# A call for transforming physicians-as-administrators into professional hybrid medical leaders: Insights from northern India

## Abstract

**Purpose** – The purpose of this paper is to understand the non-clinical challenges of physicians in northern India and to re-imagine an alternative scenario of hybrid professional medical management and leadership where physicians enact roles as strategic boundary spanners.

**Design/methodology/approach** – In this qualitative study, 30 in-depth semi-structured interviews were conducted with men and women physicians and thematically analysed.

**Findings** – Physicians reported that they were unprepared formally for mainly ad hoc non-clinical responsibilities. Findings identified a range of six types of aspirational, willing, incidental, ambivalent, agnostic, and actively resistant behaviours amongst physicians who were expected to undertake administrative, rather than strategic leadership tasks.

**Originality/value** – To the best of the authors' knowledge, this study makes a novel theoretical contribution to the dearth of literature on medical leadership in a low-middle income South Asian country. By examining physicians' views on their non-clinical responsibilities, this study highlights the strategic potential for developing physicians formally as professional hybrid managers and leaders who effectively bridge medical and managerial domains beyond the current scenario of physicians operating as untrained administrators.

**Keywords** Administration, Hybrid leadership, India, Medical leadership, Physicians

## Introduction

Effective healthcare systems increasingly rely on medical leadership (Stoller, 2020) where physicians combine both medical and managerial roles as hybrid leaders to improve quality and safety (Kirkpatrick *et al*., 2023). A hybrid leader or manager acts as a "bridge, who both represents the professional agenda and embodies...a managerial one" (Ferlie *et al*., 1996, p. 194). Scholars have argued that clinicians who are formally educated in management and occupy executive roles experience a greater sense of belonging and organisational commitment (Hoff, 2001). Yet, literature on whether healthcare organisations perform better led by individuals with medical or non-medical backgrounds is mixed (Mohmad *et al.*, 2024). In the context of India, there are significant medical leadership competency gaps and a lack of formal medical leadership development opportunities in public sector healthcare (Gulati *et al*., 2023) to support initiatives such as implementing Ayushman Bharat PM-JAY (a national public health insurance scheme) for universal health coverage (Grewal *et al.*, 2023).

While physicians accept leadership roles with varying degrees of enthusiasm (Sarto and Veronesi, 2016), we know little about medical leadership in non-western healthcare contexts (Nzinga *et al*., 2019). To address this gap, we conducted a qualitative study during 2023 in India to explore hybrid leadership behaviours amongst physicians. The findings in our study highlight the need to strengthen physicians' leadership capacity (Currie *et al.*, 2021) aligned to India's national health policy (2017) and Vision 2035 (Blanchard *et al.*, 2020) beyond the current scenario of physicians engaging in ad hoc routine administrative tasks for which they are not trained. Countries like Canada, the Netherlands, the UK, and USA have integrated leadership training and models in medicine (Keijser *et al.*, 2019; Thoma *et al.*, 2023), however, India lacks a formal approach to medical leadership development based on a national competency framework. We, therefore, seek to address the following research question:

> *What are physicians' views on the non-clinical tasks they carry out in top hospitals and medical schools in northern India?*

We begin by exploring the Indian context for physicians and review literature on leadership, particularly hybrid leadership, management and healthcare administration. We then outline the data collection and analysis methods and present findings on different types of administrative behaviours and attitudes. Finally, we discuss practical implications for upskilling physicians formally to enact effective leadership in professional hybrid management and leadership roles rather than routine ad hoc administrative tasks like rotas.

### *Context*

Traditionally, senior male physicians in India assume hospital CEO roles without any formal leadership training (Gayathri and Warrier, 2022; Gulati *et al*., 2023). Consequently, there are significant leadership competency gaps across public and private sectors (Gulati *et al.*, 2019). India also differs from countries where many hospital CEOs are from non-medical backgrounds (Bode and Maerker, 2014; Moores *et al.*, 2021).

The lack of attention to medical leadership is surprising as India's national health policy "recognizes that human resource management is critical to health system strengthening and healthcare delivery …. [and] recommends development of leadership skills, strengthening human resource governance" (Ministry of Health and Family Welfare, 2017, p. 18). India's Vision 2035 emphasizes the need to "[e]stablish a governance framework that is inclusive of political, policy, technical, and managerial leadership at the national and state level" (Blanchard *et al*., 2020, p. xiv). Meanwhile, physicians in India experience excessive workloads in delivering care and as victims of violence (Davies *et al*., 2024), which results in high levels of burnout (Purohit *et al*., 2021) and means that they must learn on the job how to undertake non-clinical tasks.

India has the world's fastest-growing major economy (Ha, 2024) and it is predicted to be the world's third largest by 2027 (Inamdar, 2024; Pal Chaudhuri and Jacobs, 2024). According to India's Ministry of Health and Family Welfare (2022), the country's doctor-population ratio in the country is 1:834, higher than the World Health Organization's (WHO) standard of 1:1,000. Medical tourism is booming but there is increasing violence against doctors (Pai *et al*., 2024; Samant *et al*., 2024) and significant emigration of physicians (Saxena and Godfrey, 2023). Despite the expansion of medical education and healthcare through the creation of 22 new AIIMS (All India Institute of Medical Sciences) nationally, medical leadership development has been neglected (Gulati *et al*., 2018).

Studies on and reviews of leadership development for physicians have mainly focused on western and Anglophone healthcare systems (e.g., Geerts *et al*., 2020). There is a need, therefore, for more insights into physicians' leadership in contexts such as India (Chambers, 2023, p. 811) "because doctors were traditionally (and still are in some countries) the de facto leaders and because the presence of doctors in leadership positions has been found, for example, as executive or non-executive members of healthcare boards, to be conducive to a better quality of clinical care." Moreover, India – as the world's most populous nation (Hertog *et al*., 2023) – merits attention as economic well-being is linked to population health and to addressing health sector workforce shortages (Mehta, 2024).

Young doctors in India face uncertain career trajectories as limited funding constrains working conditions (Jeffery, 2024), however, India has a large population of young people to transform the country (Panagariya, 2024). The brutal rape and murder of a trainee doctor at a government-run hospital in Kolkata in August 2024 revealed a culture of lack of respect and protection for physicians (particularly women) in India (Davies *et al*., 2024). Moreover, government policies on women-led development or Nari Shakti (Government of India, 2024) and reforms required for India to achieve developed country status by 2047 (Ministry of Commerce & Industry, 2024) suggest that physicians' well-being matters for the country's prosperity.

This exploratory study of physicians' views in northern India about their challenges and leadership development needs can inform how capacity building to equip physicians who enact hybrid leadership roles. This paper extends Gulati *et al*.'s (2020, 2021, 2022) pre-pandemic work on leadership competencies and evaluation of a development programme for physicians.

*Conceptual framework*

Kotter (2013) contends that "management is a set of well-known processes, like planning, budgeting, structuring jobs, staffing jobs, measuring performance and problem-solving" while "[l]eadership is about vision, about people buying in, about empowerment and, most of all, about producing useful change." Leadership has been conceptualised as influencing organisational activities (Stogdill, 1950) and mobilising others to want to achieve shared goals (Kouzes, 1997). Benmira and Agboola's (2021) review of key leadership theories in *BMJ Leader* highlight trait, behavioural, situational, and new leadership. These are based respectively on leader characteristics; transformational, and transactional behaviours (Bass, 1990); context, and a more recent focus on empowering followers through inclusive, collaborative and shared leadership styles. The authors also emphasize the value of compassionate leadership in healthcare (West, 2021). This links to Greenleaf's (1970) notion of a servant leader who seeks to serve others and take care of their needs. Using a servant leadership lens, Farrington and Lillah (2019) found a significant positive relationship between private hospital physicians developing others and job satisfaction. Importantly, we also need to understand complexity leadership (Uhl-Bien *et al*., 2007) which is required for turbulent times that demand an appreciation of dynamic systems, processes, and interactions.

