Physicians hold various leadership positions that allow (and sometimes require) them to exert power and influence in relation to others. Power, in this sense, is considered a form of “social influence” in which the feelings and/or behaviors of one party are altered or changed through the influence of another party. Successful leaders are somehow able to influence others to do what those others may not want to do, may not have thought of doing, or may not have had the courage or motivation to do.

Physician leaders exert power in numerous academic, executive/administrative, and clinical roles. Deans, medical school department chairs, and division heads are leaders in academic settings. Hospital executives, medical directors, and medical staff presidents are leaders in health care organizations. Clinical team leaders and individual physicians treating patients (as will be discussed below) can be thought of as leaders in practice settings and patient encounters. In all of these cases, to be successful, the physician must exert influence to achieve various goals.

What are the bases of power and influence that physicians have through their leadership positions? Are these the same or different depending on the individual physician, the particular role, and/or the setting? What leadership characteristics and skills make some leaders more powerful and influential than others, thus enabling them to advance their own or their organization’s objectives successfully? Can the skills and abilities necessary to achieve power and influence for positive professional ends be taught? In this article, I will use insights from social psychology to address several of these issues, an understanding of which can be of benefit to physician leaders of diverse types as well as those responsible for their current training and the training of future leaders.

The Bases of Power of Physician Leaders

French and Raven described six bases of power (with later subtypes) that have been at the forefront of considerations of power and influence in various fields, including health care, for decades (see List 1). These primary bases of power with examples relevant to physician leaders are discussed below. Physician leaders often have several roles and several bases of power at the same time, but one form may predominate.

Legitimate or positional power

This is the power exerted by an individual in a formal, designated position of leadership or authority. Deans, department chairs, and hospital executives all rely heavily (but not exclusively) on their legitimate or positional power to influence others’ attitudes, actions, and behaviors. The medical director of a hospital or a medical staff president also has designated or elected positional power that gives authority to direct others and enforce/enact policies consistent with their job descriptions and organizational policies and procedures.

Expert power

Held by those having particular (perhaps unique) knowledge, expert power influences others’ beliefs and actions. The medical director of a health care organization has positional power, but this stems from (and is maintained by) recognition of his or her clinical expertise, which is needed for the leader to serve as an arbiter in difficult clinical situations and as a role model or mentor to other physicians. The research director of a department is sought for advice on research largely because of his or her expertise in research design, development, and funding opportunities. The division head of an academic department, with previous experience...
writing published scientific papers, has expert power that can influence a junior colleague’s approach to scientific writing. The surgeon advising a patient to have or not have surgery, or the internist or pediatrician treating a patient with medication, is granted expert power by the patient and family according to the assumptions of advanced training, knowledge, and experience that can lead to an improvement in distress and relief of suffering.

Informational power
This power is at times closely linked with expert power, but it need not be. This is the power of information to aid decision making in a particular situation. Information conveyed by the physician about the effects and side effects of a medication will influence a patient’s decision about taking the medication. The medical director’s review of the hospital’s medication error rate in comparison with that of similar facilities gives her or him informational power in speaking to medical staff about quality improvement initiatives.

Reward power
Resulting from reinforcement administered, anticipated, or provided by the individual intending to influence another for the successful completion of a task, reward power may provide either material or psychological rewards. The head of an academic department is able to retain a promising resident to join the faculty in part by providing a choice mentor or protected time for research, thus influencing the decision to choose this department instead of another. A cardiologist praises a medical student’s physical examination skills during the latter’s clinical rotation, thus influencing the student to continue to do well in his or her medical studies, perhaps ultimately choosing cardiology as a subspecialty.

Coercive power
This is the power that results from actual or imagined negative consequences that accrue to the individual who does not complete a task successfully. The department chair who tells a junior faculty member who is unpublished or is a lackluster teacher that his contract will not be renewed without improvement is exerting influence through coercive power. The patient with poorly controlled diabetes mellitus who has not kept to her diet may receive an actual or perceived admonishment or rebuke from her family physician, thus possibly influencing greater dietary efforts on her own behalf.

Referent power
Referent power results from the sometimes-intangible personal characteristics and interpersonal skills of the influencing agent. Raven6-8,25-27 speaks of the influenced individual seeking “identification” with the agent of influence. Referent power reflects the ability to make oneself and one’s perspective the focus or reference point for an individual’s motivation and attention to a given task.7,8 The influencing agent sometimes is felt to have “charisma” or a particular force of personality that seems to attract and motivate others. A given department chair or dean who seems able to attract particularly qualified faculty members without greater resources than others have in comparable academic centers may have referent power in relation to the faculty in question. A practicing physician’s patients who are loyal and admiring of her and who comply with recommendations more often than is true of a colleague’s patients may have referent power in relation to many patients. She is a trusted and powerful reference point for her patients in their own considerations of health and wellness.

