PHYSICIANS IN 21st CENTURY HEALTHCARE: DEVELOPING PHYSICIAN LEADERS FOR THE FUTURE

by

KIMBERLY A. SMITH

B.A., Ottawa University, 2002

M.S., Kansas State University, 2008

AN ABSTRACT OF A DISSERTATION

Submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Educational Leadership

College of Education

KANSAS STATE UNIVERSITY

Manhattan, Kansas

2014

Abstract

This bounded case study explored ten purposefully selected physician participants' perceptions of the effectiveness of an eight session, two year in-house physician leadership development program at a major Academic Medical Center (AMC) in the Midwest.

While physicians are generally educated to care for patients in their specialty area, reforms necessitate the need for physician leadership involvement in metric tracking by healthcare organizations in order to provide a focus on quality patient care and safety.

Participants indicated finding the course effective, especially the negotiations and finance modules. These modules provided new language, a better understanding of processes and an opportunity to develop skills through interactive class exercises such as case studies. Participants described an increased self-awareness of their interpersonal skills and expressed a desire for greater exposure to emotional intelligence principles. Participants experienced a transformational shift in how they constructed their identity as a physicians and leaders, and questioned assumptions about the physician's role in healthcare.

While effective in initiating a process of exploration, this course was not sufficient to meet the goals and objectives of the program. Therefore, recommendations for the advanced course included a focus on leadership competencies identified by Dye and Garman (2006) as cited by Dye and Sokolov (2013), emotional intelligence, and transformational leadership.

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Table of Contents

Table of Contents……vi

List of Tables…….....xi

Acknowledgements...…….xii

Dedication…….....xiii

Chapter One – Introduction...……..1

Background……..1

Statement of Problem…….10

The Purpose Statement……..11

Research Questions……11

Population……..12

Sample……....12

Methodology……..12

Limitations of the Study……...….14

Human Rights and Ethical Safeguards…….....14

Significance of the Study……...15

Definitions……..16

Summary……....17

Chapter Two – Review of the Literature.....…….18

Introduction……18

Literature review……19

History of Medical Education……20

Competencies and Programs……..53

Developmental Models……..62

Leadership Development……...74

Summary……...……...78

Chapter Three – Methodology.…….....80

Introduction…….....…80

Rationale for Selection of Qualitative Research……80

Description of Researcher……..82

Justification for Bounded Case Study……82

Location of Study……...83

Population…….....…..83

Sample……84

FLA Course Description……85

Pilot Study….……85

Procedures……..86

Collection of Artifacts……86

Qualitative Data Collection……87

Data Analysis Procedures……..89

Validation……..90

Summary……91

Chapter Four – Findings……92

Introduction……92

Participants……92

Research Findings……..95

Research Question One…….…….…95

Negotiating Skills……...96

Financial Skills……103

Organizational Challenges……...104

Leadership Performance and Style……..106

Adult Education and Development……..114

Emotional Intelligence "Softer Skill"……..120

Summary of Research Question One……...122

Research Question Two……...123

Strategies Employed……123

Use of Strategies in Practice……127

Summary of Research Question Two……..132

Research Question Three……133

Career Path Progression……...134

Clinical Integration……..141

Summary of Research Question Three……144

Summary……..145

Chapter Five……..……...147

Introduction…….……147

Discussion……148

Research Question One……148

Negotiation and Finance Modules/Education Development……...148

Summary……..150

Adult Development/Leadership Competencies……...151

Summary……..153

Emotional Intelligence "Softer Skills"……154

Summary……. 154

Summary Research Question One……...…154

Research Question Two……...155

Discussion……155

Developmental Perspective on Teaching…….156

Summary……..157

Sessions with Diverse Tenure and Responsibilities

Strategies to Ensure a Safe and Challenging Learning Environment…..157

Summary……..……159

Summary Research Question Two……...159

Research Question Three…….160

Discussion……160

Leadership Roles vs. Clinical Responsibilities……160

Summary……..164

Clinical Integration – The Role of the Physician…….164

Summary……..168

Summary Research Question Three…….169

Recommendations……170

Advanced FLA…….170

Leadership Internships…….171

Participants and Projects…….171

Final Review Session……...171

Leadership Support……..172

Affinity Groups……172

Recommendations for Future Research……...……173

Final Thoughts…….173

References……176

Appendix A – Physician Satisfaction Survey……..181

Appendix B – Post Course Evaluation…….185

Appendix C – FLA Course Outline/Goals and Objectives……..202

Appendix D – Invitation to Participate……206

Appendix E – Interview Questions……..207

Appendix F – Consent to Participate……...209

Appendix G – Leadership Competencies……210

List of Tables

Table 2.1 - Flexner's Recommendations for Educating Physicians in 1910…….33
Table 2.2 - Five Leadership Development Programs and Associated Competencies……..54

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Dedication

This dissertation is dedicated to my husband

Jeff

You are my everything. Your love and devotion to our home

and family are extraordinary.

I love you.

Chapter One - Introduction

Effectively and efficiently running a medical enterprise has become a very demanding job. Per capita, in 2009 "the United States spends far more on health care…than any other nation on earth, yet approximately 50 million Americans lack health insurance", and the "United States ranks last among 19 industrialized nations in the rate of preventable death" (Gunderman & Kanter, 2009, p. 1348). While changes have been made by the most recent presidential administration, and full implementation is still in progress, the latest information available indicates this number has decreased to 48.6 million Americans without health insurance (Wayne, 2012). Healthcare leaders have been charged with reducing costs, errors and waste, while at the same time improving outcomes and developing long-term commitments to continually increase growth (Stoller, 2008, 2013). With an increasingly turbulent medical system, many (Gunderman & Kanter, 2009; Larson, Chandler & Forman, 2003), have concerns with the lack of physician engagement in leadership positions and indicate physician presence is necessary to facilitate a turnaround. The difficulty, however, lies in whether or not physicians today possess the necessary skills to lead our hospitals (Chaudry, Jain, McKenzie, & Schwartz, 2008).

Background of Problem

The first decade of the 21st century found the number of hospitals led in the United States by physicians to be fewer than 4% versus 35% in 1935 (Gunderman & Kanter, 2009). "Physician advocates tout that individuals entering

medical school do so to make a difference in the lives of the community; part of this is in helping those in need of medical services" (Smith, 2010, p. 1). Traditionally, medical education has focused on preparing future physicians for clinical practice, and "many physicians believe that the skills learned in medical school, residency, and practice in the health care environment will ensure their success as physician leaders" but "administrative and organization skills necessary for physicians leaders are, in fact, not among those skills typically developed in the medical education process" (Schwartz, Pogge, Gillis, & Holsinger, 2000, p. 133). Additionally, according to Gunderman & Kanter (2009), physicians have not seen the need to engage in coursework related to finance, development of strategic initiatives, and performing administrative tasks. These administrative responsibilities do not fit into the model of caring for patients. Most physicians expect the healthcare organization to provide and manage the resources necessary to care for patients, but do not have an understanding of the amount of effort required to balance these processes while managing the other challenges of effectively running the organization (Gunderman & Kanter, 2009). "In order to make a difference, schools need to provide education in leadership" at the same time they are providing the medical education "to address issues" such as "cost cutting by hospitals, scant opportunities for teaching and research, hospital utilization review, declining autonomy for making…decisions, and counterproductive cultures of hospitals" (Smith, 2010, p. 1).

Early in its evolution, the occupation of physician was looked down upon as being one of low status. Many who called themselves physicians were lay persons; individuals who apprenticed with physicians, or those who bought their way into a commercialized program for as little as four to six months of training. Those serious about the occupation often held two jobs to survive (Starr, 1982), and the American Medical Association (AMA), the organizing body for promoting "the art and science of medicine and the betterment of public health" (http//www.ama.assn.org/ama), was weak and floundered in its first half century. Currently, AMA are still challenged but in a much different way, focusing on topics such as maintaining high quality while reducing Medicare costs and assisting in the creation of a high performing sustainable Medicare system (http//www.ama.assn.org/ama) .

The early twentieth century started to see a shift in the status of the profession, however, the issue of standards for medical education was still a concern. Reform began to take shape beginning in 1910, and over the next decade with the help of the AMA and a young educator, Abraham Flexner. Flexner's famous Bulletin Number Four issued in 1910, sought to finally place structure and guidelines around medical education (Flexner, 1910).

Part of this change was to prepare current and future residents as they began their careers. Instructing medical students in a curriculum that encompasses not just the science of medicine, but also the business of medicine will allow physicians to take on leadership in hospitals and health systems

(Gunderman & Kanter, 2009; Ackerly, et al., 2011; Baker & Daginawala, 2011; Butcher, 2011).

Today, medical students and residents matriculate through programs and schools with strict standards, take cursory tests before advancing, and have many available options of specialties and paths (Starr, 1982). One of those paths can be in the form of leadership within the medical profession. Medical students and residents have the opportunity to obtain degrees in dual programs such as medicine and business, public health, or health services administration. These programs allow the student an option to develop clinical skills and business acumen, simultaneously engaging in curriculum with a focus towards a non-direct clinical path while still linked to a clinical impact on patient care (Gunderman & Kanter, 2009; Ackerly, et al., 2011; Baker & Daginawala, 2011; Butcher, 2011). "Currently a small number of schools are providing parallel tracks in leadership and medicine such as MD/MBA's (Medical Doctor/Masters in Business Administration) while students are in medical school and residency" (Smith, 2010, p. 2). The number of schools offering dual degree programs in the United States has grown with more than half of the nation's 133 accredited medical schools now offering concurrent pursuit of two degrees (Butcher, 2011).

Comparative studies of traditional medical school programs and dual degree programs have shown that students working on dual degrees were more aware of the challenges and the changing environment of healthcare, and of the need to rethink physician roles. Additionally, the students matriculating through

these programs expressed a greater sense of confidence in their skills upon graduation (Parekh & Singh, 2007).

However, those currently serving in mid-level and higher leadership positions have not had this experience. In large part, many of the current generation's physician leaders have been elevated into their leadership positions based on career achievements, not leadership acumen (Ackerly et al., 2011; Lobas, 2006; Stoller, 2009). Many of these leadership positions are comprised of Department Chairs, and most have had no formal training and lack skills in areas such as finance and accounting, marketing, capital procurements, human resources, or strategic planning (Ackerly et al., 2011). Career trajectories, Ackerly claimed, emphasize career accolades rather than acquisition of effective leadership skills, oftentimes results in physician dissatisfaction.

Physicians are facing increased pressure to elevate productivity while experiencing a decline in the control of their work environment, negatively impacting their physical and mental health (Schindler, et al., 2006). Schindler, et al. (2006) conducted a study of 1,951 faculty members from four academic medical schools in the United States where results indicated a preponderance of physician dissatisfaction with the practice of medicine. Physicians have been charged with educating the next generation of physicians.

Over the past 10 years, physician satisfaction surveys have reported that 30% to 40% of practicing physicians would not choose to enter the medical profession if they were deciding on a career again, and an even higher percentage would not encourage their children to pursue a medical career (Parekh & Singh,

2007). An analysis of the literature finds physicians in the 21st century will be faced with the concept of autopoesis or rethinking relationships with their organizations. Becoming a physician leader presents challenges for many physicians. Numerous issues have driven this change.

Healthcare reform is one such issue. The Patient Protection and Affordable Care Act (ACA) will challenge all healthcare organizations to reevaluate care delivery and consider strategies related to change in their operational approaches to management (Dye & Sokolov, 2013). Both physicians and administrators will be tasked with enhancing quality while reducing costs and increasing organizational efficiencies, such as looking at value based purchasing structures, and clinical integration (Dye & Sokolov, 2013; Morgan, 2006).

Some physicians have begun leadership training to overcome frustration with non-clinical executives over issues of costs, decision making and autonomy (Gunderman & Kanter, 2009; Schwartz, et al., 2000):

> There are important parallels between caring for patients and running a hospital. To ensure collaboration, both physicians and Chief Executive Officers (CEO) need to function like symphony conductors. Both physicians and executives deal with an extremely complex entity composed of different systems that must work in harmony to secure the welfare of the whole. Optimal care requires the contributions of a variety of disciplines and services. (Gunderman & Kanter, 2009, p. 1349).

Ensuring enough physician leaders will be available makes succession planning important, replacing key individuals can be a lengthy process (Ackerly, et al., 2011; Demmy, Kivlahan, Stone, Teague, & Sapienza, 2002).

Professional development programs have begun to focus on transforming physician-educators actively engaged in instructing future physicians into successful leaders (Armstrong, Doyle, & Bennett, 2003; Scott, Tangalos, Blomberg, & Bender, 1997). The Harvard Medical School and Harvard Graduate School of Education, led by Dr. Robert G. Kegan, developed the Program for Physician Educators, to transform both participants and their schools (Armstrong, et al., 2003).

Using adult education techniques, educators participate in transformational learning, reshaping perspectives about their personal and professional lives. Exercises include group presentations, journaling, observation and reflection on shared experiences. Follow-up participant surveys have indicated physician educators adopted interactive and learner-centered approaches and engaged in teaching and learning activities outside of formal classrooms. Other career enhancements included active submission and awarding of grant funding and fostering individual professional development (Armstrong, et al., 2003).

An unexpected outcome of the program has been the informal learning networks created by participants. This community of practice formation has

allowed participants to support each other in their skills development in a cohort fashion (Armstrong, et al., 2003).

Physician transformation plays a large role in transformational leadership which seeks to transform organizational culture. Bass, as described by Yukl, (2010), outlines three important aspects of the theory: the leader transforms and motivates the followers by heightening awareness of outcomes, putting the organization and team above self-interest, and activating their higher-order needs. In order for a leader to move teams to these levels, they themselves must construct meaning at a high order.

Robert G. Kegan, Ph.D., The William and Miriam Meehan Professor of Adult Learning and Professional Development, Harvard Graduate School of Education, and cognitive developmental theorist, developed his most recent theory on the five orders of consciousness. This theory discusses the organizing principles of mental organization that affect thinking, feeling, and relating to parts of self and others (Kegan, 1994). The ability to construct the world as a fourth order self, Kegan (1994) claims is important for any person interested in leading. Fourth order thinkers hold opinions, but are capable of seeing and understanding another perspective. Fourth order thinking, however, is when a leader can accept that they can change their understanding without losing sense of self. They are at a fifth world order consciousness, where they can serve as transformational leaders (Kegan, 1994).

Self-awareness, one of the five components of emotional intelligence (Goleman, 2004) has been critical for leader development (Stoller, 2008). Self-

awareness has been described as the "extent to which someone is conscious of various aspects of identity and the extent to which self-perceptions are integrated internally and congruent with the way others perceive the individual" (Day, Harrison, & Halpin, 2009, p. 302) A self-aware individual can identify areas of weakness. This type of awareness can provide the individual the insight needed for continual growth and confidence building (Goleman, 2004).

For current physicians pursuing a physician leadership track, the previously described insights will be important to develop or continue to develop. "As the concept of physician leaders is growing in popularity in the face of a more complex healthcare environment, a need for training physicians already in practice is rising to the top of the priority list" (Smith, 2010, p. 2)

Many organizations have developed their own versions of physician leadership development programs. The specific program this dissertation will address is the Faculty Leadership Academy (FLA). Embedded in a major Academic Medical Center (AMC) in the Midwest, this program has invited physician leaders from several specialties within the medical center to participate in a two year program designed to provide leadership education (Norman, 2010).

The FLA has been modeled on a program developed by a company that closely works with academic medical centers as a whole, The Advisory Board Company (ABC). The ABC's program allows for physicians to visit their on-site academy up to four times per year to participate in coursework on health care leadership, hospital economics and business, and leading hospital reform. In existence since 2004, they build upon their initial platform every year to provide

more in-depth exploration of what they identify as the key competencies identified by participants (The Advisory Board Company, 2004).

