Received: 11 April 2022 | Revised: 5 July 2022 | Accepted: 8 July 2022

DOI: 10.1111/medu.14875

RESEARCH ARTICLE

LEADERSHIP

Perspectives on physician leadership: The role of character-based leadership in medicine

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Funding information
Associated Medical Services (AMS) Phoenix Fellowship.

Abstract

Introduction: Physician leadership is multifaceted, but leadership training in medicine often is not. Leadership education and training for physicians are rarely grounded in conceptual leadership frameworks and suffer from a primary focus on cognitive leadership domains. Character-based leadership is a conceptual leadership framework that moves beyond cognitive competencies and articulates dimensions of character that promote effective leadership. The purpose of this study was to explore the relevance of character-based leadership in the medical context.

Methods: This qualitative descriptive study used semi-structured interviews to explore health care professionals' perceptions of character in relation to effective leadership in medicine. All interviews were audiorecorded and transcribed. Consistent with descriptive qualitative inquiry, a qualitative latent content analysis was used. Simultaneous data collection and analysis incorporating character-based leadership as a theoretical framework was used to help organise the analysis of the data. The researchers met regularly to clarify coding structures and categorise codes until sufficiency was reached.

Results: Twenty-six individuals (12 doctors, 5 nurses, 2 social workers, 2 directors and a pharmacist, dietician, coordinator, administrator and unit clerk) participated. Character-based leadership resonated with participants; they deemed character essential for effective physician leadership. Participants reflected on different character dimensions they attributed to an effective physician leader, in particular, collaboration, humility and humanity. They shared examples of working in interdisciplinary health care teams to illustrate these in practice. Moreover, participants believed that effective physician leaders need not be in a positional leadership role and asserted that physicians who demonstrate character stand out as leaders regardless of their career stage.

Discussion: Our findings suggest a role for a character-based leadership framework in medical education. Participants recognised the execution of character in everyday practice, associated character with effective leadership and understood leadership in dispositional rather than positional terms. These findings provide important insights for expanding and enhancing existing leadership training interventions.

1 | INTRODUCTION

Physician leadership is multifaceted, but leadership training in medicine often is not. Leadership education and training for physicians are rarely grounded in conceptual leadership frameworks and suffer from a primary focus on cognitive leadership domains.[1,2] Character-based leadership is a conceptual leadership framework that moves beyond cognitive competencies and articulates dimensions of character that promote effective leadership. Although character-based leadership is a well-recognised approach to leadership in the business domain,[3–5] we know very little about how character-based leadership translates to the distinctive space of effective *physician* leadership.[6] Understanding the potential application of character-based leadership in the medical context may help lay the foundation for more robust physician leadership education and training.[6]

Leadership is increasingly recognised as an essential medical competency. It has been incorporated into multiple medical education competency frameworks.[7,8] For example, leadership competencies have been incorporated into training and practice standards in the National Health Service in the UK,[9] the Accreditation Council for Graduate Medical Education in the USA[10] and the Future of Medical Education in Canada.[11] This evolution in leadership competencies is also exemplified by the Royal College of Physicians and Surgeons of Canada's (RCPSC) shift from the role of a physician as manager to leader in the CanMEDS roles, the only such change to a role in CanMEDS's 27-year history.[7,12] This transition goes beyond a name change and captures an evolution in thinking about competencies that meet modern health care needs. For example, management can be understood as a set of processes, 'like planning, budgeting, structuring jobs, staffing jobs, measuring performance and problem solving', whereas leadership is more 'about vision, about people buying in, about empowerment and, most of all, about producing useful change'.[13(paras. 8–9)] Effective physician *leadership* is, therefore, deemed critical to the success of all roles of a physician, whether they be direct patient care, research, education or administration. Although leadership competencies are gaining traction, this shift has not been without critical debate.

