SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE, 2017
VOL. 35, NO. 1, 105–110
http://dx.doi.org/10.1080/02813432.2017.1288819

RESEARCH ARTICLE

OPEN ACCESS

# General practitioners' views on leadership roles and challenges in primary health care: a qualitative study

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**ABSTRACT**

**Objective:** To explore general practitioners' (GPs) views on leadership roles and leadership challenges in general practice and primary health care.
**Design:** We conducted focus groups (FGs) with 17 GPs.
**Setting:** Norwegian primary health care.
**Subjects:** 17 GPs who attended a 5 d course on leadership in primary health care.
**Results:** Our study suggests that the GPs experience a need for more preparation and formal training for the leadership role, and that they experienced tensions between the clinical and leadership role. GPs recognized the need to take on leadership roles in primary care, but their lack of leadership training and credentials, and the way in which their practices were organized and financed were barriers towards their involvement.
**Conclusions:** GPs experience tensions between the clinical and leadership role and note a lack of leadership training and awareness. There is a need for a more structured educational and career path for GPs, in which doctors are offered training and preparation in advance.

**KEY POINTS**

- Little is known about doctors' experiences and views about leadership in general practice and primary health care. Our study suggests that:
- There is a lack of preparation and formal training for the leadership role.
- GPs experience tensions between the clinical and leadership role.
- GPs recognize leadership challenges at a system level and that doctors should take on leadership roles in primary health care.

**ARTICLE HISTORY**
Received 27 August 2016
Accepted 15 January 2017

**KEYWORDS**
General practitioners; primary health care; leadership; general practice; Norway

## Introduction

The majority of general practitioners (GPs) in Norway work as private contractors with the municipalities through the regular GP scheme that was introduced in 2001 [1]. Practices are usually private and financed through a combination of capitation from municipalities (30% of income), patients' co-payment and reimbursement from Norwegian Labour and Welfare Services (70%) [2]. GPs are thus self-employed and employ their staff; and they own their medical equipment, while office space can either be owned by the GPs or rented privately [3]. Other forms of practice organization includes salaried position with or without bonus and a modified version of private practice, in which the GPs hire staff, equipment, and office space from the municipality [3]. GPs are mainly organized in small teams consisting of a few doctors and some health secretaries with 1–2 years of health education [4].

While there has been considerable attention about doctors as managers in other parts of the health system [5,6], less attention has been devoted to doctors as managers in primary care, specifically in general practice. Research on leadership in general practice denotes the lack of formal management training and the reliance on ad hoc solutions for solving leadership challenges [7,8]. A study found that GPs in Ireland were influenced by structural and role-related factors when attempting to lead, such as the private ownership structure, the lack of management training, and the primacy of their clinical identity in daily work [8]. A Norwegian study found that GPs with formal

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leadership roles in rural primary care facilities felt unprepared for the leadership role and that GPs prioritized clinical work and sought ad hoc solutions to leadership challenges, taking on a problem solving or leadership by exception approach, i.e. waiting for a problem to arise before taking action [7]. There is a need for more knowledge on how GPs think about leadership roles and leadership challenges in general practice, especially in a Scandinavian setting.

Being engaged in developing and teaching a course on leadership in primary health care for Norwegian GPs, we wanted to explore GPs' views on leadership roles and leadership challenges in general practice and primary health care. We found that an explorative qualitative study was suitable in order to get insight into GPs' own perspectives and views on leadership roles and leadership challenges in general practice and primary health care. Leadership involves influencing others to bring about change [9], while management usually refers to achieving specific results through planning, organizing and problem solving. While some scholars consider leadership and management to be different constructs [10], others regard them as integrated and interrelated concepts [11]. We use the terms interchangeably in this article.

## Materials and methods

### Participants

We conducted four focus groups (FGs) among 17 GPs (11 men and six women, mean age 49, age range 34–64) who attended a 5 day course on leadership in primary health care that was jointly arranged by the University of Oslo and The Norwegian Medical Association. The course content covered theories and models about leadership, communication and conflict resolution. All of the course participants were invited to participate in the study. None of them declined to participate.

### Focus groups

The FGs were conducted at the end of the course, following a thematic interview guide that was developed by the authors. Participants were asked to recount typical leadership challenges in general practice and primary care, and how to facilitate GPs' involvement in leadership and management of primary health care. Each FG lasted for 30–60 min and consisted of three to five GPs and one moderator (IS, HS, ER or JCF).