The FLA model uses similar topics and outsourced speakers as instructors with strong local facilitation and customization of the program by the Chief Medical Officer (CMO) of the hospital. Additionally, a benefit of the in-house model has allowed participants who are colleagues, whether close partners or passing acquaintances, to form "affinity" groups much like cohorts. This allows for partnering opportunities for the hospital with different service divisions, and provides an excellent team building atmosphere for participants to continue to build on between and after the seminars (Norman, 2010).

Statement of Problem

The need for physicians who possess the necessary skills to provide leadership in hospitals today is increasing (Schwartz, et al., 2000; McAlearney, et al., 2005; Gagliano, et al., 2010). Over the past several decades, the move away from physician directed to non-clinically directed organizations has changed by 90% (Gunderman & Kanter, 2009). Changes in the healthcare landscape have forced physicians to lead. The problem lies in the lack of experience physicians currently possess in administrative practices, as well as inadequate numbers of qualified physicians to assume the helm. "Redundancy in physician leadership is important", as it can take "months to years to replace key individuals" (Demmy, et al., 2002, p. 1240). Development of physician leaders is needed based on the challenges identified above and projected ahead in healthcare. Healthcare organizations are complex and generally identified as organizations with many

professions operating in silos or fiefdoms, and physician characteristics and their training has provided for a profession unused to collaboration and followership. Medical training with its strong focus towards clinical engagement makes it difficult to devote time to mastery of leadership skills (Stoller, 2009). The FLA is an internal hybrid physician leadership seminar series that engages physicians at a major AMC to participate in a two year series of leadership seminars designed to assist them in successfully navigating the difficult complexities facing healthcare today.

The Purpose Statement

The purpose of this study was to describe and analyze the perspectives of physicians who attended the Faculty Leadership Academy (FLA) to determine their perspectives on program effectiveness in developing leadership competencies and skills, successful instructional strategies and the impact of the FLA on their intentions to pursue leadership opportunities.

Research Questions

The research questions that guided this study were as follows:

1. Based on the participants' perceptions, how effective was the FLA program in developing leadership competencies and skills?
2. What instructional strategies did program participants find helpful?
3. Did the coursework influence the participants' decision to think about a higher leadership position and if so how and if not, why not?

Population

Participants were faculty members of a closed medical staff within a major AMC located in the Midwest. All participants were former attendees of the Faculty Leadership Academy who participated in the full two year course curriculum.

Sample

This sample was purposefully selected from a group of 113 graduates of a faculty leadership development program by the co-director of the program. A total of 11 physicians were interviewed. The first physician served as a pilot, the results from that interview were only used to refine the questions and did not factor into the final coding.

Methodology

Creswell has described a case study as, "researcher focuses on an issue or concern, and then selects one bounded case study to illustrate this issue" (Creswell, 2007, p. 74); the study was focused on faculty who had actively participated in the two-year program. The researcher conducted semi-structured interviews with 10 physicians to understand their perception of the relevance of the FLA program and the impact of the program on their desire to consider higher leadership positions. Prior to start of interviews for the research project, a pilot study consisting of one interview was conducted to flesh out any unanticipated concerns or issues.

Interviews were audio recorded for transcribing by the researcher and assistant, and all interviewees' identities are anonymous. Qualitative data research

analysis software, NVivo 10 was utilized to scan for common themes and the researcher utilized validation strategies of peer review; in member checking; rich, thick descriptions; and external audits for validity of qualitative research. Additionally, a physician satisfaction survey from the AMC, course curriculum, and post course evaluations provided a qualitative basis to this study. (See Appendices for Physician Satisfaction Survey (A), a sample of post course evaluations (B), and course curriculum (C).

Participants and the researcher all work in the same environment in which the coursework was presented and where hospital based situations were discussed. Creswell states "constructivist researchers often address the "processes" of interaction among individuals"…focusing "on the specific contexts in which people live and work in order to understand the historical and cultural settings of the participants" (Creswell, 2007, p. 21).

Given the familiarity of the researcher with the participants and setting, immersion into the research setting was easily achieved. Additionally, the researcher was familiar with the medical profession, so the unique nature of the language was not an issue and the researcher was able to establish descriptive, context-relevant statements so the reader would be able to identify with the setting. Historical and cultural aspects of medical education provided a significant importance to the foundation of the research for this dissertation.

Limitations of the Study

This study has three distinct limitations. 1. The participant population came from one in-house faculty. 2. The participants for this study were selected purposefully by one of the co-directors of the program. 3. Participant bias was possible based on initial selection process by departmental chair.

Additionally, based on the qualitative nature of the study, it was presumed that all participants' responses were accurate portrayals of their experience and perceptions of what advances in medical leadership skills are necessary to competently lead an organization successfully through the difficult healthcare issues the United States faces now and in the future.

Human Rights and Ethical Safeguards

The research was conducted in compliance with Kansas State University (KSU) policy for research involving human subjects. Application was made and accepted by The Committee for Research Involving Human Subjects (IRB). Additionally, because of program location and the physicians practice at a major Academic Medical Center in the Midwest, a second IRB application for research with human subjects was made to the university for permission to conduct research on the campus of the university.

To ensure participants of appropriate research protocol format, informed consent was provided and participants' anonymity will be protected per protocol. Data correlating to participant's true identity and pseudo-identity will be kept for

three years in separate locations and researcher will be the only individual with knowledge of the location of protected information.

Significance of the Study

The objective of the Faculty Leadership Academy (FLA) program is to provide leadership guidance and mentoring to current faculty at a major Academic Medical Center (AMC) in the Midwest. The aforementioned program provides quarterly seminars, spanning a period of two years, designed to provide clinician leadership with the tools necessary to assist with issues physicians are currently challenged with, while also providing continuing medical education (CME) units for licensure requirements. Organizational in-house programs have traditionally not been effective, usually passive, and hard to measure (Schwartz, et al., 2000). Based on feedback from course evaluations and a recent physician satisfaction survey, the FLA has not only been effective in providing timely, informative and educational sessions, but it has allowed for participants to evaluate the sessions by survey. However, no in-depth interviews with participants has occurred.

Participation by physicians in programs such as the FLA provides the necessary understanding of what it takes to successfully manage in the healthcare environment today and the future. This in-house leadership program is a joint effort of the AMC and the School of Medicine, and is co-directed by the Senior Vice President and Chief Medical Officer (CMO) of an AMC in the Midwest along with two other co-directors from the university. Modules include

Negotiation Skills and Principles, Clinical Capital Investing, Quality Improvement Imperative, Managing Disruptive Conduct, Drivers of Financial Performance, Patient Safety Imperative, Problem Solving using Analytic tools, and Managing Conflict.

This program attempts to maximize the communication between physicians and administrators. In breaking down barriers and focusing on one goal, optimal patient care will continue to move forward.

Definitions

For the purposes of this research the following definitions were used:

Academic Medical Center (AMC): Medical schools and their affiliated teaching hospitals and clinics.

Affinity Groups: Groups identified as a group of individuals with common interests and/or goals.

Affordable Care Act (ACA): Designed to increase the number of Americans with health insurance while at the same time decreasing the overall costs of healthcare. Several mandates to the Act include subsidies and tax credits to employers and individuals to increase enrollment of insurance plans.

Department Chair: Position held by dean appointed physician in a medical school.

Dual Degree Programs: University degree programs with dual tracks, i.e. Medical Doctor/ Master in Business Administration (M.D. /MBA) or M.D. /M.P.H. (Master's in Public Health).

Faculty Leadership Academy: Local hybrid program designed to assist in the

development of leadership skills for physicians.

Medical School: A tertiary institution that teaches medicine. Students complete a requisite number of credits for the degree of doctor.

Value Based Purchasing (VBP): Program established by the Affordable Care Act in 2012 in an effort to promote better clinical outcomes and improve hospital experiences while lowering costs.

Summary

The Faculty Leadership Academy is a hybrid in-house leadership development program designed to prepare current faculty members (physicians) with the basic skills necessary to better provide leadership to their colleagues and organization. The academy is a two year program where participants attend quarterly seminars focused on skill development of competencies required to face critical issues in healthcare. Many have found their way into leadership positions by chance based on their clinical success and are at a disadvantage because they lack the basic competency skills necessary to lead.

This qualitative study sought to discern the perceived effectiveness of this in-house model in acquisition of needed leadership competencies in finance, human resource management, organizational strategy, and negotiations, and the softer skills such as those related to emotional intelligence. The end result was to review and interpret results from those interviews and make recommendations for the current and future programs.

Chapter Two – Review of the Literature

Introduction

Chapter two is a literature review on the history of medical education in America, the attempts physicians have made to create an effective profession, both clinically and in leadership, the challenges facing healthcare today, discussion pertaining to leadership, adult development, and the relevance these subjects have with regard to physician leadership programs.

This qualitative study explored the medical profession in its early evolution where it was viewed as a less than noble occupation, and the progression it has made into the 21st century. Throughout the journey, physicians have fought for and finally succeeded in creating a sovereign profession (Starr, 1982). Medical schools in the 18th and 19th centuries were unstructured in admission requirements and overall educational requirements. The 20th century would see a turnaround but, it also found physicians abdicating leadership responsibilities to business professionals within the hospitals and healthcare organizations (Schwartz, et al., 2000). In the 21st century, the literature discusses the complicated place in which healthcare now resides and why the call for greater presence of physician leadership is needed.

Traditionally, medical education has not incorporated leadership skills into the coursework for medical students and residents progressing through school. In the 21st century this has become more prevalent, as there are many programs offering dual degrees, but, the mid to late career physicians are challenged with

the need to acquire these skills on their own if they want to successfully move into a leadership role within organizations.

To assist with this endeavor, many organizations either support physicians through offsite courses in order to elevate their leadership knowledge, or are developing their own hybrid programs (Kaplan & Feldman, 2008; Scott, et al., 1997; Stoller, 2013). This dissertation focuses on one such program, the Faculty Leadership Academy. This local program along with others described later in the text, provides a safe environment where physicians are afforded the ability to elevate and update their business acumen, as well as hone the softer skills or people skills (Goleman, 2004). Finally, it discusses developmental theory and the close relationship it has with leadership theory.

Literature Review

The history of medical education and the medical profession in the United States has a long and convoluted but well documented journey from its weak beginnings to its present place of dominance in society (Flexner, 1910; Starr, 1982). This literature review chronicled the evolution of the profession including education, challenges, and victories. It addressed the transformations 21st century physicians and healthcare in general need to manage, and the subject of healthcare economics in the United States today.

Physician engagement will be needed in leadership roles to assist with overcoming challenges such as The Affordable Care Act (ACA), The American Taxpayer Relief Act of 2012, retrospective audits, and other healthcare initiatives

currently underway (Dye & Sokolov, 2013). Unlike the opportunities medical schools offer today's students and newer physicians, such as dual degree tracks where medical students and residents can, in conjunction with their medical studies, earn degrees in business administration or public health (Larson, Chandler, & Forman, 2003), physicians in mid to late career phases generally were not afforded opportunities for dual track degrees paths educating them on both leadership topics as well as medicine.

History of Medical Education

Flexner (1910) in his document on Medical Education in the United States and Canada divided the evolution of medical education in three characteristic eras. The first of these were the writings of Hippocrates (B.C. 460-377) and Galen (A.D. 130-200). Their writings described observation and experience as foundational to the study of medicine. Medicine during this time was dominated by scholasticism, in that physicians were primarily men of intellectual mind and the surgeons were deemed a lesser profession based on the use of their hands. As such, there were two classes of doctors, physicians, who listened and observed patients, and surgeons, whose practice was determined to be more of a trade because they employed the use of their hands (Flexner, 1910).

The empiric era followed, beginning with anatomy in the sixteenth century. This era placed value, according to Flexner (1910) on experience, but the processes employed with analyzing, classifying and interpreting information were extremely limited. Many illnesses had similar symptoms as there was a lack

of technique to distinguish and differentiate among them. Consequently, similar therapeutic regimens were employed for various illnesses and, therefore were unsuccessful. Learning was accomplished in an observation mode without any hands on opportunities.

The third era, Flexner (1910), classifies medicine as modern science. It is characterized by instruction, hands on learning, and experience. Like empiricism, where medical treatments were based on experience rather than science or theory, modern medicine uses probability and theory, but unlike empiricism, sets risk boundaries. It is not predicated on faith, nor is it an exact science.

As early as 1750, records describe informal classes and demonstrations conducted primarily in anatomy. Described as the hub for medicine for the country, Pennsylvania Hospital was founded in Philadelphia in 1752. Built as a joint effort between Benjamin Franklin and Thomas Bond, this hospital was an early example of what has become the standard for medical education training for physicians. Bond, as cited by Flexner (1910), states the student:

> …must Join examples with study before he can be sufficiently qualified to prescribe for the sick, for Language and Books alone can never give him Adequate Ideas of Diseases and the best methods of Treating them,…There the Clinical professor comes in to the Aid of Speculation and demonstrates the Truth of Theory by Facts,… he meets his pupils at stated times in the Hospital, and when a case presents adapted to his purposes, he asks all those Questions which lead to a curtained knowledge of the

> Disease and parts Affected; and if the Disease baffles the power of Art and the Patient falls a Sacrifice to it, he then brings his Knowledge to the Test, and fixes Honour or discredit on his Reputation by exposing all the Morbid parts to View, and Demonstrates by what means it produced Death, and if perchance he finds something unexpected, which Betrays an Error in Judgement, he like a great and good man immediately acknowledges the mistake, and, for the benefit of survivors, points out other methods by which it might have been more happily treated [capitalization and spelling differences by Flexner] (Flexner, 1910, p. 4).

In 1762, courses on midwifery and medical anatomy lectures by William Shippen commenced. Shippen, who received his training abroad, provided instruction for those less fortunate and unable to travel for training in Europe. In 1765, John Morgan, a fellow student who had traveled to Europe with Shippen, joined him and the two initiated steps towards organized medical education by proposing the establishment of a professorship in the theory and practice of medicine to the College of Philadelphia. The college trustees agreed, selected Morgan as the first chair of the medical school and Shippen, professor of anatomy and surgery (Starr, 1982).

Subsequently, Pennsylvania Hospital, affiliating with the College of Philadelphia, became the first large public hospital connected with a medical school. Students were required to have a bachelor's degree and then commence

with one additional year of training. Incorporated into the bachelor's degree along with Latin, Mathematics, Natural and Experimental Philosophy was an adequate apprenticeship with a reputable practitioner. The additional year focused on a significant amount of clinical opportunity and lecture curriculum (Starr, 1982). While a few additional schools were established with the same caliber of requirement, schools of lesser quality would soon find a place in America.

Education alone was not the only challenge facing medicine during these early years. The practice of the profession was also difficult. Medical care in Colonial America was provided by women in the household. Women were expected to be caretakers and healthcare providers in the domestic setting. There were some newspapers and books offering medical advice in the colonial period, however, most advice was passed by word of mouth (Starr, 1982).

Many of these publications were written by physicians. One of the most popular, *Domestic Medicine* (1769) was written by a Scottish physician, William Buchan. Written with the lay person in mind, *Domestic Medicine* had two sections, the first, gave an explanation of disease; causes and prevention, and the second, symptoms and treatment. A physician himself, Buchan proclaimed that while physicians are necessary, they should only be used in rare occasions for consult (Starr, 1982).

A second challenge for the physician was cultural. The United States had become a democratic culture. The occupation of the physician in America, modeled after their European counterparts, formed small and elite classes and

worked to establish professional societies, but this clashed with the democratic society. America experienced rapid geographical and population expansion, which included many individuals entering the practice of medicine. This growth provided for a difficult fight in attempting to establish guidelines and boundaries in a culture where there was no support politically or institutionally. Many physicians wanted strict boundaries surrounding educational guidelines, the licensing of members, and they wanted governmental involvement with the establishment of laws for practicing medicine (Starr, 1982).