Shifting from the notion of physicians as managers to physicians as leaders has created some controversy.[14] On the one hand, there is concern that the title of 'leader' may be viewed narrowly as positional, referencing a formal, titled role, when the term has evolved both inside and outside health care.[7] Dispositional leadership, the notion that individuals can lead without formal titles or positions, is one such evolution.[7] There is also concern that the term 'leader' may reinstil traditional medical hierarchies.[7] Emphasising physicians as leaders may be viewed as an attempt by physicians to reclaim their historical power in health care.[7] Yet present health care delivery is growing in complexity and quantity and is increasingly multidisciplinary, demanding higher quality care and breaking down traditional hierarchies.[7] The term 'leadership' in medicine has also since evolved to be associated with terms like 'initiating', 'engaging', 'inspiring' and 'collaborating'. Health care professionals increasingly recognise the collaborative nature of leadership and see it as a shared responsibility that is needed to improve the health care system.[7]

The evolution in our conceptualisation of leadership has been accompanied by more comprehensive leadership competencies. Yet more comprehensive leadership *training* is not accelerating at the same pace.[15] Many medical schools have begun to incorporate longitudinal integrated leadership training into their curriculums, but not without challenges. These curricular interventions compete with limited time and resources, suffer from a lack of consensus on the definition of leadership and face critiques of the subjective nature of teaching and measuring leadership competencies.[6] As a result, many of these medical leadership curricular interventions maintain a focus on cognitive leadership domains (e.g. time and financial management and technological and business skills) that are more objective and easier to define, teach and assess.[1]

Although cognitive leadership competencies are necessary for effective leadership, they are insufficient. When it comes to leadership, commitment and character are equally important.[3,5] Competencies reflect what a leader can do, commitment demonstrates a leader's engagement and character influences if a leader is trusted, as well as how a leader makes decisions about what they do, which is critical for effective leadership.[3,5] Character-based leadership is an approach to leadership education that stresses the development of and commitment to values and principles in the face of everyday situational pressures. Character-based leadership emphasises integrity, commitment to principles and a sense of a higher purpose, allowing leaders to do the right thing in the face of difficulty. If competence confers the ability to do the right thing, character is the will to do it consistently.[3,5]

Research on character-based leadership has been primarily situated in the organisational and business literature.[6] A prominent approach to character-based leadership has been developed by researchers at the Ivey Business School at Western University. The *Ivey Leader Character Framework*[5] highlights 10 dimensions 'relevant to the successful leadership of organisations'.[5] The dimensions include accountability, collaboration, courage, drive, humanity, humility, integrity, justice, temperance, transcendence and judgement.[5] Each dimension consists of associated defining character elements. For example, collaboration consists of collegiality, cooperation, flexibility, interconnectedness and open-mindedness.[5] The different dimensions of the model are interconnected and come together to influence leader character, with judgement playing a central role, deeply intertwined in each of the character dimensions. Despite the immense impact of this model in the business domain,[3–5,16] we know very little about how character-based leadership translates to the distinctive space of effective *physician* leadership.

This study aims to explore effective physician leadership through the perspectives of health care professionals. Understanding the attributes of an effective physician leader through a character lens can help to lay the groundwork for enhancing leadership education and training.

2 | METHODS

2.1 | Study design

This was a descriptive qualitative research study,[17] situated within an interpretivist research paradigm. Participants in this study were purposefully sampled on the basis of their experience working with physicians, or being a physician and working with other physicians, within a team-based environment.[18] Potential participants included physicians, nurses, allied health team members, trainees and administrators affiliated with two hospitals in Ontario. Individuals were invited by the research associate, who had no known relationship to potential participants, to participate through face-to-face conversations, team meetings, rounds presentations and e-mail. All potential participants were invited, and those that were interested contacted the research associate to schedule an interview; every participant that expressed interest was included in the study. Before each interview, informed consent was received through a signed consent form after acknowledging reading through the letter of information and understanding their rights as research participants.

Ethical approval was received from Western University's Health Sciences Research Ethics Board (Project ID 109570) and the Lawson Health Research Institute (REDA ID 3970) prior to the conduct of the study.

