Leadership Styles and Leading Clinicians

By Dr. Robert Moore, Chief Medical Officer

“The fact that we have the term "servant leadership" means to me that the definition of leadership is broken. To lead is to have a service orientation.” –Stephen Shedletzky, author of *Speak Up Culture.*

Job interviews for leadership positions often include the question, “what is your leadership style?” How does one answer such a question? Formal leadership training programs invariably include content on leadership styles which have been described and analyzed over the last few decades.

Before considering these, I will digress and note that there are centuries of writings in non-western cultures examining leadership frameworks with roots in the different cultural values in other societies. Descriptions of leadership are all frameworks that may ring true for some cultural and organizational settings, but are dependent on the place, time and mindset of the leaders being considered. This is an area of great interest to those working in companies with a multinational workforce. An excellent review article on this topic was written in 2019 by Vietnamese education scholar Nhung-Binh Ly.

The English-language leadership literature collectively includes more than 20 different leadership styles, although several are similar enough to be grouped together. Most authors select three to eight styles and describe these in more digestible comparisons. Here is a list of leadership styles that might apply to leaders of clinicians based in California:

1. Top-down Leadership: Autocratic, Authoritarian, Bureaucratic, Coercive, and Commanding

   These styles are more common (but not universal) in military, veterans administration, and large, bureaucratic organizations. In these cases, leaders make decisions themselves with little input from anyone else. This works best if the leader’s knowledge and experience is much greater than that of their followers, when decisiveness is critical (such as emergency settings), and when following a hierarchy or dogma is highly valued. Downsides include stifling of innovation and feedback and disengaging of employees. In a setting of clinician shortages where clinicians are free to change jobs, this will lead to turnover in staff. Several years ago, a medical school classmate of mine had an autocratic leader of a community health center in Washington state; the entire clinical staff quit simultaneously.

   Turnover is less likely when there is a significant penalty for a clinician to leave a position, such as a military enlistment contract, restrictions associated with immigrant visa status, a requirement to pay back a sizable advance or loan, or loss of large retirement benefits (sometimes called golden handcuffs). There is a cost to such binding covenants: those who stay in a position unwillingly will often be less efficient and empathetic towards patients.

2. Minimal Oversight: Laissez-faire, Delegative, or Absentee Leadership

   These “hands-off” approaches assume that each clinician has their own way of practicing medicine and organizing their work which can be allowed to exist without interference. Many

clinicians are partial to bosses who have this approach, feeling that their autonomy and expertise are being honored and respected. This comes with a cost, however: wide variation in practice styles leads to lower office productivity and office staff dissatisfaction associated with the mental gymnastics of meeting many different individual clinicians' idiosyncratic "rules." Similarly, improving quality of care across a practice requires standardization of processes, which is difficult in a delegative leadership environment.

3. Bottom-Up Leadership: Participative, Consensus-based, Collaborative and Democratic

   Inspired by the ideals of egalitarianism, in these leadership styles, team members are encouraged to work together and give meaningful input into policies, decisions, and strategic direction. In the absence of consensus, the leader makes the final decision. This approach allows more engagement than the top-down leadership styles, but with more standardization than the minimal oversight styles. Ideally, decisions are made based on facts and quality of arguments presented by participants. In reality, there is often a social hierarchy at play with the participation process, with some participants having more sway than others not just due to the quality of the ideas presented, but by the social standing of each participant, and their desire to influence that social standing. If this social hierarchy is unchecked by a leader who is aware of these factors, the decisions made may be suboptimal.

4. Transactional Leadership

   In this leadership style, tangible rewards and punishments are used to achieve goals. In the realm of leading clinicians, the tangible rewards may be financial (e.g. productivity incentives or quality incentives), or non-financial, such as allowing clinicians more flexible schedules or non-clinical administrative roles. Behavioral economic studies show that punishments are twice as effective at eliciting changed behavior than rewards of equivalent value but using punishments on individual clinicians often leads to turnover, so it is less likely to be useful in a setting of clinician scarcity.