By 1789, the standard set by the College of Philadelphia crumbled. The college recognized that the bachelor's degree, which provided a certificate and deemed students competent, found few were returning for the second year to receive the doctorate. Thus the requirements changed and the only pre-requisite for a Medical Doctor (M.D.) degree became a course in Natural and Experimental Philosophy or equivalent. Across America, the whole medical school concept focused on providing a solid education to aspiring physicians', began to fold as well. Those institutions choosing to maintain high standards had fewer and fewer students. Professors were only paid if students passed tests, so exams became less rigorous and the profession, seeking dignity and an elite status among men, was being undermined by its own (Starr, 1982).

Medical societies and licensing boards also succumbed to the same problems as they lowered their standards to collect tuition and graduation fees. Licensing boards were reluctant to turn away applicants and lose their fees. Self-interest continued to keep all at odds, and thus there became no immediate

solution to reining in the practice (Starr, 1982). Current physicians wanted medical societies and licensing boards to place tight restrictions on the profession, but doctors involved in the education of student physicians continued to open schools at will with little regard for boundaries related to entrance and graduation requirements. No one body had the power and authority to contain and regulate the profession and it increasingly became more unmanageable. It would be decades before medical societies and the legal system would prevail in enforcing strict guidelines (Starr, 1982).

The Colonial period gave way to the Jacksonian period, and where women once were considered the majority of the caregivers, the tide was now shifting towards male dominance. The early nineteenth century saw this shift in many areas (Starr, 1982). Public opinion began to assign women to a more domestic role after marriage, with the exception of school teachers. Women, once responsible for medical care, were only sought when male doctors were absent. The rise of the profession in the mid-nineteenth century would give women more opportunities when the New England Medical College, founded in 1848, became the first all-women's medical school in the world (Starr, 1982).

As discussed earlier, prior to the nineteenth century, doctors were traditionally divided into two categories. Physicians were basically hands-off doctors who listened to the patient's complaints, and surgeons, a lower class of doctor because they utilized the skill of touch. This, however, began to change in Paris where the two separate classes merged to become one profession. Physicians began combining what they observed through patients in their signs

and symptoms with what was observed during autopsies. It was during this period, in 1816, when the first stethoscope was invented allowing another opportunity to "see" into patients (Starr, 1982).

While advances in medical science progressed, the unrestricted entry into the profession also moved forward with continued futile attempts to create an organized, legitimate occupation. The percentage of medical school graduates to practicing physicians was relatively low, as was the total investment towards establishment of one's medical practice (Starr, 1982). A plethora of practicing physicians existed, growing faster than the population during the early to mid-nineteenth century. Growth expansion in the practice of medicine was increasing so rapidly that most physicians had second careers in order to provide an income. Economic problems of the times also contributed to the situation. The cost of medical care was something most couldn't afford. Both direct and indirect costs attributed to the general public's need to continue caring for themselves. Physicians couldn't afford to travel to all their patients and rural patients couldn't afford to spend an entire day to travel to see the physician (Starr, 1982).

The education of physicians and the professions place in society was still questionable. The elite, who had the means traveled to Europe for training, while legitimate education for those less fortunate continued to be limited. Aspiring physicians of middle class means served apprenticeships, attended lectures and possibly obtained a two semester medical degree, while the lowest of the social status were no more than autodidacts. The prevailing opinion mid-century remained; a career as a physician was an inferior career and a man was throwing

away an opportunity at a prosperous life to become a physician. In an effort to correct this mindset, the American Medical Association (AMA) was founded in 1847 in Philadelphia. At the same time the organization appointed a committee focused on Medical Education and they established standards for a preliminary medical education and the degree of M.D. (Starr, 1982).

As noted by Starr (1982) this initial attempt by the AMA to establish standards with current practicing physicians as well as establish education guidelines had a less than impactful start. Scant resources, small membership numbers, no permanent organization or financial resources to back them, and a lack of authority all led to the inability for the AMA to have much impact during its first half century of existence. For the physician who didn't meet the minimal standards of what society and the general physician population thought as standard, sectarian organizations were available for entry.

In the second half of the nineteenth century, a status and education level below the regular physician was the Eclectics and homeopaths. These groups accepted those physicians who were denied access to hospitals and medical school appointments such as immigrants and the less educated (Starr, 1982). As the principle medical sects in America, the Eclectics were botanic doctors, who mixed radical politics with herbal medicine. This group accepted and taught "conventional medical science" but in the area of therapeutics, the group was adamantly opposed to drugging of their patients. Homeopaths, "saw disease fundamentally as a matter of spirit; what occurred inside the body did not follow physical laws. The homeopaths had three central doctrines. They maintained first

that disease could be cured by drugs which produced the same symptoms when given to a healthy person…Second, the effects of drugs could be heightened by administering them in minute doses…third, nearly all disease were the result of a suppressed itch or psora" (Starr, 1982, p. 96-97).

The regular physicians and the sects began to converge in their common drive to secure legislation towards medical licensing beginning in the 1870's. While this initiative was a start towards structured guidelines, gradual stiffening and enforcement would be a long process. The toughest challenge towards strong licensing laws was said to have been with physicians themselves. Many of them had established their own schools, essentially no more than diploma mills and had no interest in strengthening the profession's resolve to tighten educational requirements (Starr, 1982).

Considered a landmark, the state of Illinois, in 1877, passed a law empowering the state board of examiners the ability to reject diplomas from disreputable schools, and under the law all doctors were required to register. Reportedly the state had 3,600 non-graduates practicing with 1400 leaving within a year of the law, and another 300 were estimated to have left the profession during the next decade (Starr, 1982). Even with this legislation in place, Flexner (1910) is said to have found no adherence to minimum admittance requirements by schools in Illinois as this law had intended.

At the same time physicians began their common drive towards structure, education reform in American universities began in earnest. After the Civil War, colleges became renewed with energy and ambition. The economy was

improving, allowing universities to have access to a surplus of capital; and wealthy families began to endow the universities with large sums of money (Starr, 1982). Leading the charge towards this reform was Harvard Medical School. Harvard began providing salaries to professors rather than the then customary fee division amongst faculty, the academic year went from four months to nine months, the length of training required to graduate increased from two years to three years, and the final requirement was requisite passing of all coursework to graduate. Based on medical education reform attempts in the past, Harvard expected and experienced enrollment drop off for a short time as this reform took hold, but unlike reform attempts in the past, education prevailed and reform efforts began to trend positively (Starr, 1982).

Johns Hopkins, which opened its doors in 1893, became the standard by which all other medical schools would be judged. Hopkins with the conception of medical education as a field of graduate study, and using a foundation of basic science and hospital medicine, required all students entering medical school to possess a college degree, and medical students were chosen rather than the school taking any person willing to pay tuition.. Additionally, Johns Hopkins Hospital was built to work in conjunction with the school of medicine and was where the term residency was first used (Flexner, 1910; Starr, 1982).

In 1901, the AMA reorganized and made medical education a top priority. The Council on Medical Education was established by the AMA in 1904 and was provided five medical professors, a permanent secretary, a budget, and the directive to elevate and standardize medical education requirements. The first of

the mandates dictated four years of high school, four years of medical training, and the passing of a licensing test. The AMA's "ideal" standard included five years of medical school and a sixth year of hospital internship (Starr, 1982). In 1906, the AMA began reviewing medical schools and their graduates' success on licensing exams. Of the 160 schools in existence at the time, the AMA found only 82 which they rated an "A", 46 ranked imperfect, a "B" ranking, but redeemable, and the final 32 were identified as non-redeemable, a "C" rating. The AMA revealed these scores and further discussed the findings in verbal format at their conference in 1906, but because AMA professional ethics would not allow physicians to take other physicians to task in public, they sought the help of the Carnegie Foundation for the Advancement of Teaching. The foundation chose Abraham Flexner, an educator, and an individual with a personal interest in medical education, as his brother, Simon Flexner was president of the Rockefeller Institute for Medical Research (Starr, 1982).

Flexner (1910), like the AMA, visited each medical school in the United States and he also reviewed schools in Canada. Included in his review were those of the different sects, the Eclectics and homeopaths, as discussed earlier in this literature review. Each school visit was evaluated and then the data was reconciled against that which was discovered by the AMA. The secretary of the AMA also traveled with Flexner to perform the review. Because Flexner represented the Carnegie Foundation, many schools were under the perception donations were a possibility, only to learn upon publication, his true mission. Flexner accused many of the medical schools he visited of not only

commercializing but also misleading the public as to which physicians had received adequate training and which had not. His purpose then was to expose those who put at risk the health of the American public (Flexner, 1910; Starr, 1982).

The five significant facts revealed by Flexner's report were:

1. The mass over-production of uneducated and ill-trained physicians. Flexner calculated the amount of physicians per capita in the United States were four to five times higher than in Germany (Flexner, 1910) .
2. The reason behind the over production stemmed from the large number of schools in existence, many of which were sustained by false advertisement. Flexner found many with schools whose catalogues were filled with false information, including non-existent laboratories, libraries without books, and reported faculty members who were actually physicians in private practice (Flexner, 1910; Starr, 1982).
3. Many of the schools had annual incomes below $10,000, which Flexner indicated was directly correlated to the quality of instruction (Flexner, 1910).

4. The mindset that the poor and inadequate medical schools

were justified for the poor boy who cannot afford the tuition of a good school, when in fact a poor boy couldn't afford not to go to a good school in order to create a better situation for himself and his community (Flexner, 1910).

5. It was imperative that hospitals, in concert with medical schools, provide as much opportunity as possible to educate the students. Universities should ensure sufficient funds for men devoted to their science to educate students (Flexner, 1910).

His recommendations (Table 2.1) were: using Johns Hopkins as the model, those schools deemed as first-class had to be strengthened to match Hopkins standards, the few residing in the middle also had to raise their standards, and the rest, which was the majority, had to be extinguished (Flexner, 1910; Starr, 1982).

Table 2.1 Flexner's Recommendations for Educating Physicians in 1910*

Theme	Challenges	Recommendations
Standardization	*Lack of standard, rigorous curricula	*Insist on four years of college and a set of specific science courses as a prerequisite to medical studies
	*Poorly prepared students	*Create a standardized four-year curriculum in 2-2 design
	*Heterogeneity in student achievement	*Establish accreditation process for medical schools
Integration	*Limited science and laboratory experience in the curriculum	*Incorporate laboratory learning into the curriculum and connect advances in the laboratory with clinical practice at the bedside
	*Limited or no interaction with patients and therefore minimal opportunity to apply knowledge from lectures to patient cares	*Expand the curriculum by two years and provide clinical training in university teaching hospitals
Habits of inquiry and Improvement	*Excessive emphasis on rote memorization rather than on learning-by-doing in the laboratory and hospital	*Train physicians to "think like scientists" using scientific inquiry and research to solve clinical problems
	*Tradition-bound rather than scientifically oriented curriculum and faculty	*Require medical education to be taught by scientifically trained faculty members within university classroom and clinical settings
Identity formation	*Teaching by unqualified faculty members	*Immerse medical education in university culture
	*Role modeling by variably competent physicians in many proprietary and for-profit schools	*Facilitate close and sustained contact between learners and scientifically based faculty role models

(Irby, Cooke, & O'Brien, 2010, p. 221).

There were three divisions of admission requirements Flexner found in his observations. The first division was comprised of sixteen schools, with an additional six at the time of Flexner's report preparing to increase their standards, required at minimum a two-year college requirement to enter. The second division's standard was a high school diploma or the equivalent, and the third for which most schools were operating with, a standard of nominal admission compliance often below the high school diploma (Flexner, 1910).

Flexner (1910) described the second division as the one difficult to discern. The schools presented with great diversity for their admission standards regarding high school diploma or equivalent. The "equivalent" had tremendous latitude. For Flexner this meant that only "approved" or "accredited" high schools "recognized by the state universities of their respective states, or by some other competent educational organization; in New England, by the College

Entrance Certificate Board; in the middle west, by the North Central Association" were acceptable (Flexner, 1910, p. 30). For the medical schools in this category there existed a separate interpretation and oftentimes students were admitted on the basis of the medical school having knowledge of and approving the candidate's high school. Most concerning were the medical schools who admitted students, whose admission, would have been rejected by the medical school's sponsoring university (Flexner, 1910).

The third division relies on a medical examiner to review submitted documents or require written tests that cover the same material. This practice was only successful in states where the state board invoked authority. In those states where they were legally powerless, consistent control and compliance were lacking. Candidates appeared at their leisure, and no definite procedure was in place as far as submission of documents, when they were presented and how (Flexner, 1910).

Flexner's concern was for the public as the recipient of consistent quality care and thus he advocated for standardized education. Therefore, a four-year curriculum, divided into equal parts was the most appropriate way to progress through a medical education program. The first two years were to be devoted primarily to laboratory sciences, that is, "anatomy, physiology, pharmacology, pathology; the last two years to clinical work in medicine, surgery, and obstetrics," in the hospital (Flexner, 1910, p. 57).

Flexner also believed that in order for a medical student to receive an appropriate education opportunity, the school must control the hospital and thus

the professors in the school were the physicians in the hospital. These two entities should be interlocked, which was a problem in the United States outside of a few examples. Johns Hopkins was one such example and until the founding of the institution, the concept of medical education, research, systematic clinical instruction and investigation, was absent in America (Flexner, 1910; Starr, 1982).

Flexner stressed affiliated hospitals and medical schools should provide a hospital of sufficient size; the school, hospital, and laboratory services must reside in close proximity, the school faculties were the hospital staff, i.e., it was a closed medical staff; and teaching arrangements were left at the discretion and oversight of the teachers keeping the patient's best welfare always in mind. While there was no definition for what a sufficient size was or the distance reflecting "in close proximity" in his bulletin, his concerns on the other points were well demonstrated in the report.

Flexner's call for the three entities to reside in close proximity is validated as important for the student to connect disease with laboratory findings and to have a cohesive unified professor/medical staff. Those schools with split campuses even within the same city found themselves at a disadvantage in their ability to get expedient results. It was important for medical students to have the laboratories close to patients for efficient diagnosing purposes. Additionally, Flexner found some schools with absolutely little to no attachment to a hospital and found some who advertised affiliations but upon site visit, none were discovered.

The role of the hospital in its own right has also faced a significant evolution over the course of time. Prior to 1870, many a practitioner would spend his entire career without utilizing hospital services for any of his patients. As the turn of the century grew closer, and at the time of the Flexner report, this changed. As discussed earlier the hospital became an integral part of medical education and medical practice in general. While advances in the practice of medicine and changes in educational needs drove a portion of this change, some of the responsibility for the transformation came from an industrializing capitalist society (Starr, 1982). As people migrated from rural areas to the cities, the self-sufficiency of the population changed. Originally, most hospitals were operated by trustees and they were primarily refuges for the homeless. At the turn of the 20th century this began to change, and many were being led by physicians. Hospitals became organizations with a focus not only on caring for the sick, but also as business enterprises (Starr, 1982).

As early as 1751, doctors had wanted to create their own hospitals. This opportunity would allow them the chance to develop medical education programs as well as earning them prestige (Starr, 1982). Additionally, these types of positions were so important that many would offer their services for free for the value they derived from them. Unlike their European counterparts, American physicians were unwilling to relinquish responsibility and care of their patients to physicians leading or working within the hospitals, so many private physicians began to open their own hospitals or began to press established facilities to open their doors and offer staff positions. Those that did open their own hospitals

found it difficult to survive. Financial struggles and public distrust propelled physicians to engage in the services and financial support of business men across the spectrum. Subsequently this led to organizational structure and control changes, including loss of decision making power for physicians (Starr, 1982).