### Written assignments

As part of their participation in the leadership course, the participants were instructed to hand in a written assignment (about 2000 words), in which they discussed a leadership challenge from their own practice or in primary health care in general. Students were informed about the written assignments before the course, and were required to hand them in electronically after the end of the course. Therefore, students were able to start writing on their assignments before the FGs were held. These assignments were read and analysed independently by IS and JCF with special interest on themes that could challenge, support or add additional insights to the focus group data.

### Data analysis

The material was analysed by all authors using systematic text condensation, which is a method for thematic qualitative analysis [12]. IS, HS and JCF did an initial analysis of the focus group transcripts for recurrent themes. This resulted in an agreed-upon coding frame. IS and HS coded the FGs and IS coded the written assignments. The analysis followed four steps: (1) reading all the materials to obtain an overall impression and bracketing previous preconceptions; (2) identifying units of meaning representing different aspects of leadership in general practice and primary health care, and coding for these units; (3) condensing and summarizing the contents of each of the coded groups; and (4) generalizing descriptions and concepts concerning leadership in general practice and primary health care. Quotes from the interviews were translated from Norwegian to English by the authors.

### Ethics

Approval to conduct the study was granted by the Norwegian Social Science Data Services (ref: 48814/3/ASF). Written consent to participate in the study was obtained from all of the study participants.

## Results

Our findings are organized under four themes: The leadership role, leading colleagues, leading employees and leading and managing the primary health care system. A number has been assigned to each FG and participant in each group.

### The leadership role

The participants noted that the role as doctor could be challenging to combine with a leadership role,

because doctors were trained to be mild-mannered and to be comforting and kind in relation to patients. A common theme was that GPs found it difficult to be strict and to sanction employees when they thought this could be appropriate. One respondent described this as a "handicap", while another used the term "an occupational injury". Participants reported a lack of leadership and management training, and consequently they tried to use their medical expertise and approach in situations that required management skills. Still, the participants expressed that the medical role was not sufficient in dealing with these challenges, as underlined by one GP: "I want to do the best I can [ … ], but I can't get that from my medical background. I need more than what I have" (FG4, participant 2).

Participants told that a flat hierarchical structure in group practices was commonplace and that members of the practice often rotated roles, such as manager, responsible of the IT infrastructure, responsible for employees or finance manager. Respondents noted that leadership issues often were handled with a laissez faire approach, with actions that were based on "reflexes", as stated by one participant: "We have practiced leadership without a foundation for it, other than our own attempts at common sense" (FG3, participant 1).

Participants also told about a lack of self-confidence in taking on leadership roles, and pointed out that leadership courses and training were important for building self-confidence in the role. Moreover, participants noted a need for more awareness of the leadership role in general practice, because the role could easily be forgotten in a workday characterized by a high-clinical workload.

One theme related to taking on the leadership role was the experience of a form of performance anxiety or fear of mismanaging, which could prevent GPs from taking on leadership roles. Participants described themselves as competent professionals who were expected, both by themselves and others, to perform on a high level. A GP stated:

"I would never voluntarily step into a management position without having acquired [management] competence. Because then I would feel that I'm doing something I don't know how to do. Like being a doctor without having attended medical school. [Management] is an important discipline and a dangerous discipline to perform without having the competence. Because you risk mismanaging" (FG2, participant 2).

### Leading colleagues

Participants underlined the importance of autonomy for GPs, and noted that it was challenging to find a balance between professional autonomy and control. A participant described GPs as "the most autonomous in an autonomous profession" (FG4: participant 5), while another participant stated:

"It's not easy to lead a herd of cats [ … ]. I think many general practitioners belong to the cat category, they're very independent and are not very fond of people who tell us how to do things" (FG1, participant 2).

Another challenge was related to the non-hierarchical organizational structure. According to participants, many small practices were in reality driven as independent solo practices under the same roof, with little formalization in terms of cooperation, routines and procedures. Participants told that it could be challenging to lead peers who had more clinical experience than themselves, especially within a rotating leadership structure, which limited the extent to which they practiced leadership over their colleagues: "Everybody is a little careful, because they know that in the next round they will be led by someone else. So that's limiting" (FG3, participant 3).

