ORIGINAL ARTICLE

Building physician capacity for transformational leadership—Revisited

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Abstract—In 2001, St. Joseph's Health Centre reported on its efforts to design and deliver a physician leadership program. The program was launched in Fall 2010 and has just completed its second cohort with a total of 29 physicians participating. The results and associated learning have been very encouraging.

In 2011, Vimr and Thompson reported in *Healthcare Management Forum*[5] on their initial design for a physician leadership development program that focused on transformational leadership, which they defined as "going beyond exchanging inducements for desired performance by developing, intellectually stimulating, and inspiring followers to transcend their own self-interests for a higher collective purpose."[6] The program was also intended to promote a culture that recognizes and supports a physician's contribution to hospital leadership.[1-4] This follow-up article is intended to report the results after offering the program to 2 cohorts of physician leaders.

MEDICAL LEADERSHIP AT ST. JOSEPH'S HEALTH CENTRE (SJHC)

SJHC, in the Toronto Central Local Health Integration Network, is a 375-bed community teaching hospital. It provides primary, secondary, and selected tertiary care through various medical, surgical, and mental health, mother/child, and ambulatory programs and services. More than 2,400 staff members and 250 credentialed physicians serve a diverse, multicultural inner-city population of approximately 500,000. SJHC is formally affiliated with the University of Toronto Faculty of Medicine and other universities and college programs in Canada and the United States.

At SJHC, administrative and medical program directors are jointly accountable for their portfolios. At the commencement of the physician leadership development program, the medical directors, who act as departmental chiefs, reported clinically to the chief of staff and administratively to the Executive Vice President (EVP). However, during the first cohort, there was a structural change. The role of EVP, clinical programs, and Chief Medical Executive was created and the medical chiefs now report jointly to both EVPs of clinical programs (the other being the chief nursing executive). At the same time, the former Chief of Staff's term ended and a new chief of staff was appointed, so the physician leaders were in a time of particularly high uncertainty and change. These medical directors play a significant role and face daily pressures to balance their clinical excellence and patient advocacy with their support for the hospital's larger goals and commitments, especially when it comes to quality and safety.

As part of the corporate strategy, the hospital developed a leadership program for non-physician leaders that was framed by a well-defined competency framework. There was considerable thought given to the potential benefits and risks of integrating physician leadership development into the existing framework. The argument in favour of this approach was that it would enhance collaboration and communication between administrative and medical leadership. Despite that, the decision was made to develop a physician-only program, framed by the same competencies. This has proven to be wise course of action, as discussed under key lessons learned.

THE PHYSICIAN LEADERSHIP DEVELOPMENT PROGRAM

A request for proposals was developed and distributed. After due diligence, the Iris Group, a Toronto-based consulting practice with significant hospital leadership-development experience and solid academic credentials was selected as the provider. The conceptual framework for their approach had 4 key elements:

1. ALIGNMENT OF COMPETENCIES. A careful review of various healthcare-related competency frameworks was undertaken and compared with SJHC's recently developed framework. The existing framework was more than sufficient for physician leaders, so all the elements of the program were aligned with the hospital's defined leadership competencies.

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2. A SYSTEMS APPROACH. Looking at organizations as complex, adaptive systems rather than industrial-age machines is the key to developing a robust, agile, and adaptive culture. Order in complex, adaptive systems emerges when the system has the space for self-correction and when change and compliance are self-generated based on the capacity of systems to self-organize. This represents a fundamental shift in the role of leadership, moving from a rational, managerial focus[7] to a focus on relationships that enable self-organization and constant adaptation.[8] This has a particular resonance in a healthcare context, as demonstrated by Anderson et al. and many others.[9]
3. COLLABORATIVE APPROACH. Collaboration is integral to a complexity approach to leadership development.[10] To model a collaborative approach and increase engagement, senior management was actively involved in all key elements of the program design and the CEO framed the program in the context of SJHC's strategic plan and the unique opportunities of providing care and leadership in a faith-based organization. In the second cohort, 1 of the physician leaders from the first cohort was part of the guest faculty.
4. AFFECTIVE LEARNING STRATEGIES. The combination of 4 elements leads to the most significant and sustained behavior change. The goal was to model transformational leadership[11] through transformative learning[12] To enhance the transformative learning, the key elements include:

A. A cohort-based learning environment in which participants meet on a regular basis with the core faculty to expand their awareness and understanding of different aspects of leadership. As part of this approach, the program faculty included physician leaders and executives from other hospitals who brought their own perspectives and experiences.
B. Self-reflection and mindfulness. Through journaling, dialogue, and readings provided by the faculty, participants engage in various processes to help them think through their learning and make conscious choices about change.[13]
C. Action learning projects. Participants work in self-organizing teams to apply their learning to specific organizational opportunities that can then be operationalized to improve patient satisfaction, quality, or other organizational priorities. Typically, the executive takes an active role in identifying these projects and then sponsoring them. This approach is aligned with the concepts of action research as a prime organization development strategy.[14]
D. Coaching. Based on participant feedback, it is clear that effective leadership coaching was a critical implementation mechanism for the new learning. In combination with the workshop content and the individual reflection, it helps each participant make effective choices.[15]