5. Evangelical Leadership: Visionary, Charismatic, and Pacesetter

   These focus on the leader themselves convincingly connecting the clinician work to a larger cause. Visionary leaders focus on the future state of the organization, and may or may not be able to connect that vision with the operational steps and staff motivation needed achieve that vision. Charismatic leaders tap into the human-mirror neuron system, building an unconscious desire to please the leader. Pacesetting leadership involves a hard-driving leader pushing followers to ever higher levels of excellence with no tolerance for mediocre effort or results.

6. Positive Leadership: Affiliative, Coaching, and Servant

   These are hands-on styles that seek to promote longevity and performance by being supportive of clinicians. There are some important differences in the three subtypes. Affiliative

leaders seek to create emotional bonds with followers, which can lead to hesitancy to have difficult conversations about performance and lack of feedback to leaders about organizational challenges. Coaching is important for new clinicians, but experienced clinicians may not see their boss as having the experience to be worthy of being a coach. Servant leaders attend to the needs of their high-performing staff, yet can give constructive feedback and have difficult conversations. Servant leadership was first described in 1970 in an essay by Robert Greenleaf, and many books have subsequently described and celebrated it. It has become so popular that author Stephen Shedletzgy implies in the quote above that all effective leaders are servant leaders.

7. Integrating Leadership: Adaptive, Situational, and Transformational

   In real life, clinician leaders use elements of several of the above leadership styles, depending on the situation and the characteristics of the clinician they are supervising. Having an awareness of the usefulness and limitations of each style can help a leader of clinicians choose the best leadership style for a given situation. Transformational leaders use the best elements of several of the earlier leadership styles simultaneously, conveying the vision effectively, taking input from the team, using charisma to build trust and buy-in, while serving their employees and setting an expectation of excellence.

Returning to the quote by Stephen Shedletzgy, does all leadership require a service orientation? Not necessarily, although effective clinical leaders are more likely to choose to leverage a servant leadership style, much of the time.

I close with two questions for clinician leaders to reflect upon:

- Which leadership style do you most see yourself using?
- Which leadership style do you want to strive to use more often?

Important Provider Notice: Credentialing - Locum Tenens

October 2024

Attention Network Providers: REMINDER

Locum tenens who provide services for fewer than 90 calendar days within a rolling 12-month period do not need to be credentialed. However, if they provide services at a site for more than 90 calendar days within a rolling 12-month period, they will need to be credentialed by the Partnership Health Plan of California.

The purpose of the practitioner credentials review is to ensure that participating practitioners meet the necessary qualifications – including experience, license, certification, privileges, professional liability coverage, and education – to deliver care that aligns with professionally recognized standards. This review also ensures compliance with Partnership policy and applicable credentialing and certification requirements of the State of California, the Department of Health Care Services, the Department of Managed Health Care, the Centers for Medicare and Medicaid Services, and the National Committee for Quality Assurance.

If you have any additional questions about credentialing Locum Tenens, please contact the credentialing department at Credentialing@partnershiphp.org

Resource:

- **Policy MPCR300** - Physician Credentialing and Re-credentialing requirements
  - Section VI. POLICY/PROCEDURE, B. Initial Credentialing Criteria, 8. Locum Tenens

Removal of Prior Authorization Requirements for Many Imaging Studies

Partnership's medical directors did an exhaustive review of imaging studies that require prior authorization and have decided to remove the TAR requirement for studies with a low probability of being inappropriately ordered.

Effective immediately, Partnership has removed the prior authorization requirements for the following studies:

- CT scans and MRI scans of the spine, head, neck and extremities
- CT angiography (any body part)
- MR Elastography

The following still require prior authorization:

- CT scans and MRI scans of the chest, abdomen and pelvis
- CT scans for patients under the age of 21
- MR angiography (any body part)
- PET scans
- Unspecified scans not covered by Medi-Cal (with CPT ending in 99).

For full list of radiological studies no longer a requiring a TAR, see the Important Provider Notice.
Changes listed in the Important Provider Notice only apply to adults.