The Bases of Power: Common and Disparate Elements
As indicated above, particular types of physician leadership are characterized by the use of one or more predominant bases of power. Using these bases of power to understand particular physician leadership roles and to improve the performance of those holding various roles is not as simple as the classification of power types might suggest, however. Sometimes individual leaders use the wrong basis of power or an inappropriate degree of a particular power source in attempting to influence subordinates or colleagues. This would be true when the medical director of a hospital, for example, acting too heavily from a positional power perspective, and perhaps responding to pressure from the hospital executive committee around budgetary considerations, attempts to increase the use of a less expensive medication over a more expensive medication without providing adequate data or information to support this effort. The medical director here sacrifices expert or informational power and his or her future referent power potential to the misuse of positional power.

Sometimes a leader’s accomplishments or background in one area result in that person’s being chosen for a position that requires the use of a different form of power than the individual is able to employ. It is well recognized that when department chairs or other academic leaders are chosen on the basis of their strong reputations for excellence in research (giving them expert power) and not for their administrative or organizational skills (legitimate or positional power), there is the potential for unrealized expectations on all sides.10,11

Although the bases of power can be described and conceptualized as being distinct, there often is much overlap in their application. The importance of expert and informational power in some situations seems clear cut, but high rates of noncompliance with medical recommendations and failure to comply with physicians’ instructions suggest that other forces are influencing patients’ decisions also.12-14 The medical director in a previous example was not able to convince medical staff to alter their prescribing practices on the basis of his positional power. Yet, using expert or informational power effectively would have increased the chances of successful influence. The same can be said for the dean or department chair who employs positional or legitimate power in the attempt to institute new strategic priorities without having the personal characteristics or interpersonal skills that would provide the referent power necessary for success.
In actuality, referent power is the basis of power and influence that often is overlooked but which frequently is crucial to the successful use of the other bases of power. \(^7\) Powerful physicians, those who exert the most influence regardless of task or role, draw others to themselves and the organizational mission and goals they espouse through their referent power. Referent power is inadequately defined in the literature, however. Can it be characterized more specifically, or must we be constrained by difficult-to-define terms or by the magical word “charisma,” whose imprecision renders it difficult to reliably recognize, study, or teach?

Referent power actually is comparable to what in organizational literature is described as “informal leadership,” a concept that also includes the ability to influence others without the influencing agent having formal or positional power. Pielstick\(^15\) has studied qualities or characteristics considered representative of informal leadership. These include having good communication skills, the ability to articulate a vision and values that are consistent with the organizational mission, the ability to foster a sense of community, and the demonstration of particular personal qualities, such as self-confidence.

Pielstick\(^15\) finds that individuals who are considered informal leaders are significantly more likely to have these qualities than others, including those in formal leadership positions. Informal leaders become for others, perhaps unknowingly, a point of reference for particular attitudes, behaviors, or actions. Medical students seeking assignment to a given unit may be influenced, for example, by the referent power of a particularly enthusiastic or dedicated resident or attending physician with no positional power. (Of course, negative influences also are possible through referent power and informal leadership, although this aspect of referent power is not the focus here.)

Referent power is largely interpersonal power, the ability to influence others through the agent’s personal qualities and interpersonal skills. Referent power is found in successful leaders regardless of position, and regardless of the primary source of power they possess. Numerous authors and researchers have recognized this, although their frames of reference may differ.

Cassidy\(^16\) has organized various skills, abilities, and approaches of successful leaders into a rating tool with 20 competences used in organizational settings. These are presented in List 2. Nearly all of these competencies of successful leaders reflect internal attitudes, adaptations, and interpersonal skills. Their impact at times is enhanced by formal leadership positions and their attendant positional power, but their expression and use do not depend on position or title. Instead, these competencies result in referent power that augments other forms of power.

### Characterizing, Studying, and Teaching Leadership and Power

It is now widely recognized that medical education should include training in effective communication, leadership, and professionalism.\(^17\) The study of power, understood as the appropriate use of social influence, is an aspect of all of these areas and should be included as a part of these curricula. The study of leadership, for example, using the perspectives offered here, can become less confusing and difficult than sometimes is thought. Clarity about the forms of power and influence that leaders can or should employ in given situations can be helpful in recognizing the potential and limitations of particular roles.

Most authors would agree that leaders must have two broad sets of skills.\(^18\)–\(^20\) One is procedural: the nuts and bolts knowledge, understanding, and technical ability to do their jobs. Knowledge of administration, finance, health care trends, quality improvement, medical staff organizations, and personnel and policy issues for executives with positional power would fall into this category. The other broad set of skills needed to maintain and enhance the leader’s power and influence is largely that described here as referent power, the personal and interpersonal skills that are crucial regardless of role.

