Clinician styles of care: Transforming patient care at the intersection of leadership and medicine

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Abstract

A key role of clinicians is to motivate their patients to initiate and maintain beneficial health behaviors. This article integrates research on transformational leadership, clinician–patient communication, and health behavior to introduce a novel approach to understanding and improving clinicians' effectiveness as motivators. We describe three dominant clinician styles or patterned approaches to patient care that derive from leadership theory (in order of least to most effective): laissez-faire, transactional, and transformational. Additionally, we suggest potential mediators and effects of the transformational style of care. Finally, we discuss future research directions for the study of clinician styles of care.

> A leader has the ability to get other people to do what needs to be done and what they don't want to do, and like it.
>
> President Harry Truman

A defining characteristic of effective clinicians is their success at motivating patients to initiate and maintain beneficial health behaviors such as increased physical activity, smoking cessation, dietary modification, and medication adherence (DiMatteo et al., 2012; Rollnick et al., 1999). Providing competent health care in itself is not sufficient for patients to achieve these health goals (e.g. Kaplan et al., 1989; Stewart, 1995). Approximately 50 percent of patients with chronic illnesses and almost 25 percent of all patients do not adhere to recommended health behavior change (DiMatteo, 2004). These patients are 3 times less likely to have desirable health outcomes compared to adherent patients (DiMatteo et al., 2002).

One way to counter this trend of nonadherence is for clinicians to take a central role in increasing patient motivation, a key factor in predicting whether patients will initiate and maintain beneficial health behavior change (DiMatteo et al., 2012). We present a novel theoretical approach that draws from the leadership literature to propose a set of clinician styles of care that may predict clinicians' effectiveness at motivating their patients. We will focus attention on the transformational style, which is

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likely to be the most effective for motivating patients toward health behavior change (see Bass and Riggio, 2006).

Novelty of the leadership approach

There is little doubt about the positive effects of clinicians' interpersonal skills (Kahn et al., 1979; Stewart, 1995). For example, effective clinician–patient communication is related to better patient health outcomes measured physiologically, behaviorally, and subjectively (Kaplan et al., 1989), and clinicians who learn appropriate interpersonal behaviors may increase patient satisfaction and decrease the number of lawsuits filed against them (Hickson et al., 2002; Stelfox et al., 2005). Our proposed theoretical approach extends current research by offering an organizational structure of clinician behaviors based on the framework provided by transformational leadership. The proposed clinician styles represent organized clusters of behaviors grouped together by underlying mechanisms that operate to motivate patients. By grouping these clinician behaviors by their similarities, we can identify the essence of each cluster and present each cluster as a style rather than an unfocused inventory of individual behaviors. Thus, efforts to increase clinicians' effectiveness as motivators can target the style level (Bass and Riggio, 2006). By embodying the essence of a particular style of care, we propose that clinicians organically exhibit individual behaviors that researchers have identified as important for effective clinician–patient interactions. Thus, an approach focused on clinician styles may be more effective at increasing patient outcomes compared to clinician interpersonal skills training traditionally emphasized in the literature. Our proposed strategy enables researchers and practitioners to overcome the impossible task of attempting to train clinicians on a seemingly endless and growing list of idiosyncratic individual behaviors.

Theoretical extension of transformational leadership to the clinician–patient relationship

Transformational leadership theory highlights the fundamental fact that individual differences exist in people's ability to motivate others toward change (Katz and Kahn, 1966). Although a leadership position inherently entails opportunities to exert influence, people vary in how effective they are at capitalizing on this influence. The frequency, degree, and manner in which leaders choose to exercise their influence predict their effectiveness at motivating their followers (Bass and Bass, 2008). Similarly, the frequency, degree, and *manner* in which clinicians capitalize on their potential to motivate patients are likely to predict their effectiveness at engaging their patients in health behavior change. Transformational leadership research identifies styles, or patterns of behaviors, that differentiate effective versus ineffective leaders based on their ability to motivate members to engage in and complete goals (Bass and Riggio, 2006; Nash, 1929; Stogdill, 1950). Substantial empirical evidence demonstrates that members who work with transformational leaders have better outcomes than members of other types of leaders (e.g. more satisfaction, less turnover intentions, higher job performance; Brown and Peterson, 1994; Podsakoff et al., 1990). These findings have been documented in numerous cross-sectional and longitudinal studies, as well as experiments using random assignment (for a meta-analysis, see Judge and Piccolo, 2004).