Other changes occurring after the Civil War were the establishment of three training schools for nurses in 1873, the advent of surgical procedures performed with anesthesia and antiseptic technique, and advances in diagnostic tools such as the discovery of the x-ray in 1895. The idea for trained nurses was born from those outside of the healthcare settings identifying the need rather than physicians acknowledging a gap in patient care. Prior to the 1870's the nursing profession, similar to that seen of the physician, was thought of as an occupation for women of a lower class status. At the time of the professionalization, physicians saw organized nursing education as a power struggle, whereby nurses would do as they chose, not what they were instructed to do. Women reformers opposing this action were successful, physicians thus acquiesced to the professionalization and have come to rely and partner with nurses (Starr, 1982).

These changes translated into large volume shifts, and hospitals now found themselves with an admissions problem. Patient volumes and demand for admission had increased dramatically, physicians were now responding to treating patients during acute illness phases rather than over the entire course of the illness (Starr, 1982). But these changes did not preclude the fact that hospitals in general were still limiting access to physicians, and many had strict guidelines for

privileges. In the late nineteenth century, a typical medical staff was arranged in four groups:

> a consulting staff, composed of older and distinguished physicians, who had no regular duties; a visiting or attending staff, made up of the active physicians who supervised treatment; a resident or house staff of young doctors in training who carried out the details of treatment; and a dispensary staff that saw outpatients (Starr, 1982, p. 163).

Of note, none of these physicians were provided a monetary compensation for services rendered, however each were provided enticements. House staff received room, board, and experience; dispensary staff hoped for the chance to become a visiting physician as well as the chance to build their own practices based on patient exposure; and visiting staff were given access to hospital capital equipment usage, surgical services, and an opportunity to build upon their growing practices. While all of this was important, physicians were still limited in their ability to grow professionally and personally on a daily basis (Starr, 1982).

Hospital control, until the turn of the century, forbade physicians, from charging fees to patients, with the exception of patients in private rooms and this was still not a clearly defined process (Starr, 1982). A practice employed by many hospitals would allow non-staff physicians to admit patients to their unused private rooms for care only to find that prior to their arrival to treat them, their

patients were given the option to have services provided free if the patient would allow a member of the house staff to take on their care (Starr, 1982).

This increased frustration with control or lack thereof fueled physicians to again ask why they were not in full control of the hospitals. The *Journal of the American Medical Association* in 1902 printed an inquiry to this point asking "Is it not about time the professional mind begin to dominate in the control of these institutions? Fairly estimated, do not our services justly entitle us to a voice in all professional questions in and out of the hospital, second to none, even to that of those benevolent individuals, charitable organizations, or religious societies that founded these institutions" (Starr, 1982, p. 164)?

To combat this frustration, physicians once again turned to proprietary hospitals to establish professional control, and joint ventures were formed as a way to combat corporate domination and supply enough patients to turn a profit (Starr, 1982). Many of these were formed in small, rural areas and in the West where trustee-dominated facilities had not yet ventured. The increased pressure of providing hospital services to these patients, who normally would have been a private paying patient in the community hospital, forced hospitals to review their practices and change their medical staff privileging guidelines and the move towards stable, permanent medical staffs began to shift strongly by 1907. This process satisfied critics of the old system who felt the instability of an ever changing visiting staff. Hospitals did not have the ability to regulate visiting staff physician hours and patient focus, and the move towards a permanent house staff would benefit not only the patients, but the community as a whole (Starr, 1982).

In 1919, the American College of Surgeons (ACS) initiated a push towards standardization requiring any hospital wishing to receive approval from the ACS to organize their medical staff. The ACS was not concerned with whether the staff was open or closed, as long as they limited access to competent and reputable physicians. By the 1920's, most hospitals informally required staff physicians to have membership in the local medical societies (Starr, 1982).

The year 1919 also saw the AMA's Council of Medical Education (known a year later as the Council on Medical Education and Hospitals) adopt minimum standards for hospital internships. While compliance was voluntary, it created a paradigm shift for hospitals towards greater organizational structure (Starr, 1982). The AMA, in 1934, forced its hand further in support of physicians and required all hospitals, accredited for internship training, to limit their medical staffs to only physicians who were members of their local medical societies thus placing physicians in a position of power. Where hospitals had once been a threat to their profession, now physicians were clearly in a position of power (Starr, 1982).

This position came with unforeseen obstacles. As American hospitals became standardized, they individually lacked coordination. Each hospital, absent of an integrated management system, needed to build their own administrative process, including setting patient fee schedules, acquisition and allocation of capital, recruitment and retention of medical and other professional staff, and other associated duties necessary to sustain an organization (Starr, 1982). Additionally, physicians were maintaining practices and requiring more assistance from hospital staffs. All of these activities led to a need for a more

sophisticated administrative model in American hospitals. As such, beginning in 1899, hospital administrators, at the turn of the century formed their own association, the Association of Hospital Superintendents, presently called the American College of Healthcare Executives (ACHE) (Starr, 1982).

Many physicians were still attracted to administrative leadership roles and in the 1920's began to engage in educational tracks in hospital administration (Starr, 1982). By the 1930's and 1940's, the non-medical administrators began to challenge physician authority. The physicians saw the hospital as an extension of their clinics and the administrators saw it as "serving the community as the main coordinators of health services" (Starr, 1982, p. 178).

Charles Perrow, Professor Emeritus of Sociology, Yale University and Organizational Theorist, as cited by Starr (1982), chronicled the reasoning behind the changes in authority of the hospital in three phases: one, as a need early on for trustee control to ensure public trust and capital investment, physician control dominated in the second phase based on their ability to manage increasing complexities with technical skills and finally the last phase, and most current trend is that of non-physician administrative domination. This phase was marked by increasing organizational complexities coupled with the challenges of managing outside agency relations. In the late 20th century and into the early 21st century, this last phase is shifting and physicians have begun to seek more administrative responsibility. But health-care organizations have unique challenges and in general have not kept up with industry in development of leaders and physician leaders specifically (Stoller, 2009).

As Stoller (2009) pointed out, there are several reasons why healthcare organizations today are a special challenge and why the need is great for physician leaders.

> First, health-care organizations are complex, usually characterized by many professional work forces and silos or "fiefdoms". Second, characteristics of physicians and of their training conspire against the needed "reflexes" for collaboration or followership, traits which are necessary for effective teamwork that leaders must harness for positive organizational change. Third, the demands of training and, in academic settings, of developing academic skills performance, often compete for physicians' attention to mastering leadership competencies, thereby potentially handicapping physicians' leadership skills. Finally, health care today faces a number of pressing challenges regarding access, affordability, and quality. These challenges call for and, in fact, demand great leadership from within health care (Stoller, 2009, p. 876).

Stoller (2009) then recognized the perspective from Leatt and Porter on the special challenges leadership in healthcare face. Leatt & Porter (2003-4) in their article *Where are the healthcare leaders? The need for investment in leadership development,* proposed a new direction in healthcare leadership development that is adult education based and includes principles of competency-based development, interdisciplinary and team learning, and continuous

assessment. Leadership development should not be focused as an individual program but rather one that involves the entire organization. Including the entire senior management team will afford the organization to experience a greater return on investment in terms of organizational effectiveness.

1. The external environment (e.g., insurance, reimbursement, regulation) is very complex and dynamic,
2. New technologies are continuously evolving and the evidence about their effectiveness may be incomplete,
3. The professional workforce is difficult to manage,
4. The goals of service delivery are multiple and potentially competing, e.g., the tension between expense, clinical care, and patient quality. (Stoller, 2009, p. 876)

The challenges have become more complex as the 21st century progresses. Many changes affecting healthcare's national focus on quality and safety are beginning to take shape. Presently 17 cents of every circulating U.S. dollar is spent on healthcare and this spending continues to increase. With this type of cost expenditure becoming the norm rather than the exception, "using payment/reform payment reductions to increase efficiency and effectiveness" will be the new focus" (intranet.kumed.com, 2013). By using this type of structure, the government hopes to ensure patients will continue to receive safe, high quality care, while at the same time reducing their costs to providers.

All of this means hospitals will incur a significant financial impact. The most striking of changes will be felt from the Affordable Care Act (ACA). This

legislation is seen as possibly the most significant legislation since Medicare. The primary focus of the ACA is increasing the amount of Americans with health insurance. Another element of the ACA is a decrease in Medicare and Medicaid payments. The decrease translates into millions of dollars hospitals stand to lose over the next four years.

Additionally, the ACA, requiring better clinical outcomes, has established Value-Based Purchasing (VBP). This is a pay-for-performance program designed to reduce Medicare reimbursement to hospitals. This approach, developed by The Centers for Medicare and Medicaid Services (CMS), will pay for inpatient acute care services "based on quality not just the quantity of services" (intranet.kumed.com, 2013). Payments will be made based on performance scores hospitals earn respective to clinical process care measures, clinical outcomes, and patient care experience of care dimensions (intranet.kumed.com, 2013). Physicians actively engaged in leadership will be important to organizations based on these new guidelines.

Dye and Sokolov (2013) in *Developing Physician Leaders for Successful Clinical Integration*, state there are multiple factors which they cite have converged to make physician leadership essential to healthcare and are driving greater interest in physician leadership:

- Significant changes in the healthcare delivery system
- Greater emphasis on quality and patient safety
- Reimbursement mechanisms now paying for value, not volume
- Growth of population health management

- Movement from acute care to ambulatory and home care
- Different styles in the practice of medicine
- Newer physicians expecting more input
- Movement toward the employment of physicians by health systems and corporations
- Clinical integration (Dye & Sokolov, 2013, p. xxiv)

Within the healthcare setting the physician order is the catalyst for all other activities that follow for the patient and providers. For example, when a patient enters the system with a group of symptoms, a laboratory test may be ordered or a radiological exam performed. Based on the results of those test findings, additional testing or procedures may follow which could involve admission into the hospital. In the healthcare ecosystem all eyes will be strongly focused on "reducing costs, transforming the way care is delivered, increasing preventative care, improving quality, creating larger and more efficient care delivery entities, reducing unnecessary utilization, integrating community health into the system, and placing a greater emphasis on wellness" (Dye & Sokolov, 2013, p. xxv). One disclaimer Dye and Sokolov made clear though, is physician led does not mean an organization must have a physician Chief Executive Officer (CEO) or a Chief Operating Officer (COO), but it does refer to the need for physicians to be "actively involved in policymaking and strategy setting in some form and play a continuous role in the dynamic changes that occur" (Dye & Sokolov, 2013, p. 19).

There are several physician led organizations and many have their own leadership development programs. For physicians, understanding the business aspects of medicine may prove challenging, but the change can be rewarding in many ways (Dye & Sokolov, 2013).

The Academic Physician Administrators and Leaders or APALs are growing in number. The APALs concept "represents an opportunity for academic physicians interested in working at the interface of clinical medicine, health care, finance, and management" to actively engage in administrative duties while still maintaining "scholarly work activities" (Fairchild, Benjamin, Gifford, & Huot, 2004, p. 214).

Another example of a program offered for current practicing physicians is the "The American College of Physician Executives (ACPE). The ACPE organization provides over "60 education programs in the area of medical management" (McAlearney, Fisher, Heiser, Robbins, & Kelleher, 2005, p. 12) however, many organizations are interested in developing their own programs to address specific organizational cultures, and are designing in-house programs to aid in the development process.

The Physician Executive Management Academy (PEMA) is a program in partnership with the ACPE. This program provides a formal education plan to develop a continuous succession line of physician executives for the ProMedica Health System (Dye & Sokolov, 2013). This program is unique in many ways as it also includes non-physician administrators as part of a dyad model. Determining that there is a shared responsibility in achieving the "ultimate

organizational goal of producing value for patients and payers", ProMedica determined administrative operational responsibilities were in need of aligning with medical operations. As such, they clearly defined areas that required physician leadership while assuring non-physicians of the importance of their roles. Sample curriculum topics include: Governance, Medical informatics, Physician in management, Disruptive behavior, Physician-hospital relations, High stakes negotiation, Practice management, Change leadership, Healthcare finance and law, Lean/Six Sigma, and Medical staff officer leadership (Dye & Sokolov, 2013, p. 177).

McAlearney, et.al. (2005) described a program at The Columbus Children's Hospital (CCH), where the hospital administration and medical staff realized they had separate and at times conflicting goals; and saw a need to invest in a physician leadership program. CCH developed their own version as generic programs didn't align with their strategic need to focus on common goals and establish collaborative relationships. The Medical Leadership Program (MLP) goals for their program included a curriculum that was focused on "educational strategies, ongoing career development mechanisms and barriers to physician involvement, and evaluate the efficacy and effectiveness of the program" (McAlearney, et al., 2005, p. 13). Different from the ProMedica model, the MLP was designed specifically for physicians. The Steering Committee and administrators felt that limiting the participation pool to just physicians would foster a learning environment that was nonthreatening and participatory. Additionally, the committee designed the program to support and sustain the

transformational change implementation underway at the time. Part of this change involved the Medical Director becoming the hospital CEO which further allowed for the organizational alignment of mission, vision, and goals. CCH utilized Kotter's transformational change model which consists of an eight-stage process of leading change. Kotter, a member of the Harvard Business School Faculty is internationally known and is a widely regarded speaker on leadership and change.

Those eight stages are:

1. Establish a sense of urgency
2. Create the guiding coalition
3. Develop a vision and strategy
4. Communicate the change vision
5. Empower employees for broad-based action
6. Generate short-term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the culture (McAlearney, et al., 2005, p. 14).

Establishing a sense of urgency requires helping others see the need for change. Organizations then need to assemble a team of individuals with enough power to lead people through the change as a team. Anytime you have change, developing a vision and strategy for directing and achieving the change will be necessary, but, equally important is communicating the message and ensuring people understand and accept the vision and strategy involved. Empowering

broad-based action entails removing barriers that seriously undermine the vision, and then encourage risk-taking and non-traditional ideas. Generating short term wins is essential to a successful transformation. Kotter (Kotter International, 2013) stresses the importance of making these wins visible, unambiguous, and clearly related to the change effort. These wins allow change agents to receive positive feedback and build momentum, but also send a message to critics of the change by openly showing success related to the change. Once the process is in motion, it is imperative to keep moving forward using credibility to change "systems, structures, and policies not aligned with the vision. Kotter's model also suggests hiring, promoting, and developing any employees able to implement the vision and acting as the catalysts that continue to energize the process. Finally, incorporating changes into the culture means articulating the relationship between the new behaviors and organizational success, developing future avenues to ensure continued leadership development and succession (Kotter International, 2013).

In order to realize CCH program success, the steering team noted how physicians were traditionally trained and what would be required to take on administrative leadership roles. Physician characteristics lean towards autonomous thinking; they work independently, value one on one interaction, and are science based. As such CCH developed a curriculum that acknowledged the cultural differences but would bridge the gap and foster the transformational changes (Dye & Sokolov, 2013; McAlearney, et al., 2005; Stoller, 2009).

Physician leadership development programs have also begun to find a place in residency programs. Duke Medicine developed a graduate medical educational track for residents combining clinical and management training. The Management and Leadership Pathway for Residents (MLPR) created in 2009 had the inaugural cohort beginning in 2010 (Ackerly, et al., 2011). Combining a rigorous clinical rotation with managerial mentorship and other management opportunities, the program provides guidance in finance, patient safety, health systems, and strategy along with other topics related to leadership.

Duke has been targeting those graduates who have completed their medical doctor (M.D.) degrees as well as possess a Master's of Business Administration (MBA) degrees as they enter their residency tracks. Their program, described as a first of its kind, attempts to develop skill sets in these individuals engaging them early in their careers to prepare physician executives for the future.