2.2 | Data collection and analysis

Individual interviews took place in private offices and were audiorecorded with permission. The researcher (J. M. I. T.) used a semi-structured interview guide to capture perceptions of what physician leadership meant to the participants and explored the concept of character-based leadership in medicine. The development of the questions for the latter part of the interview guide that focused on character-based leadership was guided by both the literature on character-based leadership and the *Ivey Leader Character Framework*.[5] Examples of questions included, 'What does an effective physician leader look like to you?', 'Can you think of a physician who you think is an effective leader?' and 'What do you think makes them an effective leader?'. In the latter portion of the interview, we asked participants about character-based leadership. Although we did not explicitly define character-based leadership or provide an overview of the conceptual model, we provided the following definition of character to participants to help guide our conversation: *character is the formation of an individual's internal traits, virtues and values.*

Data collection and analysis occurred simultaneously, with previous interviews and preliminary insights used to inform future data collection. Field notes were also used during the interview process to help contextualise the data and provide insights for areas of further inquiry.[19] Data collection was considered complete once the research team reached a level of thematic sufficiency as part of the ongoing data analysis.[20] Thematic sufficiency was achieved when patterns within the data were deemed consistently strong and no new themes were identified as part of further analysis.

After the interviews were audiorecorded, the recordings were sent to a professional agency for transcription. Returned transcripts were then reviewed for accuracy, and field notes were used to contextualise components of the transcripts for the analysts that were not present during the interviews. All transcripts were imported to NVivo (QRS International Pty Ltd, Burlington, Massachusetts, United States), a qualitative data analysis software, and analysed by three members of the research team (J. M. I. T., A. I. and H. I.).

Consistent with descriptive qualitative inquiry, a qualitative latent content analysis[21] was used to analyse the data. Latent content analysis consisted of identifying, coding and categorising patterns within the data.[22] Researchers interpreted the data within its context by drawing subjective meanings of latent content.[23] The *Ivey Leader Character Framework* was used as a theoretical framework to help guide the analysis of the data.[5] The researchers met regularly to clarify coding structures and categorise codes until a consensus was reached and primary patterns within the data were identified. N. S. was involved in the later stages of data analysis when themes were identified to further organise the data and contextualise the study's findings.

2.3 | Research team and reflexivity

In qualitative research, the research team must consider how its orientations shape the study and influence the credibility of the findings.[24–26] The research team consisted of the following: N. S., a practising physician and medical education researcher who was the principal investigator; J. M. I. T., PhD-trained qualitative researcher with expertise in medical education who was the research associate and oversaw recruitment, data collection and analysis; A. I. and H. I. who were undergraduate students and aided in data analysis; and L. L. who is a medical education researcher and W. H. who is a clinician and medical educator, both of whom contributed to the overall design of the study and the interpretation of study findings. N. S. had a working relationship with some participants and was not involved in recruitment or data collection. The remainder of the study team had no prior relationship with participants. All researchers are interested in physician leadership, which was made known to participants in the study. In addition, all researchers value character and, based on personal and professional experiences, assumed that character-based leadership would resonate within the medical context. The researchers mitigated these assumptions by seeking out negative or discordant cases and using non-leading questions as part of their data collection strategy.

3 | RESULTS

Twenty-six individuals participated, including 12 doctors, 5 nurses (including 2 nurse practitioners), 2 social workers, 2 directors, and a

pharmacist, dietician, coordinator, administrator and unit clerk. Interviews ranged from 28 to 68 minutes, with the average interview lasting 52 minutes. The study findings revealed that both cognitive competencies and character are important attributes of an effective physician leader. Character-based leadership resonated with health professionals who provided examples of character in practice and how this was attributed to effective physician leadership. Conversely, physicians who lacked character were seen as ineffective leaders. Lastly, participants saw leadership as dispositional, reflecting on the importance of character at all levels and in all roles within the health care team.

3.1 | Connections between competence and character

Participants recognised that competence is important: 'you have to know how to do your job, you have to know the pieces that need to be done, as a leader, and how to do them', but acknowledged that just as important is 'character, which is the way you do it … It's kind of like competence is the what, and the character is the how' (Participant 1, allied health [AH], female [F]). Although competent physicians were seen as effective physician leaders, competence alone was deemed insufficient. Participants reflected on the need for physicians to use the competence they had in effective and meaningful ways and believed 'there is an important role for character' in effective leadership practices (Participant 13, AH, F). In fact, competence without character was deemed problematic. For example, Participant 17 (AH, F) reflected on what it means to lead with competence but without character: 'they can be extremely competent … but with poor character … it bodes very poorly on them', reflecting how character was an important characteristic of effective leadership. Participants recognised the complex interplay between competence and character but acknowledge that both are essential for effective physician leadership.

