Power, leadership and transformation: the doctor’s potential for influence

Stewart Gabel

CONTEXT Power and leadership are concepts that are linked. Both are studied too infrequently in medical and health care settings, given the responsibilities and opportunities doctors and other health care personnel have to exert leadership and power appropriately to foster patient-centred and health care organisational goals.

METHODS This paper reviews Raven’s concept of power, clarifies the bases of power that are available to doctors in different roles and provides illustrations of the application of the bases of power in medical practice. The relationship between power and leadership is explored, with an emphasis on how power and leadership are linked through the personal characteristics and competencies of the leader.

RESULTS Transformational leadership illustrates the incorporation and elaboration of power strategies into a principles-driven, relationship-oriented and empirically grounded form of leadership. Illustrations of the appropriate and inappropriate use of power and leadership in health care settings are provided.

CONCLUSIONS The study of power, the study of leadership and their linkage should be incorporated to a greater degree into medical education at all levels. Strategies to achieve this end are suggested.
INTRODUCTION

The issues of leadership and power are rarely discussed in medical training and the mechanisms underlying the doctor’s potential for leadership and power, as well as the competencies that might help the doctor to employ leadership and power for the benefit of patients and the fulfilment of health care organisational objectives, are rarely taught.

Leadership involves working in socially appropriate ways to influence others in subordinate or follower positions to achieve principle-driven goals and objectives that these individuals may not have wanted to reach, may not have thought of reaching, or may not have had the courage or motivation to attempt on their own.1 For the purposes of this paper, power involves the strategies used by leaders to influence those in subordinate or follower positions to achieve these important goals. Doctors and health care professionals have the responsibility and opportunity to exert leadership and to employ power in many roles, such as those of hospital executive, medical staff president, residency director and private practitioner.

This paper will discuss the bases of the doctor’s power and the means by which doctors in different roles exert power. The paper will focus on the personal characteristics and competencies of leaders that result in the effective use of power that is incorporated into relationship-oriented and empirically grounded transformative leadership. To this end, the paper reviews dominant themes of power and transformative leadership from the fields of social psychology and leadership study, respectively, that have been and can be further advanced in medical settings. Educational strategies to foster an understanding of the link between power and leadership are provided and illustrations of how these concepts can be incorporated into medical education are offered.

TYPES OF POWER

Social psychology views power from the perspective of ‘social influence’.2 Individuals with power are able to influence others to think, feel and act in ways that these other individuals may not have chosen before this influence was exerted. French and Raven3 and subsequently Raven2,4,5 have developed and expanded a theoretical framework through which to understand the bases of power that has been highly influential over the last several decades. Raven defines six primary and several secondary bases of power.4,5 The roles that doctors assume and their abilities to influence others (e.g. medical staff members, students, patients) can be studied from within this framework.6-9 The six primary bases of power refer to, respectively, legitimate or positional power, expert power, informational power, reward power, coercive power and referent power.2,4,5 Table 1 provides descriptions of these six bases of power.

Doctors in administrative or supervisory roles (e.g. hospital executives, medical staff presidents) exert legitimate or positional power; specialist consultants tend to exert both informational and expert power in relation to medical, patient or lay groups which seek their advice on clinical issues. Supervisors of medical residents have, in addition to positional and expert power, potential reward and coercive power that manifest in the forms of formal evaluations and less tangible praise or criticism of the resident. The hospital executive, the specialist consultant and the supervisor will all be more successful (have greater influence) if they are also able to exert referent power, which is the power conferred by their followers’ or subordinates’ identification with the leaders (the empowered party) and their goals, which are then taken up by the followers.

THE IMPORTANCE OF STUDYING AND CLARIFYING TYPES OF POWER

There are diverse forms of power available to doctors as they attempt to influence patients, colleagues, administrators and others from the various roles they hold. Recognising and exercising the right type of power singly or in combination is important to achieve successful interactions and appropriate influence, as the following illustrates.

Illustration 1

A long-standing and successful chairman of a department of surgery had become less involved in the direct delivery of clinical care and more involved in administration over time. Nonetheless, the chair was asked to perform a complex procedure on a relative of another chairperson in the hospital. This request was made out of courtesy or because it was assumed that chairs would be among the most competent clinicians in their departments. The surgery chair felt he could not turn down a referral from a fellow chair and accepted the patient. Unfortunately, the surgery did not go well and complications ensued. It became clear to the chair himself, and to others in the department, that this complicated
procedure required more surgical skill than he possessed at that time.

