Straddling Dual Roles: The Family Physician as Clinical and Administrative Leader

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Navigating dual roles requires a deliberate set of tools and a strategy to build new leadership muscles.

"Leadership is not about being in charge. It is about taking care of those in your charge."
— Simon Sinek[1]

It's 8:00 a.m., and your first patient just arrived. By noon, you've navigated multiple complex cases, comforted a patient's grieving spouse, and fielded a dozen portal messages. But your day is far from over. At 12:30 p.m., you're expected in a leadership meeting to review clinical performance metrics and finalize next quarter's budget plan before you return to the clinic midafternoon to see a few more patients. All in a day's work.

While all physicians are leaders,[2] many of us at some time in our career will feel called to take on specific administrative leadership roles, such as lead clinic physician, medical director, or chief medical officer, in addition to ongoing clinical work. Often, this is because we feel we have something important to offer beyond the exam room or we are seeking greater professional influence, variety, or opportunity to use our unique skills.

Key Points

- Family physicians are uniquely positioned to serve as clinical and administrative leaders because of their broad training, clinical experience, relational orientation, and population health perspective.
- Successfully navigating these dual roles requires the ability to shift your perspective from micro (the immediate needs of patients and the care team) to macro (the long-term needs of the population and system).
- Tools such as time blocking, adapting communication styles, and setting boundaries can help physicians manage dual responsibilities along with building new leadership competencies and seeking mentorship.

This article explores the professional realities of this dual-role leadership and offers practical insights on how to succeed in both worlds without losing your way — or your why. It also includes some coaching questions to clarify your readiness for administrative leadership.

The Case for Dual Roles: Why Health Care Needs More Physician Administrators

The health care landscape has become increasingly complex. Systems are expanding, regulations are evolving, technology is exploding, and finances are tightening. In this environment, there's an urgent need for physician leaders who understand not only the intricacies of patient care but also the levers of system change, such as value-based care, clinical quality improvement, patient safety, evolving care models, and meaningful use of technology. Each of these areas require certain skills, but also a certain perspective. A skilled physician who understands the downstream consequences of administrative actions can help the organization make smarter decisions that are patient- and community-focused and that lead to more efficient system-level changes, whether that "system" is a single practice or a large multispecialty organization.

Family physicians' broad training, clinical experience, relational orientation, and population health perspective make them uniquely positioned to step into this space. Our ability to see the big picture, prioritize relationships, communicate effectively, and practice patient-centered care naturally equips us for leadership at multiple levels, whether it's redesigning team workflows, improving access, or championing quality initiatives.

And yet, the path to dual-role leadership isn't without friction. Many physicians find themselves caught between competing priorities — trying to stay present in the exam room while fielding emails about staffing models or policy changes and running late due to leadership meetings. Administrative leadership also demands fluency in unfamiliar languages: finance, strategy, operations, organizational behavior, human resources, risk management, and regulatory compliance. Most of us weren't trained for this. In fact, many of the skills needed for effective administrative leadership are exactly the opposite of the skills needed for effective clinical care.[3–5] This can result in role conflict, impostor syndrome, cognitive exhaustion, and chronic frustration. A physician who is well-intentioned but unprepared for an administrative role can bring more harm than good to an organization and to themselves.

Understanding the Differences

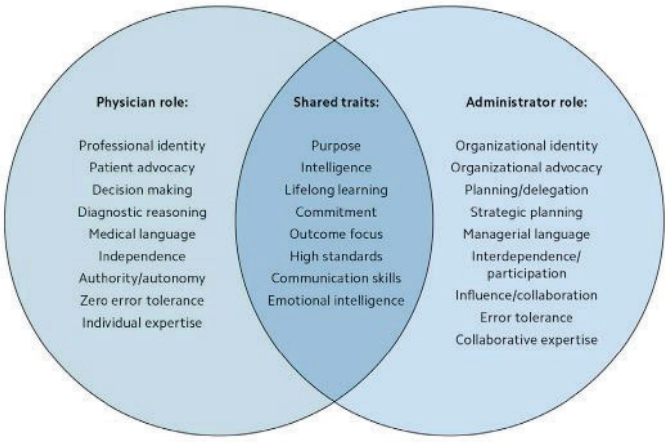
Being a physician leader in the clinic and also an administrative leader may seem like two sides of the same coin, but in reality they are entirely different currencies. While both roles rely on communication, professionalism, and expertise, they diverge in focus, time frame, relational dynamics, and decision-making processes.[6] (See Figure 1.)

