President’s Column

Leadership for Change: A Vital Area for Faculty Development, Continuing Education, and Resident Education

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During the biannual meeting of the leaders of our family medicine organizations in late August, there were several discussions that touched on the coordination of our various leadership development efforts. A repeating theme that arose in those and other discussions was that a primary area of need during this time of transformation of our health care system and our discipline is training in leadership for change. This need clearly touches all members of our organizations as well as our residents, who will be leading redesign and quality improvement efforts when they enter practice. So, focusing on this very important area, what characterizes effective leadership for change?

This was a topic several months ago for brainstorming and discussion in a meeting of the leaders and practice coaches from the Patient-centered Medical Home (PCMH) projects in Colorado. We regularly gather to share experiences in key areas, and we chose this topic as the most important issue impacting our initial PCMH efforts in practices across our various projects. The task for the group was to describe the characteristics of effective leaders for change in the practices working toward becoming medical homes, and below is the list of those characteristics. While this list particularly refers to clinician and staff leaders within practices attempting to become medical homes, I believe it has great applicability to leaders on multiple levels within our practices, programs, and organizations.

Characteristics of an Effective Leader in a Medical Home

An effective leader for change in a medical home does the following things:

1. Sets an initial vision but then allows the team to further refine it.
2. Takes responsibility for making sure that the defining vision is voiced clearly and repeatedly and is not forgotten in the press to solve one problem after another.
3. Creates a true shared leadership model.
4. Identifies and empowers key innovators in the practice to get things moving.
5. Establishes time and space for reflection, improvement, and innovation.
6. Is able to establish a sense of urgency to change and improve without freaking everyone out.
7. Is able to relinquish control appropriately—moves to support the team when needed but backs off and lets others decide or control the process the rest of the time.
8. Often works through others to achieve goals, empowering them, allowing them to be successful and to be recognized.
9. Helps everyone figure out how they can contribute to the vision.
10. Gives recognition and rewards to those from the team who contribute.
11. Establishes accountability—for self and for everyone else.
12. Buys into a true team approach.
13. Supports an open flow of ideas—an environment where everyone is free to share their ideas.
14. Is not afraid of failure, which can be the best way to learn; risk aversion kills innovation.
15. Helps the team in dealing with naysayers or persistently negative people.
16. Helps the team to get over barriers—shows everyone a way forward when the team is stuck.
17. Helps people make sense of what happens, especially in difficult or novel situations (sense making).
18. Actively engages in the tasks at hand, including responding to people in a timely manner.
19. Sticks to decisions unless new information arises.
20. Is visible within the practice and to the team but doesn’t show a need to control things.
21. Pays attention to the important role of data in guiding improvement and change.
22. Empowers people with the information they need to do their job.
(23) Shares information freely instead of holding on to it as part of their power or “not to burden people.”

(24) Empowers effective middle managers—who also use all of these skills.

(25) Hires for fit into the system and the team instead of simply based on qualifications.

While this is obviously not an exhaustive list of the characteristics and skills that we need to have as the core leadership competencies for our practices, programs, and residents—it is not a bad place to start. This list is based on a great deal of practical experience in working with practices and programs engaged in this change process. Many of these items are things that apply to leaders in pretty much any situation or type of organization, but some are specific to leaders of practices and programs engaged in a period of active change, such as the one in which we are currently embroiled.

Current Hierarchical Framework

This list delineates a model of leadership that is much less hierarchical than that found in most of our practices and programs. This is a shared leadership model in which the leaders have important roles but do not make all the decisions, instead engaging and empowering interdisciplinary teams in planning and implementing change and improvement on an ongoing basis. This type of leadership and teamwork is central to the PCMH model and represents an initial cultural transformation that enables most of the rest of the changes necessary to become a true medical home. I would like to say that this is how most of our practices and programs are already structured—but I don’t believe that is the case. Most practices I have worked with in our practice redesign projects have been extremely hierarchical and have not displayed many of the characteristics listed above, so that much of our initial work and energy is directed toward this crucial transformation. There are multiple reasons for the hierarchical nature of our practices. The larger systems in which some of us work, and particularly our medical schools and teaching hospitals, are generally hierarchical and bureaucratic, and this is transmitted through to our own departments, programs, and practices. As a result, this is the model of leadership that most of us have experienced in our training and that we replicate in our own professional behavior. Medicolegal concerns also have often caused physicians to believe that they have to be at the center of all decisions impacting care in their practices, with a “buck stops here” attitude.

Splits in Practice Leadership

In many, if not most, practices a lack of training in or time for the daily practice operations on the part of the physicians has led to a split between the medical and operations sections of the practice, with an office manager with primary responsibility for operations. The physicians and sometimes other clinicians meet occasionally to discuss medical care issues and higher-level business decisions, the office manager meets with the staff to discuss operations issues, and there are rarely effective meetings or opportunities for problem-solving across this role-based split. In these practices, there is no leadership, time, or forum for shared communication and decision making by the two split portions of the practice, and there is a striking lack of nimbleness for responding to issues or needs for change. In residency practices, this split is further exacerbated by the fact that the practice staff is often paid and managed by the sponsoring hospital, with its own set of rules and processes. Pulling together the leaders of the two sides of the practice is sometimes like bridging the Grand Canyon, and this represents only a first step in moving toward a shared leadership model across the entire practice and program.

Leadership Development Agenda

All of these dynamics cause our practices and programs to struggle greatly with change and improvement efforts. A different model of leadership based on teamwork and shared decision making is required on all levels for our practices and programs to move successfully into the future and to function as effective medical homes. Beyond the needs of our community practices, it is important that this model be demonstrated in our teaching practices and taught to our learners, and this defines a large interdisciplinary faculty and staff development agenda for our discipline. We will not be able to achieve the level of change that will be necessary for family medicine and primary care to become the centerpiece of our health care system without a cadre of family physicians (and other disciplines) prepared to successfully lead the process.

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