Comment

The chair would have acted more appropriately if he had considered the best interests of the prospective patient and recognised that he could not fulfil the other chair’s expectations. His positional power had resulted in the referral to him, but he no longer had the expert power required to perform the surgery. He should have then referred the relative to a doctor in the department who was experienced in the clinical area of relevance and who could appropriately treat the patient based on his or her own expert power. Potentially, this might have resulted in a loss of future referent power and admiration for the surgery chair by the other chair or, depending on circumstances, may have increased his referent power because he showed integrity.

Illustration 2

The senior doctor in a busy group practice was treating a new patient with recently diagnosed hypertension. She advised the patient to take a particular medication twice daily, saying that it should help to control the patient’s blood pressure. She told the patient that the medication might make her sleepy and that she should avoid driving until the patient saw its effects. She asked the patient if she had any questions, but the patient, sensing the doctor was in a hurry, and feeling vulnerable and anxious about her condition, said she had none and thanked the doctor, who told her to return in 1 month. The patient made the 1-month appointment, but, subsequent to experiencing a rash and stopping the medication, decided not to keep it. She had not called the doctor when the rash appeared and confided to her husband that she did not ‘like’ the doctor, who had seemed curt, and thought she might

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<th>Table 1</th>
<th>The primary bases of power*</th>
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<td>1</td>
<td>Legitimate or positional power. Influence exerted by a person is considered ‘legitimate’ by others based on the position and authority that person holds. The medical staff president has authority that is accepted by all (e.g. conduct of medical staff meetings, implementation of procedures consistent with medical staff bylaws)</td>
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<td>2</td>
<td>Expert power. Influence exerted by a person based on his or her recognised knowledge, experience and expertise. The practising doctor has ‘expert’ power and influence on the beliefs and actions of patients, who assume that doctors are knowledgeable about various diseases and able to diagnose and treat their illnesses</td>
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<td>3</td>
<td>Informational power. Influence exerted by a person based on the ‘information’ he or she provides. This form of power overlaps in some areas (including medicine) with ‘expert’ power. The doctor recommends a particular medicine that he or she says has been shown to cure or improve a condition in a high percentage of patients. This information influences the decision of the patient to take the medicine</td>
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<td>4</td>
<td>Reward power. Influence exerted by a person based on tangible or intangible ‘rewards’ that are provided depending on particular actions. Medical school teachers influence students to study for examinations based partly on the rewarding power of praise and good grades</td>
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<td>5</td>
<td>Coercive power. Influence exerted by a person based on actual or threatened negative consequences that are or will be dispensed for particular deeds or actions. Medical school teachers influence students to study for examinations based partly on the coercive power derived from the threat of poor grades, potential failure and social stigma</td>
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<td>6</td>
<td>Referent power. Influence exerted by a person that often works in conjunction with another power type and increases or decreases the latter’s efficacy. This is a subtle and at times difficult to describe form of power that has been called ‘charisma’, the influence exerted by individuals through the force of their personalities that seems to make others identify with them and their beliefs or approaches. The individual exerting referent power becomes the object of reference for the person who is the target of influence, thus making the beliefs and values of people having referent power influential</td>
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*Based on the work of Raven and colleagues2–4
be ‘angry’ that she had not called after noticing the rash.

Comment

The senior doctor is recognised as having expertise in the treatment of hypertension. She has expert power in the eyes of the patient, and it might be expected that this would influence the patient to call when problems arose with the prescribed medication, but she did not. The patient may not have called because of the manner and style in which the earlier encounter had been conducted, which disregarded the need to establish a stronger relationship in order to build trust and influence the patient’s decision making in a positive way. The patient’s care suffered because the doctor had not developed or expressed her referent power, the power that motivates others, and results from identification with the referent power holder’s goals and values, which in this case referred to the doctor’s desire to see the patient’s condition treated successfully.

In both of these illustrations, the clinical encounter and potential for patient satisfaction and healing were weakened by the doctors’ inability to choose or express his or her power appropriately. In the first illustration, clarification of the appropriate type of power available to the chair was important and would have enabled him to exercise good judgement around a patient referral. In the second illustration, expert power was insufficient to achieve a good outcome and a positive doctor–patient relationship. The appropriate use of referent power might have helped. Yet, of the types of power discussed by Raven and colleagues, referent power, which has to do with interpersonal skills and social interactions, is probably the least used in health care.

The doctors in these two illustrations might have become more effective agents of influence through the appropriate use of power. Could they also have become leaders, individuals who use the bases of power broadly and on a sustained basis to influence others toward principle-driven goals and objectives? To address these questions, knowledge of transformational leadership is important.

TRANSFORMATIONAL LEADERSHIP

There are many forms of leadership and numerous descriptions and survey studies that characterise effective leadership in the health care field. Although some of these reports are helpful in particular contexts and in forming hypotheses, they often provide limited empirical support for their recommendations.