Even if it appeared to be a consensus about the need for a more formalized leadership structure, participants told that it was challenging to incorporate this because they had no possibility of sanctioning other GPs. Many of the participants worked in practices where the GPs had agreed on rules and guidelines, but in instances where someone chose to not follow the rules, there was nothing to be done to sanction them formally.

Similar themes were brought up in the participants' written assignments, specifically the challenge of leading colleagues in an organizational culture that emphasized individual autonomy and the question of how to sanction those who did not abide by the rules.

### Leading employees

Participants told that it was challenging to lead their employees (which were predominantly health secretaries), because it was difficult to gain insight into their motivations and expectations. Participants noted that secretaries appeared to have lower aspirations towards their work place and work assignments compared to GPs. Some participants had tried to encourage their secretaries to take on new, developing challenges, but told that they were surprised to find that the secretaries did not want to assume new responsibilities. These accounts illustrated a form of cultural gap between the GPs and secretaries, in which GPs found it hard to lead and motivate the latter group.

"We don't really know what their ambitions are. Where they want to go. They may not necessarily think the same way as we do" (FG4, participant 2).

Some respondents contemplated whether GPs should become better at involving the secretaries in change processes in order to increase their sense of affiliation and involvement, and to give the GPs better insight into their expectations and preferences.

Participants mentioned that the current challenges related to the employer role could be a "teaser" (FG4, participant 2) for the future, because of the trend for general practices to evolve into bigger multidisciplinary centres. They noted a need for more knowledge about how to lead employees with different backgrounds from themselves.

The themes that were identified in the participants' written assignments reinforced the impressions from the focus groups. The majority of the themes were centred on challenges related to leading the secretaries. These involved conflict resolution and motivating the employees to take on new responsibilities or change their work routines. The experience of a cultural gap between doctors and secretaries were also notable in these descriptions, especially in how GPs struggled to motivate the employees through change processes.

### *Leading and managing the primary health care system*

Participants argued that GPs were important candidates for leadership positions in primary care, because they had more knowledge about medical aspects than other professional groups, and, therefore were crucial contributors to the design of future primary care services.

Participants told that the motivation to lead and take on management positions in primary care (i.e. in the municipalities) had been low among doctors, but that the influx of other non-medical professionals and occupational groups into management had motivated them to become more involved in leadership- and organizational processes. There was an experience of GPs being left out from decisions affecting their work. A participant gave an example of how the municipalities developed cooperation agreements with hospitals with regard to treatment decisions without involving GPs:

"The GP is stuck with the work, but we haven't been involved in the process in any way" (FG3, participant 3).

Formalization of leadership competence through formal courses and diplomas was seen as a necessity for being able to compete with other occupational groups for management positions. Participants mentioned nurses as a professional group that had been early to pursue formalized degrees in management, and, therefore, were strong competitors for leadership positions in primary care.

Although the GPs spoke of a need to become more involved in leadership processes in primary care, they told that it was difficult to take time off from work to participate in daytime meetings at the municipality level, because this could mean a significant financial loss for their business. The GPs recounted that they had been invited to participate in councils and committees, but that it was hard to participate without some form of financial support scheme.

## Discussion

### *Principle findings*

Our study suggests that the GPs experience a need for more preparation and formal training for the leadership role, and that they experienced tensions between the clinical and leadership role. GPs recognized the need to take on leadership roles in primary care, but their lack of leadership training and credentials, and the way in which their practices were organized and financed, were barriers towards their involvement.

### *Strengths and weaknesses of the study*

The authors of this article were involved in developing and teaching a course on leadership in primary health in which the GPs in this study participated in. Although the authors had a dual role as teachers and researchers, the material for this study was based on participants' own experiences with and views on leadership. Because the GPs in our study participated in a course in leadership, they may have constituted a selection of doctors who were more interested in leadership than the average GP. However, by recruiting these doctors, we were able to elicit the accounts of GPs who had experience in management roles. There were similarities in how participants described their views on leadership roles and challenges across all of the focus groups, which increases our confidence in the results. Our results are also in line with previous studies on doctors in hybrid roles, and thus we think that our results may be transferable to other GPs who combine a role as clinician and leader. A limitation of our study is that we only elicited the experiences of GPs, and not of their employees or other groups in primary health care.