It is important to distinguish literature on healthcare/hospital administration and to consider how administration, management and leadership complement each other (Algahtani, 2014). Cronin *et al*. (2018, p. 8) suggest that "a hospital administrator's primary role is to plan,

coordinate, and deliver health care services to a defined community." Our original assumptions in this study to focus on physician leadership in top institutions in India were questioned in practice when we found highly educated physicians being drawn into mundane administrative non-clinical work because of their lack of confidence in hospital administrators. These physicians undertook administrative tasks themselves related to rotas, appointments, admissions and procurement which could be delegated/automated to enable them to engage in more meaningful institutional work and innovations through pluralistic (Currie *et al*., 2021) leadership. An understanding of the downsides of transformational leadership approaches (Van Knippenberg and Sitkin, 2013) found in high power distance cultures like northern India (Mathew and Taylor, 2019) with heroic hospital CEO physicians in charge who draw on what Haslam *et al*. (2024) call "zombie leadership", and outmoded approach that "flatters and appeals to elites."

An understanding of hybrid managers is useful in this study to help us to re-imagine how physicians in India might rise above being draw into routine administrative tasks to become more strategic in adding value by combining clinical and non-clinical expertise. Hybrid managers are "individuals with a professional background who take on managerial roles, requiring them to move between different organizational groups" (Croft *et al*., 2015, p. 1). In contrast, Buchanan (2013) calls non-clinical managers "pure play" managers. In this field of literature, Kitchener (2000) studied hospital clinical directors, McGivern *et al*. (2015) focused on medical consultants, and Currie (2006) researched nurse managers.

The concept of hybrid leadership is used widely in leadership literature (e.g., Byrkjeflot and Jespersen, 2014; Fulop, 2012; Llewelyn, 2001) to understand how physicians bridge and blend both managerial and clinical responsibilities. This enables physicians to influence processes and systems informally or formally with managerial behaviours (Sartirana *et al*., 2019; Spyridonidis *et al*., 2015). Mintzberg (1997) warned, however, that "bundling" clinical activities, teaching, research and administration in hybrid roles can be distracting and result in sub-optimal outcomes. Goodall (2011) found that the highest ranked hospitals in the *US News and World Report's* "Best Hospitals" ranking were disproportionately led by physicians. However, some studies on physician leadership provide mixed results about its efficacy (Mohmad *et al*., 2024). Fulop (2012) conceptualizes hybrid leadership enacted by clinician managers as a challenge to traditional assumptions about heroic leadership and more recent interest in distributed leadership. She claims that leader hybridity enables an individual to act as a boundary spanner in facilitating healthcare changes to address both professional and organisational challenges.

Rotenstein *et al*. (2018) argue that "[m]edicine involves leadership. Nearly all physicians take on significant leadership responsibilities over the course of their career, but unlike any other occupation where management skills are important, physicians are neither taught how to lead nor are they typically rewarded for good leadership." Even in Switzerland, which in 2020 had 4.4 physicians per 1,000 population (World Bank, 2021), Lüchinger *et al*. (2024) found that physicians were unsure about their roles as leaders as they lacked leadership training. Physicians felt insecure, confused, and frustrated with low feelings of self-efficacy because of the over-emphasis on academic medical knowledge and skills in siloed organisations. Physicians in Geneva University Hospitals in this qualitative study (Lüchinger *et al*., 2024) resorted, therefore, to learning from observing role models, experimentation, and drawing on their personal resourcefulness instead of formal leadership development. Thoebes *et al*.'s (2024) systematic review emphasizes the importance of identity, integrity, and trust in physician-leadership in addition to expert leadership. The latter is characterised in terms of inherent task and relational knowledge with high levels of ability in the core business, years of industry experience, and effective leadership capabilities drawing on cognitive ability, resilience, confidence and self-control (Goodall, 2012). Problems arise when physician leaders struggle with their dual identity conflict in their hybrid roles as physicians and administrators (Andersson, 2015; Kippist and Fitzgerald, 2009). Higher status physicians, especially surgeons,

who are used to a command-and-control style of leadership (Tarnoff *et al*., 2020) may find more empowering, persuasive and political leadership styles required in hybrid roles harder to enact to achieve medical and business objectives (Stewart *et al*., 2017). Elzahhar *et al*.'s (2023) work on consultant surgeons' motivations to lead and the impact of their leadership styles on junior doctors' motivations from a relational perspective drawing on Goleman's (Goleman, 1995, Goleman *et al*., 2013) six styles of authoritative, coaching, affiliative, democratic, commanding and pacesetting approaches. Savage *et al*. (2020) advocate for a virtuous cycle by creating willing medical leaders by investing in them and engaging through participative approaches.

Literature on hybrid leadership suggests a range of behaviours adopted by professionals. An aspirational approach is evident when healthcare professionals view hybrid roles as opportunities to be more influential and make a difference with the prospect of moving into a managerial career (Bresnen *et al*., 2019). Willing hybrids embrace their core professional identity and managerial role (McGivern *et al*., 2015). In contrast, McGivern *et al*. (2015) suggest that incidental hybrids can be encouraged/persuaded into a managerial role while remaining strongly clinically oriented. On the other hand, ambivalent hybrids may be open to moving into management and adaptable, but they remain in two minds about the transition (Bresnen *et al*., 2019). A fifth type of hybrid is the agnostic who is sceptical, unenthusiastic, and "strongly disinclined to accept the mantle of manager" (Bresnen *et al*., 2019, p. 1359). Finally, there are individuals who can be characterised as active resistors who strongly oppose taking on administrative tasks that detract from their primary professional identity.

Ideally, hybrid leaders reconcile professional and managerial narratives and logics (Currie and White, 2012; Llewellyn, 2001; McGivern *et al*., 2015) as boundary spanners and knowledge brokers (Burgess *et al*., 2015; Kislov, 2014). This capability relies on hybrid leaders retaining their legitimacy amongst peers who are from their primary profession (Burgess and Currie, 2013; Dopson and Fitzgerald, 2005). Hybrid managers often face identity challenges (Croft *et al*., 2025) with difficulties in reconciling different ideologies and understanding their sense of self to achieve stability in their role (Watson, 2008, 2009). They must deal with ambiguity and changing narratives (Sveningsson and Alvesson, 2003).

## Methods

### *Study design*

This exploratory qualitative research is designed to investigate physicians' attitudes to undertaking non-clinical tasks and scope for them to be professional hybrid leaders. Semi-structured interviews were conducted to understand physicians' perspectives on non-clinical challenges and development needs despite relentless and excessive clinical workloads. The interviewer was a semi-insider non-clinician in one of the institutions who was able to access very busy physicians (Brannick and Coghlan, 2007). The first author's institutional ethics committee approved the study.

### *Sampling*

Thirty consultant-level physicians from three leading medical institutions were interviewed (Table 1). Interviewees were conveniently sampled based on their potential to yield relevant information (Kelly *et al.*, 2010). They were 34 to 65 years old, with five to 35 years' experience. In the sample, 53% were women, there were 97% postgraduates, and participants were working in clinical (37%), surgical (30%), para-clinical (23%), and administration (10%) departments.

