiration, and energy. The three approaches most commonly employed by the leaders were being mission-driven, systematic, and advocating for the team. Interestingly, one participant described themself as introverted. Self-defined leadership skills included being organized, communicating well, delegating efficiently, and developing others while completing tasks on time.

Leadership Positions

The leadership positions held by the participants included those outside the specialty of family medicine (eg, designated institutional official and faculty development) and those within the specialty (eg, chair). Career path decisions primarily were influenced by personal factors, with the most common being family interests and military obligations.

Leadership Style

Overwhelmingly, respondents' leadership philosophies (Table 1) reflected a resonant style (affiliative, coaching, democratic, visionary), with few responses indicating a dissonant style (pacesetting). No participant supported

a commanding style of leadership philosophy. Participants reported that their family medicine training contributed to their leadership style in various ways that aligned with the specialty's core skills. Identified subthemes all were matched to Stoller's leadership competencies[5] (Table 2, Appendices 2 and 3).

Leadership Development and Contributors

Study participants reported participation in a variety of leadership development activities at the personal, institutional, and national levels. Membership in family medicine–oriented and other national organizations also was noted as important to leadership development. Contributors to career advancement were categorized into four themes: personal traits, approaches, resources, and experiences (Table 3). The theme of resources was cited almost twice as often as the next most frequently cited themes, approach and personal traits. Within the resources theme, mentors and access to networks were cited as the most frequent contributors. When asked what mission helped them become successful leaders, participants identified teaching and clinical work slightly more frequently than service and research (Appendices 4, 5, and 6).

Barriers

Study participants reported a variety of personal barriers to leadership (Table 4, Appendix 7), including a lack of early mentorship, limited experience, and competing demands. Societal barriers included themes related to natural disasters, racism, and sexism. Professional barriers included themes related to institutional challenges.

Conclusions

Leadership and Identity

Our study found that family physician leaders have dual professional and personal identities, as evidenced by the abundance of personal and professional titles and descriptors that they used when asked to describe themselves. Three participants identified themselves as underrepresented in academic medicine leadership because of their specialty, suggesting that some family physicians may feel isolated in high-level leadership positions. While loneliness or isolation may be multifactorial and common among leaders, little research has examined feelings of loneliness specifically among physician leaders; this presents a possible area for future study.[7]

Participants most frequently reported feeling underrepresented in academic medicine leadership because of their gender, a finding supported by the literature. While a 2019 investigation of specialty, gender, and race/ethnicity of deans of allopathic schools demonstrated an increase in the percentage of women deans to 18%, women continue to be underrepresented at the highest levels of academic medicine leadership.[8]

We found no common leadership position among the study participants, with interviewees noting positions equally within and outside of family medicine. Our findings are limited to physicians, as we had no participants with backgrounds in other training fields. Physicians' career decisions were most influenced by personal factors, suggesting that personal and familial support may need to be combined with professional development to facilitate career advancement. Not surprisingly, family physician leaders overwhelmingly describe resonant leadership styles, which align with the values and ethos of family medicine training.

Leadership and Professional Development

Family physician leaders reported participating in numerous leadership development opportunities, both within and outside the specialty, at various stages of their professional timeline, including early in their careers and at career turning points. Membership in professional organizations was noted as important to leadership development, likely because these memberships may lead to opportunities for involvement in task forces, committees, or other programs. Most interviewees emphasized the importance of mentorship and access to

networks for career advancement. Additionally, teaching, clinical, and research missions equally impacted leadership experiences. This finding supports the idea that the diversity of the specialty of family medicine helps build leaders—people who lead collaboratively and build alliances within and between teams, much like the alliance between a family physician and a patient.