Ackerly, et al. (2011) found a significant portion of today's physician leaders are described as accidental administrators. Or rather, those physicians who have been elevated into the positions based on career achievement and not leadership acumen. Further, many leaders in academic medicine have acquired leadership positions this way and lack the needed skill sets and experience these positions require for success and career satisfaction (Ackerly, et al., 2011; Chaudry, Jain, McKenzie, & Schwartz, 2008).

On the job training for leadership positions has created situations whereby leaders are elevated to positions where their confidence levels are low and even

worse, systems and service lines are compromised because of mismanagement (Ackerly, et al., 2011). This has created a cycle that can result in repeated transitions of poor leadership. Early cultivation and recruitment of qualified physician leaders into programs such as the MLPR can provide the needed pipeline of physician executives for the future, in a time when physicians need to play a vital role towards healthcare leadership in organizations (Ackerly, et al., 2011).

In an effort to evaluate physician development programs across the United States, The Mayo Foundation conducted a study in 1995. While the response, 26 of 122 institutions invited to participate was low, it was deemed comparable to other industry nationwide (Scott, et al., 1997).

Slightly over half, 15 of 26, used either all or a combination of both internal and external programs to assist with development. Of the eight institutions providing strictly in-house development, the topics ranged from seminars on mutual respect to quality management. Scott, et al. (1997) cited courses dealing with communication and interpersonal skills were less prevalent. Topics on finance/accounting, economics of healthcare, management principles, strategic planning, leadership principles, issues in healthcare, and quality management were found to be most important entering the later part of the 20th century (Scott, et al., 1997).

The authors identified the rapidly changing healthcare environment as a major impetus towards preparing physicians for future roles. In-house programs allow for tailoring of the coursework to meet the needs of identified deficiencies

in physician leadership knowledge while at the same time imparting important business and management skills. Additional benefits identified were faculty expertise and a team atmosphere. Scott, et al. (1997) also cited similar program benefits as improvements in survey results from Joint Commission on the Accreditation of Health Care Organizations (JCAHO). Finally, the authors indicated that while a uniform approach towards physician leadership was not clearly identified, the demands of a rapidly changing healthcare environment will continue to drive the trend line upwards on more in-house programs (Scott, et al., 1997).

Five years after the Scott, et al. survey, Schwartz et al. (2000) offered their perspective of what physician leadership programs should consist of. While they identified the popularity of off-site Continuing Medical Education (CME) programs on this subject matter as a valuable baseline introduction, these programs, often attended by a small group and by those already in leadership roles, lacked needed key components local or internally designed programs provide. The authors supported programs with a local focus and noted that physicians will never be taken seriously in leadership roles until their commitment towards leadership training is as strong as their clinical training was (Schwartz et al., 2000).

Further, Schwartz, et al. indicated the value a distance program provides is the intensity, to which a bulk of material is presented, as it allows for an introduction of key concepts, provides participants with a detailed understanding of what they need for successful transition into leadership, and allows the

physician to re-orient to a classroom setting. Distance program weaknesses were outlined as:

1. Breadth and depth of leadership development
2. The personal focused attention afforded in smaller settings
3. Material presented in a regularly scheduled interval over a long period of time
4. Focus towards teamwork with timely subject matter
5. Tailored subject matter to locally specific healthcare issues
6. Provides physicians the ability to form relationships with their local peers.

Schwartz, et al. (2000) identified the last two items as not only interrelated but necessary elements to a successful program managing tremendous culture changes. Additional options available with the advent of technology are web-based programs. This type of learning must be approached cautiously to avoid continuing the autonomous culture physicians are accustomed to and is counter to the needed teamwork and group interaction experienced in the classroom setting (Schwartz et al., 2000).

Competencies and Programs

The opinions of what competencies are necessary for physician leadership development have ranged from a very short list to 300 in number, with many authors debating which competencies are deemed most important. Stoller (2008), citing multiple perspectives in his article *Developing Physician-leaders: Key*

Competencies and Available Programs, examined the view of five programs regarding leadership development competencies.

The five programs: Cleveland Clinic, Mayo Clinic, Aurora Health, University of Kentucky, and Medical College of Wisconsin all varied on competencies they find important to development. Of 17 key competencies identified in the article, only two courses were included in all five programs; Understanding Financial Metrics and Business Plan Development. The remaining (Table 2.2) 14 were varied among organizations.

Table 2.2 Five Leadership Development Programs and Associated Competencies

Course	Cleveland Clinic (Leading in Health Care and Cleveland Clinic Academy)	Mayo Clinic Foundation (Career and Leadership Development	Aurora Health (South Dakota) (Mini MBA)	University of Kentucky Certificate in Medical Management	Medical College of Wisconsin
History of the Institution	✓	✓	✓	✓	✓
Strategic Planning	✓	✓	✓	✓	
Teamwork and Teambuilding	✓	✓		✓	✓
Understanding Financial Metrics	✓	✓	✓	✓	✓
Business Plan Development	✓	✓	✓	✓	✓
Marketing	✓		✓	✓	
Emotional Intelligence	✓		✓		
Situational Leadership	✓	✓	✓	✓	
Conflict Resolution	✓			✓	✓
Innovation	✓		✓		
Conflict of Interest	✓				
Process Improvement	✓	✓	✓		✓
Medic-legal Issues	✓				✓
Optimizing the Patient Experience	✓	✓			
Diversity in Healthcare	✓				
International Business	✓				
Development	✓				

(Stoller, 2008, p. 313)

Stoller (2009), in review of all competencies finds six common domains: 1. Technical skills and knowledge (regarding operational, financial and information systems, human resources, and strategic planning), 2. Industry knowledge (clinical processes, regulation, and healthcare trends), 3. Problem

solving skills, 4. Emotional Intelligence (EI), 5. Communication, and 6. A commitment to lifelong learning (Stoller, 2009, p. 307), are key to leadership development. While Stoller found common threads in many of the programs and in his literature reviews, one area, emotional intelligence was lacking in most and as part of a domain focused on interpersonal skills seemed to be a common area of physician leader failure, thus deserving of greater attention (Stoller, 2009).

Daniel Goleman introduced EI to a wide audience in 1995. His book of the same name indicated leaders were judged based on traits such as intelligence, toughness, determination, and vision but through research of global companies, such as Lucent Technologies, British Airways, and Credit Suisse; found these characteristics were insufficient to be a successful leader. Goleman (1998) as cited by Goleman (2004) found effective leaders had a need for softer skills and that EI may be the most important characteristic that separates out great leaders from the good leaders and can be related to a company's overall success. Goleman also indicates that EI can be learned over time and the benefits for both organization and individual are worth the effort.

There are five components of EI:

Self-Awareness – The ability to recognize and understand your moods, emotions, and drives, as well as their effect on others.

Self-Regulation – The ability to control or redirect disruptive impulse and moods. The propensity to suspend judgment – to think before acting.

Motivation – A passion to work for reasons that go beyond money or status. A propensity to pursue goals with energy and persistence.

Empathy – The ability to understand the emotional makeup of other people. Skill in treating people according to their emotional reactions.

Social Skill – Proficiency in managing relationships and building networks. An ability to find common ground and build rapport. (Goleman, 2004, p. 88)

Goleman conducted his research using psychologists to interview senior management within the companies. Managers were asked to identify specific capabilities of their most outstanding managers. The psychologists then analyzed business data regarding profitability in those divisions. When the data was analyzed, Goleman found that intellect was a key driver of outstanding performance, as well as cognitive skills like big-picture thinking and long-term vision. But when they "calculated the ratio of technical skill, IQ, and emotional intelligence as ingredients of excellent performance, emotional intelligence proved to be twice as important as the others for jobs at all levels" (Goleman, 2004, p. 84) and it seemed to be of higher importance the more senior the person was within the company because technical skills at that level are not as important. Stoller, in a more recent journal article, 2013, again points to the need for a comprehensive curriculum for physician development inclusive of both subjects related to the business of an organization as well as what Goleman refers to as the

softer skills. A member of the staff at the Cleveland Clinic, Stoller details a myriad of tools necessary for emerging physician leaders and outlines the extensive portfolio the Cleveland Clinic Academy (CCA) has to offer, with programs fitting a variety of needs and situations. The CCA, offered for the past 20 years, offers programs for emerging physician leaders, leadership courses for all professional disciplines, courses for incoming chief residents, developmental coaching for newly appointed chairs, plans personalized to fit individual needs, and their most recent offering is for visiting nurses, physicians, and administrators. The "CCA curriculum is framed by a matrix for leadership and management competencies (e.g., EI, communication skills, team building, conflict management) with the courses that highlight these competencies, thereby providing a roadmap for participants who wish to develop their own portfolios of leadership skills" (Stoller, 2013, p. 13).

Stoller (2013) recommends developmental classes include three main components: didactic/curricular teaching, mentorship and coaching, and experiential leadership. By incorporating these three elements, emerging leaders learn the principles and competencies, gain experience, and are able to receive feedback on their progress while located in a safe developmental environment. Additionally, Stoller advises leadership coursework should enhance the interest of the participants over and above the educational benefit by offering Continuing Medical Education credits (CME) or credit towards a degree such as a MBA or Masters of Health Administration (MHA) and finally blending other faculty, such

as business school faculty with the physicians provides for a well-rounded experience with content experts from other fields (Stoller, 2013).

In house programs offer many benefits to an organization and participants:

1. Creates a pipeline of leaders for the future (Stoller, 2013; Scott, et al., 1997).
2. Can enhance the careers and career satisfaction for participants (Stoller, 2013).
3. Local programs can enhance the camaraderie, encouraging ongoing collaboration and synergy among colleagues (Stoller, 2013).
4. Courses like the CCA allow for innovation (Stoller, 2013).

The CCA requires participants to bring ideas and present them to the group at the first meeting and over the duration of the course participants work in teams to develop the ideas into full business plans and then bring the final product to the class and organizational stakeholders at the final meeting. Results through the first 49 business plans to date (as of January 2013) showed that 61% had either been implemented or at least considered for implementation. Those considered but rejected, had flaws found after presentation that caused them to be shelved after initial review (Stoller, 2013).

The Faculty Leadership Academy (FLA) originally introduced as the Physician Leadership Academy is a hybrid version of the program developed by The Advisory Board Company (ABC). This curriculum, delivered over two years with four half –day sessions each during the year, targets early and mid-career

faculty leadership as well as clinical department chairs. Offering CME to participants, the program is a joint venture between an Academic Medical Center (AMC)/Hospital Authority and the School of Medicine in a major Midwest City. The course overview is described below:

> To broaden the perspective and leadership expertise of physicians and faculty in leadership positions. Through intensive on-site coursework and mentoring from institutional leaders, participants develop the critical skills, knowledge, and perspective required to act as successful peer advocates, organization representatives, and change leaders (Norman, 2009, p. 1).

Academy I modules are Negotiation Skills and Principles, Quality Improvement Imperative, Drivers of Financial Performance, and Problem Solving Using Analytic Tools. Academy II modules are Clinical Capital Investing, Managing Disruptive Behavior, Towards a Higher Standard of Patient Safety, and Mediating Medical Staff Conflict. Of note, over the course of the past six years, as the times have changed so have the specific module titles. While the basic topics have remained the same, the target area has been tailored to fit the changes in healthcare (Norman, 2010). Each course is taught by ABC educators and is facilitated by the local experts of the organization. The Senior Vice President (SVP) and Chief Medical Officer (CMO) for the hospital authority and one of the course co-directors cites the many changes happening within the healthcare arena as reasons to look at programs such as these:

1. Medicine is changing:

a. From patient-doctor model to public health and population models

b. Increasing focus on team

c. Performance measures and outcomes are extremely important

2. Careers in Sciences:

a. Competition for talent and resources

b. Migration from department focus to integrative "institute" focus

c. Plurality of promotion and tenure models (Norman, 2010)

With these ideas in mind the underlying premises are based on leadership as an activity, not a position or authority, it is about vision and motivating (Norman, 2010). Additionally, the course stresses the risks of exercising leadership are both personal and professional. It is important that the competencies are well understood, even though some are technical and others are adaptive. The broad competencies important to this program are the ability to diagnose the situation, the ability to manage oneself, the ability to facilitate interventions and the ability to mobilize and energize others (Norman, 2010).

Course participants are provided with workshop evaluations after each session and results have been very positive throughout the duration. Each speaker is evaluated as well as course content and free text comments are also welcome. The SVP/CMO indicated that the biggest challenges facing leadership today are communication and professionalism (Norman, 2010).

Designing an overall leadership development program can be challenging in meeting the needs of many constituents. As examples above provided, each program detailed their overall structure and offered their opinions on what was necessary for successful programs. Dye and Sokolov (2013) suggest six key areas for consideration when developing programs: Mission and Objectives, Analysis of Current Programs, Strategy Formulation, Execution through Clear Objectives, and Program, Curriculum, Budget, Procedures, Written Plan and Follow-up (Dye & Sokolov, 2013).

Dye and Sokolov also advocate as important to a program are "16 Exceptional Leadership Competencies" (2013), developed by Dye and Garman, (2006). Dye, as discussed by Buell (2012) labels these as critical behavioral competencies they (Dye and Garman) found "reliably differentiated the highest-performing leaders" from the rest. Dye and Garman categorized these competencies into "four cornerstones: a well-cultivated self-awareness, a compelling vision, a real way with people and a masterful style of execution" (Buell, 2012, p. 19).

> Cornerstone 1 includes: Living by Personal Conviction and Possessing Emotional Intelligence. This cornerstone provides for the ability to "understand yourself and see your blind spots, and the ability to see the environment and how your activities and behaviors fit in your environment" (Buell, 2012, p. 19).
>
> Cornerstone 2 – Compelling Vision involves Being Visionary, Communicating Vision, and Earning Loyalty and Trust. Dye

> explains this cornerstone is the "ability to define strategies and the risk and reward aspect of strategy". Cornerstone 3 – Real Way with People focuses on the competencies of Developing Teams, Energizing Staff, Giving Feedback, Listening like You Mean It, and Mentoring Others is all about working with people. Dye considers this the "lifeblood of a leader's world", and finally, Cornerstone 4 – Masterful Style of Execution comprises Building Consensus, Cultivating Adaptability, Driving Results, Generating Informal Power, Making Decision, and Stimulating Creativity. Dye indicates leaders possessing these "trait[s] drive decisions, keep their staff focused on the end results, and use creativity and adaptability to make adjustments to the plan" (Buell, 2012, p. 20).

Competencies such as living by personal conviction, being visionary, earning loyalty and trust, listening like you mean it, generating informal power, building consensus, stimulating creativity, and cultivating adaptability all require living at a higher stage of development than the average person and are aligned with developmental models found in adult educational literature.

Developmental Models

Robert Kegan, a constructive developmental theorist, centered his most recent theory on the five orders of consciousness. This theory encompasses organizing principles of mental organization that affect thinking, feeling, and relating to parts of self and others (Kegan, 1994). Orders one and two are focused

on children and adolescents. Beginning with the third, Kegan begins to focus on the adult, and it is at third order that most adults live out their lives. Third order adults are able to "think abstractly, identify a complex internal psychological life, orient to the welfare of a human relationship, construct values, and ideals self-consciously…and subordinate one's own interest" (Kegan, 1994, p. 75). Third order adults lack the ability though to stand apart, they still rely on others to identify problems and determine the status of the situation.

At fourth order, or self-authorship, Kegan argues individuals are effective as partners, parents, at work, and in leading. Individuals have the ability to incorporate the ideas of self-formation, self-regulation, identity, autonomy, and individuation (Kegan, 1994).

Fifth order thinking according to Kegan is where individuals are most transformational in their thinking. Kegan describes fifth order thinkers as "Self-Transformation[al]". Few individuals are able to achieve this level according to Kegan (1994). These individuals view others and their systems not as separate but across inner systems, i.e., are able to dismiss what previously was appreciated as differences and now viewed as unseen similarities.