**Table 1.** Interviewees' profiles. Codes: M - man; W - woman

| Code | Age (Years) | Degree | Experience (Years) | Position | Department | Time on non-clinical tasks | Public or private |
|---|---|---|---|---|---|---|---|
| 1M | 40 | MD | 12 | Associate Professor | Internal & emergency medicine | 20% | Public |
| 1W | 41 | MS | 11 | Associate Professor | ENT | 70% | Public |
| 2M | 48 | MS | 17 | Associate Professor | Orthopaedics | 30% | Public |
| 2W | 44 | DM | 22 | Professor | Neurology | 15% | Public |
| 3M | 60 | MS | 30 | Chairman | Orthopaedics | 100% | Private |
| 3W | 35 | MD | 9 | Associate Professor | Pathology | 20% | Public |
| 4M | 44 | MD | 20 | Medical Officer | Clinical | 30% | Public |
| 4W | 48 | MS | 18 | Associate Professor | Paediatric surgery | 40% | Public |
| 5M | 47 | MD | 16 | *Additional Professor | Hospital administration | 100% | Public |
| 5W | 56 | DM | 30 | Professor | Neurology | 15% | Public |
| 6M | 46 | PhD | 25 | Head of Department | Physiotherapy & medical rehabilitation | 40% | Public |
| 6W | 57 | MD | 35 | Professor | Psychiatry | 30% | Public |
| 7M | 52 | DM | 28 | Professor | Neurology | 40% | Public |
| 7W | 45 | MBBS | 20 | Director | Hospital administration | 100% | Private |
| 8M | 46 | MD | 22 | Professor | Laboratory oncology | 30% | Public |
| 8W | 46 | MS | 18 | Associate Dean & Head of Department | Obstetrics and gynaecology | 90% | Public |
| 9M | 65 | MPH | 30 | Professor and Head of Department | Community medicine | 30% | Public |
| 9W | 34 | MS | 5 | Assistant Professor | Obstetrics and gynaecology | 40% | Public |
| 10M | 39 | DM | 20 | Additional Professor | Psychiatry | 15% | Public |
| 10W | 37 | MD | 8 | Head of Department | Haematology | 70% | Private |
| 11M | 50 | MD | 13 | Head of Department | Hospital administration | 100% | Public |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 11W | 39 | MD | 10 | Associate Professor | Anaesthetics | 50% | Public |
| 12M | 44 | MD | 17 | Additional Professor | Anatomy | 40% | Public |
| 12W | 44 | MS | 17 | Associate Professor | Obstetrics and gynaecology | 50% | Public |
| 13M | 42 | MD | 14 | Additional Professor | Paediatric surgery | 100% | Public |
| 13W | 38 | MD | 15 | Associate Professor | Anatomy | 60% | Public |
| 14M | 47 | DM | 17 | Consultant | Cardiology | 25% | Private |
| 14W | 45 | MD | 20 | Consultant | Radiology | 30% | Private |
| 15W | 40 | MS | 9 | Associate Professor | General surgery | 50% | Public |
| 16W | 37 | MD | 8 | Assistant Professor | Medical oncology | 80% | Public |

*Data collection*

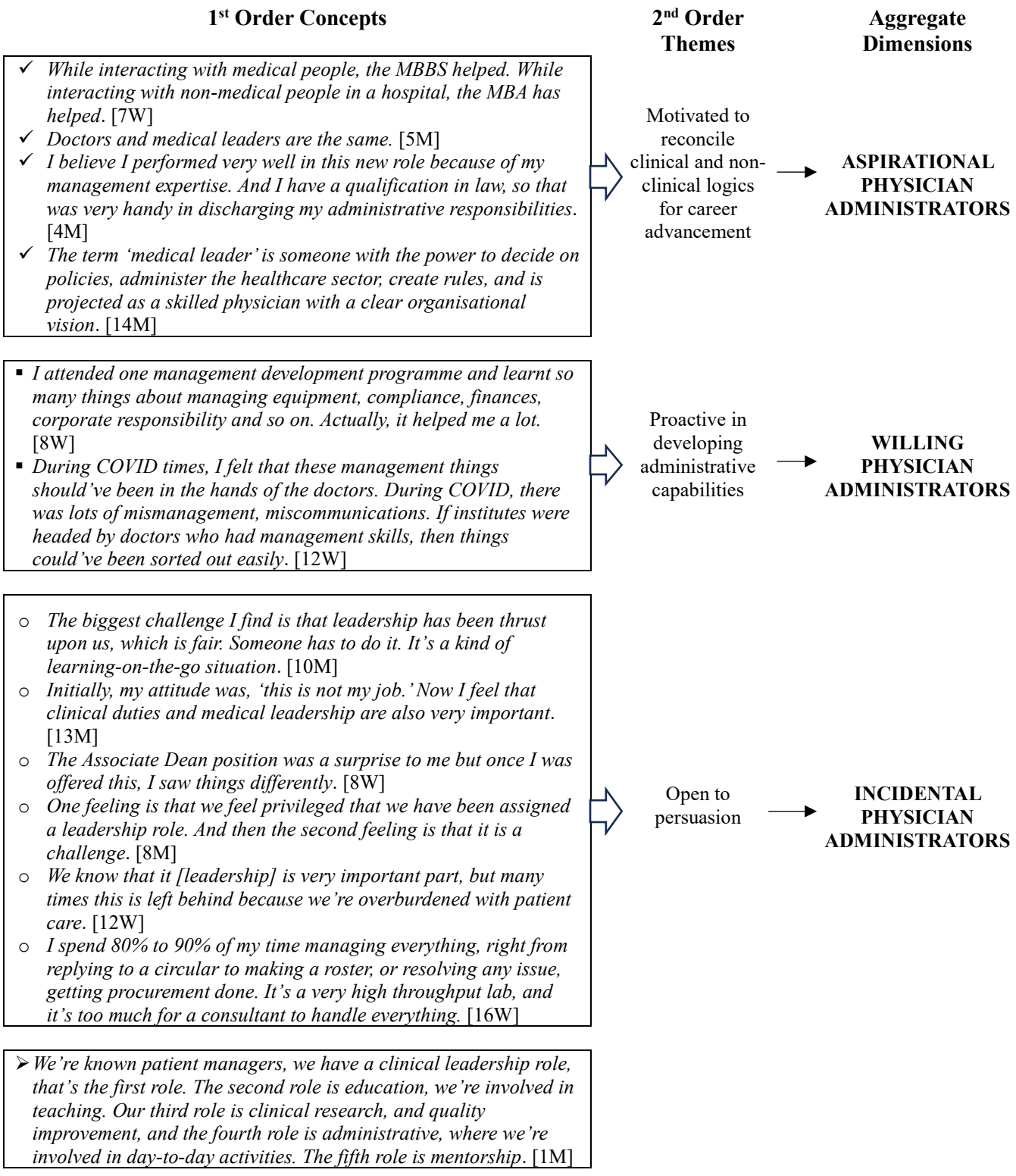
Sixteen (53%) interviews were conducted using Google Meet and 14 (47%) interviews were conducted in person between May-July 2023. Interviews were audio-recorded, lasted 40-60 minutes and transcribed verbatim. Discussions were complemented with notes. Interviews were conducted until data saturation was reached when no new themes emerged (Braun and Clarke, 2021). Interviewees were pseudo-anonymised for confidentiality.