Limitations

While factors such as race, ethnicity, sex, gender, and age are well-known to influence leadership philosophy and career opportunities, given the small sample size, the need for anonymity for participants, and the exploratory nature of our study, we chose not to focus on detailed and categorized demographic data of our interviewees. Additionally, the generalizability of our findings may be limited because all participants were recruited through STFM; family physicians outside this network may have different experiences, characteristics, and philosophies. Given the qualitative nature of our study, all information was self-reported; perceptions of leadership styles may be influenced by self-perception and bias. Additionally, we allowed leaders to self-identify, thereby resulting in interviews of people across a spectrum of leadership positions; a future study limited to one role (eg, medical school deans) may provide more consistent or nuanced findings. Furthermore, while the initial intention of this study was to examine the experiences of all family medicine leaders, only physicians responded to our recruitment efforts, thereby limiting our study findings to family physician leaders.

Our qualitative, hypothesis-generating study suggests that no singular skill set, philosophy, or characteristic is required for family physicians to obtain leadership positions. Future research should explore the characteristics and philosophies of family physicians in distinct roles, such as deans, chief executive officers, and designated institutional officials, as well as the leadership experiences of family medicine leaders who are not physicians. This research could help support the diverse training backgrounds of those who contribute to the specialty of family medicine and enable family physicians to make informed choices aligned with their unique skills, philosophies, and characteristics, ultimately enhancing their leadership trajectories.

Tables and Figures

Table 1. Leadership Style Philosophy

Style type	Leadership style	Codes	Representative quote
Resonant	Affiliative	Love over fear	"I think that I am a trusting and accepting person. I think that in my leadership role I am quite tolerant of a wide range of ways that people contribute to the organization."
		Elevating others to come together	
		Investing in team	
		Focus on culture and values	
		Trust, respect, integrity, honesty	
		Provide resources	
		Servant leader	
		Defined by the success of others below	
		Relationship focused	
		Let people be people	
		Assume best intentions	
		Approachable	
		Leading by example	
	Coaching	Be the mechanism	"The best preparation . . . was being a family doctor. I never knew what was going to walk into the door, so I had to be prepared to be diverse in problems. . . . Hell of a lot of counseling skills, just like you do in the exam room with patients."
		Recognize talent	
		Promote development	
		Counseling skills	
		Educate/negotiate	
	Democratic	Variety of perspectives/inclusive	"I try to be participatory and I aim for consensus. I remember many times defining consensus for people in a variety of meetings at many organizations. . . . Consensus means not necessarily agreeing with but being willing to live with a decision."
		Egalitarian and nonhierarchy, democratic style, consensus	
		Participatory	
		Transparency	
	Visionary	Say yes to any challenge	"I tend to set out a vision or a goal and then give people a lot of autonomy to allow them to accomplish that goal."
		Driven by the why	
		Setting a vision	
		Make bold choices; be the decision-maker	
Dissonant	Pacesetting	Leading not managing	"It's essentially: 'Hey, I'm going to work hard and show people how to do this' and then hope others adopt that similar attitude or trade."
		Pacesetter	
	Commanding	(none)	

Note: The self-reported leadership style philosophy was coded according to Stoller's definitions.[5]

Table 2. Family Medicine Approach to Leadership

Leadership competency,[5] subcompetency*	Codes	Representative quote
Knowledge of health care Quality assessment and management*	Population health approach	"We're family docs because that's truly how you make people and populations healthier . . . to get good people who want to be part of your team and want to do what you're doing and want to lean in and engage."
Problem-solving	Seeks resources to answer problems	"If you have a problem, do you know where to go to get that problem fixed?"
Communication	Patient centeredness	"My job is to make sure that things work for people that are trying to work for me."
	People-oriented	
	Approachable	
	People skills	
	Desire to stay connected and involved	
	Interprofessional experience perspective	
	Motivational interviewing	
Communication Leading groups*	Listening to every voice/listening skills	"I think it's a give and take really. So, I think, to be a good family physician you have to know how to play as a team and what a team does and what patient centeredness is really all about."
	Engaged with everyone	
	Team player	
Communication Negotiation*	Give and take	"I think it's been a give and take that my leadership informed my family doctoring."
Commitment to learning	Breadth of training	"Just being eager to participate in things and learn more. I think that that was probably part of the reason that I was even approached about [a position]."
	Comprehensive approach	
	Took on opportunities	
	Continues to keep changing and growing	
	Eager to participate and learn	
	Chief resident	
Emotional intelligence	Compassion	"We feel really comfortable with gray. We don't always have the answers right away. We're not black and white, but in some areas we may be, but for the most part we're comfortable with gray."
	Align with others	
	Comfort with broad or unexpected issues	
	Comfort with uncertainty	
	Comfort with working in the gray	
	Working in any environment	
	Admit to not knowing everything	
Fixed mindset	N/A	