In contrast to Kegan, Perry offers nine positions. William Perry, Professor of Education at the Harvard Graduate School of Education, was head of the Bureau of Study Counsel at Harvard University. His model on cognitive development reveals most changes in people focus on how they perceive their world rather than with attitudes or concerns. "Perry developed methods of mapping the cognitive and moral development of college students" (Knefelkamp,

1999, p. xlvii). His scheme is divided into four major development stages; Dualism, Multiplicity, Relativism, and Commitment. Dualism focuses on absolutes, or right from wrong, knowledge is quantitative. Multiplicity states there is diversity in opinion and values and these are recognized, a state in which everyone has an opinion, but one's own opinion remains primary. In relativism there is diversity of opinions, values and judgment, and the individual can analyze and compare and has the ability to understand and change their opinion, knowledge is now qualitative (Perry, 1999). Stages 6,7,8,9 all focus on commitment or who I am, who I will be, "development is therefore more qualitative than structural, and its steps are not readily demarked by major changes in forms" (Perry, 1999, p. 171). Thus, without certainty, we must "make and commit to decisions in the face of relativism and also be open to reconsidering those decisions as new circumstances warrant" (Hoare, 2006, p. 202).

Another developmental theorist whose models provide a similar perspective on this situation is Jane Loevinger. Loevinger's Stages of Ego Development also provides nine stages, each "progressive stage representing increased personal and interpersonal awareness, self-regulation, autonomy, conceptual complexity and integration" (Manners, Durkin, and, Nesdale (2004). Stages E1-E4 are devoted to newborn to adolescence, labeled as Pre-social, Impulsive, Self-protective and Conformist, and focused on self to what society demands. Stages E5 identified as self-aware is the place where Loevinger indicates most adults will not progress past (Manners, et al., 2004) and E6,

conscientious. Loevinger's stages E7, E8, E9 are those where transformational leaders would reside. Loevinger postulates in the E7 or Individualistic level there is a "heightened sense of individuality" whereby the individual is aware of their inner self; they "value[s] relationships over achievement". This would suggest the person would be able to have the ability "to encourage individual and organizational transformational learning" (Hoare, 2006, p. 510).

More likely to possess the capacity to provide transformational leadership are Loevinger's E8 and E9, autonomous and integrated respectively. Autonomous or E8 egos are not only aware of individual inner conflicts, but have the fortitude to acknowledge and cope with it. Additionally, these individuals are able to handle ambiguity and see relationships in an inter-dependent manner. Finally, E9 or integrated egos are approaching Maslow's idea of self-actualization. These individuals have completeness of their identity (Manners and Durkin, 2001).

Transformative learning theory also speaks to adult development in critically assessing our frames of reference that define our lives. Mezirow (1997) states transformative learning is the "essence of adult education" (p. 11). According to Mezirow, Transformative learning theory "help[s] the individual become a more autonomous thinker by learning to negotiate his or her own values, meanings, and purposes rather than to uncritically act on those of others" (Mezirow, 1997, p. 11).

As humans we acquire and adopt opinions, feelings, values, and automatic responses all of which are frames of reference which define our world. These

frames of reference are structures of assumptions which enable us to understand experiences. But these same assumptions also cause us to reject ideas and opinions which don't fit into our frame. Transformative learners can move that frame of reference towards a "more inclusive, discriminating, self-reflective, and integrative experience" (Mezirow, 1997, p. 5).

Frames of reference are comprised of "cognitive, conative, and emotional components" and have "two dimensions: habits of mind and a point of view" (p. 5). Our assumptions of the world create these habits of mind which Mezirow defines as "broad, abstract, orienting, habitual ways of thinking, feeling, and acting" (p. 6), and in turn become our point of view.

Cultural assimilation provides for our frame of reference, and while habits of mind are resilient to change, our point of view is flexible and subject to change based on specific problem solving outcomes which do not conclude as anticipated. This allows us to try out another's point of view and determine its applicability.

To help understand this concept more fully, Mezirow refers to Jürgen Habermas (1981) who states that problem solving and learning may be instrumental, impressionistic, normative, or communicative. In instrumental learning one learns "to manipulate or control the environment or other people to enhance the efficacy in improving performance"; impressionistic, is "learning to enhance one's impression on others, to present one's self"; normative refers to "learning oriented to common values and a normative sense of entitlement"; and communicative learning is understanding the meaning of what is being

communicated and involves at least two people working towards defining an interpretation or justifying a belief, but the ideal situation will be consensus (Mezirow, 1997, p. 6).

Through critical reflection we can transform our frames of reference of our "interpretation, beliefs, and habits of mind or points of view" (p. 7) on four learning processes: 1. Elaborating on an existing point of view; 2. Establishing new points of view; 3. Transform our point of view; and 4. "Becoming aware and critically reflective of our generalized bias in the way we view groups other than our own" (p. 7).

Mezirow states the fourth way of learning is less common as individuals are generally unable to readily make the change to learning outside of their existing frames of reference. Further, he indicates for successful transformation into productive and responsible adults, it will be essential for individuals to learn to be autonomous thinkers and then move forward in a collaborative context.

The 21st century will find a more abstract and technologically complex work environment where workers will need to acquire new skills and competencies, and have the ability to understand and manipulate information rather than just acquiring it. Further, Mezirow cites economists as recognizing the importance of a workforce able to: adapt to "changing conditions of employment", and "exercise critical judgment" towards technological advances, and participate in "collaborative decision making" (Mezirow, 1997, p. 8).

Adults tend to focus on short term objectives, but, crucial to successful transformation towards autonomous thinking will require educators to define

learners' needs with both short term objectives and long term goals in sight. This, Mezirow states, may require educators to incorporate instrumental learning into the process. However, we are cautioned by Mezirow that acquisition of the knowledge, skills, and competencies will not automatically allow us to think autonomously. We will need to build on the foundation we learned as children to understand these new skills and competencies. Adult learners will need to become "more aware and critical in assessing assumption",…more aware of and better able to recognize frames of reference and paradigms (collective frames of reference); and more responsible and effective at working with others to collectively assess reasons, pose and solve problems, and arrive at a tentative best judgment regarding contested beliefs". This will be a key to the transformation. (Mezirow, 1997, p. 9).

Towards educators of adults, their role will be to assist learners in their process by helping them "become aware and critical of their own and others assumptions" (p. 10). Exercises aimed at identifying frames of reference and creatively viewing and assessing issues from other perspectives as well as learning to participate in effective discourse will be important. Additionally, exercises focused on the learners' lives and environment including role play, case studies, and small group participation experiences will allow participants to actively engage in the educational process and are also important to transformative education.

Towards responsible teaching, Wlodkowski (1999) states learning opportunities will need to be equitable and culturally responsive. Wlodkowski

posits as adults we are motivated to learn when we find meaning, the subject makes sense in our world, and it pertains to something we value. Further it is up to the instructor or facilitator to effectively "evoke and encourage this natural inclination" (Wlodkowski, 1999, p. 141). Responding effectively to a diverse group of adults requires what Wlodkowski describes as the five pillars or core characteristics; expertise, empathy, enthusiasm, clarity, and cultural responsiveness.

When we offer expertise:

1. We know something is beneficial for adults.
2. We know our subject well.
3. We are prepared to convey or construct knowledge with adults through an instruction process.

Having Empathy: The Power of Understanding and Compassion

1. We have a realistic understanding of the learners' goals, perspectives, and expectations for what is being learned.
2. We have adapted our instruction to the learners' levels of experience and skill development.
3. We continuously consider the learners' perspectives and feelings.

Showing Enthusiasm: The Power of Commitment and Expressiveness

1. We value what we teach for ourselves as well as for the learner.

2. We display our commitment with appropriate degrees of emotion and expressiveness.

Demonstrating Clarity: The Power of Organization and Language

1. We plan and conduct instruction so that all learners can follow and understand.
2. We provide a way for learners to comprehend what has been taught if it is not initially clear.

Being Culturally Responsive: The Power of Respect and Social Responsibility

1. We create a safe, inclusive, and respectful learning environment.
2. We engage the motivation of all learners.
3. We relate course content and learning to the social concerns of learners and the broader concerns of society. (Wlodkowski, 1999, pp. 26-63)

Brookfield (1996, p. 379) as cited by Wlodkowski (2004) emphasizes the need for a culturally relevant perspective on adult learning: "the differences of class, culture, ethnicity, personality, cognitive styles, learning patterns, life experiences, and gender among adults are far more significant than the fact that they are not children or adolescents…" (Wlodkowski, 2004, p. 143).

Wlodkowski, discussing intrinsic motivation and its relationship to learning states as human beings we learn through our "interactions[s] with and support from other people and objects in the world" (Wlodkowski, 1999, p. 68),

and culturally responsive teaching becomes more effective when one is able to motivate adults to learn, and points to motivational strategies that surround individualistic and socio-constructivist worldviews as considerable assets when instructing adults.

The Motivational Framework for Culturally Responsive Teaching combines four conditions considered essential in assisting culturally diverse adults to learn (Wlodkowski, 1999, 2004). Those conditions are: Establishing Inclusion; Developing Attitude; Enhancing Meaning; and Engendering Competence.

Establishing inclusion speaks to individuals who come to the learning environment and are able to feel a sense of respect and connectedness. Wlodkowski states it is important for learners to feel safe in an environment where their opinion matters and they are in a group where common interests are shared as they pursue a joint goal. Garnering inclusion allows learners to feel free to openly share and risk making mistakes in an effort to truly learn. Strategies towards inclusive teaching include setting a norm "supportive of equity, collaboration, and the expression of each adult's perspective" (Wlodkowski, 2004, p. 147).

The criteria for developing attitude include personal relevance and choice. Personal relevance speaks to learning that has personal and cultural meaning, and identifying one's perspective as their reality. This in turn evokes curiosity, leading to interest which leads to a positive attitude. Additionally, adults are interested in the ability to have choices and choose something that interests them.

This activity provides the opportunity to be intimately involved with their learning journey as it allows them to make sense of their world (Wlodkowski, 2004.) Strategies towards developing attitude include allowing adults time to master a specific subject or concept. Wlodkowski list three ways to make a positive influence towards this concept: 1. Effective instruction that will help them to learn if they try to learn; 2. Concrete evidence that their effort makes a difference; and 3. Continual feedback regarding the progress of their learning (Wlodkowski, 2004, p. 157). Additionally, Ogle (1986) as cited by Wlodkowski, developed the K-W-L strategy where learners are able to construct meaning as a result of a previous learning experience. This strategy, in the first of three phase's states that the learner identifies what they KNOW about a subject, secondly it identifies what they WANT to know about it, and finally it allows learners to identify what they LEARNED about it. This strategy not only provides learners with new information about a topic but can also give them information that corrects inaccuracies they may have had from prior learning experiences.

Engagement and challenge are the criteria essential towards enhancing meaning. In this condition, the learner is ultimately trying to reach a goal or end product by means of "searching, evaluating, constructing or organizing" information (Wlodkowski, 2004, p. 148). Wlodkowski presents challenge as a goal-like quality requiring learners put forth "some degree of capacity, skill or knowledge" to accomplish a task (p. 148). These two elements provide a sense of fulfillment to adult learners by incorporating their goals, interest, and perspectives into their learning experience.

Strategies towards enhancing meaning include: posing a problem and providing instruction in a variety of methods. In posing a problem, Wlodkowski suggests presenting it in a case story fashion to increase learner motivation. Simulation techniques such as role-play, exercises, or games allow learners to assume the "viewpoints or rationales of people from different backgrounds" (Wlodkowski, 2004, p. 158). And finally towards providing variety, learner engagement is enhanced when the facilitator uses a mixture of instructional methods, materials, and interpersonal learning patterns (Wlodkowski, 2004).

The final condition is engendering competence. This element's criteria during adult learning are effectiveness and authenticity. Evidence of success in this condition finds adults effectively able to practice newly acquired skills and mastering challenging tasks. Importance is placed on applicability towards real world experiences and strategies towards competence include "assessment through simulations, case studies, problems, and projects that replicate their real world" (Wlodkowski, 2004, p. 149).

In summary, individuals compose meaning in different ways. According to developmental theory, in order to be effective, leaders need to open themselves up to learning and growing beyond understanding their own perspectives to acknowledging and sometimes accepting opinions and ideas of others. Transformative learning theory states adults need to be aware of and critically assess assumptions in order to become transformed towards our frames of reference as they relate to our "interpretations, beliefs, and habits of mind or point of view" (Mezirow, 1997, p. 7) Educational programs and schools should place

focus not only on the specific topics of a given course of study, but should also be attentive to the growth and development of the actual person.

Leadership Development

As identified in the developmental models, growth moves from an individual focus to a global focus. Both adult development and leadership development are related to those in many professions including the military, as "demonstrated in the Army leadership framework (i.e. BE, KNOW, DO) which captures identity-defining aspects of leadership build[ing] one's leader identity" (Day, et al., 2009, p. 57) but is also applicable when discussing medicine.

Regarding growth towards a global focus (as cited by Hoare, 2006, p. 509) Bartumek, Gordon, & Weathersby (1983); and Senge, (1990); speak about increased leadership effectiveness when leaders are able to view situations from "multiple perspectives, understand dynamic system complexity, empathize with others, productively benefits from dissent, and flexibly adjust to dynamic environment".

When leaders are confident and identify themselves as leaders in their skill set, they are able to project this out to others. This assists them in eliciting positive behavior in others and additionally empowers them to define and set priorities, goals, and garner trust in others. These characteristics are foundational for leaders and set the stage for transformational leadership.

Transformational theory unlike traditional leadership theory emphasizes emotions and values. Yukl, referring to Bass (1985, 1996) lists "three types of transformational behaviors: Idealized influence, intellectual stimulation, and

individualized consideration" (Yukl, 2010). Broken down, these three behaviors match well with physicians and the physician leader concept. Physicians themselves identify with physician leaders and similar behaviors of courage, dedication, and self-sacrificing and placing follower needs over the leader's needs. Increasing follower awareness of issues within the environment and assisting them with viewing them in another perspective is representative of intellectual stimulation, additionally seeking input from followers on new ideas and solutions to organizational concerns are representative of intellectual stimulation. Finally, individualized consideration includes leadership behaviors of support, encouragement, and coaching. Importance is placed on the leader's communications skills for this behavior.

Expanding upon the model outlined here, Bromley and Bromley (2007) outline six competencies necessary for transformational leading:

1. Having, holding, conveying and fulfilling the vision of the transformed organization.
2. Learning systems thinking and creativity
3. Effective communication and interaction
4. Building capability in self and others (empowerment)
5. Passion, charisma and energy
6. Protecting the organization and its employees through proper ethics and morals.

Bromley and Bromley stress the importance of leaders understanding and enacting transformational leadership, but also that transformational leaders are not

plentiful in number. Key to the process is: continuing to learn, grow, exhibit energy, be open and responsive to change, and utilize creativity in thinking processes. Equally as important is honest communication with staff and continuously improving one's communication skills. Showing trust in others by empowering them with organizational responsibilities will allow growth in the employee; organization, leader, and finally maintaining strong morals and ethics are all a part of transformational leadership.

As identified, an important function of any leadership role is to identify with and elevate ethical awareness and assist in resolving conflict (Yukl, 2010). One aspect, found in many of the developmental theories as particularly relevant is self-awareness. Self-awareness is a common theme among developmental models and "in the leadership literature…is often described as being critical for leader development (Day, et al., 2009, p. 65). Self-awareness is described as the "extent to which someone is conscious of various aspects of identity and the extent to which self-perceptions are integrated internally and congruent with the way others perceive the individual" (Day, et al., 2009, p. 302) When an individual is self-aware they are able to identify areas requiring additional work or effort. This type of awareness can provide the individual the insight needed for continual growth and confidence building.