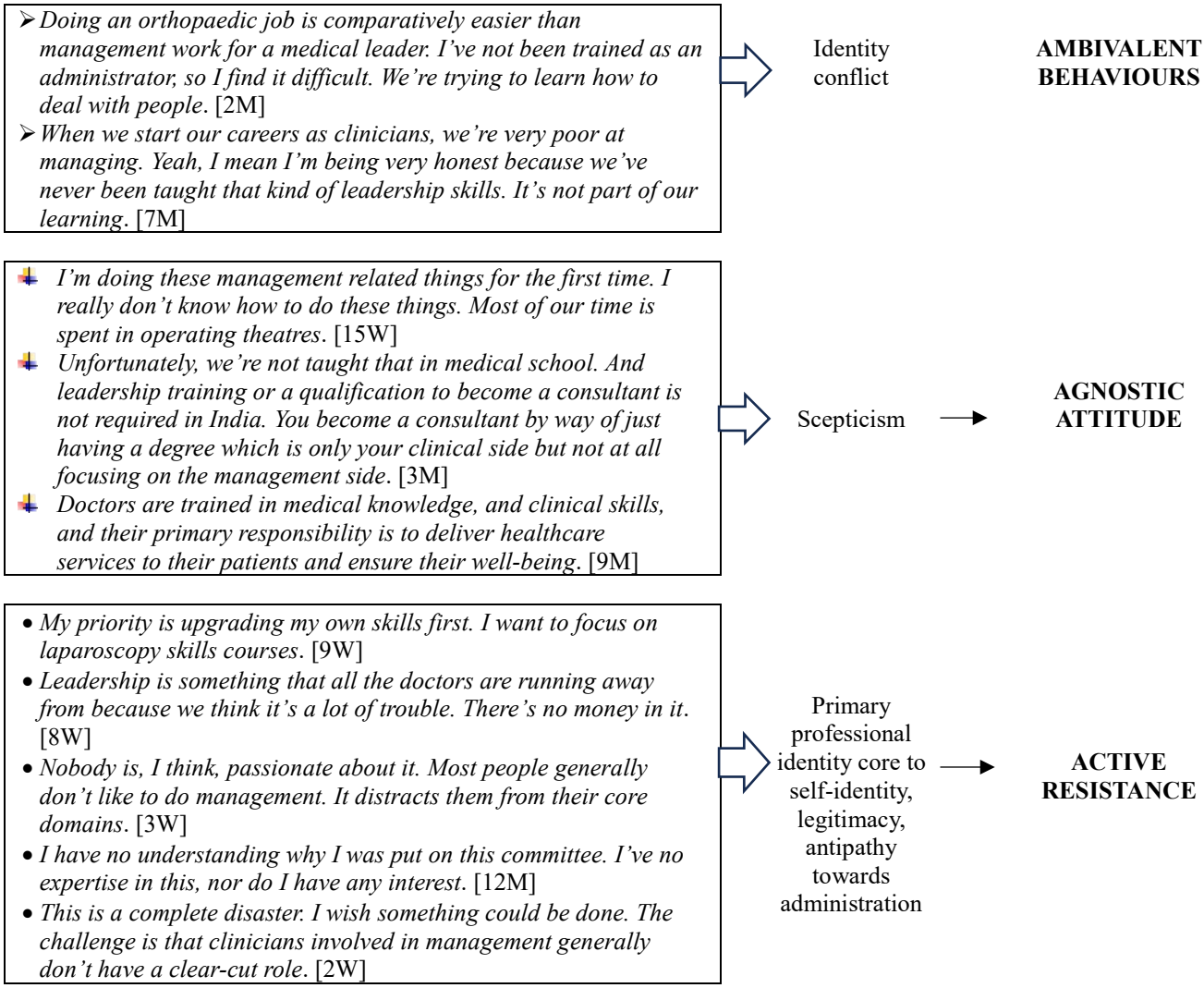
*Data analysis*

Members of our research team thematically analysed the transcripts (Saldaña, 2021) and safeguarded against personal assumptions by anchoring interpretations firmly in the data (Wang and Cheng, 2020). We adopted Gioia *et al.*'s (2013) method (Figure 1) by initially structuring data using first-order concepts. These were derived from interviewees' comments, subsequently categorised into second-order themes. These themes were then organised into aggregate dimensions. Initially, each researcher comprehensively (re)read the transcripts, identifying overarching themes. Subsequently, the dataset underwent meticulous coding using NVivo, leading to the delineation and refinement of (sub)categories. The second stage included a theoretical focus, with researchers continuously iterating between data analysis and interpretation, unveiling key themes and discerning interrelationships between hybridity, challenges, and development needs. Finally, the team synthesized conceptual patterns and illuminated connections among various sub-themes. To ensure research rigour, the coding process was meticulously documented (Braun and Clarke, 2012). Two coders independently analysed the data and compared notes. A third researcher resolved any disagreements between the coders.

To ensure transparency and resonance within the medical community and among fellow researchers, findings were actively disseminated through workshops and blogs. We invited constructive feedback to validate the relevance of insights (Saldaña, 2021). This iterative process of analysis and engagement with "reflexive participant collaboration" (Motulsky, 2021, p. 389) enriched the depth and applicability of the research outcomes.

**Figure 1.** Data structure






## Findings

A key finding was that many tasks mentioned by physicians in India related to routine administrative tasks such as rostering and equipment procurement rather than strategic activities such as service and business development, innovations and external partnerships.

Our findings echo Nzinga *et al*.'s (2019) study, which found that hybrid clinical managers in Kenyan public hospitals were unprepared for non-clinical tasks and managerial roles. They were usually reluctant to undertake non-clinical tasks and felt unsupported by formal hospital management, which they regarded as dysfunctional. Our interviewees' comments also reflect Bååthe and Norbäck's (2013) Swedish study which emphasized communications challenges about organisational improvements with physicians and managers having different mindsets and professional identities. Their observations also confirm Jeffery's (2024) concern in India about professionalizing the status of physicians. Figure 1 illustrates data structure based on the Gioia *et al*. (2013) method.

*1. Aspirational administrative behaviours*

We found cases of physicians who had completed relevant formal courses as part of their ambitions to become medical administrators. They had been proactive in developing managerial knowledge related to administrative tasks and relationships beyond their medical peers. Following Bresnen *et al*.'s (2019) categorisation of hybrid healthcare managers' career narratives and identity work, we labelled these types of behaviours as aspirational.

*2. Willing administrative behaviours*
Several individuals reported that they had initially been reluctant about undertaking non-clinical work. Later, however, they became willing hybrids as their realised how clinical work and leadership can be complementary and mutually reinforcing although potentially daunting in some cases.
*3. Incidental administrative behaviours*
Most interviewees did not see their primary identity as a medical leader since their clinical priorities were so demanding. In this sense, they fit McGivern *et al*.'s (2015) label of an incidental hybrid who is engaged temporarily in hybrid leadership. They were preoccupied with episodic patient care, which is unrelenting in the Indian healthcare context. Incidental hybrids were disposed towards accepting temporary management tasks while focusing on their primary clinical identity. They did not aspire to be permanent administrators.

*4. Ambivalent administrative behaviours*
Our empirical study also provided evidence of a fourth hybrid leader type of an ambivalent hybrid (Bresnen *et al*., 2019). These physicians were unsure about undertaking non-clinical work. Although they were sceptical about administrative tasks, they could be persuaded. Nevertheless, they were concerned about their own levels of management competence. Their ambivalence was linked to comparing their expertise as clinicians based on solid training with the lack of training for engaging in non-clinical tasks and their concerns about incompetent central hospital administrators who had no clinical background.

*5. Agnostic administrative behaviours*
Several interviewees were unconvinced and highly sceptical about how physicians could add value without adequate training or remuneration. These individuals fit the behaviours which Bresnen *et al*. (2019) characterise as agnostic.

*6. Actively resistant administrative behaviours*
The final group identified in our study included physicians who actively resisted undertaking non-clinical responsibilities. This approach may be understandable early in a physician's career when they are seeking to move into a specialised position, some physicians are openly hostile towards managerial work. One physician expressed a general feeling of indignation at being asked to take on unremunerated administration which distracted him from adding value as a clinical expert. Active hostility to carrying out non-clinical tasks may be explained by a lack of communication about the rationale for a physician being allocated such duties and physicians' lack of knowledge and confidence about how to fulfil these expectations.