3.2 | The relevance of character-based leadership

The notion of character-based leadership resonated with participants. Participants believed that when it came to leadership, so much is attributed to 'who you are as a person … people value different things, but ultimately, you have to be someone that other people want to emulate.' (Participant 11, AH, F). Character was deemed essential for effective physician leadership: 'I think that some people will never be leaders, no matter how they are taught, if they do not have the character for it.' (Participant 16, AH, F). Similarly, participants attributed ineffective leadership to a lack of character; as Participant 17 (AH, F) stated, '… without character, I believe it does not bode well for the person. I think that it stunts the people whom they are trying to lead. I do not think people with poor character make good leaders, period.'

There was, however, one discrepant case. One physician participant indicated that he did not feel that character was essential for effective physician leadership. In his mind, 'It's less important … I think there are a lot of people who, who they are as individuals may not be the … best … yet they can still be very effective.' (Participant 8, physician [DR], male [M]). Arguing that 'people who I do not think are people I would befriend … can be effective at what they do and still lead a situation', his perception ran counter to the dominant perception among participants that character was necessary for leadership.

3.3 | Expressions of character in physician leadership

Although the interviewees were probed to discuss character and leadership, they were free to reflect on what character meant to them and discuss the components of character they felt were attributed to effective physician leadership. Using the *Ivey Leader Character Framework*[5] as a theoretical framework in our analysis, we identified connections between their experiences and perceptions of physician leadership and the framework's dimensions (Table 1). Participants described how physicians manifested both positive and problematic expressions of character. Physicians were seen as effective leaders when they positively expressed aspects of character and were most often described as individuals who demonstrated collaboration, drive, humanity, humility and integrity. Physicians were seen as ineffective leaders when their demonstration of character was problematic and were most often described as individuals who demonstrated a lack of collaboration, humility, integrity and temperance.

3.4 | The disposition to lead

Most interviews extended beyond answering the final question, and it was clear that many participants wanted to share more. This was especially true for allied health professional participants, a number of whom commented that our focus on physician leadership should be extended because the question of effective leadership and character is relevant more broadly. For instance, Participant 13 (AH, F), an allied health professional, stated that '… a lot of the competencies that we talked about today would apply to anybody. It could be any role in the hospital, from housekeeping to clerical to nursing. I think leadership happens at all levels'; they also reflected on their own leadership and offered that 'I think everything we have talked about applies to me as an administrative leader.' Other participants shared this sentiment, asserting that 'everything we have spoken about for physicians definitely applies to any role in healthcare' (Participant 3, AH, F).

Not only did participants view the principles of effective leadership as applicable beyond physicians, but they also viewed leadership as possible outside of leadership positions. They offered 'the idea of a

TABLE 1 Dimensions of the *Ivey Leader Character Framework* and their importance to effective physician leadership