Although researchers typically examine leadership styles in the context of leader–member relationships in industry, leadership is relevant in other contexts as well (Bass and Bass, 2008). For example, health researchers have applied leadership theories to study provider–provider level dynamics (e.g. nurse managers' leadership styles, Medley and Larochelle, 1995; physicians as executive directors, Xirasagar et al., 2005). This article takes the novel approach of examining leadership at the clinician–patient level. This

theoretical extension is congruent with the idea that leaders are most effective when they can motivate their members through interpersonal influence (Bass and Bass, 2008; Hogg, 2010). This view emphasizes how clinicians can engage patients to initiate and maintain health behavior change through motivation and inspiration, and specifically, without the use of force, dominance, or coercion (Hogg, 2010). This caveat is noteworthy because there are inherent power, influence, and information asymmetries between leaders and members, just as between clinicians and patients (Bass and Bass, 2008; French and Raven, 1959; Wrong, 1980). Thus, superficially, the conceptualization of clinicians as leaders and patients as members appears to support the parentalism model of patient care (Emanuel and Emanuel, 1992). However, the essence of paternalism is the exact *opposite* of our proposed theoretical framework. Clearly, clinicians are in a position to influence and persuade patients to engage in beneficial health behaviors, but clinicians do not have the means to directly regulate such behaviors, nor should they coerce patients into changing their behavior (see Pellegrino and Thomasma, 1988).

Overview

In the following sections, we describe three dominant clinician styles of care that parallel the leadership styles proposed by Bass and Avolio (1991) in the Full Range of Leadership (FRL) model. We also illustrate how these styles can be translated to the context of clinician–patient relationships. Because this approach is novel and thus lacks direct empirical evidence to date, we cannot be sure that clinicians exhibit analogous styles of care with their patients. However, there is extensive evidence for the pervasive and consistent existence of these styles in other dyadic relationships. For example, the styles identified in this article are present in teachers (Beauchamp et al., 2010; Morton et al., 2010) and in leaders of many diverse industries such as banking, military, and education (Brown and Moshavi, 2002; Dvir

et al., 2002; Rai and Sinha, 2000). In the medical context, these styles arise in directors of community health centers and nurse managers (Medley and Larochelle, 1995; Vandengerghe et al., 2002). The evidence for the ubiquitous occurrence of the FRL strongly suggests that transformational leadership transcends contextual constraints and occurs in the clinician–patient dyad as well.

Next, we integrate leadership and health research to identify mediators and consequences of transformational clinicians. We close by suggesting future directions for research on clinician–patient relationships using a transformational style approach.

Translating leadership styles into clinician styles of care

In line with the FRL model (Bass and Avolio, 1991), we propose that clinicians display a full range of patient care styles. These styles can be categorized into three types: (1) laissez-faire, (2) transactional (including three subtypes: problem focused–passive, problem focused–active, and contingent reward), and (3) transformational (including four components: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration).

Essential to the extension of the FRL model is the idea that all clinicians, on one occasion or another, display the full array of styles of care (Bass and Avolio, 1991; Bass and Riggio, 2006). However, clinicians exhibit a certain style more often than the others, and their dominant approach represents their style of care (Bass and Bass, 2008). In addition, the transformational and transactional styles are not at opposite ends of a spectrum (Bass, 1998). Instead, the transformational style augments the effects of the transactional style by allowing clinicians to motivate and inspire their patients to exert more effort and perform beyond expectations in the context of transactions. In other words, certain types of transactional styles represent necessary but insufficient

conditions for superior outcomes (Bass, 1998; Waldman et al., 1990).