**Discussion**
All the interviewees noted the accidental, unexpected yet inevitable nature of physicians taking on non-clinical, mainly administrative, duties. This is distinct from literature on medical leadership which focuses on physicians' managerial and strategic leadership responsibilities in spanning boundaries and brokering knowledge (Burgess *et al*., 2015; Kislov, 2014). Most physicians agreed that there is a critical need for formal development to support their dual responsibilities as clinical leaders and administrators. They felt unsupported by full-time hospital administrators. Willing and aspirational physicians who appeared to show an interest in becoming hybrid leaders (Bresnen *et al*., 2019) accepted non-clinical responsibilities. However, they questioned how decisions were made to allocate administrative tasks and their own competence to implement them. On the other hand, agnostic hybrids (Bresnen *et al*., 2019) in the sample prioritised their expert clinical knowledge over proactively leading and implementing changes (e.g. Waring *et al*., 2022) beyond their clinical expertise. They were less compromised by identity challenges (Croft *et al*., 2025) as they avoided the liminal challenges of hybridity. Others were actively hostile to any administrative tasks imposed on them. Several

physicians who were initially wary about engaging in administrative tasks became reconciled to these responsibilities and enjoyed the experiences. This type of physician-leader can develop their diplomatic skills and appreciate the need for adapting professional identities and engaging in micro-politics (Waring *et al*., 2023). They need to their retain legitimacy as physicians (Burgess and Currie, 2013; Dopson and Fitzgerald, 2005) to avoid being destabilised in hybrid roles (Watson, 2008, 2009).

Hofmann and Vermunt (2021) highlighted the benefits of physicians leading organisational change. However, this is hampered by punishing workloads, shift work, and by others actively discouraging physicians from engaging in executive decisions (Waddimba, 2013). As more women and Generation Z with work-life balance priorities (Srivastava *et al.*, 2019) enter the medical profession, there are increasing opportunities to address power inequalities and workloads. Nevertheless, it is important that western models of medical leadership development (NHS Leadership Academy, 2013) are not imposed in South Asian healthcare settings (e.g., Bate *et al*., 2007).

*Implications for practice*

If hybrid medical leadership is important for patients' and employees' well-being, we suggest that physicians who are ambivalent, agnostic or actively opposed to undertaking administration might be persuaded to be more willing to engage with non-clinical activities if they can see the strategic value of engaging to benefit patient care ultimately and advance their careers through value-adding non-clinical involvement. Physicians who are professionally trained as leaders to feel confident and capable in hybrid roles and who are connected with networks of peers in similar leadership positions with appropriate feedback, coaching, and mentoring in the context of India are more likely to succeed than isolated individuals who are overburdened by "administrivia", i.e. uninteresting and non-value adding trivial administrative tasks. Hospital accreditations and technology-enabled administration systems may also enable higher standards of medical leadership, with physicians actively engaging with India's digital public infrastructure as Chandwani *et al*. (2023) advocate. There is a gap between literature on medical leadership and everyday realities.

*Strengths and limitations of the study*

The interviewer is a non-physician employed by one of the institutions, which enabled him to develop rapport rapidly for participants to express their feelings (Aburn *et al*., 2023). We sought to mitigate bias by coding the data individually in the research team. Clearly, interviewees' social desirability bias affects the validity and reliability of findings (Kim and Kim, 2013), however, we sought to mitigate this with an interviewer from India whom respondents felt they could trust and speak with candidly. Generalisation of the results is limited to physicians included in the sample which excluded demographics related to ethnicity, caste, socio-economic class or religion.

We published blogs (Gulati *et al*., 2024) and commentary (Gulati *et al*., 2023) for practitioner and peer review feedback which emphasized for the research team the relentless working conditions and lack of infrastructure for physicians in India. The limitations of a single country cross-sectional case study and one occupational group's views based on self-reports suggest that further cross-national and cross-professional research might compare views of different types of healthcare professionals and line managers, Future research on physicians, administration, management, and hybrid leadership in LMICs could use longitudinal and quantitative data, observations and focus groups as alternative methods.

## Conclusion

By applying the lens of hybridity to physicians' non-clinical challenges in India we illustrate their involvement in mainly administrative tasks rather than strategic leadership. We found examples of aspirational, willing, incidental, ambivalent, agnostic, and active resistor

behaviours. The ad hoc nature of assigning non-clinical institutional work to physicians and the lack of leadership training reported in a context of excessive workloads suggest that the current situation is unsustainable. It is not aligned to ambitions for India to become a developed country by 2047. The study's findings provide a useful foundation for opportunities to integrate formal leadership development opportunities into medical education and continuing professional development for physicians in leading public research medical schools and hospitals in India. There needs to be contextually relevant, participative, and competency-based leadership development with an appreciation of national culture to bridge clinical and managerial cultures for successful hybrid medical leadership in a non-western context beyond the current scenario of physicians as untrained administrators.

**References**


Aburn, G.E., Gott, M. and Hoare, K. (2023), "Experiences of an insider researcher–interviewing your own colleagues", *Nurse Researcher*, Vol. 31 No. 3, pp. 1-8, doi: 10.7748/nr.2021.e1794.

Algahtani, Ali. (2014), "Are leadership and management different? A review", *Journal of Management Policies and Practices*, Vol. 2 No. 3, pp. 71-82, doi: 10.15640/jmpp.v2n3a4.

Andersson, T. (2015), "The medical leadership challenge in healthcare is an identity challenge", *Leadership in Health Services*, Vol. 28 No. 2, pp. 83-99, doi: 10.1108/LHS-04-2014-0032.

Bååthe, F. and Norbäck, L.E. (2013), "Engaging physicians in organisational improvement work", *Journal of Health Organization and Management*, Vol. 27 No. 4, pp. 479-497, doi: 10.1108/JHOM-02-2012-0043.

Bass, Bernard M. (1990), "From transactional to transformational leadership: learning to share the vision", *Organizational Dynamics*, Vol. 18 No. 3, pp. 19-31, doi: 10.1016/0090-2616(90)90061-S.

Bate, P., Mendel, P. and Robert, G. (2007), *Organizing for Quality: The Improvement Journeys of Leading Hospitals in Europe and the United States*. Boca Raton, FL: CRC Press.

Benmira, Sihame and Moyosolu Agboola, (2021), "Evolution of leadership theory", *BMJ Leader*, doi: 10.1136/leader-2020-000296.

Blanchard, J., Washington, R., Becker, M., Vasanthakumar, N., Gopal, K.M. and Sarwal, R. (2020), *Vision 2035–Public Health Surveillance in India*. *A White Paper.* Delhi: NITI Aayog. Available at: https://osf.io/preprints/osf/8bvaq.

Bode, I. and Maerker, M. (2014), "Management in medicine or medics in management? The changing role of doctors in German hospitals", *International Journal of Public Sector Management*, Vol. 27 No. 5, pp. 395-405, doi: 10.1108/IJPSM-06-2012-0068.

Brannick, T. and Coghlan, D. (2007), "In defense of being "native": the case for insider academic research", *Organizational Research Methods*, Vol. 10 No. 1, pp. 59-74, doi: 10.1177/1094428106289253.

Braun, V. and Clarke, V. (2012), "Using thematic analysis in psychology", *Qualitative Research in Psychology*, Vol. 3 No. 2 pp. 77-101, doi: 10.1191/1478088706qp063oa.

Braun, V. and Clarke, V. (2021), "To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales", *Qualitative Research in Sport, Exercise and Health*, Vol, 13 No. 2, pp. 201-216, doi: 10.1080/2159676X.2019.1704846.

Bresnen, M., Hodgson, D., Bailey, S., Hassard, J. and Hyde, P. (2019), "Hybrid managers, career narratives and identity work: a contextual analysis of UK healthcare organizations", *Human Relations*, Vol. 72 No. 8, pp. 1341-1368, doi: 10.1177/0018726718807280.