Character dimension	Positive examples	Problematic examples
Accountability	'When you have someone who owns what they want to do and how they feel about it, you have a great leader.' (Interview 5, AH, F) 'Accountability … that if they commit to doing something, that they stand behind that even though it may be tough.' (Interview 20, AH, F)	'They're not able to deal with accountability. When everything is good, they're good, but if it isn't good, they're not able to confront it and move it forward in a constructive manner.' (Interview 4, DR, F)
Collaboration	'The most important thing to me when I'm working with any physicians or any leader … is the willingness to be seen as a colleague and a partner. To be an effective leader, you have to be willing to see others as equals, and not see leadership in any way as a hierarchy.' (Participant 1, AH, F) 'Taking the time to make note of the contributions of their team members, be it nursing or allied health or their administrative assistant, whoever it is. I think that goes a really long way.' (Participant 2, AH, F) 'What I'm seeing more and more nowadays is that the physicians see themselves as part of the team, not the head of the team, and again, having worked in this position for over 20 years, that's very refreshing.' (Participant 3, AH, F) 'I think promoting a sense of teamwork, fairness, and having a group of people you can work with collaboratively. I think that kind of team building, if you're good at that, as opposed to being strictly top-down and dictatorial, that's probably a good skill set to have.' (Participant 26, DR, M)	'Any leader doesn't matter physician or whatever, if you're opinionated, if you're close-minded, you're less effective.' (Participant 1, AH, F) 'A physician that shuts down the opinions of others, who has the body language of not appreciating the input of others, who is close-minded in approach that it's their way or the highway.' (Participant 3, AH, F)
Courage	'A characteristic that I like within physician leadership is courage, that they are able to lead things where you're not going to have consensus. But if you know it's the right thing to do or the right direction, that you've got the courage to draw the line in the sand and say, this is where we need to go with the program with this rationale.' (Participant 20, AH, F)	'I would say the common trademark of ineffective leaders are that they just don't have the skill sets to do the job, nor do they develop over time so that when they are in good times, they're great, and when they're in bad times, they are a disaster. And that's because they don't wish to make the group face difficult decisions together, and it's much easier to avoid than to actually confront. I don't mean confrontational in the sense of a negative thing, but they have to realize that if the environment is changing, and it is changing, then they have to encourage others to see the possibilities that exist within the changing environment, and that's really what a good leader does.' (Participant 6, DR, M)
Drive	'The other individual is a researcher-clinician who is world-class, who again could speak to a wide range of individuals even though he had a great deal of expertise. He was very enthusiastic about what he did, and I think that some people don't understand that particular ability, but I think that if you're enthusiastic, it rubs off on everyone around you in a very positive way. Some people just have that capacity to keep on trying and keep on getting up for the next encounter, so that they are quite able to do that, and he was that kind of individual, so he inspired others to really achieve to their best ability.' (Participant 6, DR, M) 'I have seen physician leaders who have lost their drive, and that's not pretty. I think it's an all-encompassing job. I would never want it, but I think it really requires a lot of drive to remain engaged and keep going with it. So, I think that's key for a leader.' (Participant 10, AH, F)	'Their unwillingness, I think. They would be the ones who only want to do what's necessary to do. They're good physicians, and they do what they're scheduled to do … if they're told that they have to observe so many line insertions. Let's say you have to observe three. They'll observe three. And if they're given opportunities to observe another five, well, they already did three.' (Participant 17, AH, F)
Humanity	'I think it means a lot to patients' families when there is a real emotion from the doctor and the nurses. I lost a sister who was 17, and they did CPR on her for 40 minutes. There were just a lot of tears amongst the staff who were working on her because they had given it their all, and they couldn't understand what had happened. She ended up dying of an aortic aneurysm, but that emotion meant so much to my	'I struggle with some physicians because they say, yeah, a patient is saying that they don't want dialysis, but wait 'til the day that it comes, and then they're going to want to start. I get really frustrated with that because it's the doctor putting their values on that decision, and then really negating what it is that the patient and family are trying to say.' (Participant 14, AH, F)

TABLE 1 (Continued)

Character dimension	Positive examples	Problematic examples
	parents, who were there and just being real people, I think, is key. You can only internalize so much. The family wants to know that their loved one meant something, that there was something human about them. They weren't just another patient, and you moved on to the next patient. That it meant something. I think doctors who can demonstrate humanity and compassion take the time to talk to family and recognize that this is horrible and just be in the moment, just be human.' (Participant 10, AH, F) 'From a social worker's perspective, the ability to have compassion, to come in and do their job well, to always be aware of how everyone is doing in terms of staff and the patients I think that that's a good sign of a leader. Because we know that they're extremely intelligent … but having all of that knowledge and still being a wonderful person, I think makes an exceptional leader.' (Participant 14, AH, F)	
Humility	'I think a good leader takes time to self-evaluate and is receptive to feedback too. So, it's someone who is willing to continuously grow and develop so then they would hopefully recognize, either on their own or through feedback from others, that they have over-committed themselves and maybe need to scale back, or it's okay to say no and all that stuff, and then they can make adjustments as needed.' (Participant 11, AH, F) 'They're very respectful to the staff on the level of expertise and knowledge that they bring and their particular area of expertise, especially in our allied health. So, it's not always just a doctor and nurse. There's often other social work, pharmacy, dietician who come into play. And so, just that respect of their knowledge base and their specialty.' (Participant 13, AH, F) 'Yes. And, I think, too, that physician leaders need a certain degree of humility. I mean, ego is important in a certain part of everything, but just being able to say I could have done that differently, I could have done that better. Given a chance again, I think I might approach it this way. To show that they're not perfect either. None of us are perfect. But, just to show, I could have done better.' (Participant 19, DR, F)	'The perception is that they are the be-all and end-all. They have the answer; they don't need to look for the answer. They know what they want, they want everybody to fall in line, to do what they say, to follow their lead. They're not looking for anyone else's opinions, they're not looking for anyone else's insight. They've already got the answer that they want, and everybody else, like I said, just needs to listen, and fall in line. And from a team perspective, that really is ineffective for me.' (Participant 13, AH, F) 'Anyone who has arrogance, that gets in the way of building relationships … You have to value relationships as a leader. And if you don't value building a relationship, I think you're going to be set up for failure in whatever you do … So, there are some people who do have an ego and are hierarchal that have not been successful.' (Participant 20, AH, F)
Integrity	'You don't just behave like this here, and behave differently here, you've got to be consistent, so there's a consistency in leadership that's really important as well.' (Participant 1, AH, F) 'Those informal influencers are the ones that they've got the ability, the personality, the confidence, the rapport, and the trust. They've got all of that that makes that person as a human being a trustworthy person, and when you take that towards a role, that can be a role in any healthcare position, but we're talking about physicians. When you have people that are reliable, honest, trustworthy, and vulnerable, they'll put their vulnerabilities out there and openness to accept others' opinions; they also are substantial informal influencers around them. Because team members, people, and patients, they know that they're real, and so that comes with a sense of authenticity. I think nowadays if you have an authentic person, it does a lot for the team to rely upon each other in that same kind of culture and spirit, so that's what I'd say is key for me.' (Participant 3, AH, F)	'We can pick out those who are all about being popular with the patient or being popular with their colleagues but could care less how they treat the nurses or the peons. It just feels that way, and so, you see two faces in a person, and that's not cool.' (Participant 10, AH, F)