Laissez-faire style of care

We propose that the laissez-faire style of clinician care is likely to be the most ineffective style for clinicians (see Bass and Riggio, 2006). A laissez-faire clinician is irresponsible and negligent and unlikely to exist in reality for very long, at least in the most extreme form. These clinicians are unsympathetic to patients and leave important health concerns to patients to sort out for themselves. Clinicians who engage in laissez-faire care do not embody the spirit and authority associated with the position of a clinician. For example, these clinicians may order unnecessary tests or refer their patients to specialists in order to avoid responsibility for final decisions about their patients' health (Axt-Adam et al., 1993).

Transactional style of care

The transactional clinician style characterizes clinician–patient interactions in which clinicians set health goals for patients and provide them with instructions, feedback, and reinforcement as the patient pursues those behavior goals. For instance, a clinician–patient "transaction" may begin when a clinician sets a goal of weight loss and lays out procedures during an initial visit for completing that goal (e.g. an exercise regimen, dietary changes), and the transaction may end when the clinician provides feedback regarding the attainment (or lack of attainment) of the health goal to the patient at a follow-up appointment. The transactional clinician style includes three subtypes: problem focused–passive, problem focused–active, and contingent reward.

Problem focused–passive. We propose that clinicians who engage in the passive form of problem-focused care concentrate on corrective actions, such as only treating symptoms of illnesses when they appear. Clinicians engaging in this style of care wait for patients to display serious health problems or failures in their health behavior before taking action. These clinicians do not actively monitor their patients' health behavior until or unless a problem arises. For example, they may prescribe medication but fail to follow up with patients until patients present unresolved or worsened symptoms.

Problem focused–active. We propose that clinicians who engage in the active form of problem-focused care monitor and follow up with patients after a visit. They seek to identify failures in adhering to treatment recommendations or deviations from patients' standard level of health. They take action whenever necessary to avoid or prevent major health problems. For example, these clinicians may set adherence goals for patients who are prescribed a complex medication regimen and then actively monitor the patient's progress and make adjustments to prescriptions to ensure that the medications interact well to achieve the desired effect.

Contingent reward. We propose that clinicians who exhibit the contingent reward component clearly express the goals of treatment and the beneficial outcomes associated with adherence to treatment recommendation. Clinicians provide extensive feedback and offer reinforcements to patients on their pursuit of health goals (see Bass and Bass, 2008). For instance, clinicians may rebuke their patients for having failed to follow treatment guidelines (Seaburn et al., 2005).

Transformational style of care

We propose that the transformational clinician style of care characterizes clinicians who not only provide health and treatment goals but also inspire and motivate patients to be personally engaged in those goals. Transformational clinicians challenge themselves and their patients to come up with new or innovative treatment options that the patient believes will be effective in addressing an illness or health risk, and

they coach patients throughout the execution of the treatment plan or behavior change. The transformational style includes four components: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. These four components are not mutually exclusive; a transformational clinician may engage in any or all of these components in order to fit the needs of individual patients (Bass and Avolio, 1991; Bass and Riggio, 2006).

Idealized influence. We propose that clinicians who engage in idealized influence serve as role models for their patients by embodying various aspects of health that they want their patients to exhibit (see Bass and Riggio, 2006). These clinicians engage in good health habits, which are often apparent to patients (e.g. nonsmoking behavior, regular exercise, maintenance of healthy weight; Harsha et al., 1996). These clinicians may more easily form patient trust, perceptions of responsibility, and professionalism (Sams, 2002); thus, they are likely to be effective at motivating patients toward health behavior change.

Inspirational motivation. We propose that clinicians who engage in inspirational motivation create a compelling vision for the patient's health and clearly communicate that vision to the patient (Bass and Riggio, 2006). The vision of health is attractive in part because clinicians engage patients in an information exchange process and receive patient consensus in the course of formulating the behavioral change strategy (Charles et al., 1997). This shared decision-making process may lead the patient to feel as if the patient and clinician are working together as team toward the goal of better health for the patient (Bass and Riggio, 2006; Charles et al., 1997). Additionally, clinicians who engage in inspirational motivation display enthusiasm and optimism when they express their vision for patients' health. When clinicians are optimistic about the success of a procedure, patients are likely to be more hopeful about their treatment outcomes (Schwarze et al., 2007).