Transformational leadership is an empirically grounded form of leadership in which the leader models commitment to higher-order values and goals in a manner that motivates and inspires followers to achieve mutually recognised objectives. J. M. Burns is associated with the origins of transformational leadership: ‘The transforming leader … looks for potential motives in followers, seeks to satisfy higher needs, and engages the full person of the follower. The result of transforming leadership is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents.’

Transforming leadership ‘ultimately becomes moral in that it raises the level of human conduct and ethical aspiration of both leaders and led, and thus it has [a] transforming effect on both.’

Bernard Bass and colleagues have described four characteristics or activities through which transformational leadership moves followers beyond their immediate self-interests to greater accomplishments consistent with higher-order values and goals. These characteristics or activities are: idealised influence; inspirational motivation; intellectual stimulation, and individualised consideration. They are described in Table 2.

POWER AND LEADERSHIP: BRIDGING THE GAP

As the descriptions of the core elements of transformational leadership make clear, this form of leadership is principles-driven, values-oriented and relationship-based. Power holders become transformational leaders at least in part when they emphasise principles, values and relationship as core elements of their efforts.

Referent power, the most difficult to define of Raven’s bases of power, is a good example. Referent power is a form of actual or potential influence that relies on the personal characteristics of the agent. Referent power emphasises the identification of the subordinate with the power holder and the power holder’s goals and objectives. Transformational leadership also emphasises the personal qualities, principles and values of the leader, who serves as a vision-oriented and principled model for the follower. Both holders of referent power and transformational leaders who model idealised influence and inspirational motivation have been termed ‘charismatic’, although
the term should not be taken to imply an inherent, immutable characteristic which cannot, at least in part, be developed or learned.\textsuperscript{19}

Doctors also utilise legitimate or positional power and expert and informational power a great deal in their various roles. Doctors who model principles-driven approaches underlying these power types (as well as reward and coercive power types) become transformational leaders. Supervisors who simply tell a resident to increase a medication dosage beyond usual recommendations rely on expert and informational power (with some positional power added). Discussing with the resident the pros and cons and various considerations behind particular medication choices, while soliciting feedback around risks and benefits, provides not only knowledge and information (expert and informational power), but also leadership as the supervisor models the important principles of careful consideration, consultation and judgement in medical care. A resident with this type of supervisor is more likely to choose to emulate the supervisor and to ultimately become a leader with similar qualities than a resident who is simply told what to do.

The two illustrations used here highlight aspects of the bases of power. They can also be used to emphasise important aspects of transformational leadership. To do this, it might be well to imagine a medical student or resident or trainee in any of the health care-related fields observing these events.

**Illustration 1**

The chair of the surgery department would not be a good exemplar of idealised influence. He may be concerned that his standing in the medical community will suffer if he admits he is no longer ‘expert’ in performing a given clinical procedure. If he had recognised and stated his limitations, and referred the patient, he would have fostered the principle that patients should be provided with the best medical care available. He may or may not have increased his own referent power at that point, but he would have provided a model of principles-driven concern for the well-being of patients, regardless of who provides the specific treatment. This approach might have been more helpful to the professional growth of the resident or trainee than the experience of seeing the chair perform the surgery.

**Illustration 2**

The patient consulted the doctor, who is expected to have expert power, for treatment. The doctor did have expert power, but not referent power. She did not create an image or goals with which the patient could identify. Had this doctor modelled principles-driven care, she might have instructed the patient more broadly, spent more time with her, and conveyed to her the importance of the medication regimen to her health (idealised influence). She would have tried to motivate her to adhere to the medication regimen, possibly by talking about

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**Table 2 Characteristics of transformational leadership\textsuperscript{*}**

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<th>Type of Influence</th>
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<td>1. Idealised influence</td>
<td>The leader conveys support for principles-driven approaches to the many tasks in which he or she is involved. The leader’s behaviour and statements follow mission-driven objectives and a vision for the future that is values-oriented. Leaders of this type act as role models for others. They are persistent and focused, and show dedication and commitment to their vision. They are sometimes thought of as charismatic.</td>
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<td>2. Inspirational motivation</td>
<td>The leader inspires and motivates followers to pursue with him or her principles-driven approaches and a vision of the future. The leader accomplishes this by displaying qualities such as conviction, dedication, energy and optimism, and expressing his or her own values.</td>
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<td>3. Intellectual stimulation</td>
<td>The leader challenges subordinates to find new or better solutions to existing questions or problems. The follower is encouraged to be a problem solver, to embrace creative and empowered approaches.</td>
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<tr>
<td>4. Individualised consideration</td>
<td>The leader attends to followers as individuals and shows interest in their growth and development. The leader encourages followers and supports and mentors them in their work.</td>
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\textsuperscript{*}Based on the work of Bass and colleagues\textsuperscript{10,18,19}
the benefits to her health and sense of well-being if she was adequately treated (inspirational motivation). She might have suggested that the patient read appropriate literature about hypertension (intellectual stimulation) and asked about any concerns she might have about diet or lifestyle changes that a stricter medical regimen would require (individualised consideration). All of these are signs of transformational leadership.