The process of identity development begins in "adolescents and young adults learn[ing] about work roles and opportunities and [how] they become increasingly aware of the blend of their personal interests and aptitudes that are attractive to the employing world" (Hoare, 2006, p. 345). It is important for

workers to understand who they are and the part they play towards successful work relationships.

Hoare writes that identity plays an important role in life's accomplishments, goals, expectations, and the direction life takes us. People in general, and physicians specifically need to realize the importance of understanding one's identity for a successful transition into leadership. Identity, as Hoare points out, is an "outgrowth of ego and its evolution". Identity encompasses more than work and occupation, it is life in totality. Erik Erikson, (as cited by Hoare, 2006) as the originator of the construct, posits "In youth, adolescents (and today, some young adults as well) project themselves into work roles. This is identity's genesis" (Hoare, 2006, p. 347). Identity then develops evolves, changes, and sometimes becomes rigid throughout adult lives.

When adults enter into their vocations, Hoare states there is little doubt they do so with strong motivation to develop work-related identities. Additionally, identity achievement in one's profession has been "equated with enhanced autonomy, good judgment, an internal locus of control and increased responsibility, tolerance, greater achievement and on-the-job performance, resiliency, and interpersonal integration" (Hoare, 2006, p. 350). These characteristics are also synonymous with physicians.

Finally, Hoare states the work identity is one of personal commitment to a "compelling idea and its expression in a role that inspires an unending, evolving quest of self". This is achieved by continuous, engaged learning and engaging work (Hoare, 2006, p. 353).

Summary

The history of medicine and physicians in America has been a convoluted road marked by lack of organization, discipline, and at times, ethics, within the profession. The career path of the physician began as one low on the social status and professional ladder, rising, to a level of a highly respected career. Along the way, physicians have led organizations, documented as early as the mid-eighteenth century, relegated authority post World War II, and now in the 21st century, history is repeating itself. Physicians are again interested in leading organizations, and many in healthcare feel it is essential for the health of American hospital organizations to have physicians back in leadership roles. This literature review also identified an area where physicians are lacking. Acquisition of the necessary skills and competencies related to leadership in healthcare organizations will be needed for physicians to actively participate and hold leadership roles in the future. Physicians spend a tremendous amount of their professional existence in autonomous work, focused on their patients, identifying primarily with their profession. On the opposite end of the spectrum, as organizational leaders they will need to work collaboratively with many individuals and professional groups, while maintaining a dual focus on clinical and non-clinical aspects. Many organizations have taken on the task of building and facilitating local in-house physician development programs, focused on providing the necessary tools for physicians to successfully meet the challenges of leadership. Local programs provide for a more tailored approach that experts argue are more beneficial to physicians. Leadership development programs

provide a good foundation for physicians, but in order to successfully transition into leadership roles they will need to maintain a continued focus on their developmental perspective including adoption of critical leadership competencies as identified in the literature.

Further, transformational leadership development and identity development in one's work is a continuous learning process. Transformational leaders are not only responsible for transforming organizations but themselves as well. Key competencies including vision, communication, empowerment of staff, passion, charisma, energy, and strong morals and ethics are important aspects of transformational leadership.

Many of the characteristics associated with identity development theory are the same characteristics associated with physicians and their careers. Identity theory plays a role in what goals you set and roles you play. It impacts how you feel about the learning and work environment and how you approach life. A common theme throughout this review bears repeating and that is the concept of life-long learning is a necessary element for leaders to embrace.

Chapter Three – Methodology

Introduction

Chapter Three describes the methodology for the qualitative inquiry regarding the participant perspectives on a physician leadership development program. It examined the local in-house program using a single site bounded case study. The researcher used in-depth interviews from former course participants, data from the national program from which it is derived, physician satisfaction survey results, course curriculum, and actual post course summary evaluations for analysis.

The research questions that guided this study were as follows:

1. Based on the participants' perceptions, how effective was the FLA program in developing leadership competencies and skills?
2. What instructional strategies did program participants find helpful?
3. Did the coursework influence the participants' decision to think about a higher leadership position and if so how and if not, why not?

Rationale for Selection of Qualitative Research

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative

> research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2005, p. 3).

This research inquiry took a (social) constructivist worldview. As described by Creswell (2007),

> individuals seek understanding of the world in which they live and work. They develop subjective meanings of their experiences-meanings directed toward certain objects or things…the goal of research, then, is to rely as much as possible on the participant's views of the situation (p. 20).

Qualitative research was conducted because we, have a

> *complex* (emphasis provided by Creswell) and detailed issue, want to empower individuals to share their stories, and hear their voices,… want to understand the context or settings in which participants in a study address a problem or issue and to develop when partial or inadequate theories exist for certain populations and samples or existing theories do not adequately capture the complexity of the problem we are examining (Creswell, 2007, p. 40).

Creswell states the primary reason to do qualitative research is "to level all individuals to a statistical mean overlooks the uniqueness of individuals in our

studies" (Creswell, 2007, p. 40). This research focused on a hybrid model of physician leadership development where the participants were well-established physicians highly regarded for their clinical acumen in an academic medical center.

Description of Researcher

An "interpretive framework" or "paradigm" on the "basic set of beliefs" is "guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2005, p. 22).

With 35 years of experience in healthcare, the researcher has spent greater than a decade embedded within the organizational setting where the research was conducted, in a mid-level leadership position where mission, vision, and values are heavily impressed upon hospital staff and physicians alike.

Justification for Bounded Case Study

A bounded case study "has clearly identifiable cases with boundaries and seeks to provide an in-depth understanding of the cases or a comparison of several cases" (Creswell, 2007, p. 74). This research focused on a single location hybrid program's prior attendees' perception towards the course offerings. "Is typically extensive, drawing on multiple sources of information, such as observations, interviews, documents, and audiovisual materials" (Creswell, 2007, p. 75). This study verified the objective data of the course curriculum along with post course evaluations, physician satisfaction survey information as it pertains to physician leadership needs and opinions of the organization leadership as a whole.

Location of the Study

The most recent statistics published (2013) by this large Midwest Academic Medical Center (AMC) identified a medical staff of over 600 attending physicians (www.kumed.com). This organization operates as a closed medical staff, indicating that only those physicians who are listed as part of the School of Medicine faculty can participate as an active staff member.

Facility has: a 600 bed plus major tertiary medical center, ranked number one in the region and state overall for quality of care, and third among the nation's academic medical centers, as well as ranking among the nation's best with several top distinctions including an accredited Level 1 trauma center, regional burn unit, National Cancer Institute (NCI) designation, and nationally ranked, award winning programs in nine of the twelve specialties with the final three as regionally ranked award winning programs as defined by 2013 U.S. News and World Report (www.kumed.com).

A leadership development program has been instituted at this organization focusing on development of physician leadership. Beginning in 2008 this program consists of eight courses spread out over two years, with a total of four cohorts completing all coursework.

Population

Approximately 30 members are enrolled into the FLA program each year. Attendees are nominated by their respective department chairs. A total of four cohorts and 113 graduates have completed the coursework (Norman, 2010). Only

those physicians completing the entire two year course curriculum were eligible for this study.

"Seeing a need to assist in the development of leadership skills in early and mid-career healthcare professionals, Hospital and School leaders began the FLA" (Norman, 2010). Originally began as a training sequence for physicians, it has been expanded to include other professions: nurses, PhD's, teachers, researchers, and allied health personnel.

Sample

The key characteristic for each participant was attendance in and completion of the Faculty Leadership Academy (FLA), a two year, multi-session physician leadership development program conducted as a joint effort between the hospital and the medical school of an AMC located in the Mid-West.

The Course Co-Director purposefully selected a total of 19 physicians representative of the whole. Merriam (1998) states that in qualitative research the sample is often nonrandom, purposeful, and small. Initially, the researcher sent invitations to the first 12 physicians selected by the course co-director. From that group 11 physicians responded. The researcher set the first responder to the pilot interview and the rest were subsequently scheduled for interviews based on availability of the interviewee. During the initial course of email correspondence, there were two physicians who were dismissed from the study as they self-admitted to missing courses during the two year process. Additionally one physician did not respond to the invitation or follow up reminder. The researcher in turn contacted the course co-director and asked for an additional four names.

From this second set two additional physicians responded and interviews were arranged.

FLA Course Description

The FLA course overview is described as a "program to broaden the perspective and leadership expertise of physicians and faculty in leadership positions. Through intensive on-site coursework and mentoring from institutional leaders, participants develop the critical skills, knowledge, and perspective required to act as successful peer advocates, organizational representatives, and change leaders". The course outline describes the target audience as training "designed for early and mid-career physician leadership and department chairs"…and "early and mid-career faculty leadership and department chairs" (Faculty Leadership Academy I and II, 2010-2011). (See appendix C)

Pilot Study

One physician, meeting the criteria for the subsequent research project participated as the pilot interview. The interview results were not included in the purposeful sample group interview transcriptions. Purpose of the pilot interview was to determine effectiveness of interview questions and subsequent follow up questions and review opportunities to revise and redirect the focus of the overall project.

The outcome of the pilot interview did involve minor revisions of the questions, including prompting verbiage. Those revisions were a direct result of the differences between the languages learned in medical education versus adult

education. Prompting questions were provided to assist in understanding teaching strategies and a list of leadership skills was provided to participants prior to the interview. (See Appendix E)

Procedures

Collection of Artifacts

Written assessments, interviews, and a formal opinion survey were collected over the five year program. Evaluations showed the attendees stated the content was relevant and helpful in enlarging their leadership roles. "Many have added new leadership tasks to their professional roles, some have gone on to pursue Masters in Business Administration (MBA), Masters in Health Administration (MHA) programs, and the like" (Direct Quotes from Chief Medical Officer of Major AMC, 2013).

The following materials were collected as artifacts:

Physician Satisfaction Survey

Course Curriculum Sample

Post Course Evaluation

The Physician Satisfaction Survey consists of eight demographic questions, 60 closed-ended items, and three open-ended items. Forty-eight of the closed-ended items tied to the National Staff physician average and 10 closed-ended items tied to the national University HealthSystem Consortium (UHC) average. Closed-ended items use a performance scale of 1-5 with 1 = strongly disagree through 5 = strongly agree. (See Appendix A for survey template). The physician satisfaction survey indicated that responding physicians wanted

opportunities to engage consistently in leadership responsibilities and to have a voice in the overall decision making process in the organization.

The post course evaluation was provided after every course session and allowed for attendee perspective of the speaker(s), learning outcomes, application of content to clinical or organization practice, barriers, course integrity statement, commercial balance statement, and personal needs assessment. All areas use a scale of A-E with A = Excellent through E = Poor. (See Appendix B for sample evaluation and random sampling of responses)

The curriculum included core courses that focus on operations management, negotiation skills, conflict resolution, financial management, patient safety, clinical quality, and the like. The course leadership and curriculum has been acquired by contract with the Advisory Board Company and its faculty, with strong facilitation by local experts of the respective modules (Norman, 2010).

Data Collection Procedures

1. An initial email and/or personal contact informed potential participants of the request to interview. Follow-up emails were sent one week past the initial request as a reminder to those not responding during the first week. (See Appendix D)
2. Following acceptance of the invitation, a mutual location, date, and time conducive to both parties was negotiated and decided upon. With the exception of one interviewee, all chose their respective offices for the interview and provided the interviewer with a one hour time block.

3. Respect of participant time was crucial and interviews respected time parameters of 60-90 minutes firm. To assist with this, participants were provided a list of standard competencies for effective physician leadership as described by Dye and Garman (2006) and cited by Dye and Sokolov, 2013, prior to the interview. (See Appendix E)
4. The researcher provided a consent form for signature prior to the start of the interview and informed the participant of the standard practice of anonymity and process to be followed with regard to information storage and length of storage per standard research protocol. (See Appendix F)
5. The researcher began the interview with an overview of the research and research questions guiding the research as a directional reminder to participants of the information being sought.
6. The researcher then advanced to the questions and follow up questions based on responses.
7. The researcher used field notes and digital voice/data recorders to adequately capture the interview and geographical settings. Additionally, some participants required reminders of all courses in the program. The researcher was prepared to provide a list if requested.
8. The researcher used a journaling technique post interviews to capture aspects of the interview process as a reminder of the overall atmosphere of the day using rich, thick description.

9. Post interview, the researcher indicated to the participant that they would be forwarded a copy of the transcript to ensure data was transcribed accurately and their answers were representative of their intent. This is part of the triangulation process referred to as in-member checking, as described below. In addition, to capture like information across all interviews, follow up questions were sent via email with a request for response based on feedback provided during the interviews by participants.

Data Analysis Procedures

Creswell (2007) describes this process as "preparing and organizing the data" (p. 148). Qualitative data involves thematic coding by content and was conducted with the aid of computer assisted software, NVivo 10. In addition, data was hand coded by theme. Notes of observations were organized, personal journal entries reviewed, recordings transcribed, and the interpretation and synthesis of this information was evaluated and presented. Part of this evaluation included implications including what Denzin and Lincoln (2005) describe as research as a "conduit" for moving the message forward in a public forum. Creswell also described this process as non-linear, more of a spiral shape containing "reading and memoing; describing, classifying, and interpreting; and representing and visualizing the data" (Creswell, 2007, p. 173).

Validation and Trustworthiness

Validation strategies or trustworthiness establish credibility and dependability were determined by utilization of the following as described by Creswell:

*Peer review - Additional coding was completed by the researcher and independent experts to mitigate any researcher bias. This was completed by the co-director of the program as a subject matter expert.

*In member checking – Post transcription and coding process, the researcher re-engaged interviewees for a review of preliminary analyses, and subsequent follow up questions to ensure a well-rounded information gathering process.

*External audit – Researcher engaged outside sources, Ph.D. and Ed.D. individuals knowledgeable with qualitative research to review transcripts and code for additional themes post researcher coding. All are former graduates of the Kansas State University Doctoral program, with recent qualitative experience.

*Rich, thick description was utilized to enable readers the opportunity to determine transferability into other settings using similar characteristics.

Creswell (2007) notes triangulation involves "corroborating evidence from different sources to shed light on a theme or perspective" (Creswell, 2007, p. 209). Forms of triangulation in this research included the comparison data from interviews with artifacts of evaluation summaries from the specific cohort year of graduate and then checking it against the relevant areas of the physician

satisfaction survey taken in 2011. Additional comparison was made against the information gleaned through journal articles listed in chapter two for the literature review.

Summary

Chapter Three provided a summary of the methodological approaches used in this study that were based on a qualitative bounded case study protocol utilizing direction as presented by Creswell (2007) and Denzin & Lincoln (2005). Additionally it outlined the research questions explored, described the researcher, justified the study, described the population, outlined the sample and details regarding facility demographics, participant selection, data collection procedures used, analysis of the data, and finally the validation strategies the study employed.

Chapter Four – Findings

Introduction

Chapter four provides a summary of the results of qualitative research concerning perceived effectiveness by a small purposeful sample of an in-house program focused on physician leadership development. Three primary research areas explored topics of (1) how effective is the FLA program in developing leadership competencies and skills, (2) what strategies utilized during the program did participants find helpful, and (3) did the coursework influence the participant's decision to think about a higher leadership position, if so how and if not, why not.

Following is a brief introduction to the ten physician participants (all names were anonymized) in this study including their length of time as a licensed, practicing physician, training generalities, and leadership appointments. Based on the small population of physicians participating in the course and size of the medical staff, and in keeping with complete confidentiality practices, the researcher will make only generalized statements, physician specialties will not be disclosed, and pseudonyms are used in place of actual names. The remainder of the chapter focuses on a summary of the participant responses relevant to the three research questions of this study.