Physician vs. Administrator Roles: Distinctions and Shared Traits

As a clinical leader, your world revolves around the immediate needs of patients and your care team. Decisions are typically case-based, individualized, nuanced, and made in real time. The emphasis is on relational presence, compassion, and diagnostic precision to improve the health of the person across from you in the exam room.

Figure 1

Physician vs. Administrator Roles: Distinctions and Shared Traits



Adapted and expanded from Guthrie, Birerr, and Barnhart [3-5]

Your clinical leadership may also include mentoring learners, streamlining care plans, or inspiring trust during difficult conversations.

Administrative leadership, by contrast, zooms out. It requires population-level thinking, long-term planning, and systems-level strategy. Decisions often unfold over weeks or months, involve diverse stakeholder groups, and must balance clinical integrity with budget constraints, policy considerations, and organizational priorities.

Shifting gears can be jarring. It is both an intellectual and emotional shift — and one that isn't always smooth.[5] Many physicians experience dissonance or guilt when stepping away from patient care to attend a leadership retreat or budget meeting. Others feel isolated when the relational energy of the clinic is replaced by board room agendas and spreadsheets. A toxic cognitive fatigue can result when physician leaders find themselves unable to be fully present in either the exam room or the board room and both roles suffer.

Scan the QR Code to read the rest of the article.

A Family Physician's Perspective

Dr. Frank Animikwam

Below, MAFP member **Frank Animikwam, MD**, (Petoskey) shares how his background in family medicine prepared him for administrative leadership, the importance of balancing patient care with leadership responsibilities, and the role mentorship and advocacy play in helping physicians succeed in leadership positions.

Q: *How has your background in family medicine prepared you for administrative leadership?*

A: It has allowed me to have a skill set to look at the big picture as well as be thorough. Medical school and residency prepare you for being a doctor, and in particular being a family medicine physician. We look at patients holistically across all their systems, including family and community health.

Furthermore, in practice, networking and partnerships help to prepare for administrative leadership through experiences and training. MAFP and AAFP are both very supportive of family medicine physician advancement through their advocacy and provision of leadership opportunities. One of the valuable lessons I have learned from these opportunities and training is the understanding of our larger health system, which is very complicated, and highlights the need for continued networking, partnerships, and advocacy. I have also had the opportunity to practice resolution writing, giving and receiving testimony, to inform and to shape policy.

Q: *How do you navigate between patient care and leadership duties?*

A: I do so by putting patient care first. Then, with the help of scheduling and support team members, I am able to balance leadership duties. It helps to have the protected time to do both. I have had a variation of time percentage allotments in the past 5 years of being a medical director. When we have had enough physician/provider coverage my time was 50% clinical and 50% administrative. Due to staffing changes, the clinical demands have increased to where my allotment is 80% clinical and 20% administrative. Additionally, team coverage is needed when leadership duties make me unavailable for patient care. Moreover, the administrative team at our organization helps to take on more demanding and nuanced administrative responsibilities when I am unavailable due to patient care. I am truly grateful for my team to help ensure that we can best care for our patients. I am a huge proponent of team-based leadership.

Q: *What tools or strategies have been most helpful for you in managing dual roles effectively?*

A: Helping to transition our electronic health record to a higher-functioning and more up-to-date electronic health record has allowed more efficiency with seeing patients, documentation, and care coordination. There are also integrated AI technologies, that are HIPAA secure, that also aid with further efficiency and documentation.

Administratively, we utilize a storage platform for policies and procedures that can be shared across staffing. It also allows for timely updates, reviews, and signatures. I have used AI technologies to also aid in template and document creations to improve efficiency.

Q: *What advice would you give family physicians considering adding administrative leadership to their workload?*

A: I would advise to first ensure that they have the capacity and access to maintain physical, mental, emotional, and spiritual health. Being a family medicine physician is challenging and rewarding. Adding administrative leadership to the workload certainly creates more challenges. One has to ensure that they have healthy outlets to be able to manage stress and decrease risk for burnout. It is also important to schedule family time, especially if you have young children.

It also helps to ensure that the health system and organization that one works for is supportive of physician representation at the administrative leadership level.

Lastly, engage actively with MAFP and AAFP for leadership training and opportunities to help become more prepared for administrative leadership. Medical schools and residencies teach us about being a doctor and a family medicine physician. There is not much training in the curricula for the business aspect of medicine; understanding insurance, billing, health policies, clinic budget, physician contracts and hiring. Experiences and training are valuable for growth and for helping physicians feel more comfortable and confident in taking on administrative leadership roles. Advocacy, networking, and partnerships can help take this further by fostering a supportive system that helps physicians succeed and thrive in their administrative leadership roles. We cannot lead alone and we are not alone when we lead.