**Empirical evidence**

Although many of the concepts of power and of leadership presented here have intuitive appeal, there is also empirical evidence supporting the appropriate use of power in the medical setting and a good deal more supporting the value of transformational leadership applied in health care settings. Raven’s bases of power model is partly categorical: for example, leaders who hold appointed positions are designated as having ‘legitimate’ or positional power, whereas doctors with medical training are considered to have expert power. Other components, such as reward, coercive and referent power, are more process-oriented and can be operationalised for empirical study, although more needs to be done to realise this goal for the concept of referent power in the health care setting.

Health care researchers, however, increasingly study the importance of ‘communication’, which is conceptually allied with referent power. Communication has been defined in several ways, including as the ability to actively listen to patients, to show empathy, to speak clearly and directly, and to convey information appropriately. These are all qualities that establish stronger relationships between health care providers and patients and influence the latter to comply with the recommendations of their providers. Essentially, good communication skills would be expected to enhance the referent power of providers. Kerse et al., for example, enrolled over 300 patients in a study to assess the relationships between various factors and medication compliance. Patients completed assessments related to their relationships with their doctors prior to and after medical visits. They were later asked about their compliance with medication that had been prescribed. The major finding was that the patient’s perceived ‘concordance’ with the doctor around the presenting problem and how it might be managed was significantly related to medication compliance. Patients who reported high levels of concordance with their doctors were one third more likely to demonstrate medication compliance than those with lower concordance ratings.

Transformational leadership has been studied extensively over the last several decades. It has been applied within and outside of health care settings and has been shown to increase staff satisfaction and perceptions of leader effectiveness. It has been shown to reduce burnout. Empirical study has been facilitated through the development of the Multifactor Leadership Questionnaire (MLQ) by Bass and Riggio, of which several versions exist. Using the MLQ (or another scale), respondents rate their leaders on items developed to assess the core components of transformational leadership. Questions also elicit respondents’ level of satisfaction with their leaders. Many studies have used this approach. Menaker and Bahn, for example, used the MLQ to study the perceptions and satisfaction of over 300 doctors at an academic medical centre with their primary doctor leaders (division or department heads). Findings indicated that higher ratings of transformational leadership on each of the dimensions of the MLQ were significantly associated with faculty members’ expressed satisfaction with their leaders.

Other studies have addressed the relationships of transformational leadership with external criteria, such as workplace satisfaction, productivity or burnout. Weberg, for example, reviewed the literature on the relationships between transformational leadership and nursing staff satisfaction and burnout. There were significant associations between higher ratings of transformational leadership among nursing staff and increased staff satisfaction and decreased burnout. Xirasagar et al. asked executive directors of community health clinics to rate the medical directors of the clinics using the MLQ. They were also asked to assess the medical director’s effectiveness, subordinates’ degree of effort and the achievement of clinical goals. Significant associations were found between these dimensions and the ratings of medical directors on transformational leadership scales.

**Educational strategies**

Power, and its transformation into leadership that will enhance patient care, health care practice and the effective use of resources in health care organisational settings, depend greatly on medical education. The conceptual bridge between ethical and appropriate power and leadership, as described here, must be taught to, understood and later applied by students and trainees in the health professions at all levels in order that the benefits of these concepts might be realised. How can this be accomplished?
The first step requires the recognition by current health care leaders and decision makers of the importance of education in power and leadership for students and trainees who are soon to become leaders and decision makers themselves. This will mean more than theoretical agreement about the importance of these topics and will require willingness to devote resources to education about these areas at multiple levels. This, in itself, involves the use of power and leadership in the provision of the highest-quality medical education to those who are being trained in the health care professions. Fortunately, the number of leaders and decision makers who recognise the importance of the topics involved appears to be increasing.

Courses, seminars and discussion groups all have a place to play in the implementation of training and education in the dynamics and application of power, leadership and the relationship between the two. Basic questions pertaining to issues such as what power is, what types of power can and should be exerted in given situations, and how leaders might use power appropriately and ethically are important to ground the educational effort, which should be focused on the numerous arenas in which health care is delivered or expressed, from practice to academic institutions to organisational settings.