Leadership training and education should emphasize both sets of skills relevant to the particular role in question. In general, for the development of referent power,
The opportunity to observe leaders in difficult situations, as well as personal experiences in the leadership role, mentorship, and supervision, may be more valuable than didactic instruction. Role-plays, interactive discussions, and problem solving may be helpful also for the development of referent power or informal leadership skills.

The issue of who should receive leadership training is an important one. It is being increasingly recognized that those who aspire to academic or organizational leadership positions ideally should receive training in both the formal requirements of their roles and in the development of the types of skills that lead to what has been characterized as referent power. Those who receive leadership training seem more likely to actually wind up in leadership positions.

Individual physicians diagnosing and treating patients in their offices or clinics are not usually thought of as “leaders,” but I believe they should be considered “clinical leaders.” Physicians in full-time clinical practice may have no formal or positional power, but they do have expert and informational power that can be coupled with referent power to influence patients positively toward their own health care decisions. For patients in the clinical setting, the physician is the automatic reference point, the individual of greatest power and influence. A large part of this influence derives from the same types of referent power and leadership skills noted above—for instance, the ability to develop a vision (a patient partnered with the physician and fully engaged in his or her own health care needs), the ability to set goals with the patient (a normal cholesterol level), the ability to communicate clearly verbally and in writing, the demonstration of personal integrity, and the ability to nurture others’ growth. These qualities are not automatically present in physicians or in others. Given that all physicians are, through their roles, inherently powerful in the lives of their patients, they should be provided with the leadership training that allows this power and influence to be used most effectively for their patients’ benefit.

The senior medical student or junior resident, for example, standing at the bedside of a high-level executive whose own positional power seems paltry to him subsequent to a myocardial infarction, may have been given a great deal of expert power by this vulnerable individual. The information presented and the manner in which it is presented (expert or informational power and referent power) by the medical student or junior resident may have significant impact on the executive, although the student or resident often has little sense of the “power” he or she holds.

When the same medical student or junior resident speaks to the executive’s relatives, the family also may view the student or resident as an “expert” whose words and approach become highly influential for all. Later, the same student or resident may be called back to speak to the family after learning from the chief resident or attending physician that the nursing staff have said the family has additional questions.

The student or junior resident does not/should not feel like an “expert,” of course, but he or she may feel uncomfortable yet compelled to provide information and support to the family (and patient) in order to respond to the positional or legitimate power of the chief resident or attending physician. The latter may have chosen to avoid this discussion for reasons that are understandable (e.g., another emergency) or not (e.g., anxiety about discussing life-threatening issues). The reasons and manner by which the chief resident or attending physician conveys his or her orders or request to the student or junior resident, and how those orders or request are perceived by the student or junior resident, speak not only to the positional power of the chief resident or attending physician but also to the chief resident or attending physician’s referent power and the model of what it means to be a physician that he or she presents to his or her junior colleagues.

Situations like this and countless others at all developmental levels of undergraduate and graduate medical education provide important insights and instructional material about the types and uses of leadership and power that can and should be incorporated into appropriate curricula, such as those noted above. As noted also, techniques that go beyond lecture format, and include interactive seminars, review of potential and actual scenarios that have occurred, and reenactments and role-plays, all can be used beneficially in this endeavor.

Finally, it may be asked whether leadership skills or leadership training actually result in positive health care organizational, departmental, or clinical outcomes. Although not addressed sufficiently in this manner, there are suggestions that training of this type may be beneficial, at least in clinical contexts. Much of the research touching on this question comes from studies of “communication skills,” an important component of leadership. Here we see clear benefits. Communication skills, a sometimes vaguely worded set of behaviors that can be clarified and measured, has been found to improve patient compliance, acceptance of recommendations, and patient satisfaction. The term reflects attributes such as the physician’s interpersonal style and his or her ability and willingness to listen, provide information, foster involvement in decision making, and express appropriate concern.

These qualities can be encompassed within the framework of leadership, although leadership, as discussed here and applied also to an academic and health care organizational context, is a broader concept. It would be valuable to study additional aspects of leadership, such as the ability to lead others in defining a vision (an aspect of referent power) in relation to the achievement of goals and objectives that are part of a particular academic or organizational mission.

**Concluding Remarks**

There are several bases of power and influence that can be employed by physician leaders. Easily recognized are power bases gained through position and appointment or through expert knowledge and information. More difficult to conceptualize is referent power, the form of influence that enhances other bases of power and derives from the personal qualities and interpersonal skills of the physician regardless of role.

Understanding the types of power, their appropriate and inappropriate uses, and
ways to use power for positive health care objectives would enhance physicians’ effectiveness in numerous leadership roles—academic, organizational, and clinical. The study of power, therefore, should be more fully incorporated into appropriate curricula at the undergraduate and graduate levels of medical education.

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References

25. Warren O, Carnall R. Medical leadership: Why it’s important, what is required, and how we develop it. Postgrad Med J. 2011;87:27–32.