Identifying Distinctive Traits of Healthcare Leaders in Israel:

In-depth Interviews with Senior Physicians

**Abstract**

*Background*: The public healthcare system in Israel is complex and diverse. Healthcare leadership is unique in its pursuit of preserving human life and other critical outcomes, including: patient satisfaction, employee satisfaction, and economic outcomes.

*Purpose*: To examine the views of physicians in senior management positions regarding the distinctive characteristics and roles of leaders in the Israeli healthcare system.

*Methodology:* 13 semi-structured in-depth interviews were conducted with physicians in senior management positions. Interviews were recorded, transcribed, and analyzed using the qualitative-phenomenological method.

*Findings:* Interviewees discerned leaders as exhibiting traits of transformational leadership and managers, as expressing characteristics of transactional leadership. Most interviewees asserted that physicians should act as social leaders promoting public health and equality in healthcare, beyond their clinical practice. They agreed that physicians should fill most senior positions in the healthcare system, provided they undergo appropriate training in management, leadership, and interdisciplinary collaboration.

*Originality:* Interviewees revealed gaps between the aspiration to lead, perceptions of physicians as leaders, and what occurs in reality: physicians wish to assume leadership roles in the healthcare system, and emphasize the qualities of transformative leadership, but medical education does not include leadership training. Therefore, there is a need to develop training programs for physicians in management and leadership. There is also a need to integrate physicians from various communities to promote local leadership in the healthcare field and to reduce disparities. Recently, the Covid-19 pandemic has placed the question of leadership within and outside the medical community in a broader social context.

*Keywords:* public healthcare system, transformational leadership, transactional leadership, social leadership, management

**Introduction**

“A manager in the healthcare system needs to understand the privilege granted him to practice this profession, to lead people in this profession, and to touch a person’s most sensitive places during his most difficult hours.” (Interviewee 5)

The public healthcare system in Israel is complex and diverse. It is comprised of health maintenance organizations (HMOs) and hospitals (which may be public non-profit hospitals, government or health-fund owned, or private). The system is regulated by the Ministry of Health and is greatly influenced by the Ministry of Finance. The Israeli healthcare system operates in line with several laws, including the National Health Insurance Law, the Patients’ Rights Law, the State Budget Law and others. The system faces pressure to reduce medical care costs. At the same time, it must strive to improve the quality of care, safety in care, and service for patients (Dodson, 2019). In the last decade, attention has been focused on the role of leaders and managers in healthcare services (Kumar, 2013). Leadership in the healthcare system is associated with crucial outcomes, such as: patient satisfaction, mortality rates, economic factors, employee satisfaction, and more (Rowitz, 2013). Some scholars see management and leadership as similar concepts. Others see them as opposites and believe that a good leader is not necessarily a good manager and vice versa (Wajdi, 2017).

The current study examines perceptions of healthcare leaders in Israel regarding their distinctive characteristics and their role in Israel’s healthcare system. Understanding these characteristics can serve as criteria for accepting healthcare workers into leadership training programs and for career advancement. No previous studies have been conducted in Israel that include in-depth interviews with physicians in senior management positions on the topic of leadership in the healthcare system.

*Background*

 Contrary to other systems, the healthcare system is unique in its impact on human life (Ayeleke *et al.,* 2018). Leaders in healthcare organizations must be committed to quality of medical care. They make decisions and draft guidelines that affect thousands of employees and hundreds of thousands of patients. Leaders have a decisive impact on the quality of medical services, on setting priorities within their institutions, on employees, and on patients. Managing a hospital, for example, involves complex and unique coping skills, given the constant stewardship over human life and the intense atmosphere in which a hospital operates (Dodson, 2019). Like other leaders, healthcare managers are expected to lead their organizations and employees with honesty, energy, and enthusiasm. However, healthcare leaders must also respond to the distinctive characteristics of the industry, as they strive to promote excellence in quality of care, patient satisfaction, relationships with physicians, and relationships with the community (McAlearney, 2006).