Buchanan, D. (2013), "Pure plays and hybrids: acute trust management profile and capacity", *Journal of Health Services Research & Policy*, Vol. 18 No. 2, pp. 90-97, doi: 10.1177/1355819613480350.

Burgess, N. and Currie, G. (2013), "The knowledge brokering role of the hybrid middle level manager: the case of healthcare", *British Journal of Management*, Vol. 24, pp. S132-S142, doi: 10.1111/1467-8551.12028.

Burgess, N., Strauss, K., Currie, G. and Wood, G. (2015), "Organizational ambidexterity and the hybrid middle manager: the case of patient safety in UK hospitals", *Human Resource Management*, Vol. 54 No. S1, pp. s87-s109, doi: 10.1111/1467-8551.12028.

Byrkjeflot, H. and Jespersen, P.K. (2014), "Three conceptualizations of hybrid management in hospitals", *International Journal of Public Sector Management*, Vol. 27 No. 5, pp. 441-458, doi: 10.1108/IJPSM-12-2012-0162.

Chambers, N. (Ed.) (2023), *The Research Handbook on Leadership in Healthcare*, Cheltenham, Edward Elgar.

Chandwani, R., Edacherian, S. and Sud, M. (2023), "National digital infrastructure and India's healthcare sector: physicians' perspectives", *The Qualitative Report*, Vol. 28 No. 2, pp. COV1-COV1.

Croft, C., Currie, G. and Davies, J. (2025), "The (non)integration of social identity demands and implicit leadership expectations: a challenge for professional hybrids", in Epitropaki, O. and Kark, R. (Eds.) *Oxford Handbook of Leadership, Followership and Identity*, Oxford, Oxford University Press.

Croft, C., Currie, G. and Lockett, A. (2015), "Broken 'two-way windows'? An exploration of professional hybrids", *Public Administration*, Vol. 93 No. 2, pp. 380-394, doi: 10.1111/padm.12115.

Cronin, Cory E., Kristin A. Schuller, and Doulas S. Bolon. (2018), "Hospital administration as a profession", *Professions and Professionalism*, Vol. 8 No. 2, pp.e2112-e2112, doi: 10.7577/pp.2112.

Currie, G. (2006), "Reluctant but resourceful middle managers: the case of nurses in the NHS", *Journal of Nursing Management*, Vol. 14 No. 1, pp. 5-12, doi: 10.1108/14769011211255285.

Currie, G. and White, L. (2012), "Inter-professional barriers and knowledge brokering in an organizational context: the case of healthcare", *Organization Studies*, Vol. 33 No. 10, pp. 1333-1361, doi: 10.1177/0170840612457617.

Currie, G., Gulati, K., Spyridonidis, D. and Vaitheswaran, S. (2021), "Distributing leadership for scaling up evidence-based innovation in LMICs: a case for leadership development in India", *BMJ Leader*, Vol. 6, pp. 35-38, doi: 10.1136/ leader-2020-000230.

Davies, J., Yarrow, E. and Gulati, K. (2024), "The R G Kar Medical College rape and murder highlights the need for leadership in Indian medical training and research", *LSE Impact of Social Sciences Blog*, 3 October.

Dopson, S. and Fitzgerald, L. Eds. (2005), *Knowledge to Action? Evidence-Based Health Care in Context*, Oxford, Oxford University Press.

Elzahhar, R., Aylott, J., Indrasena, B.S.H., Wrazen, R. and Othman, A. (2023), "Exploring the motivation of surgeons to lead juniors and the impact of their leadership on junior doctors' motivation and leadership preference", *Leadership in Health Services*, doi: 10.1108/LHS-05-2023-0027.

Farrington, Shelley Maeva and Riyaadh Lillah (2019), "Servant leadership and job satisfaction within private healthcare practices", *Leadership in Health Services*, Vol. 32 No. 1, pp. 148-168, doi: 10.1108/LHS-09-2017-0056.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996), *The New Public Management in Action*, Oxford, Oxford University Press.

Fulop, L. (2012), "Leadership, clinical managers and a thing called "hybridity"", *Journal of Health Organisation and Management*, Vol. 26 No. 5, pp. 578-604, doi: 10.1108/14777261211256927.

Gayathri, K. and Warrier, U. (2022), "Doctors as leaders – how essential is leadership training for them?", *Vilakshan - XIMB Journal of Management*, Vol. 19 No. 1, doi: 10.1108/xjm-08-2020-0099.

Geerts, J.M., Goodall, A.H. and Agius, S. (2020), "Evidence-based leadership development for physicians: a systematic literature review", *Social Science in Medicine*, Vol. 246, pp. 112709, doi: 10.1016/j.socscimed.2019.112709.

Gioia, D.A., Corley, K.G. and Hamilton, A.L. (2013), "Seeking qualitative rigor in inductive research: notes on the Gioia methodology", *Organizational Research Methods*, Vol. 16 No. 1, pp. 15-31, doi: 10.1177/1094428112452151.

Goleman, D. (1995), *Emotional Intelligence*, New York, Bantam Books.

Goleman, D., Boyatzis, R. and McKee, A. (2013), *Primal Leadership: Unleashing the Power of Emotional Intelligence*, Boston, MA, Harvard Business Review Press.

Goodall, A.H. (2011), "Physician-leaders and hospital performance: is there an association?", *Social Science & Medicine*, Vol. 73 No. 4, pp. 535-539, doi: 10.1016/j.socscimed.2011.06.025.

Goodall, A.H. (2012), "A theory of expert leadership", *IZA Discussion paper No. 6566*, doi: 10.2139/ ssrn.2066989.

Government of India (2024), *NARI SHAKTI: From women development to women led development*. Press Information Bureau Delhi, 6 March. Available at: https://pib.gov.in/PressNoteDetails.aspx?NoteId=151861&ModuleId=3

Greenleaf, Robert K. (1970), *The Servant as a Leader*, Indianapolis, IND, Greenleaf Center.

Grewal, H., Sharma, P., Dhillon, G., Munjal, R.S., Verma, R.K. and Kashyap, R. (2023). "Universal health care system in India: an in-depth examination of the Ayushman Bharat initiative", *Cureus*, Vol. 15 No. 6, doi: 10.7759/cureus.40733.

Gulati K., Sarkar, C., Gupta, S.K., and Madhukar, V. (2018), "Importance of medical leadership development: a global perspective with special reference to the Indian healthcare system", *International Journal of Research Foundation of Hospital and Healthcare Administration*, Vol. 6 No. 1, pp. 37-42, doi: 10.1002/hpm.2709.

Gulati, K. and Kirkpatrick, I. (2021), "Developing medical leadership in India: a mission impossible?", *BMJ Leader*, Vol. 5 No. 4, pp. 247-251, doi: 10.1080/20479700.2019.1647381.

Gulati, K., Davies, J. and de la Fuente, Á.G. (2023), "Addressing leadership competency gaps and gender disparities in India's medical workforce: a call to action", *The Lancet Regional Health-Southeast Asia*, 16, doi: 10.1016/j.lansea.2023.100247.

Gulati, K., Davies, J., Gonzalez de la Fuente, A. and Singh, A. (2024), "Striving for equity: exploring gender-inclusive medical leadership in India", *BMJ Leader*, doi:10.1136/leader-2023-000970.

Gulati, K., Madhukar, V., Verma, V., Singh, A.R., Gupta, S.K. and Sarkar, C. (2019), "Medical leadership competencies: a comparative study of physicians in public and private sector hospitals in India", *International Journal of Health Planning & Management*, Vol. 34 No. 1, pp. e947-63, doi: 10.1002/hpm.2709.

Gulati, K., Sarkar, C., Verma, V., Singh, A.R. and Gupta, S.K. (2021), "Assessment of medical leadership competencies and development needs: first comprehensive study from India", *International Journal of Health Planning & Management*, Vol. 14 No. 2, pp. 363-374, doi: 10.1080/20479700.2019.1647381.

