Navigating role conflict: one professional's journey as a new clinician leader

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ABSTRACT

Transitioning from full-time clinical work to a leadership position can be a difficult transition for healthcare professionals. Competing demands, new responsibilities and changes in how one measures success in this new role often leave new clinician-leaders feeling lost, stymied or ineffectual.

Role conflict is one phenomenon which can impact a healthcare professional's transition into leadership. Role conflict occurs when the clinician turned leader experiences a sense of dissonance between a highly valued identity as a clinician and a developing identity as a new leader.

This article shares my personal experience as a new clinician leader in the field of physical therapy. I offer reflections on the impact of professional role identity conflict during my transition into leadership, and how this role identity conflict led to early leadership failures, but also how addressing role conflict contributed to leadership success later on.

More importantly, this article offers advice to the new clinician leader for navigating role identity conflict during a clinical to leadership transition. This advice is based on my personal experience in physical therapy and on the growing body of evidence on this phenomenon in all healthcare professions.

INTRODUCTION

My first management/leadership position was at a rural hospital in the Midwestern USA. At the beginning of my tenure, the reputation of the therapy services department was not the best. Local residents were known to drive 30–40 miles out of town for therapy, instead of coming to the hospital.

Seven years into my tenure, the size of the therapy services department had tripled. Gross revenue production and new patient referrals experienced a threefold increase. More importantly, the department was demonstrating improved patient outcomes and achieving them in fewer overall visits. Therapy services consistently scored in the 95th percentile on patient satisfaction surveys and stories of local residents travelling out of town for therapy had ceased.

I was confident going into my annual performance review that year. The metrics on which I gauged departmental success were doing well. Little did I know my confidence was about to be challenged. The experience would force me to re-evaluate how I saw myself as a physical therapist, and how my professional role identity was affecting my performance as a leader.

THE EMPLOYEE ENGAGEMENT SURVEY

At that time, employee engagement surveys were emerging as a measure of departmental performance. In the course of my annual performance review, the chief executive officer (CEO) brought up results from the previous 2 years' surveys. In no uncertain terms, the CEO let me know the results were not meeting expectations. The CEO began by asking why other hospital managers, patients, referring physicians, and the local community were happy with my performance. After giving it thought, I told her it was because I gave them everything I had. I did not quit until I helped them or found someone who could. The CEO then asked, quite directly, why I seemed incapable of doing the same with my employees. It was a question to which I did not have an answer.

After speaking with my team, the CEO had some ideas. The team felt I was not approachable, interrupted frequently, failed to listen, and was always in a hurry. I responded quite honestly that, yes, I was in a hurry; seeing 20 or more patients a day and attempting to complete management duties in between. The CEO agreed, and proposed we hire an additional physical therapist to reduce my time in patient care and devote more time to the leadership of my team.

NAVIGATING ROLE CONFLICT

On a rational level, I knew the CEO was correct. My stress level was high. I was spending too many hours at work. This was affecting relationships with my staff. I also knew my performance in both roles, as a manager and as a clinician, was beginning to slip. Carrying a high patient case load is common for hybrid physical therapy clinician managers, while feeling ineffective in either role is common among clinician managers in multiple settings.[1 2]

Despite agreeing with the CEO on an intellectual level, emotionally, I wanted nothing to do with her suggestion. The thought of seeing fewer patients seemed wrong. The thought of shifting away from a high volume of patient care made me feel like less of a physical therapist.

Over the course of their education and early to mid-careers, professionals work hard to nurture and grow their professional role identities as strong, individual contributors.[3] The clinician identity is central to the professional role identity of many health professionals.[2 4 5] I didn't know this at the time, but I was experiencing a phenomenon called role conflict. Role conflict occurs when there is dissonance between a valued prior identity and one's attempts to cultivate a new role identity. Role conflict may result from a perceived lack of alignment between one's values and the role one

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inhabits.[3] In a systematic review, Masoumi found role identity conflict to be one of the issues impacting first-time clinician manager effectiveness.[2]

New healthcare leaders/managers, particularly those engaged in hybrid clinician leader/manager roles, are attempting to fill two competing roles simultaneously.[2 6] Often times, these new leaders/managers will attempt to retain a strong clinical professional identity, resulting in ongoing role conflict. Unresolved role conflict may result in the clinician manager feeling isolated, stymied and failing to meet the requirements of either role effectively.[2 6]

Looking back, I perpetuated this role conflict unknowingly. I continued to approach interactions with patients, physicians, and other professionals from a position of service. I set goals and prioritised measures of success which were important to them. Even while collaborating with my employees as a fellow therapist, I was willing to schedule a new evaluation or see an extra patient to help them get caught up. My role as a physical therapist held meaning for me. My role as a physical therapist was worth my time because it involved helping people.

What also became clear, however, was my failure to embrace what it meant to be a leader. I viewed my leadership position as a separate persona, one I inhabited when not acting as a physical therapist. In retrospect, this psychological separation was born of two issues. First, by holding onto a rigid perception of myself as a physical therapist, I failed to see the ways in which leadership and physical therapy shared the same goal of helping others. Second, my failure to recognise the fundamental differences between leadership and management perpetuated this sense of conflict, leaving me focused on the wrong measures of departmental success.