Burns (1978) distinguished between two types of leadership that are at opposite ends of a spectrum: transformational leadership and transactional leadership. According to the transformational leadership approach, leaders do not simply respond to expectations, but rather shape, create, and define them, together with those being led. Transformational leadership has four components. The first component, *individualized consideration*, refers to being an empathic and instructive leader. The second component, *intellectual stimulation*, represents aspects of leadership related to solving problems, challenging prevalent thought patterns, and encouraging creative thinking. The third component, *inspirational motivation*, involves emotional connection, trust, integrity, initiative, and the ability to look towards the future. This often distinguishes between an ordinary and an extraordinary leader; the latter has a clear vision, and enthusiastically conveys it to subordinates. The fourth component, *idealized influence,* refers to acting as a role model that others can emulate and identify with. This is the highest level of transformational leadership. This type of leader provides followers with a shared vision and mission, upholds worthwhile values and norms that give meaning to their actions, instills pride and a sense of mission, improves performance, and sets a personal example. Employees trust and value these types of leader, identify with and internalize their goals, wish to emulate them, and are likely to view them as role models and behave according to their ‘spirit’ even when not in the leader’s presence (Berkovich, 2016; Roth and Eyal, 2011). In contrast, transactional leadership refers primarily to leaders’ influence on followers in “relationships of exchange.” Transactional leaders determine what subordinates need to do in order to achieve the organizational goals and reward them according to their level of performance. This is a technical style, aimed at achieving short-term goals.

A survey of educational leaders in the fields of medicine and medical education in five countries investigated the core skills necessary for healthcare leaders (Çitaku *et al.*, 2012). The findings yielded five dimensions of health leadership: social responsibility, innovation, self-management, task management, and justice orientation. A study conducted in the USA (McAlearney, 2006) identified five key challenges to health care organizations in developing leadership: (1) financial constraints and budget-related challenges; (2) the organization’s representativeness in the community and among the patient population; (3) conflicts created by pressure to differentiate between groups of professionals and the leadership; (4) time constraints and challenges of finding time to participate in the program; and (5) technical obstacles related to the organization’s capabilities. The study found that looking outside the healthcare system can provide examples of program design and practices that can be adopted by healthcare organizations, such as leadership development programs in universities. A follow-up study by McAlearney (2008) based on 200 interviews with key figures in the field highlighted four ways to improve quality and efficiency in healthcare through leadership development: (a) improving the quality of the staff; (b) improving the efficiency of the organization's educational and development activities; (c) reducing ancillary expenses; and (d) focusing corporate attention on specific strategic priorities. Similarly, using a combination of surveys, interviews, and visits in US hospitals, Saint *et al.* (2010) investigated how leaders implement healthcare-related practices to prevent infections among patients at home. The researchers identified traits that characterize the behaviors of successful leaders who: (1) foster a culture of excellence and transmit it to their employees; (2) focus on overcoming barriers; (3) serve as inspiration for their employees; and (4) display strategic thinking and vision. Thus, healthcare leaders can play an important role in infection-prevention strategies. Successful leaders serve as role models and inspire employees, and they operate according to the organizational culture that the leaders are trying to integrate.

Some researchers have considered leadership among physicians in a broader sense and have examined the public and social aspects of leadership. Kirch and Vernon (2009) indicated that the medical profession must provide leadership in creating a healthcare system that does not tolerate discrepancies in treatment or outcomes and requires equal healthcare opportunities for every individual. As part of its professional charter, the American Board of Internal Medicine (ABIM, 2002) called for a commitment to public advocacy by every physician. The American Medical Association has recommended finding ways to encourage, facilitate, and reward physicians’ activities that promote social justice.

**Research Methods**

*Sample and Sampling Method*

Thirteen senior physicians in Israel were interviewed. They were selected using intentional sampling, based on their potential to offer rich information related to the purpose of this study. To maintain the anonymity of the interviewees, we did not specify interviewees’ role, workplace, and field of expertise, because the combination of these characteristics may reveal their identity. Table 1 presents the characteristics of the interviewees according to general categories.

[Table 1: Characteristics of Interviewees]

*Research Tools*

 Semi-structured, in-depth interviews were conducted, allowing for flexibility and for raising questions in addition to those that were pre-formulated. Sometimes the wording and order of the questions were changed according to the dynamics of the interview, in order to maintain continuity and flow, and to encourage openness among the interviewees. The questions were based on the literature in the field of healthcare leadership. Questions included (but were not limited to): How would you define a “leader” in the healthcare system? What do you think leaders’ qualities and skills should be? Are leaders in the healthcare system different, or should they be different, from leaders in organizations outside the field of medicine? What are the two or three main challenges facing the healthcare system today? What are the two or three main challenges you face? How can a leader motivate an interdisciplinary team?