If the author’s experience is a measure, the most engaging educational activity for those in the health care professions are actual discussions and reviews of scenarios in which power and leadership have been exerted, with positive or negative outcomes. These reviews may involve actual scenarios that have occurred (with appropriate safeguards around confidentiality) or vignettes formulated to illustrate particular issues, as do the vignettes presented in this paper.

For example, trainees and students would review and respond to the vignette of the doctor with expert power, who found her patient did not comply with recommendations (and indeed did not even return for an appointment). They would respond to questions such as: ‘What were the underlying assumptions of the doctor that made her believe her “expert” advice would be followed?’ ‘Are these valid assumptions?’ ‘How might the doctor have tested these assumptions?’ ‘How might the use of “referent” power or the ability of the doctor to communicate more effectively have influenced the patient to be an ally in the latter’s own health care?’ Other questions on the same scenario might include: ‘What were the possible reactions of the patient to the doctor?’ ‘Was this patient (or other patients) more likely to be influenced by expert power or by referent power?’ ‘What are the dangers for the patient (and the health care provider) of the application of referent power without expert power?’

Another educational approach goes further by asking students and trainees to role-play the respectively more and less powerful roles of leader and subordinate. For example, in the vignette involving the department chair who felt compelled to demonstrate his expert power by performing a surgery, one trainee might play the department chair and offer his or her thoughts, concerns and fears around personal standing and reputation when considering the request made of the chair, and other trainees might role-play or express what they might be thinking or feeling about the chair’s predicament and decision. Would these trainees, now asked to consider themselves as transformational leaders, react the way the chair had reacted? Considering the resolution of the chair’s dilemma through his recognition of the need for transformational leadership that would prioritise the patient’s well-being would be an important dimension of the educational exercise. This would refer to the issue of ‘idealised influence’, upholding the values orientation of medicine and the principle of beneficence that is at the heart of health care.

DISCUSSION

The study of power and leadership and the relationship between them provides important information that can potentially improve the delivery of health care at multiple levels. The study of power, leadership and the relationship between them also provides important opportunities and challenges for medical educators (and for health care trainees at all levels) who should implement additional education and training in these concepts in order to achieve wider health care goals.

The study of power and the bases on which it rests provides a framework from which doctors and other health care personnel can consider how they might increase their appropriate use of power (e.g. by communicating information or expertise more effectively) and avoid the pitfalls associated with the inappropriate use of power (such as that exhibited by the doctor who assumed that patients’ assumptions about her expertise would lead them to comply with recommendations and that it was unnecessary to establish a strong relationship or referent power).
Transformational leadership goes further than the study of power in providing a framework for leaders to follow in demonstrating effective, relationship-oriented leadership. It adds additional dimensions to the ‘charismatic’ aspects of transformational leadership (idealised influence and inspirational motivation) through the importance it attaches to intellectual stimulation and individualised consideration. These latter areas focus more directly on the leader’s attention to the follower’s own creative behaviour that challenges existing assumptions and on the follower’s own growth and development.

Additional emphases of transformational leadership refer to the follower’s perceptions of the effectiveness of the leader and to the ‘transformation’ of followers (and perhaps leaders too). Transformational leadership intends for followers to become leaders, a process that is enabled by the experiences, education and training afforded to these future leaders.19

In some ways, referent power represents the most direct bridge from the application of power to the application of transformational leadership. It is often through referent power, which focuses on the power holder and his or her values, goals and aspirations, that power is successfully wielded. As holders of referent power increasingly model principles-driven and values-focused attitudes and behaviours, they become more transformational leaders, able to function as models for and to inspire others.

In the same way, as doctors and other power holders define, clarify and embody principles-driven approaches to their positional or expert/informational power, they become transformational leaders. The same may be said for power holders who exert reward and coercive power. It is also important to model and communicate the principles and values behind the use of these types of power.

CONCLUSIONS

Power and leadership are linked. From the perspective of social psychology, both can be seen as involving ‘social influence’, the attempt of one or more individuals to alter, modify or change the attitudes, reactions or behaviours of another individual or group. Leadership in health care involves the employment of various power strategies or tactics to achieve ongoing and often longer-term principles-driven and values-oriented goals in the service of patients and the health care mission.

There are several types of power that can be employed to influence personal or organisational change. The exercise of power becomes transformational leadership when the principles, values and relationship orientation of the leader or power holder are emphasised and modelled on an ongoing basis across a range of goal-directed activities. The study of power and leadership, and the relationship between them, should receive increased emphasis in graduate and postgraduate medical education.

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