### *Occupying a hybrid role*

GPs who combine a medical background with managerial tasks and responsibilities occupy a dual role as doctor and manager. Previous studies have shown that hybrid roles can present challenges related to identity and role conflicts [8,13–15]. Role conflict has been defined as the simultaneous existence of two or more incompatible expectations for a person's behaviour [16]. In our study, it seems that the challenges in GPs' hybrid roles stem from three sources, which may all contribute to role conflict: (1) the emphasis that GPs place on autonomy; (2) the lack of a formalized leadership structure; (3) the lack of management training and awareness.

Firstly, participants struggled to find the balance between directing other clinicians and granting autonomy. The challenge of managing and leading professionals with a high expectation of autonomy has been highlighted by Mintzberg [11], and one source of this role conflict seems to stem from GPs' own recognition of the importance of autonomy. GPs' wish for a more formal structure while maintaining professional autonomy creates a tension in which one element threatens to diminish the other.

Secondly, the lack of a formalized structure, in which management roles are rotated instead of fixed, could prevent the GPs from taking on an identity as leader, because the role as leader will be passed on to another. Individuals experiment with provisional identities when exploring new roles, which allow them to try out new behaviours [17]. Lord & Hall have argued: "We may see greater leader development in those individuals who are more open, exploratory, and flexible about adopting provisional identities and learning from them" [18]. The lack of formalized leadership structures and more permanent leadership roles could, therefore, be a barrier to adopting and internalizing a leader identity.

Thirdly, we found that GPs experienced a lack of self-confidence in the leadership role, resulting from inadequate training and preparedness for the role. The participants in our study argued that the clinical role limited their repertoire as leaders and was inadequate in dealing with situations that demanded a stricter approach, such as reprimanding employees or colleagues, or making decisions about long-term outcomes. Hana & Rudebeck have described GPs as "action-focused problem-solvers", and that their approach to clinical problem-solving can rub over to their leadership behaviours: "The more strained the situation the more probable it is that "clinical reflexes" also dominate leadership behavior" [7]. Such an approach limits GPs' overview and prevents them from taking long-term structural actions. The lack of competence in the leadership role, together with the primacy of the clinical identity, might serve to create internal tensions and conflict in GPs.

A previous study of clinicians' experiences of becoming managers in hospitals [19] found that their trajectories had left them ill equipped for dealing with their new role. A central feature of their trajectories was the lack of knowledge and awareness about management and the experience of being thrown into the management position. These accounts appear to be similar to those of the GPs in our study, and should, therefore, be a concern for both stakeholders and educators.

### *Leading in primary care*

While Norway has a strong primary health care system, the system is in a mode of transformation due to demographic changes, a coordination reform, and political signals about more multiprofessional team organization [4]. Leadership training for GPs may serve two separate purposes. Firstly, the GPs in our study recognized the need to improve their leadership skills in order to become better leaders in their own practice and in the system. Secondly, they viewed the formalization of leadership competencies as a prerequisite for competing for leadership and management positions in primary care. However, the way in which their practices are organized and financed implies that the very process of engaging in leadership processes outside of their own practice has an immediate and negative effect on their own work. This might pose a challenge for GPs' involvement in decision-making processes in primary care, even if they obtain formal leadership credentials. Greater involvement of doctors could probably be achieved if the system facilitates and supports doctors' engagement in health care planning, improvement and leadership.

### *Implications*

There is a trend in healthcare towards larger, multiprofessional practices and health centres. The need for leadership and management competency in general practice will likely increase. If policy makers and stakeholders want to include GPs in leadership positions in primary care, they should tailor a more formalized and structured career path for GPs, characterized by early and on-going leadership education. The curriculum should be adapted to the specific challenges noted in this study and should include components related to

communication, motivation and conflict resolution. In addition to general management skills and competencies, training should include role and identity processes and how to lead multidisciplinary teams. Involvement in leadership decisions also requires that GPs themselves demonstrate willingness and initiative towards taking leadership roles in primary care.

## Conclusion

GPs experience tensions between the clinical and leadership role and note a lack of leadership training and awareness.

## Acknowledgements

We wish to thank the 17 GPs who participating in the focus group interviews.

## Ethical approval

The participants gave written informed consent to the study. The Norwegian Social Science Data Services (ref: 48814/3/ASF) approved the project. Approval from the Regional Ethics Committee was not required.

## Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

## Funding

All authors' salaries were funded by their host institution. No funding body was involved in manuscript preparation or the decision to submit the manuscript for publication in Scand J Prim Health Care.

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