*Research Procedure and Ethical Aspects*

After approval was received from the Ethics Committee at the Ashkelon Academic College, Israel, potential interviewees were contacted by telephone. The interviews were conducted by the researchers during the months of December 2019-February 2020. The duration of the interviews ranged from 25 to 45 minutes. Prior to the start of the interview, the objectives of the study were explained to the interviewees. They were asked to sign a consent form agreeing to participate in the interview and to it being recorded.

The interviews were conducted at a time and place convenient for the interviewees. All phases of the study were documented. Transcripts of the interviews were kept in a dedicated folder protected by a password. We contacted 14 potential interviewees, 13 of whom were interviewed. The 14th interviewee agreed to be interviewed, but due to the Covid-19 crisis, the interview had to be canceled.

*Analysis of Interviews*

The first author analyzed the recorded and transcribed interviews, using a qualitative-phenomenological approach (Moustakas, 1994) in three stages. First, the interviews were read carefully, in order to understand the perceptions of the interviewees. Notes were written and key phrases in the text were marked in order to identify preliminary thematic categories. In the second phase, the interviews were divided into categories, based on the identification of salient themes. In the third phase, these themes were organized into an integrative picture that described the interviewees’ perceptions of the phenomenon of leadership in the Israeli healthcare system.

**Findings**

The findings are presented according to the salient themes that emerged from the interviews: (1) the difference between a manager and a leader in the healthcare system; (2) the qualities, skills, and distinctiveness of a leader in the healthcare system; (3) the dilemma of whether a leader in the healthcare system should be a physician; (4) leaders’ role in addressing change and motivating an interdisciplinary team; and (5) perceptions of the physician as a social leader.

*Theme One: Differences between a Manager and a Leader in the Healthcare System*

 The interviewees differentiated between a “leader” and a “manager.” They agreed that there were similarities between these concepts, as well as significant differences. As stated by Interviewee 7, “Not every good leader is a manager, and not every good manager is a leader.” Some noted the difference between the short-term thinking and focus on achieving goals that is common among managers, as opposed to long-term thinking and ability to motivate people and work in a team, which are common traits of leaders. As Interviewee 8 described: “A manager gives the impression of someone who studies accounting and learns about subjects like human resources, etc. I think if a manager does not also have leadership qualities, it would be very bad. Leadership is knowing how to motivate people, work in a team, make decisions. I think these are worlds of content that touch upon and connect with each other and enrich each other.” Interviewee 10 added: “In management, there is a lot of the present tense. A lot of the here-and-now. A leader needs to create the future. To create direction. To make people believe in him, to believe in an institution, to believe in a framework, and to work with him to achieve a better tomorrow.” Interviewee 12 summarized it this way: “A manager takes care of the present, takes care of the execution of current tasks. A leader looks years ahead.”

 Other interviewees described management as technical or schematic, as compared to leadership, which indicates the ability to motivate people with a focus on creating a vision for the future. Interviewee 2 said: “They are completely different things. A manager can be very schematic. Very square. Not someone that people follow. He’s my boss, so I do what he wants. A leader is someone who serves as a role model. You want to be like him. Someone people will follow.” Respondent 11 spoke about perception from the subordinates’ point of view: “When someone says X is my manager, it’s a statement of fact. If someone says X is my leader, this is already a statement of judgement. This person leads me. I follow him. There is a significant difference between a leader and a manager.”

Respondent 13 presented a slightly different position, in which every manager is also a leader: “I do not differentiate between these concepts. I think there is no management without leadership. Every manager is a leader. A manager who is not a leader is not a good manager.”

*Theme Two: Qualities, Skills and Distinctiveness of a Leader in the Healthcare System*

This second theme is divided into two sub-themes. The first pertains to the qualities and skills of a good leader in the healthcare system. The second refers to the distinctiveness of a leader in healthcare organizations, as compared to other types of organizations.