Please note: It is important that providers always perform and document a physical examination prior to ordering an advanced imaging study. While the above CT/MRI scans will no longer have 100% TAR review, we will look for patterns of over-ordering and refer clinicians with a pattern of over-ordering to our Quality team to review for potential over-utilization. Thus, we ask our clinicians to be careful in their evaluations and documentation, even when ordering CT/MRI that don't require a TAR.

Addressing Challenges in Perinatal Care

March 10, 2025

9 a.m. – 4 p.m.

Eureka | Fairfield | Redding

To register, please click here
or scan the QR code below.

Join Partnership HealthPlan of California as we discuss timely, important topics to improve perinatal services in our network.

Topics Include:

- **Diabetes Management in Pregnancy (Sweet Success)**
- **Infectious Diseases in Pregnancy**
- **Role of Midwifery in Improving Quality and Access**
- **Substance Use Disorder/Opioid Use Disorder and Medication-Assisted Treatment**

Check-in starts at 8:15 a.m. and opening remarks start at 9 a.m.

Continental breakfast and lunch will be served.

Registration ends on Friday, February 21, 2025

AAFP CME and BRN CE continuing education credit will be available.

Questions? Contact Liezel Lago at LLago@partnershiphp.org

ABCs of Quality Improvement

PartnershipHP.org (800) 863-4155

The ABCs of Quality Improvement is a training designed to teach you the basic principles of quality improvement:

- Introduction to Quality Improvement and the Model for Improvement
- Learn how to create an aim statement (project goal)
- Learn how to use data to measure quality and drive improvement
- Tips for developing change ideas for improvement
- Testing changes via the Plan-Do-Study-Act cycle

Who should attend? *This course is designed for clinicians, practice managers, quality improvement team members, and staff who are responsible for participating and leading quality improvement efforts within their organization.*

Date: Thursday, January 30, 2025
Time: 8 a.m. – 4 p.m.
Location: Ukiah Valley Conference Center
200 S. School Street, Ukiah

Registration and light breakfast from 8 – 8:30 a.m.
Lunch will be provided.

Registration is FREE

Scan me

*The AAFP has reviewed ABCs of Quality Improvement (QI) and deemed it acceptable for AAFP credit. Term of approval is from 11/07/2024 to 11/07/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session ABCs of Quality Improvement (QI) is approved for 5.50 Live AAFP Prescribed credits. **Provider approved by the California Board of Registered Nursing, Provider Number CEP16728, for 5.50 contact hours.

Questions: *Email improvementacademy@partnershiphp.org*

UCI School of Medicine

Train New Trainers

Primary Care -Training and Education in Addiction Medicine (PC-TEAM)

One-Year Fellowship Training

Innovative and Targeted Training to Optimize the Treatment of Substance Use Disorders

Fellowship Objective:

UCI TNT PC-TEAM Fellowship is a comprehensive certificate program specifically designed to address substance use disorders (SUDs) and pain related conditions most frequently encountered in primary care. TNT PC-TEAM uses the existing and successful curricular foundation from the TNT Primary Care Psychiatry (PCP) Fellowship and incorporates high-yield topics in the treatment of SUDs to promote the development of SUD treatment champions.

This is not a traditional or ACGME- approved fellowship. The TNT PC-TEAM year-long clinical education certificate program is intended mainly for primary care and ER-oriented clinicians interested in advanced SUD training and opioid management. Fellows will learn how to complete evidence-based substance use screening in busy primary care or other general medical settings. TNT PC-TEAM fellows will also be trained to effectively *prevent*, *diagnose*, and *treat* commonly encountered substance use and pain-related disorders (e.g., opioids, alcohol, stimulants, and benzodiazepines). Most importantly, graduates will be thoroughly trained in SUD and, as TNT PC-TEAM Champions, know how to train other providers.