Intellectual stimulation. We propose that clinicians who engage in intellectual stimulation encourage their patients to think about health problems or concerns in new and innovative ways (see Bass and Riggio, 2006). These clinicians engage their patients intellectually by asking them open-ended questions that may prompt patients to think of different angles from which to approach health problems (Levinson and Roter, 1993). They may also pose questions about patients' health in a new way that prompts patients to engage in deep reflection about the causes or consequences of their behavior. These clinicians avoid coercion and confrontation; they facilitate an environment where patients can reflect on their health and elicit a desire to change based on their personal assessment of the values and drawbacks of adopting a new behavior (Rollnick and Miller, 1995).

Individualized consideration. We propose that clinicians who engage in individualized consideration personalize the patient care process by making meaningful distinctions between patients as individuals (see Bass and Riggio, 2006). They tend to remember past interactions and attempt to put patients at ease by establishing warm interpersonal relationships (Beck et al., 2002). Moreover, these clinicians also act as mentors and coaches to patients as they engage in health behavior change (Fitts et al., 1999; Oliver et al., 2001). Clinicians who engage in individualized consideration may set health goals that increase in difficulty, such that patients can achieve successively better health outcomes (Koenigsberg et al., 2004). Finally, clinicians who exhibit individualized consideration adjust their style to meet the needs of individual patients. For instance, they may provide more guidance about treatment options to some patients but allow other patients more autonomy in directing their care (Arora and McHorney, 2000; Deber et al., 1996).
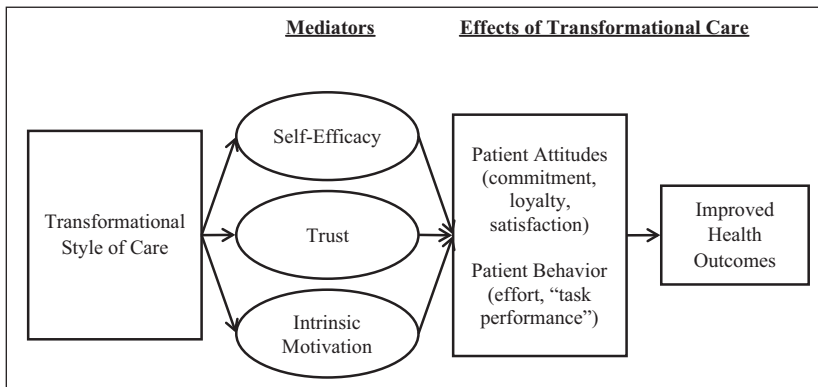
Figure 1. Summary of mediators and effects of the transformational style of care.

Relative effectiveness of clinician care styles

The distinctions between clinician styles may be more salient and consequential in certain health contexts than in others. For example, emergency room clinicians often interact with patients on a single occasion, and even then only briefly and perhaps while the patient is unconscious. Moreover, in the context of emergency care, responsibility may be shared among a team of many personnel. Under these circumstances, clinician styles may have little effect on patient outcomes, particularly if these clinicians play little or no role in ongoing care and treatment recommendations. In contrast, primary, preventative, and chronic illness care typically entail repeated interactions between patients and their clinician. This care context affords the opportunity for clinicians to develop relationships with their patients (see leader–member exchange theory, Graen and Uhl-Bien, 1995). Transformational clinicians may be more likely to form high-quality personal relationships with their patients than are other types of clinicians (Bass and Bass, 2008). Such high-quality relationships allow transformational clinicians to exert greater influence and be more effective motivators than clinicians who exhibit other styles of care. See Figure 1 for a summary of the potential effects and mediators of transformational care.

Effects of transformational clinician care

In this section, we outline the potential patient outcomes that are likely to be improved by transformational clinician care, based on documented effects of transformational leaders. We focus on two primary types of outcomes: patient attitudes and patient behaviors. The recurring theme is that the transformational style elicits a variety of social, cognitive, and behavioral changes in members that extend beyond the transactional and laissez-faire styles.

Patient attitudes

Commitment and loyalty. Research affirms a strong relationship between charisma (a combination of idealized influence and inspirational motivation) and member commitment (Bass and Riggio, 2006; Conger and Kanungo, 1998). For example, a meta-analysis found a strong positive correlation (0.43) between a leader's charisma and member commitment (DeGroot et al., 2000). In industry, members can be committed to different entities (e.g. organization, leader, and task), and transformational leaders motivate members to commit to all entities (Bass and Bass, 2008).