*The qualities and skills of a good leader in the healthcare system*. Interviewees agreed that good leaders in the healthcare system should have humane qualities (such as altruism, compassion), be charismatic, inspire and motivate people, have a vision, work collaboratively, and be role models for the teams working under them. As noted by Interviewee 4: “There is something powerful about leadership; leaders are people who manage to motivate others to move towards a common goal. The ability to work collaboratively with different people and integrate them is very important. To separate the wheat from the chaff. Ability to organize and charisma are important in really getting people to act.” Interviewee 5 reinforced this idea and raised a difficulty commonly faced by leaders in the healthcare system; that of having to maneuver between ethical and economic aspects when resources are scarce: “This is a very complicated system. This is a system that, on the one hand, is a purely business-economic system, and on the other hand, it is a very empathetic, moral and ethical system. There is a lot of tension between the economic system and the ethical system in an era of resource scarcity. The leader needs to swim in all this, and, we hope, not drown.”

Interviewee 10 emphasized the need for having a vision for the future: “A leader needs to ‘mark the future’ in all sorts of ways – whether this means writing a visionary statement, communicating the vision, speaking about the vision, or helping others see this vision, to make it something real for them. To convince them that it can be accomplished. This process is, to my understanding, a significant component of this concept called leadership.” Interviewee 1 added: “The department manager is the father, mother, role model, leader, basically everything ... he has to love what he does. It involves a lot of altruism and sacrifice and setting a personal example.”

*Distinctiveness of a leader in healthcare organizations, as compared to other organizations*. The interviewees agreed that a leader is such regardless of the nature of the organization. Leadership requires the same foundation of qualities and skills regardless of the field in which one leads. However, they asserted that the medical field does have something inherently unique in its goal of preserving human life. Hence there is a need for a leader to make sacrifices and uphold a sense of justice, as the medical profession is a way of life. This is less often required in non-healthcare organizations. For example, Interviewee 1 illustrated the difference between engaging in the preservation of human life in the medical field and dealing with Excel spreadsheets. “Medicine is not a profession. It is a way of life ... it is much more than being a manager in a bank, or a manager in a government office. And, of course, it is related to human life. Who hasn’t woken up in the middle of the night, distressed that he had failed and a patient had passed away? It’s a bit different from saying, okay, this chart didn’t come out so well for me, and the national deficit went up or down by half a percent.”

Interviewee 2 mentioned the need to combine teaching and research beyond the clinical work itself: “In medicine, you have to be a clinician and a teacher and do research. You have to dedicate almost your entire life to these things. This profession and way of life is much more complex than that of other organizations.”

Several interviewees emphasized the impact of the public nature of Israel’s healthcare system. Interviewee 3 noted the contribution to the public healthcare system, calling it a kind of “Zionism”: “They should be people with grand vision and a great desire to contribute to the public system. They are all doctors who could make a lot of money working in the private sector, for drug companies or private clinics, but they literally dedicate their whole lives to the public healthcare system. So, they have to be people with a lot of commitment and a lot of Zionism. They are people who see the patients and the needs of the state as the central goal.” Interviewee 8 reinforced this idea: “Once the goal is to promote the health of the population, not to make money, then leadership should be very different, participatory. One should also be charismatic and motivate people, because people are already burned out.”

Several interviewees spoke of sharpening the focus on the humane and ethical aspects of leaders in the healthcare system. Interviewee 12 said: “They should be different. They should be especially attentive to the patients and have great humanity and compassion.” Interviewee 11 added: “The healthcare system is more complex because in the end it is about people. People who need medical care. And this is something else, something different, something valuable.”

*Theme Three: Professional Dilemma: Should Leaders in the Healthcare System be Physicians?*

Most of the respondents (11 out of 13) agreed that most senior positions in the healthcare system should be filled by physicians, with economists alongside them. The explanation for this was the need for familiarity with the healthcare system and an understanding of medical ethics. Another benefit noted was that physicians may be able to better motivate other physicians to follow them. Two interviewees argued that although it is preferable for such positions to be filled by doctors, in their opinion it is not mandatory.