UCI School of Medicine

Multi-faceted Curriculum

The following is an outline of the curriculum, developed by the UCI School of Medicine Train New Trainers PC-TEAM faculty. The Fellowship includes more than 45 required hours of training and results in a certificate of completion from UCI School of Medicine:

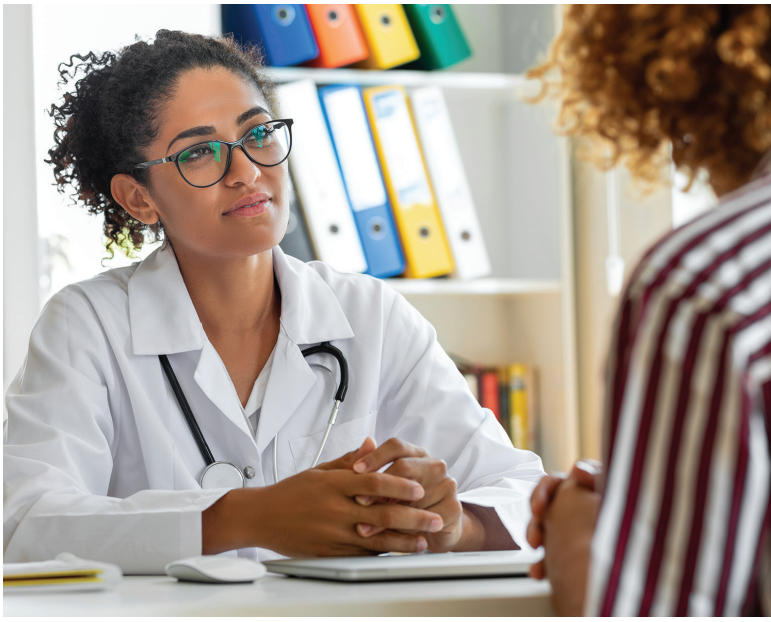
- Two in-person teaching conferences (approximately 25 CME hours)
- Live, case-based discussions with a focus on primary care pain and addiction-related disorders and treatments twice a month (at least 20 CME hours)
- Monthly small group mentorship sessions with a PC-TEAM faculty mentor
- Complimentary lifelong learning for TNT PC-TEAM alumni

TNT PC-TEAM Fellowship Curricular Topic Overview:

- Substance use and withdrawal symptoms
- Responsible use of opioids / Medication for Opioid Use Disorder (MOUD)
- Assessment and treatment of common pain conditions in the context of SUD prevention and management

Core Topics Include:

- Addressing Health Disparities in Addiction Medicine
- Medication for Opioid Use Disorder (MOUD)
- Chronic Pain Management and Opioid Prescribing
- Common Pain Disorders and Treatment Considerations
- Prevention, Assessment, Diagnosis, and Treatment of:
  - Nicotine Use Disorder
  - Sedative/Hypnotic Use Disorders
  - Alcohol Use Disorder
  - Stimulant Use Disorder
  - Cannabis Use Disorder
- Special Populations- Adolescents & Children
- Motivational Interviewing



This activity series has been approved for *AMA PRA Category 1 Credits*™.

Reading materials will be provided. Emphasis will be placed on how to provide culturally and linguistically competent and person-centered clinical care. Pre, mid, and post-testing will measure practice patterns and general knowledge in primary care addiction and pain management.

2023 Tuition: $15,500

Target Audience:

- MDs
- DOs
- NPs
- PAs

For more information about the fellowship, please contact us at **tntpcteamfellowship@hs.uci.edu**, 949-824-4910 or visit **www.meded.uci.edu/CME/PC-TEAM.aps**

UCI School of Medicine

Train New Trainers

Primary Care -Training and Education in Addiction Medicine (PC-TEAM)

One-Year Fellowship Training

Innovative and Targeted Training to Optimize the Treatment of Substance Use Disorders

Who Benefits?

The program is designed for primary care providers working in Internal medicine, Family medicine, Emergency medicine, Pediatrics, or Neurology. Past fellows have included MD, DOs, NPs, and PAs.