(Continues)

TABLE 1 (Continued)

Character dimension	Positive examples	Problematic examples
Justice	'Seeing that, in terms of that value of everybody is an equal, everybody is important, everybody needs to win, is a really different kind of relationship, when you work with other leaders, and not just physician leaders, other leaders.' (Participant 1, AH, F) 'I think the fact that he embraced everyone regardless of their training or background and constantly encouraged them to excel. I think that is really the essence of what he did as a leader.' (Participant 6, DR, M) 'Being fair and equitable means that sometimes when we have a limited piece of pie, everybody is getting a smaller piece than they want. I think the ability to mete out justice, even when it's uncomfortable and leads to negative fallout, is something that leaders need to be willing to do. (Participant 26, DR, M)	'I think we have to sometimes be careful that some physicians rely very heavily on one or two particular nurses. Maybe they're the most experienced in that area, but it may discount the thoughts of the newer, younger nurses who maybe don't have as much experience but may have an innovative thought … But that can be short-sighted, and it may not allow us to have a great idea come to the table.' (Participant 13, AH, F)
Temperance	'And what I appreciated is if we were in a high stakes meeting, that if things started to become tense because it's a crucial moment, stakes are high, emotions are involved, that he held a code of conduct, he would hold those values and hold people accountable to that. And he would stop a meeting and draw people back to why are we here and hold people accountable for their behaviours and how they need to act professionally. I just think he showed exceptional leadership in that way.' (Participant 20, AH, F)	'Some of them can be so ambitious that they fail to treat the team members in a respectable manner to get to the end, whether that's how they behave in a research capacity when you're working with them as a colleague or with patients, that type of thing. I think they are ambitious, but it's how they deal with that ambition.' (Participant 7, AH, F)
Transcendence	'They need to be visionaries, they need to see where we're going and how we might get there, be willing to change.' (Participant 4, DR, F) 'So, it's someone you want to be around. They inspire you to raise your practice, to be better, to influence … You want to work with them to learn from them. They listen and learn from the team.' (Participant 7, AH, F)	'I like leaders to be optimistic about stuff. I hate being around morose people because they bring everything down. You could complain about a lot of things.' (Participant 18, DR, M) 'Some of them can be so ambitious that they fail to treat the team members in a respectable manner to get to the end, whether that's how they behave in a research capacity when you're working with them as a colleague or with patients, that type of thing.' (Participant 7, AH, F)
Judgement	'And then there are physicians who are willing to try things and be decisive in difficult situations and I think you learn to put your trust in them. And that comes from a sense of confidence and experience but even experienced doctors I've seen that seems to be their go-to, they're just not willing to make the tough calls. And so I think to be a leader you have to be decisive.' (Participant 10, AH, F) 'A leader has to make decisions and has to be aware of the circumstances around whatever it is that needs to be decided. All of these factors come into play in terms of what kind of a decision we make. And there are so many factors we have to think about. Yeah, are we being considerate to the other member of the group? Are we willing to take ownership if the decision is incorrect? Are we being transparent with all of the criteria that we're using to make this decision?' (Participant 21, DR, M)	'Lack of knowledge or not taking into account all of the various bits of knowledge before making a decision … I think that's an example where maybe situational awareness was not present.' (Participant 22, DR, M) 'I think you can analyze stuff to death and be not willing to take a decision on things. I've certainly seen that happen in situations where we just need to get on with it.' (Participant 23, AH, M)