Interviewee 5 explained why, in his opinion, a leader in the healthcare system should be a physician: “I have always argued that a leader or manager in the healthcare system should be a physician, and not a businessperson or economist. The person should have an understanding of the healthcare system. A person who has experienced working with patients, who breathes with the patients. Someone who understands patients’ needs, who understands the ethics and morals of the medical profession. Someone who has compassion for patients and can draw on experiences and knowledge accumulated in thousands of hours spent by patients’ beds. Someone who has moved up through the management roles in healthcare organizations, from the most junior level to the most senior.”

Interviewee 13 agreed, adding: “Someone who is not a physician will need five consultants who are physicians, and confer with them every time, which is, in my opinion, ineffective and incorrect.” Interviewee 6 spoke about the conflict of interest between economics and public medicine, which is built into the healthcare system. Commitment to patients should outweigh commitment to the system. Further, there is a built-in hierarchy in healthcare organizations: “I am convinced it should be a physician, because the economic interests are always in opposition to the interests of the quality of medical care, even in the Israeli public healthcare system. In order to choose between these two things, the manager needs to be a physician. They need to know economics, but must be committed first to the patients, not to the system.” Interviewee 3 emphasized the dilemmas and the need for decision-making, which may be more difficult for a non-medical person: “It is better for the leader to be medical personnel, because there are so many dilemmas and so many decisions to make, that the process is simpler if he is a physician.”

Two interviewees specifically spoke about the Director General of the Israel Ministry of Health (who resigned at the end of June 2020), who had formerly been a senior official in the Ministry of Finance. Interviewee 4 claimed: “The fact that the Ministry of Health in Israel is not headed by physician severely damaged the ability to serve as a leader in the world of healthcare. It is almost impossible to gain the trust of professionals and the general public, when you do not come from the world of healthcare.” Respondent 11 was less emphatic, and noted pros and cons, when referring to the former director general of the Ministry of Health: “In hospitals, the director is always a physician. The executive directors of some of the HMOs are not physicians. The Director General of the Ministry of Health is not a physician. Is it impossible? Certainly, it is possible. Do they successfully run the HMOs? They do successfully run the HMOs. It has advantages and disadvantages. The disadvantages are that it is more difficult for someone who is not in the system and does not understand its needs. On the other hand, he is not committed to anyone. He comes innocent, without prejudices, without a decision made in advance. He comes to learn.”

Interviewee 7 asserted that it is not necessary for everyone who manages an aspect of the healthcare system to be a physician: “I am in a minority position in this matter, but I don’t think there is any part of the healthcare system in which the person who manages it must be a physician. Today, there are so many considerations in the system that require knowledge in economics, engineering, motivating people, service, and marketing. Someone who comes from other worlds of content can definitely be a good manager.”

*Theme Four: Leaders’ Role in Addressing Change and Motivating an Interdisciplinary Team*

 All interviewees agreed that the primary and most significant challenge facing healthcare professionals today is providing quality medical services in an age when resources (budgetary, human resources, and infrastructure) are scarce. Leaders must argue with the Ministry of Finance to get additional budgets, as well as making reforms and changes within the system and motivating interdisciplinary teams. Interviewees stressed the need for cooperation in order to motivate people to follow them. Interviewee 1 offered the perspective of a departmental head: “There is what may be called the material challenge. The quarrels with the Ministry of Health and with the Ministry of Finance ... material things ... I say to my interns, friends, you got 800 in psychometric exams, but you are a bit more than that. We need to lead, we must have an opinion, we must have a direction. If we are specialists in internal medicine, then a third of the healthcare system in the country depends on us. We need to lead it and chart its path. Here and there, other people will join and contribute, each according their abilities.”

Interviewee 2 emphasized the need to develop individual pride and a sense of belonging, in order to promote cooperation between the various disciplines: “One of the important things in leadership is instilling individual pride. Therefore, if you are a leader and if you are talking about excellence, quality of work, and individual pride, then I think everyone will follow you. When people are proud to belong to a place and feel it is a good place, that makes everything easier.”

Interviewee 4 emphasized the need to motivate people and involve as many as possible in making decisions: “There is a strong phenomenon of conservatism and resistance to change. The leader has an important role in removing barriers, offering solutions. The approach should be participatory. On the other hand, we need a leader who ultimately makes the decisions, who sets the tone. So, there is a certain tension between someone who encourages cooperation and someone who, in the end, decides.”