Prior to the commencement of the program, each participant completed the Physicians Universal Leadership Skills Survey Enhancement 360 survey, an instrument developed by PDP. The Physicians Universal Leadership Skills Survey Enhancement 360 is the only 360° assessment tool specifically designed for healthcare leaders. It allows the participant to receive feedback from 5-8 clinical colleagues and a similar number of administrative colleagues. This was reviewed in confidence with their coach. Each cohort was together over a period of 8 months, meeting 5 times for 1.5 days (Thursday evening and all day Friday). Modules were spaced approximately 6 weeks apart to allow opportunities for the application of their learning. In between modules, each participant had the opportunity to engage with a leadership coach who helped them assimilate their new learning into their day-to-day activities. During the course of the program, participants also worked on action learning projects. These were self-identified initiatives that were directly related to their work and to which they could apply their learning. These projects were then presented to the executive of SJHC with an eye towards ongoing implementation. The project process was challenging with the first cohort, as there was a significant level of resistance by some of the participants. In the second cohort, we encouraged the participants to work in self-organizing teams if and when it was appropriate. We also increased the amount of in-class discussion about the application of the learning to the projects, which increased the relevance of the project development process.

ASSESSMENT METHODOLOGY

To assess the immediate effect of the program, a combination of quantitative and qualitative assessment was completed at the end of each cohort. Quantitatively, the average rating for all components was 4.64 on a 6.0-point Likert scale. Qualitatively, when the participants were asked how they had changed as a person, the comments included: "I have become more aware of leadership principles and have explicit ideas for their implementation," "I now have a better understanding of how to engage with stakeholders and achieve both corporate and educational objectives. I am more reflective as a leader and person. The importance of 'why' has been reinforced and I can engage better to achieve goals," and "I will continue to endeavor to think about the way I think about things, and appreciate that others don't think as I do—and that's okay."

When asked what they would do differently in their leadership practices, comments included, "I will focus on building relationships with colleagues. I will reflect routinely in my journal and implement (the leadership) principles learned to positively contribute to SJHC," "I will ensure there is much more discussion before moving to solutions," and "I will think of others' perspective when in conflict."

In addition, the Office of Continuing Education and Professional Development, Faculty of Medicine, University

of Toronto approved the program for 46 CMEs from both the Royal College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

The longer-term effect would be harder to assess, but several of the action learning projects have been implemented and are demonstrating a positive effect on quality and the patient experience. Many of the projects were noteworthy because their success was credited to the commitment of physicians to taking a collaborative approach.

KEY LESSONS LEARNED

THE IMPORTANCE OF SELF-SELECTED PARTICIPATION. The first cohort was a pilot project and all physicians in the role of Medical Program Director were required to attend. This created a certain amount of tension from the outset. The program was also conducted when there were significant tensions between the physician leaders and the administration. Although it made delivery more challenging, the program also provided a place for the physicians to vent some of their frustration and to create relationships so that people could moderate extreme positions and articulate a less inflammatory approach. The second cohort, primarily made up of emerging leaders, was invited to participate so there was a much higher level of uptake and enthusiasm. This suggests that, when such programs are being designed for both medical and administrative leaders, voluntary participation is foundational to transformative learning.

CREATING A SAFE ENVIRONMENT FOR LEARNING. A key learning from the process was that when the participants were in a physician-only environment where the focus was not on the clinical aspects of their role, there was clear evidence that as the cohort got to know each other the setting provided a safe environment in which the participants could speak candidly and shed their "expert role."

DEVELOPING REFLECTIVE CAPACITY. The need to diagnose quickly and accurately is a core skill of a physician, so it took some time for the participants to embrace a more inquiry-focused, reflective posture. Once they did, there was a significant shift in their ability to slow down their thinking, enhance their listening skills, and feel comfortable about "not knowing." This capacity was increased by the coaching relationship, as reflected by the willingness of some participants to continue with coaching after the end of the official program.

EFFICIENT DELIVERY. The content exposed the physicians to current, well-researched information on leadership and change at a pace and in a format they wanted. The key was to provide any theoretical information as efficiently as possible and to provide ample time for discussion in both small groups and the group as a whole. This emphasized 2 things; the concepts had to be theoretically sound, but the emphasis in terms of time needs to be on small group discussion to internalize their learning. Case study approaches were particularly effective for this outcome.

COHORT-BASED LEARNING. By working in a cohort model, participants had the opportunity to develop relationships and hear perspectives from a variety of physicians across several disciplines, so they were able to develop much more of a systems view. By bringing in other physician leaders and hospital executives, participants heard meaningful "stories from the trenches" so that they could develop an understanding of different leadership role, accountabilities, and approaches.

EFFECT OF COACHING. Finally, the coaching proved invaluable in providing a safe, totally confidential environment as participants were able to identify self-imposed limitations and blockages that were disabling their leadership and relational efforts. In fact, some of the individuals from the first cohort continued to work with their coach after the program was over.

WHERE TO GO FROM HERE

There are 2 key questions yet to be answered. The first is, if a physician-only approach is effective, as it appears to be, what are the other strategies and mechanisms to bring all of the leaders in SJHC together? Several ideas are being considered, including a regular leadership forum in which leaders could continue their own learning and work together on organizational initiatives. The second question relates to building the sort of critical mass of physician leaders who begin to shift the leadership culture to one that is more relational and reflective. Various strategies are now also in discussion.

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