Gulati, K., Singh, A.R., Gupta, S.K. and Sarkar, C. (2022), "Strengthening leadership capacity: an unaddressed issue in Indian healthcare system", *Leadership in Health Services*, Vol. 35 No. 3, pp. 428-442, doi: 10.1108/LHS-11-2021-0094.

Gulati, K., Singh, A.R., Kumar, S., Verma, V., Gupta, S.K. and Sarkar, C. (2020), "Impact of a leadership development programme for physicians in India", *Leadership in Health Services*, Vol. 33 No. 1, pp. 73-84, doi: 10.1108/LHS-05-2019-0027.

Ha, L. (2024), "Top five fastest-growing economies in 2024", *EuroMonitor*, 10 June.

Haslam, S. Alexander, Mats Alvesson, and Stephen D. Reicher, (2024). "Zombie leadership: dead ideas that still walk among us", *The Leadership Quarterly*, p.101770, doi: 10.1016/j.leaqua.2023.101770.

Hertog, S., Gerland, P. and Wilmoth, J. (2023), *India Overtakes China as the World's Most Populous Country*. United Nations, 15 June.

Hoff, T.J. (2001), "Exploring dual commitment among physician executives in managed care", *Journal of Healthcare Management*, Vol. 46 No. 2, pp. 91-111, doi: 10.1097/00115514-200103000-00006.

Hofmann, R. and Vermunt, J.D. (2021), "Professional learning, organisational change and clinical leadership development outcomes", *Medical Education*, Vol. 55 No. 2, pp. 252-265, doi: 10.1111/medu.14343.

Inamdar, N. (2024), "India's economy: the good, bad and ugly in six charts", *BBC News*, 1 May.

Jeffery, R. (2024), "Current challenges for doctors in India: deprofessionalisation, reprofessionalisation or fragmentation?", *Sociology of Health & Illness*, Vol. 46 No. 5, pp. 795-814, doi: 10.1111/1467-9566.13564.

Keijser, W.A., Handgraaf, H.J.M., Isfordink, L.M., Janmaat, V.T. *et al*. (2019), "Development of a national medical leadership competency framework: the Dutch approach", *BMC Medical Education* Vol. 19 No. 1, pp. 441, doi: 10.1186/s12909-019-1800-y.

Kelly, S.E., Bourgeault, I. and Dingwall, R. (2010), "Qualitative interviewing techniques and styles", in Bourgeault, I., Dingwall, R. and de Vries, R. (Eds.) *The SAGE Handbook of Qualitative Methods in Health Research*, Vol. 19 pp. 307-326.

Kim, Seung Hyun and Sangmook Kim (2013), "National culture and social desirability bias in measuring public service motivation", *Administration and Society* Vol. 20 No. 10, pp. 1-3. doi:10.1177/0095399713498749.

Kippist, L. and Fitzgerald, A. (2009), "Organisational professional conflict and hybrid clinician managers: the effects of dual roles in Australian health care organisations", *Journal of Health Organization and Management*, Vol. 23 No. 6, pp. 642-655, doi: 10.1108/14777260911001653.

Kirkpatrick, I., Altanlar, A. and Veronesi, G. (2023), "Doctors in leadership roles: consequences for quality and safety", *Public Money & Management*, pp. 1-8.

Kislov, R. (2014), "Boundary discontinuity in a constellation of interconnected practices", *Public Administration*, Vol. 92 No. 2, pp. 307-323, doi: 10.1111/padm.12065.

Kitchener, M. (2000), "The 'bureaucratization' of professional roles: the case of clinical directors in UK hospitals", *Organization*, Vol 7 No. 1, pp. 129-154, doi: 10.1177/135050840071007.

Kotter, John P. (2013), "Management is (still) not leadership", *Harvard Business Review*, 9 January. Available from: https://hbr.org/2013/01/management-is-still-notleadership.

Kouzes, James M. (1997), *The Leadership Challenge: How to Keep Getting Extraordinary Thing Done in Organizations*, San Francisco, CA, Jossey-Bass.

Llewellyn, S., 2001. 'Two-way windows': clinicians as medical managers, *Organization Studies*, Vol. 22 No. 4, pp. 593-623, doi: 10.1177/0170840601224003.

Lüchinger, R., Audétat, M.C., Bajwa, N.M., Bréchet-Bachmann, A.C. *et al*. (2024), "Physicians' perceptions and experiences regarding leadership: a link between beliefs and identity formation", *Journal of Healthcare Leadership*, Vol. 16, pp. 263-276, doi: 10.2147/JHL.S464289.

Mathew, Sagi and Greig Taylor (2019), "Power distance in India: paternalism, religion and caste: some issues surrounding the implementation of lean production techniques", *Cross*

*Cultural & Strategic Management*, Vol. 26 No. 1, pp. 2-23, doi: 10.1108/CCSM-02-2018-0035.

McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L. and Waring, J. (2015), "Hybrid manager-professionals' identity work: the maintenance and hybridization of professionalism in managerial contexts", *Public Administration*, Vol. 93 No. 2, pp. 412-432, doi: doi: 10.1111/padm.12119.

Mehta, V., Ajmera, P., Kalra, S., Miraj, M. *et al*. (2024), "Human resource shortage in India's health sector: a scoping review of the current landscape", *BMC Public Health*, Vol. 24 No. 1, p. 1368, doi: DOI: 10.1186/s12889-024-18850-x.

Ministry of Commerce & Industry (2024), *India on track to become $35 trillion, fully developed economy by 2047: Shri Piyush Goyal*. Press Information Bureau Delhi, 19 February. Available at: https://pib.gov.in/PressReleasePage.aspx?PRID=2007105.

Ministry of Health and Family Welfare, (2017), *National Health Policy*, New Delhi, Government of India, available at: https://mohfw.gov.in/sites/default/files/9147562941489753121.pdf

Ministry of Health and Family Welfare, (2022), *Government has taken multiple steps to further increase availability of doctors in the country*, Press Release, New Delhi, Government of India, 26 July. Available at: https://pib.gov.in/PressReleseDetailm.aspx?PRID=1845081.

Mintzberg, H. (1997), "Towards healthier hospitals", *Health Care Management Review*, Vol. 22 No. 4, pp. 9-18.

Mohmad, S., Lee, K.Y. and Bakit, P. (2024), "Do health-care institutions perform better under leaders with medical or non-medical backgrounds? A scoping review", *Leadership in Health Services*, Vol. 37 No. 5, pp. 142-156, doi: 10.1108/LHS-11-2023-0084.

Moores, L.E., Landry, A., Hernandez, S.R., Szychowski, J.M. and Borkowski, N. (2021), "Reported clinical and financial performance of hospitals with physician CEOs compared to those with nonphysician CEOs", *Journal of Healthcare Management*, Vol. 66 No. 6, pp. 433-448, doi: 10.1097/JHM-D-20-00157.

Motulsky, S.L. (2021), "Is member checking the gold standard of quality in qualitative research?" *Qualitative Psychology*, Vol. 8 No. 3 pp. 389-406, doi: 10.1037/qup0000215.

NHS Leadership Academy. (2013), *The Healthcare Leadership Model*, London, NHS Leadership Academy.

Nzinga, J., McGivern, G. and English, M. (2019), "Hybrid clinical-managers in Kenyan hospitals: navigating between professional, official and practical norms", *Journal of Health Organization and Management*, Vol. 33 No. 2, pp. 173-187, doi: 10.1108/JHOM-08-2017-0203.

Pai, S.N., Jeyaraman, M., Jeyaraman, N. and Yadav, S. (2024), "White coats under fire: understanding the epidemic of violence against doctors", *Cureus*, Vol. 16 No. 8, doi: 10.7759/cureus.66346.