Interviewee 5 emphasized the role of a leader in creating enthusiasm among all the professional disciplines and providing a sense of partnership in the process: “He must convey to the organization the need for change or the process he wants to change, to consult with staff members, according to their professions, to give a full picture, then to inspire them with enthusiasm and commitment. Giving them a sense that they are essential to the change, that their professionalism is important, and that this the only way to achieve it.”

Interviewee 7 stressed the need to reach people and evoke an emotional commitment, within a conservative system with many conflicts of interest: “One of the difficult problems of the healthcare system is that it is a very conservative system. You can do magic with your financial abilities and marketing, but if you do not reach people you will remain a good manager but not a leader.”

*Theme Five: Perceptions of Physicians as Social Leaders*

Some interviewees perceived the role of the physician as including being a social leader who participates in social processes and works to advance public health, beyond clinical practice. Interviewee 10 explained: “I personally believe that a physician has additional roles. I believe being a physician is something greater than the medical business. Someone must have qualities of leadership in order to make an impact in improving quality of life, or in preventive medicine. I think if a physician’s entire role is to be in the office, and there is a knock on the door, and a patient who has made an appointment to deal with something comes in and deals with it, and that's all – it’s a huge missed opportunity.”

Interviewee 5 agreed that every physician should also engage in the social aspect and show concern for the public: “Doctors cannot wash their hands of [public affairs] and stay only in the hospitals and engage only in their work. Whoever has the spark, the desire to change, must lead and be part of social, legislative, and governmental changes.” Interviewee 3 reinforced this: “Physicians are usually people with high capabilities. They are also people who others tend to listen to. They are considered intelligent, special people, so it is certainly possible to utilize these traits to advance public agendas.”

Interviewee 8 agreed with the above issues, and added that he sees public activity as a way of dealing with physicians’ burnout from their day-to-day work with patients: “I think it is good for the physician’s soul, to prevent burnout, to do things that are beyond the normal job. In the end, this is something that should be part of being a physician.”

In contrast, other interviewees did not think it is necessarily the role of all physicians to promote programs, legislation, or policies for public health. Interviewee 4 said: “It is perfectly legitimate for physicians to do their medical work and not serve as leaders and not be socially active. I think that, unfortunately, in our time of shortages in human resources, many people do not have the energy to make an impact in other areas. I think it’s a shame, because the voices of physicians are very important.” Later in the interview, this interviewee added that if physicians would be rewarded for social activities as part of the criteria for promotion, it would encourage them to be more involved.

Interviewees spoke about time constraints that limit what physicians can do. They noted physicians should engage in specific activities that others are incapable of. According to Interviewee 9: “Physicians’ time is precious. They must deal with the most critical things and not with things that others can do. The population will do things as they should, and physicians will be consultants for the medical aspect.”

Interviewee 1 agreed about physicians’ duty to act on behalf of society but noted a challenge in some physicians’ attitude towards activities they perceive as political in nature: “There is no doubt that physicians should have an opinion and a conscience. They should have a say in what needs to be addressed. The problem is that some physicians perceive themselves as simply ‘wanting to practice medicine’ Everything else is perceived as things to be understood, or things that are degrading, or God knows what. They want to come to the ward in the morning, take the cart, take care of their thirty patients as best they can, and that’s all. They do not want to argue. There is a lot of reluctance about these things. They are perceived as political or shallow or even a little bit degrading.”

Interviewee 7 presented a different angle, that of physicians as top students in the class, but conformists, not leaders or revolutionaries: “A physician is a conformist, not a rebel. Today, with this filter of admission [to medical school] of those who were most successful on the exams and had the highest grades, they are usually the most conformist youth, those who could sit for hours studying, not necessarily the type to be leaders. It’s true that you occasionally find ones that are exceptions.”

**Discussion**

The main goal of the present study was to explore the insights and opinions physicians in senior management positions have regarding the concept of leadership in the healthcare system. The interviewees agreed that “a leader is a leader not matter what,” and therefore the same basic qualities and skills are required, regardless of the nature of the organization. However, they expressed the belief that there is something unique about the field of medicine due to its goal of preserving human life. Therefore, there is a greater need for the leader to have a strong sense of justice and be willing to make sacrifices. The medical profession is a way of life entailing altruism, compassion, values, and fairness, which are less often required in organizations not dealing with healthcare. As explained by McAlearney (2006), there are enormous leadership challenges in organizations in all industries. However, leaders in healthcare must also promote high quality medical care, patient satisfaction, and relationships with physicians and the community.