disposition to lead; you can see that in any role' (Participant 1, AH, F), and they perceived that there are those 'who I would consider leaders. I think people recognize their value and consider them a role model … but would not necessarily call them a leader.' However, not being 'called' a leader did not render leadership impossible. Participants were clear that those who lead with character 'do not need a title to be a leader' (Participant 4, DR, F).

4 | DISCUSSION

Our study participants recognised the execution of character in everyday health care practice, associated character with effective leadership by physicians and other team members and understood leadership in dispositional rather than exclusively positional terms. These findings are consistent with a role for a character-based

leadership framework in medical education, and they provide important insights for designing leadership training interventions within a competency-based framework.

Character-based leadership is a conceptual leadership framework that can be applied to medicine to move beyond cognitive competencies and meet modern health care needs. More explicitly, dimensions of the *Ivey Character leadership Framework*,[5] although conceptualised around organisational leadership in the business domain, are interwoven into the fabric of effective leadership in medicine. Not only can character push us beyond cognitive competencies, but it can also complement these competencies. Character and competence are deeply connected and mutually reinforcing. This idea that character enhances competence and promotes effective leadership has been described as the 'character-competence entanglement'.[16] In addition, physicians who demonstrate character and enact these values in practice contribute to developing a culture of character in medicine.[15] Our findings are similar to other work exploring effective physician leadership. For example, in exploring health care professionals' perceptions of qualities necessary for physician leadership, researchers found a leader's attributes, such as their collaborative nature (being supportive, approachable and respectful) and humility, contributed to leading and optimising clinical team functioning.[6] Another study exploring effective physician leadership found that integrity, authenticity and drive resonated with senior physician leaders and were deemed critical for professional ethos.[27] As Stoller (2021) states when reflecting on leadership for medical professionals, 'Effective leadership is characterized by clear attributes, including acting in ways and promoting cultures that are informed by the classical virtues of trust, compassion, courage, justice, wisdom, temperance, and hope.'[15] Our findings advance this work by demonstrating the relevance the *Ivey Leader Character Framework*, an established character-based framework, to physician leadership.[5] We can build leadership training on this established theoretical framework, promoting rigour and coherence in medical education's efforts to develop leadership training to reflect cognitive competencies and character-based constructs.

A strength of qualitative research is that it does not set aside outliers or incongruities, and our findings alert us to the possibility of resistance to character-based leadership frameworks. The discrepant case illustrates that character may not be embraced by all as a necessary aspect of training for effective physician leadership. A culture persists in medicine that values 'objective' cognitive competencies over 'subjective' character attributes.[28] Shifting this culture can prove challenging, given its deep roots in the psychometric era.[29] The shift to the post-psychometric era, which has fundamentally reconceptualised subjective competencies, may be accompanied by a shift to embrace character. This shift is not without tension. Therefore, future research examining whether character is potentially undervalued in medicine and navigating the implications of these perspectives on clinical practice and training is warranted.

An appreciation of character-based rather than exclusively competency-based leadership allows us to recognise dispositional in addition to positional leadership in medicine.[1] When we view leadership as a disposition, it opens a path to view leadership not exclusively as a physician role but as a role for any health care team member. This has implications for when and how we teach leadership. Leadership training should be incorporated at all levels of medical training, from undergraduate to postgraduate settings and practising contexts.[7,30] Across each of these, the disposition to lead should be cultivated regardless of the specific leadership positions that learners might have available to them. The RCPSC shift from manager to leader reflects this notion of dispositional leadership. The RCSPC recognises that 'there are a few, necessary, titled positions, but there are countless ways to lead in everyday practice and to share the opportunity to lead in team-based health care.'[7] The emphasis on character-based and dispositional leadership also opens space to think about collaborative leadership competencies. There is value in providing an interdisciplinary learning environment for leadership training in health professions.[31] We recognise an inherent tension between collaborating and leading,[32] but character may help us grapple with this complexity and should be considered an area for future research.