Note: All competencies are self-reported.
*Subcompetency (listed when applicable)
Abbreviation: N/A, not applicable

Table 3. Career Contributors to Leadership Trajectory

Themes	Subthemes	Representative quote
Personal trait	• Grit • Drive to be and do better • Observant • Willing to take feedback	"Always being willing to take feedback and make changes. You know, I mentioned I was probably too authoritarian and too demanding early on in my career, and that kind of feedback is not easy to take. But being willing to hear it and change is what enabled me then to go further."
Approach	• Skill mastery • Political exposure • Luck • Adaptability • Saying "yes" to opportunity • Always doing a good job • Active mentee	"Always doing a good job, you know. Fulfilling my commitments. You know, if I said I was going to do something, I would do it. It may have taken longer than planned, but I would get it done and that also led to my being given other opportunities."
Resources	• Networking outside of FM • Networking inside FM • Academic fellowship • Mentor/sponsorship • Professional organizations	"I learned a lot on the job; I learned a lot through STFM and other people and ADFM when I was a department chair. Those organizations and going to those meetings helped immensely. I didn't ever have a single mentor, but I certainly met people in similar roles or who had been before me who I could email or talk with or see at a conference."
Experience	• Student government • Clinical leadership • Exposure to influential people • Exposure to minority communities • Breadth of experience • Quality Improvement background	"I think having a broad breadth of experiences as a chair and in the military and then in the civilian world, in my first job out of the military in Vermont, really put me in a great position."

Abbreviations: FM, family medicine; STFM, Society of Teachers of Family Medicine; ADFM, Association of Departments of Family Medicine

Table 4. Biggest Barriers or Challenges to Career Advancement

Themes	Subthemes	Representative quote
Lack of mentorship	• Lack of family members in medicine	"Not having family mentorship in higher education, not really having that voice that could say and guide you while you're trying to find your way, I think that's a barrier."
Personal perspective	• Lack of enjoyment with the work • Differing perspectives • Imposter syndrome	"So, I think that there are barriers there that are partially real and partially in my head for sure. The whole idea of like fake it 'til you make it. I think that that's hard for women, it's hard for family docs. I mean, we know everyone in the world has impostor syndrome."
Institutional	• Faculty unwilling to change • Political leadership decisions • Competitive academic environment • Lack of institutional support • System barriers	"I think the biggest barriers were the high degree to which certain parts of the department or certain parts of the school, certain staff members, certain faculty members were just dug in and unwilling to change."
Lack of experience	• Not knowing what I didn't know	"I think one of the hard parts when you're first Gen, and I imagine this first Gen of medicine, in addition to first Gen of college, it's a culture shock and not knowing."
Competing demands	• Competing family, personal, and professional obligations • Burnout • Location locked based on family	"So, my number one barrier was really that we were location locked, meaning I had to find opportunities where my husband was stationed in the Navy."
Racism	• Being Latino • Minority tax • Race	"Yeah, the barriers I overcame was just being Latino. Oh, you got it just because of affirmative action, you got it just because you were Latino sort of thing. That's even before people even know the merits."
Natural disasters	• Natural disasters	"Two years after Katrina, I was so frustrated and burned out that it precipitated a sabbatical."
Sexism	• Gender • Perceptions of effective style as a woman leader	"[Institution] is an all-white, male institution when it comes to leaders, it's a cultural thing. Things are changing, but you have to be persistent . . . and they're looking at a female who is not white . . . you can be easily overlooked. So, you really have to create your place and your worth . . . to prove yourself."

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Conflict of Interest Statement:

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