The interviewees differentiated between the characteristics that are necessary for hospital administrators or academics, and the heads of hospital departments. For the former group, they emphasized the need for having charisma, a broad and long-term vision, etc. For the second group, they added the aspect of educating the next generation of physicians and the importance of leaders being role models for subordinates. This finding can be explained by the varying nature of their work and contact with subordinates. Hospital administrators have a broader vision and look at the long term and the direction they want to lead the hospital. Department managers are responsible for smaller units. They have close and direct contact with departmental staff members and with the patients. Since they are responsible for teaching interns, the future generation of physicians, there was greater emphasis on them imparting values of the profession and setting a personal example. Dodson (2019) explained, in this context, that hospital management involves complex and special coping skills, given the constant responsibility for human life and the intense atmosphere under which the hospital operates. Hospital administrators are committed to ensuring the quality of medical care. They must concentrate on three courses of action, defined by the interviewees as: defining a common vision and goal for all employees, being committed to striving for continuous improvement, and making informed decisions while prioritizing resources.

The interviews did not reveal any conceptual confusion between ‘management’ and ‘leadership,’ as indicated in previous literature (Wajdi, 2017). The interviewees were able to distinguish between the two concepts, despite their similarity. They attributed to leaders the qualities associated with transformative leadership: charismatic, inspiring, visionary, able to work collaboratively, and serving as a role model for the teams working under them. In contrast, managers were attributed features of transactive leadership: technical, a focus on results rather than processes, centralized, focus on immediate or short-term tasks, less visionary, and less concerned with the long-term. However, it was noted that despite the difference between managerial and leadership qualities, a leader should also have managerial qualities such as understanding financial issues and the ability to prioritize when faced with both short-term goals and long-term visions.

The four components of transformative leadership: individualized consideration, intellectual stimulation, inspirational motivation, and idealized influence, were defined by the interviewees as leadership traits. In contrast, interviewees attributed to managers the characteristics of transactional leadership, who they said acts in a more technical style, aimed at achieving short-term goals.

An interesting point that emerged in this context was that the interviewees did not address the growing tension between the characteristics of transformative leadership, on which they placed great emphasis, and the reality that the healthcare system is moving in a direction that is increasingly technocratic, bureaucratic, and measurable (accreditation, quality metrics, etc.). Such regulatory intervention impairs the autonomy of leaders, whose authority is reduced by systems of external control, monitoring, and supervision. They mentioned the need to maneuver between economics and medical ethics but did not mention the fact that they are subject to close bureaucratic and technical supervision, which must also dictate some of their daily conduct in all areas of management and practice.

Most of the interviewees, like Loh (2015), argued that there are many benefits to physicians leading healthcare organizations, such as: bottom-up leadership rooted in the field, professional and clinical knowledge, greater political influence, support for quality and safety, and greater trust of the public and peers. Physicians are perceived as having greater power and influence, as compared to those from other professions. Despite these advantages, they also noted disadvantages: difficulty in balancing between clinical practice and managerial challenges, a limited view of the profession, and lack of leadership training.

Regarding the healthcare system in Israel today, they noted that the executives of three out of Israel’s four HMOs are not physicians, the Director General of the Ministry of Health (at the time of the interviews) was an economist, and some authority has passed from physicians to various other professionals in healthcare. For example, cause of death may be determined by paramedics, and medication may be administered by a clinical nurse specialist. It can be said that the status of physicians is being undermined. The interviewees indicated that physicians are clinging to the past, a kind of "rearguard" for the preservation of physicians’ professional dominance in the system.

There is an inherent conflict that arises between different types of physicians. On the one side were those who viewed themselves as leaders, navigating the healthcare system into the future. They emphasized innovation, managerial as well as technological. They tended towards out-of-the-box thinking, organizational reforms, collaboration, developing new departments and services, etc. On the other side were those who adhered to traditional conceptions regarding management and leadership positions in the healthcare system. In many developed countries, it is considered acceptable to appoint directors of health institutions who are not physicians, but it seems that those in Israel are less ready for this change.