We would argue that given the relevance of character-based leadership to the medical context, competencies related to character remain under-represented in many medical education competency frameworks. For example, character-based leadership competencies are absent from the RCPSC CanMEDS Leader Role. In the RCPSC's 'From Manager to Leader' document describing the College's rationale for this change, the narrative captures the importance of dispositional and collaborative leadership competencies, highlighting the importance of character-based leadership. However, when you examine both the key and enabling competencies, the emphasis on this transition is lost. The competencies still lend a managerial focus, like applying 'evidence and management processes to achieve cost-appropriate care'.[33] Although certainly a necessary and important competency for physicians, we would argue there is room to incorporate character. Some of the other CanMEDS roles do an excellent job of incorporating character competencies. For example, physicians are expected to be competent *Professionals* who demonstrate 'honesty, integrity, humility, commitment, compassion, respect and altruism' and uphold these values consistently.[34] They are also expected to be competent *Communicators* who use a patient-centred approach 'characterized by empathy, respect and compassion'.[35] Yet the potential for character-based leadership has not yet been recognised for the Leader Role. As the CanMEDS 25 project unfolds, we would encourage key stakeholders to consider incorporating character competencies into the key competencies of the Leader Role to reflect these recent developments and contribute to the strategic direction of leadership competencies in medical education. These changes would emphasise the importance of the disposition to lead and support collaborative leadership efforts in team-based health care.

The design of this research influences how its insights might guide others. Because our study participants came from two affiliated hospital sites located in a single city in Ontario, Canada, the transferability of our findings cannot be assumed. This limitation may be offset by the fact that our participants had worked in different institutions and provinces and their interviews drew on their exposure to various leadership styles throughout their careers. The rich

description of the context and participants' perceptions may assist researchers in applying the study's findings to other contexts. In addition, although we have a variety of allied health professionals in our sample, certain allied health professions may be under-represented in our data. The rich insights provided by allied health professionals suggest that there is much to be learned from them about collaborative leadership in medicine. Lastly, amid the broad scholarship on leadership in the health professions, which includes propositions, such as emotional intelligence,[15] disruptive leadership[36] and compassionate leadership,[37] we have chosen character-based leadership as the focus of our programme of work in this domain. As such, we recognise that this choice has implications for the knowledge we produced in this study and future research might consider examining physician leadership from other theoretical perspectives.

In summary, health professionals believe character matters. Character can complement existing leadership competencies, and character development should play a role in leadership training. The use of an established theoretical framework for this training in health care will improve the rigour and coherence of efforts to develop more comprehensive leadership training programmes and assess their impact.

ACKNOWLEDGEMENTS

None.

CONFLICTS OF INTEREST

None.

ETHICS STATEMENT

Ethical approval was received from the Health Sciences Research Ethics Board (HSREB) at Western University (Project ID 109570).

AUTHOR CONTRIBUTIONS

J. M. I. T., L. L. and N. S. made substantial contributions to the conception and design of the work. J. M. I. T., H. I., A. I., L. L. and W. H. contributed to the acquisition of data. J. M. I. T., H. I., A. I. and N. S. contributed to the data analysis, and all authors contributed to the interpretation of the data. J. M. I. T. drafted the work, and H. I., A. I., L. L., W. H. and N. S. critically revised it. All authors read and approved the final manuscript. All authors have agreed to be accountable for all aspects of the work and to ensure that questions related to the accuracy or integrity of any part of the work, even ones in which the author was not personally involved, are appropriately investigated, resolved and the resolution documented in the literature.

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How to cite this article: Torti JMI, Inayat H, Inayat A, Lingard L, Haddara W, Sultan N. Perspectives on physician leadership: The role of character-based leadership in medicine. *Med Educ*. 2022;56(12):1184-1193. doi:10.1111/medu.14875