Curriculum

The following is an outline of the curriculum, developed by the UCI School of Medicine Train New Trainers PC-TEAM faculty. The Fellowship includes more than 45 required hours of training and results in a certificate of completion from UCI School of Medicine:

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Goals of PC-TEAM Fellowship

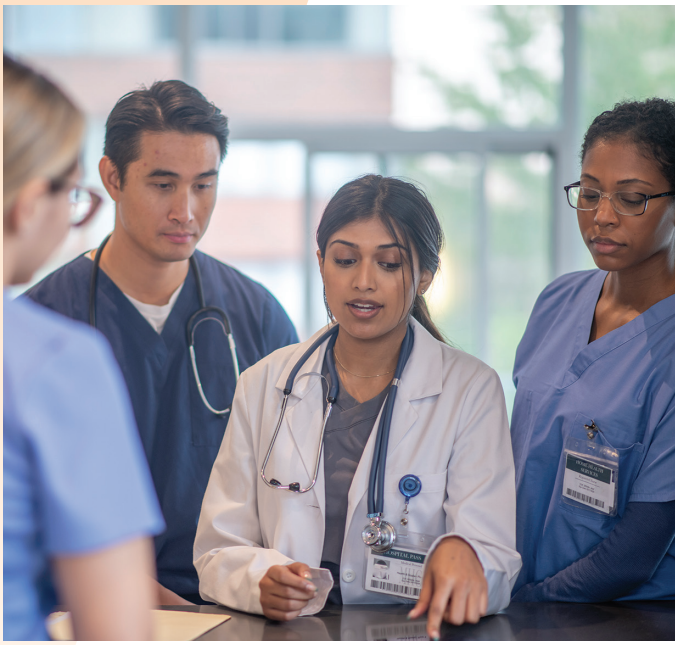
Trainees will learn:

- How to complete an evidence-based substance use screening in busy primary care or other general medical settings.
- How to effectively prevent, diagnose, and treat commonly encountered substance use and pain-related disorders (e.g., opioids, alcohol, stimulants, and benzodiazepines).
- How to teach these principles to their primary care colleagues

UCI School of Medicine

Tuition

$15,500 per fellow OR applicant may be eligible for a full scholarship. Upon acceptance to the TNT PC-TEAM Program, a scholarship application will be sent with instructions for completion and submission for consideration by the Department of Health Care Access and Information (HCAI).

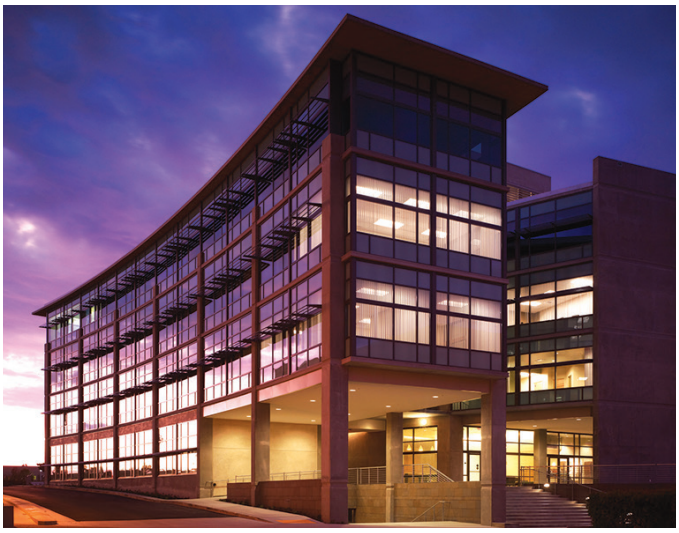


This is not a traditional or Accreditation Council for Graduate Medical Education (ACGME) approved fellowship.

Department of Health Care Access and Information (HCAI) Scholarship

You must meet the minimum requirements to be considered:

- Be currently employed or have accepted employment as a primary care provider (MD, DO, NP, PA) in the following specialties: family medicine, internal medicine, OB/GYN, or pediatrics
- Work at a qualifying practice site in a Federally Qualified Health Center/lookalike, Health Professional Shortage Area – Primary Care (HPSA-PC) or Primary Care Shortage Area (PCSA) in California
- Work at a practice site with at least 50 percent of patients from a medically underserved population (Medi-Cal, uninsured, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level)
- Currently, serve or plan on serving children and youth 25 years of age or younger



For more information about the fellowship, please contact us at **tntfellowship@hs.uci.edu**, 949-824-4910, or visit medschool.uci.edu/pc-team.