Theoretically, patients in medical settings may also have three different sources toward which to direct their commitment: the organization (e.g.

the hospital or health network), the clinician, and the treatment or health behavior change (Platonova et al., 2008). Clinicians can serve as "ambassadors" and increase commitment to all three entities through transformational care (Bass and Avolio, 1991; Bass and Riggio, 2006).

Satisfaction. Members of transformational leaders are more satisfied with their work and their leaders than are members of other types of leaders (Lowe et al., 1996). Similarly, patients of transformational clinicians are likely to be satisfied with their clinicians and with their own efforts at health behavior change (Pascoe, 1983). This relationship arises from the ways in which each component of transformational leadership addresses patients' needs. For example, patients may be more satisfied with clinicians who display values that they admire (idealized influence), make meaningful distinctions between them and other patients (individualized consideration), provide them with opportunities to contribute to the solution (intellectual stimulation), and express optimism about their potential to complete the health behavior change (inspirational motivational).

Patient behaviors

Effort. Members of transformational leaders typically exert additional effort to complete the task at hand and to the overall goal (Bass, 1990; Bass and Bass, 2008; Bass and Riggio, 2006). Similarly, patients of transformational clinicians may exert particular effort toward health behavior change. Transformational clinicians encourage patients' efforts by engaging patients in treatment decisions in order to identify effective solutions that the patients also believe will be effective. When patients believe that a behavior change or treatment is feasible and effective, they may be more likely to exert more effort toward that end (e.g. Charles et al., 1997).

Task performance. Members of transformational leaders are more productive than members of other types of leaders (Bass and Bass,

2008). This finding holds regardless of whether performance is measured objectively (e.g. sales figures) or subjectively (e.g. self-rated outcomes; MacKenzie et al., 2001). Similarly, we propose that transformational clinicians engender better health outcomes from their patients than other types of clinicians. For example, patients of transformational clinicians are more likely to adhere to recommendations for health behavior change than patients of transactional or laissez-faire clinicians.

Potential mediators

In the following section, we describe potential mediators of the relationship between the transformational style of care and patients' health behavior. We focus on mechanisms that have empirical support from both the health and leadership literatures, namely, self-efficacy, trust, and intrinsic motivation.

Self-efficacy

Self-efficacy is an important factor in determining health behavior change (Bandura, 1977; Schwarzer, 1992). For example, the health belief model, one of the most prominent models of behavior change, originally included only beliefs about susceptibility to and severity of certain illnesses, effectiveness and feasibility of treatment, and barriers to treatment (Rosenstock, 1974). However, self-efficacy was later added to the model and became one of the most consistent and strongest predictors of health behavior change (Martin et al., 2010). By identifying self-efficacy as a predictor of behavior change, researchers underscore the clinician's role in motivating and inspiring their patients toward desired health behaviors by increasing patients' self-efficacy (Martin et al., 2010).

Fittingly, leadership research suggests that transformational clinicians may be able to enhance patients' self-efficacy (Shamir et al., 1993). These clinicians set high but achievable health goals and express confidence that patients will be able to successfully adhere to

recommendations (Koenigsberg et al., 2004). By involving the patient in the design of the recommendation through intellectual stimulation (or critical thinking; e.g. Campbell et al., 2010) and individual consideration, patients gain confidence in their ability to make beneficial health behavior changes. Moreover, transformational clinicians express optimism and enthusiasm for patients' progress, which elicits positive emotional responses from their patients and empowers patients to feel more self-efficacious (Kavanagh and Bower, 1985).

Trust

Patients' trust in their clinician can lead to many important patient outcomes (Kao et al., 1998; Lee and Lin, 2009; Thom, 2000). Our approach suggests a new method for gaining patients' trust: engage in transformational care (Gillespie and Mann, 2004; Pillai et al., 1999). For instance, when clinicians make meaningful distinctions between their patients (i.e. individualized consideration; Gerteis, 1993), or when clinicians work together with patients as team toward the goal of improved health (i.e. inspirational motivation), patients may be more trusting of their clinicians (Cook et al., 2007). This trust may lead to greater adherence to recommended health behavior change and ultimately to improved health.