Pal Chaudhuri, G. and Jacobs, J. (2024), *Insight on India, the World's Fastest-Growing Major Economy*, BlackRock, 1 May.

Panagariya, A. (2024), *India at 125: Reclaiming the Lost Glory and Returning the Global Economy to the Old Normal (No. 163)*, National Council of Applied Economic Research.

Purohit, B., Lal, S. and Banopadhyay, T. (2021), "Job satisfaction among public sector doctors and nurses in India", *Journal of Health Management*, Vol. 23 No. 4, pp. 649-665, doi: 10.1177/09720634211050444.

Rotenstein, L.S., Sadun, R. and Jena, A.B. (2018), "Why doctors need leadership training", *Harvard Business Review*, Vol. 17, pp. 1-5.

Saldaña, J. (2021), *The Coding Manual for Qualitative Researchers*, 4th edition, Los Angeles, CA, Sage.

Samant, M., Calnan, M. and Kane, S. (2024), "A critical analysis of newspaper accounts of violence against doctors in India", *Social Science & Medicine*, Vol. 340, p. 116497, doi: 10.1016/j.socscimed.2023.116497.

Sartirana, M., Currie, G. and Noordegraaf, M. (2019), "Interactive identity work of professionals in management: a hospital case study", *Public Management Review*, Vol. 21 No. 8, pp. 1-22, doi: 10.1080/14719037.2018.1549269.

Sarto, F. and Veronesi, G. (2016), "Clinical leadership and hospital performance: assessing the evidence base", *BMC Health Service Research*, Vol. 16 No. 2, pp. 85-97, doi: 10.1186/s12913-016-1395-5.

Savage, M., Savage, C., Brommels, M. and Mazzocato, P. (2020), "Medical leadership: boon or barrier to organisational performance? A thematic synthesis of the literature", *BMJ Open*, Vol. 10 No. 7, p. e035542, doi: 10.1136/bmjopen-2019-035542.

Saxena, S.G. and Godfrey, T. (2023), "India's opportunity to address human resource challenges in healthcare", *Cureus*, Vol. 15 No. 6, p. e40274, doi: 10.7759/cureus.40274.

Spyridonidis, D., Hendy, J. and Barlow, J. (2015), "Understanding hybrid roles: the role of identity processes amongst physicians", *Public Administration*, Vol. 93 No. 2, pp. 395-411, doi: 10.1111/padm.12114.

Srivastava, S., Misra, R. and Madan, P. (2019), "The saviors are also humans: understanding the role of quality of work life on job burnout and job satisfaction relationship of Indian doctors", *Journal of Healthcare Management*, Vol. 21 No. 2, pp. 210-229, doi: 10.1177/0972063419835099.

Stewart, G.L., Astrove, S.L., Reeves, C.J., Crawford, E.R. and Solimeo, S.L. (2017), "Those with the most find it hardest to share: exploring leader resistance to the implementation of team-based empowerment", *Academy of Management Journal*, Vol. 60 No. 6, pp. 2266-2293, doi: 10.5465/amj.2015.1173.

Stogdill, Ralph. M. (1950), Leadership, membership and organization. *Psychological Bulletin*, Vol. 47 No. 1, pp. 1-14, doi: 10.1037/h0053857.

Stoller, J.K. (2020), "Developing physician leaders: does it work?", *BMJ Leader* Vol. 4 No. 1, pp. 1-5, doi:10.1136/leader-2018-000116.

Sveningsson, S. and Alvesson, M. (2003), "Managing managerial identities: organizational fragmentation, discourse and identity struggle", *Human Relations*, Vol. 56 No. 10, pp. 1163-1193, doi: 10.1177/00187267035610001.

Tarnoff, M. (2020), "Dissecting the important difference between good surgeons and good leaders", *JAMA Surgery*, Vol. 155 No. 9, pp. 801-802.

Thoebes, G.P., Porter, T.H. and Peck, J.A. (2024), "Physicians as leaders: a systematic review through the lens of expert leadership", *Leadership in Health Services*, Vol. 37 No. 1, pp. 95-111, doi: 10.1108/LHS-02-2023-0008.

Thoma, B., Karwowska, A., Samson, L., Labine, N. *et al*. (2023), "Emerging concepts in the CanMEDS physician competency framework", *Canadian Medical Education Journal*, Vol. 14 No. 1, pp. 4-12, doi: 10.36834/cmej.75591.

Uhl-Bien, Mary, Russ Marion, and Bill McKelvey. (2007), "Complexity leadership theory: shifting leadership from the industrial age to the knowledge era", *The Leadership Quarterly*, Vol. 18 No. 4, pp. 298-318, doi: 10.1016/j.leaqua.2007.04.002.

Van Knippenberg, Daan and Sim B. Sitkin. (2013), "A critical assessment of charismatic—transformational leadership research: back to the drawing board?", *Academy of Management Annals*, Vol. 7 No. 1, pp. 1-60, doi: 10.5465/19416520.2013.759433.

Waddimba, A.C., Burgess, Jr J.F., Young, G.J., Beckman, H.B. and Meterko, M. (2013), "Motivators and hygiene factors among physicians responding to explicit incentives to improve the value of care", *Quality Management in Healthcare* Vol. 22 No. 4, pp. 276-292, doi: 10.1177/1077558709342882.

Wang, X. and Cheng, Z. (2020), "Cross-sectional studies: strengths, weaknesses, and recommendations", *Chest*, Vol. 158 No. 1, pp. S65-S71, doi: 10.1177/1077558709342882.
Waring, J., Bishop, S., Black, G., Clarke, J.M., *et al*. (2022), "Understanding the political skills and behaviours for leading the implementation of health services change: a qualitative interview study", *International Journal of Health Policy and Management*, Vol. 11 No. 11, p. 2686, doi: 10.34172/ijhpm.2022.6564.
Waring, J., Bishop, S., Clarke, J. and Roe, B. (2023), "Becoming active in the micro-politics of healthcare re-organisation: the identity work and political activation of doctors, nurses and managers", *Social Science & Medicine*, Vol. 333, p. 116145, doi: 10.1016/j.socscimed.2023.116145.
Watson, T.J. (2008), "Managing identity: identity work, personal predicaments and structural circumstances", *Organization*, Vol. 15 No. 1, pp. 121-143, doi: 10.1177/1350508407084488.
Watson, T.J. (2009), "Narrative, life story and manager identity: a case study in autobiographical identity work", *Human Relations*, Vol. 62 No. 3, pp. 425-452.
West, M.A. (2021), *Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care*, London, Swirling Leaf Press.
World Bank (2021), *Physicians (per 1,000) people – Switzerland*. Available at: https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=CH

**Funding**

AIIMS-UCL Grant No. AIIMS-UCL/15/RS.

**Authors' contributions**

KG and JD made equal contributions to this article, both sharing first authorship. ARS assisted in data collection and literature review. The collaborative efforts of the authors culminated in unanimous approval of the final manuscript.

**Acknowledgements**

The authors gratefully acknowledge UCL/AIIMS-Delhi Joint Research Grant funding and support from Prof. Shakti Kumar Gupta, Prof. Meeta Gupta, Professor Monica Lakhanpaul and Dr Amit Khandelwal. We are thankful for insights from the project participants and for feedback during workshops held in Delhi, Jammu, London, and at the 2023 Academy of Management meeting in Boston, USA. We also acknowledge Dr. Sanjolly Gupta's and Ms. Tanika Giri's invaluable research support.

**Data availability statement**

The data that support the findings of this study are available on request from the corresponding author. This study was approved by the first author's institutional ethics committee (No: IEC-958/13.01.2023).

**Conflict of interest statement**

The authors declare that they have no conflict of interest among the authors. All authors read the manuscript and approved it.