Working with various disciplines, each of which are protected by workers’ committees, requires system-wide thinking, cooperation, and a great deal of patience, according to the interviewees. These findings are consistent with those of McAlearney’s (2006) research on topics related to leadership development and challenges for healthcare organizations. Additionally, West *et al.* (2015) noted that a leader should serve the organization’s interests, taking into account the feelings and rights of those being led. Most of the interviewees said physicians are expected to be social leaders working on behalf of public health, beyond their clinical practice, for several reasons. First, the choice of a medical profession entails a value of responsibility towards the public. Second, public activity can be one of the ways physicians deal with burnout in their daily work. These reasons for public involvement among physicians were previously described by Savage *et al.* (2017). However, as the findings of this study show, not all interviewees share the view that physicians should work to promote health in the public arena. In part, this is because of what they see as a lack of leadership drive among graduates of medical school (“top students in class”).

In summary, on the micro-level, interviewees spoke about their feelings, experiences, and perceptions as physicians in senior leadership roles in the healthcare system. On the macro-level, they spoke about a preference for medical professionals to manage the healthcare system, and their perception of the physician’s role in the broadest sense (including public health advocacy). The medical profession dictates the special qualities that must be developed among leaders in the healthcare system: professionalism, gaining the trust of subordinates, having “backbone” in dealing with moral dilemmas, ability to make decisions on a regular basis, understanding the fine line between what is ethical and unethical, collaboration that includes providing explanations, compensation, and equanimity. At the same time, they must dictate uncompromising expectations and norms, insist on quality, create a humane and tolerant connection with subordinates, and set a personal example as a role model. Leaders who express these qualities can transform the healthcare system into an incubator of values, altruism, and quality, which will gain the public’s trust. Various programs around the world are trying to advance the field of leadership in healthcare. It is crucial to understand how to integrate the insights gained from research into medical education, taking into account the positions of physicians working in the system, and their attitudes towards the various healthcare professions. The Covid-19 pandemic of recent months raises additional questions regarding the role of leadership within and outside the world of medicine, in a broad social context.

**Study Limitations**

Only physicians were interviewed in this study. No representatives of other healthcare professions participated. The sample is relatively small (13 interviewees), since with the onset of the Covid-19 pandemic, physicians were no longer available to be interviewed. The current study took a qualitative approach, and by its nature required a careful integration between interviewees’ external and internal messages. Therefore, the credibility and reliability of the research must be maintained. According to Nutt-Williams and Morrow (2009) there are three main issues that ensure maintaining credibility and reliability throughout a study. The first is data loyalty. As described, the interviews were recorded and transcribed verbatim. The description of the findings was accompanied by a detailed presentation of quotations from the interviewees. This provided evidence for a match between the interpretation (categorization of themes) and the distinctive voices of the interviewees. Another issue is balancing between the meanings given by the interviewees (subjectivity) and the researchers’ interpretation (reflectivity). The interviews were transcribed accurately by a professional. The interpretive and cataloging analysis was done soon after the conclusion of the interviews. Finding common meanings and repetitive content in the analytic procedure reinforces credibility. The third issue is clear formulation of the research findings, potential methods of implementation, and a reference to their meaning and implications in social reality, as described in the following section on recommendations.

**Recommendations**

Considering the findings of this study, it is possible to recommend training programs for physicians in management and leadership during their medical studies, as part of their residency, and during continued studies. Physicians from various communities must be included in strategies to reduce health disparities in order to ensure and develop local leadership in the field of healthcare. Nash (2019) argued that healthcare leadership training programs have the potential for far-reaching impact. These leaders can then train and educate others, thus extending the benefits of leadership training programs beyond the participants themselves. In addition, in light of the interviewees’ statements, it would be beneficial to develop promotion and reward criteria reflecting physicians’ social leadership and activity on behalf of public health. Currently, the promotion track in the medical field is solely based on publications. In addition, the need for interdisciplinary work and cooperation with other healthcare professions should be instilled beginning in medical school and continued in subsequent leadership training programs. Future research in this field could include a larger sample of physicians and compare the different avenues of management and the various settings (hospital, communities, etc.). It is even possible to examine the special requirements for leadership during the Covid-19 pandemic. In addition, it is important to expand the scope to leadership in the various healthcare professions.

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