Intrinsic motivation

Health researchers recognize that patients have different types of motivation for pursuing health behavior change (Deci, 1975; Pelletier et al., 1997) and that patients who are intrinsically motivated are more adherent to recommendations (Ryan et al., 1997). Leadership research suggests that clinicians may elicit more intrinsic motivation from patients by exhibiting the various components of the transformational style. For example, by exhibiting intellectual stimulation, clinicians ask simulating questions that prompt patients to think about their health in new ways, and they allow patients to work

through their ambivalence about initiating a new behavior (Rollnick and Miller, 1995). Therefore, when patients engage in behavior change, they may be more likely to accomplish the task because they themselves value the task, instead of initiating a new behavior because they want to avoid disapproval or rebuke from the clinician. Moreover, by engaging in individualized consideration, clinicians and patients work together to create a plan that is tailored to the patients' needs. Patients may be more intrinsically motivated to execute this plan because they are likely to offer suggestions that are inherently interesting and enjoyable to them.

Future directions for research on clinician styles of care

The study of clinician styles is likely to benefit most from research focusing on three primary goals: (1) developing valid and reliable measures of the full range of clinician styles of care, (2) examining mediators and effects of clinician styles, and (3) designing and developing evidence-based intervention programs to train clinicians to be more effective at motivating their patients. We discuss these research directions in the order in which we believe they should be pursued. That is, a valid and reliable measure of clinician styles is a necessary precursor to studies examining mediators and effects of clinician styles, and a body of evidence for the strongest mediators and effects of clinician styles is a necessary precursor to designing and implementing clinician training.

Developing measures of clinician styles of care

The development of valid and reliable measures of clinician styles is a critical step in advancing this novel line of research. Initially, researchers may benefit from adapting established leadership assessments into measures tailored to reflect clinician–patient relationships. For example, the Multifactor Leadership Questionnaire (Bass and

Avolio, 1999) may provide an appropriate foundation from which to build a measure of clinician styles.

Furthermore, researchers should engage multi-method approaches that extend beyond self-report questionnaires to avoid some pitfalls of leadership research. A prominent criticism of leadership research is that its conclusions have been drawn from data that suffer from common source bias (see Spector, 2006). To avoid this problem, health researchers can develop rater-based assessments that provide a valid and reliable way for trained coders to evaluate clinician styles by observing recorded interactions between clinicians and patients (e.g. Haskard et al., 2008).

Testing mediators and effects

Following the development of valid and reliable measures of clinician styles, researchers can then use these measures to examine mediators and effects of the various styles. We have proposed a set of mediators and effects that may be most fruitful to explore; however, our list may be incomplete, and as such, future research should cast a wide net.

Training clinicians

Effective leadership is teachable (Avolio, 2005). Researchers have been highly effective at designing and implementing leadership training to improve leaders' and members' outcomes (Collins and Holton, 2004; Dvir et al., 2002). Similarly, health research indicates that clinician training is an effective way to improve clinician and patient outcomes (e.g. Gysels et al., 2004; Thom, 2000). Therefore, future research on clinician styles can utilize the knowledge gained through studying the mechanisms of clinician styles to design and implement programs that train medical students and clinicians to be effective motivators. Researchers can borrow from established leadership training protocols as a source of information about the best strategies for teaching clinicians to be effective motivators (see Bass and Riggio, 2006).

Conclusion

Patient adherence to clinician recommendations is critical for improved health, yet nonadherence is pervasive. This article presents a novel and innovative approach for clinicians to increase adherence by increasing patients' motivation to initiate and maintain health behavior change. Clinician styles of care were conceptualized from the integration between the large but disparate fields of leadership and patient care, and our approach presents the potential for researchers and clinicians to enhance the value of clinicians by making them more effective motivators, especially in the context of primary, preventative, and chronic illness care. The novel tactic of examining clinician behaviors as patterned styles of care serves as an attractive training protocol that can achieve global positive outcomes for patients including increased trust, commitment, effort, satisfaction, and self-efficacy, with the ultimate reward of sustained and successful health behavior change.

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