A BROADER PROFESSIONAL ROLE IDENTITY

Being a physical therapist was integral to my identity. Letting go of that identity would have been impossible. Recognising this fact led to a powerful realisation. I did not need to let go of my physical therapist identity at all. I needed to stop seeing my professional identity as static. Physical therapists regularly exercise agency over their professional role identity.[7] Research also suggests physical therapists perceive of themselves as leaders.[8–10] This self-perception appears confined to leadership at a clinical level, however. Physical therapists often fail to recognise their ability to lead at an organisational or societal level.[8]

Indeed, this was the position I found myself in. The issue was not a conflict between the two roles I was inhabiting. The issue was my perception of conflict. By clinging to a narrow view of who I was as a physical therapist, I failed to see how the skills which make a good clinician were applicable to leadership. Service to others represents a key component of identity which clinicians may reference when developing a leadership identity.[11] More specifically, recognising the consistency between serving as a patient advocate and serving as an advocate for team members may help reduce the dissonance inherent in a clinician to leader transition.[11] Maintaining a consistent focus on service during the transition may help clinicians retain a core aspect of their professional role identity while expanding their service focus to a larger audience.[11]

SEPARATING LEADERSHIP FROM MANAGEMENT

Another barrier to making this psychological transition was my failure to recognise the difference between leadership and management. Despite some overlap, leadership and management have been identified as separate constructs.[12] While definitions of leadership remain nebulous at best, most recognise leadership as the ability to influence, motivate, and enable others in the pursuit of a common goal.[12] Influencing and motivating an individual in pursuit of a goal was my primary role as a physical therapist every time I saw a patient. As such, one might think the connection between clinical practice and leadership would be readily apparent. Despite these inherent similarities, my attention was focused on departmental budgets, efficiency and growth. While this approach yielded obvious improvements in productivity and clinical outcomes, it failed to engage employees as active and inclusive participants in these improvements, resulting in a constant need for managerial oversite and direction.

Physical therapy managers are known to focus on management tasks and metrics rather than prioritising leadership activities.[1 13] A focus on management over leadership contributes to role conflict as new clinician leaders/managers grapple with conflicting logics of professionalism and managerialism.[14 15] In contrast, physical therapists in new leadership positions who separate leadership from management in their work may avoid role conflict by compartmentalising less palatable management tasks while merging leadership and clinical identities into a new, more expansive professional role identity.[11] Compartmentalising management tasks may be difficult for the new clinician leader, particularly since entry-level positions of this type are often a blend of leadership and management work flows. As such, successful clinician leaders may need to make this separation psychologically as opposed to physically. Doing so may aid the new clinician leader in embracing their developing identity as a clinician leader and avoiding an outright rejection of the new role.[11] This may help mitigate the effects of role conflict which is, likewise, a psychological construct.

EMBRACING THE ROLE IDENTITY CHALLENGE

Instead of fighting my role in leadership, I began to embrace it. I began to seek out ways to develop my identity as a leader yet remain authentic to my identity as a clinician. The simple answer was to help people. I was already equipped with the skills to make this happen. The ability to integrate clinical and leadership roles into a new professional role identity are a hallmark of successful clinician to leader transitions.[2 6 11 15]

When my employer repeated the employee engagement survey a year later, the results were clear. Team morale improved. Staff began taking initiative, holding each other accountable, accepting additional responsibilities and doing so independently. Soon after, I took a different leadership position, once again taking over a therapy department in need of some attention. I chose to develop relationships with my staff before addressing departmental and operational metrics. Approaching the leadership role from a servant mentality, linking my desire to help others as a clinician to my desire to help my staff and department thrive, made it easier to effect change.

By embracing a professional identity which merged clinician and leader, I was able to facilitate improvements in patient satisfaction, wait times, patient outcomes, and financial performance, but this time with overwhelmingly positive employee engagement scores. These improvements materialised in 2 years instead of seven.

CONCLUSION

A sense of conflict between one's role as a clinician and one's role as a leader is not unique to the physical therapy profession.

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Role conflict has been cited as a factor in work role transitions in other healthcare professions including medicine and nursing.[2]

In light of this, my advice to new healthcare leaders would be to take a moment and step back from the flood of new responsibilities, metrics and reports. Do not let the tasks of the position define your role. Doing so will only increase the sense of dissonance between your valued identity as a clinician and your new role as a leader.

Instead, recall why you became a clinician in the first place. Find the links between being a good clinician and a good leader. Try letting go of how you think things have to be so you can see the way things can be. Embrace the common desire to make the lives of those around you better. Never lose sight of the clinician identity which made you who you are, but also recognise it as a guidepost on the road to who you can become.

STATEMENT OF POSITIONALITY

I am a licensed physical therapist in the USA with 22 years of clinical experience. Additionally, I spent 13 years in clinical leadership. For the past 5 years, I have served in a leadership capacity as director of clinical education for a doctor of physical therapy educational programme. I received my undergraduate degree in biology followed by masters and doctoral degrees in physical therapy. Coming from a science-based background, I approached my early professional career from a strongly positivistic and objectivist philosophical perspective, a perspective which, I believe, contributed to the lived experience described in this piece. Having this lived experience contributed to a philosophical shift in my work as a clinician and leader. Transitioning to academics and pursuing a PhD in Education helped me recognise the value of self-reflection, but also the value of sharing such lived experiences with others. This was the stimulus for sharing this experience in a manner I hope others may find value in.

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Competing interests CW is a member of the American Physical Therapy Association's Academy of Leadership and Innovation and a member of the LAMP Leadership committee which provides leadership training and development workshops to healthcare professionals throughout the USA.

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