Participants

Thomas Kyllian has 15 years of experience in medicine post formal education. His medical school training was completed internationally, with subsequent

internship, residency, and fellowship in his prescribed field completed in the United States. Educationally, he also has an MBA. He serves as the chair of his department now, but at the time of his course participation he was in a lesser leadership role. He serves as a member on many teams within the university physicians' professional group.

Annalise Grimaldi has 12 years of experience in medicine post formal education. Her medical training was entirely completed at the university where she now practices. She serves her department primarily as a clinical provider, but also acts as a mentor with residents and students on research projects, and is a director in the hospital on one of the units her specialty serves.

Trent Sanders has 12 years of experience in medicine post formal education. His medical school training was done at the university as well as his residency and fellowship. He serves his department as a clinical provider but also has many leadership responsibilities outside of his clinical focus. These leadership roles are primarily hospital based.

Robert Grant has 24 years in medicine post formal education. His medical school education, internship, residency, and fellowship were gained internationally in his specialty. He serves his department in a clinical capacity and as Chair of the department. Additionally he recently began participating as a physician leader on one of the hospital's executive team committees.

Lauren Miller has 14 years in medicine post formal education. She received all of her training at the university and serves her department in a clinical capacity as well as program director for the residents in that specialty. During her tenure she

also participated in a master's level health professions educator's course tract as part of a faculty development project.

Ian Barker has 22 years in medicine post formal education, but as a formal licensed physician he is in his eighth year. His initial medical school training and practice was international. After two years of practice he came to the United States and enrolled in a residency program at the university. Educationally, he has also completed a PhD. He serves many roles within the hospital and university in support of his department in educating medical students and residents. His leadership responsibilities in the hospital include participation as a medical director and other committee assignments related to organizational activities.

Reed Yordano has been in medicine 22 years post formal education. His entire education from medical school through fellowship was done internationally. He serves as a program director for his specialty within his clinical practice and a medical director partner in the hospital.

Valerie Gallarde has been in medicine nine years post formal education. Her medical training was entirely completed at the university she is now affiliated with. She serves her department in her current role as a residency program director for her specialty. Prior to her current role she was in the associate program director role for five years.

Ryse Stewart has been in medicine 21 years post formal education. He graduated from a regional medical school and then his residency and fellowship were both

outside of the region. He serves his department in his current role as the director of his specialty's program.

Maxim Lanardi has been in medicine 20 years post formal education. He attended medical school on the west coast and internship, residency, and fellowship were all on the east coast. He serves his department both in a clinical capacity and is the medical program director for hospital service lines as well as the medical director partner for one of the many hospital units.

Research Findings

The purpose of the following interview excerpts attempts to examine the overall effectiveness of FLA sessions attended by participants throughout the history of the academy. Many themes emerged during the interviews; one common thread from the FLA identified by all participants throughout indicated the program provided participants with an increased awareness of the organization's complexity.

Research question number one sought to understand participants' perceptions, on how effective the FLA program was in developing leadership competencies and skills.

When physicians were asked the competencies/skills learned while participating in the FLA, major themes were related to the actual module topics, i.e. negotiating skills, finance management, and discussion related towards the "softer skills" or the 16 competencies identified as leadership competencies.

The physicians identified the subject of "softer skills" most frequently after actual course topics. All of the physicians were provided a copy of competencies (See Appendix G) to refer to during the interview, amongst them emotional intelligence.

Adults while engaged in the course began to question their assumptions and examine alternative perspectives. As they did so they developed new meaning and became more cognitively complex.

Negotiating Skills

Negotiating skills was the most prevalent theme and course module that emerged from the interviews. The subject of negotiating skills elicited the following themes/comments:

Dr. Ryse Stewart found beneficial not only the information the negotiating module provided but also a better understanding of people in general.

> You take away some negotiating skills. You take away a better understanding of the different priorities and agendas that people have. You take away an ability to better negotiate your way through difficult human situations, human behavioral situations with your colleagues and with the people who report to you and with the people to whom you report.

Dr. Reed Yordano, a physician who used the FLA as foundational for seeking out another more advanced program discussed negotiation skills from a different perspective.

> But from my point of view, it's not about me; it's about getting the operation shifted. So, what you needed to provide individuals with was information that was meaningful. We've got a patient care issue. We've got a performance issue. We've got a time issue. Here are your data; this is how we should approach it. Can we have a time line? And that's again when they talked about management. That's the thing, there is not enough management skill set focus and that's where your advanced academy needs to be. Management negotiating between the department heads. Something focused on an academic medical center, and believe it or not, management, medical physician groups negotiating with hospitals. How we should do that. How the hospital should negotiate with us. So when we go into a discussion, although we have information and they've got information that neither of us knows this information about which we can frame our petitions. That's what was taught at the Kellogg School we were talking about. I remember, I got to negotiate with another person with another group and they were leaders and they wanted to get everything. On things that weren't important, you let them have everything and they thought they actually did really well. But they

didn't realize that everything on something that I am so easily prepared to give up is going to call for counter negotiation. I say well we can only file that negotiation, let's talk about this area too. I mean, is that terribly important to you because it's a little bit more important to me and I think it's actually as important as yours. Okay, that's fine, flip. So, suddenly they've given me everything on something that was actually where they should have been negotiating and from my point of view I gave them everything on something that was not important and so I win the negotiation. So, that's the sort of things that probably transparency and integration will actually dispel, but then that's going to come back to your think tanks. The organization here is going to critically need structures where everyone within the organization is not threatened by change and that you have a think tank that oversees potential change and that analyzes it and provides some sort of report of the vulnerability that may occur as a consequence. What the potential impact is. What the opportunity cost is. Those sorts of things. Tie things to business models. Doctors need to think like we run a business. Find the people who think like they run a business.

Another physician who drew from the negotiations module experience to inspire further learning was Dr. Trent Sanders.

> I think the biggest thing I use every day is the quality improvement stuff. But I think even if it's been awhile and I've probably forgotten some of that stuff, there are things, for example the best alternative to a negotiated agreement (BATNA) that we learned in the negotiation skills. I didn't learn to be a highly trained negotiator but at least I have that basic concept in the back of my mind. If I'm approaching something pertaining to that concept of that or I go into something with what I've learned with that basic understanding of what my leadership style is and how that impacts things so even though it's been several years, I think there are still things that we use from that.

Dr. Thomas Kyllian found the negotiation module elaborated on skills learned from his prior MBA coursework.

> I think where I found it useful was to participate in some of the areas that were not as deeply studied during my MBA class. So negotiation and conflict management were two areas where I found it was very useful and I thought they did help me to understand my limitations, helped me to analyze my thought processes, I was going through the case scenarios and negotiating with my peers even though it was kind of an inconsequential non-medical negotiation but yet still I think based upon the lecture that he had provided with the broad principles of negotiation, tried to

> utilize those skills, hone those skills. In fact I did learn a lot in the class, but even after that it intrigued me so much that I went out and looked up a few books that I could help enhance those areas further.

Dr. Maxim Lanardi commented on his increased effectiveness in negotiations "But also in the dealings that I have, I think I've been a little bit more effective as far as negotiating and kind of convincing others of the effectiveness of a particular program".

> …it's not about beating them down and getting them to do whatever you want, but coming to something that's mutually beneficial. But also in the dealings that I have, I think I've been a little bit more effective as far as negotiating and kind of convincing others of the effectiveness of a particular program.

Dr. Valerie Gallarde recalled the module gave her something she hadn't been taught in medical school.

> I think the ones that were most new to me were probably the ones that were most helpful. There was one on finance and budgeting, I think it was and there was one on negotiation. Those two were almost entirely new content for me that I really hadn't had in medical school or anywhere along the way and certainly in my pre-med world. So, those I guess I would say were the most

> helpful just because they were new territory…I think differently when I go into meetings now about trying to put myself in the shoes of the other person. I think about kind of what's going to lead to the best outcome.

Dr. Ian Barker had a similar experience identifying he learned something about himself during the negotiations module.

> They introduced little things like some competitive elements to it, for example, we had a situation where we were talking about there is a session on negotiation and we were paired up and we had to negotiate with our colleague and the intention was to see who would negotiate the best between the two of you. So there was a little bit of competitiveness and it was a lot of fun. It kind of illustrated a lot of things, not just in terms of what skills you are learning in leadership and management but also pointing out to many of us, things about ourselves. I am not generally very confrontational or in your face type of person, but I found that environment where I wanted to get the best deal I could to score higher score or whatever it was in the class. It made me negotiate more aggressively with my colleague. Maybe something that I might not necessarily do in real life. So, things like those. So you learn some things about yourself. You were able to pick up some things also about other people, about your colleagues. I could pick

> out that my colleague that I was working with was a much more reserved person and was able to give up or ended up giving up literally everything because of my negotiating style. Then I learned something about people, yes, people can, you know, give away the house if put under the right amount of pressure.

Dr. Annalise Grimaldi found the negotiations session insightful.

> Had I not been to that, it would have never occurred to me to look at it in a kind of different perspective or ask more questions like really pointed questions like that. Because I think you kind of go in sometimes with your notions of the individuals you are dealing with and think well, they are kind of irrational anyway. Just kind of almost go into it thinking we are not going to come to a conclusion here or it's going to be what I want and not what they want. So, just being able to look at something less as winning and losing and more how can we come together and really come up with a solution. So, that was really fun.

Dr. Robert Grant stated, "Things like negotiating contracts. I picked up some different approaches that I think have been helpful".

Financial Skills

The module on finances was also discussed by course attendees as an area where they were able to identify opportunities of new information.

Grant provided;

> I certainly picked up just some little better understanding when I'm listening to the [titled omitted] talk about things. They're just starting to bring physicians in at the executive level for [topic omitted] and so I was put on the [committee omitted] budget. So, I'm there with the [names/titles omitted] as the [title omitted] is describing the budget and how much money would be available, I said now wait a second, at previous meetings you indicated that you have pushed forward some of your expenses from fiscal '13 to fiscal '14 because you are running short on capital, yet you haven't shown that on your balance sheet where that's going to come out, so that what we're actually going to have available and he said, well, yeah, that's true so really we only have this. So being more aware of that or a better understanding of that.

Grant also stated "but to say that by going to the financial planning sort of portion of it that there was any sort of new concepts that I wasn't really aware of. There wasn't any sort of like a fundamental seed change".

Lanardi; "learning the lingo that's used in the C Suite such as profit margin costs, all the financial tools that are utilized to determine viability of a program or to even come up with a pro forma to put forth a proposal for a program".

Grimaldi discussed how the FLA provided her with a better understanding of what the capital and budget processes consisted of.

> very basic understanding of some of the financial drivers of decisions within the institution and trying to leverage with investors and just things that as a clinician you are not exposed to and you don't really consider…we function so much just trying to do the right thing for the patient that cost really doesn't come into it…we don't have a good sense of how we practice and the financial implications of that.

Sanders articulated similar sentiments in that the "basic financial vocabulary was helpful because most people go into that without any sort of basic finance understanding I think that was a huge component of it".

Organizational Challenges

Discussion outside of comments pointed towards specific modules were diverse in nature, including a better understanding of the challenges related to organizational decision making.

Sanders comments towards this subject were similar to Grimaldi above related to the capital and budget processes. The capital approval and procurement process is a year round process after the budgets are locked and for many physicians, they now possess a greater understanding from the FLA, but, the senior leadership is now engaging physicians in the approval process so there is a greater physician presence and involvement in capital decisions and purchases.

> a lot of the decisions that get made, I think without a course like that people have a sense that there is more subjectivity than there really is…actually, there is not nearly as much subjectivity in decisions that get made as I imaged there were before I took that course. There are a lot of analysis that go into almost essentially everything that gets done in an institution…extraordinary complexity that exists in an institution like this, and so this course at a minimum broadens your perspective on exactly what an institutional leadership is contending with and what's on the plate basically.

Grimaldi;

> looking at hospital structure and the things that kind of guide decision making at higher levels was really helpful for me and kind of answered some of those questions as to well this seems so intuitive that if you make this decision it would be better for patient care but realizing that there are so many other kinds of

factors that go into it and it's not just sort of the altruistic we'll just do the right thing because you have so many competing interest and I think that was one the things that was really helpful for me.

Leadership Performance and Style

Leadership performance and style were both identified as common themes but not as major as the actual course modules. Physicians were asked about whether they felt the FLA had an influence on their leadership performance and style, there were some who didn't find an appreciable difference but rather gave definition to who they already knew they were, one interpreted the question more as big picture, and others who felt it gave them direction.

Many of the leadership skills were not taught in medical school. Physicians attending the FLA imparted that as an element the coursework provided to them. These comments included:

Barker;

finer things that are not part of a medical career curriculum…things like those that are not what they train you when they are teaching you how to care for a patient and when going through the program those are not necessarily things that I feel I was trained in to a great depth but I had my eyes open and realized that these were things that were now relevant to my current universe and things that I could also explore more.

Sanders;

"it gets people who are not thinking about health care leadership to start thinking about health care leadership".

Kyllian;

> there are so many elements that came out of both classes I would say both my coursework through my MBA class as well as further skills that were focused during the FLA, I found have been very helpful because going through medical school you learn medicine, you don't learn management, you don't learn human resource management, you don't learn either the finer points of negotiation or strategy formulation or even interpretation of a financial balance sheet. All those skills were immensely helpful.

Yordano felt the academy's "greatest influence is actually identifying mentors from that academy who are now acting as mentors for me now". He has taken the opportunity with his mentors, who are all outside of his department, to explore topics and people like Peter Drucker, a consultant, educator, author, leader in the development of management education, and inventor the concept known as management by objectives.

> What the FLA also taught me was to slow down and push a little less hard. Because what it showed me in terms of process is that it is about process not about pushing. So it challenged me to change my personality and to some extent I have. But again, personality is

> the thing you have and it's just a question of what external personality is seen.

Grant couldn't definitively say whether the FLA enhanced his performance, he suspected that it did.

Stewart imparted the FLA gave him a more global view of the organization.

> It has made me see my role in a more broad sense than I had previously…it allows you to see beyond the forest and to be able to see more clearly. It has helped me have a better understanding of how others perceive me in my role which helps me better interact with them and get the job done for the sick patients that we take care of. It helps me maintain objectivity in difficult circumstances and listen more carefully to what people are saying and where they are coming from and approaching them. I have a better understanding and I can follow [that] conversation better than I was able to previously.

Yordano articulated that his business acumen is better. Towards his performance;

> Yes. Numbers. I like numbers. I'm trying to influence policy. I can understand from the meeting how you influence

> people. So I understand now, having gone to the academy, that our programs performance is tied to our supplier. I know that the supply side is the critical element. So we know that supply has the ability to negotiate with us. We know that supply actually controls how many [procedures] we do and it controls our costs because if the supply is low, our [procedural] costs are high because our [procedure] costs are bundled. So I want to influence supply. If I can increase supply, I can decrease costs.

Sanders found he also had an idea of who he was but the FLA solidified his thoughts and provided him validation towards his next steps.

> Yes, I think understanding of the style. It just seemed the very basic. I mean, I probably knew this about myself on some level before. I went through four different leaders and I tried to figure out which one I identified with. I think defining it is important but also understanding other styles but also understanding it is okay to have a different style because I think there is a sense of leaders have to fit a certain…you know they have to be a Jack Welch type, but there can be different types of effective leaders and I think that was probably one of the first times that I really kind of heard that…One can have different styles and still be effective and accomplish stuff.

Sanders continued with, “Again, probably the biggest thing that made me aware that I wanted to do more in healthcare leadership and so then, then started the pre reqs for the master’s course and I think that’s the biggest outcome for me”.

The sessions provided “a starting point of vocabulary and framework…it got me interested in topic matter that then drove me to go elsewhere to get additional training. So for me it was really the starting point”.

Grimaldi verbalized;

> I think realizing there are different leadership styles. Again, I am kind of one of those people that would rather work alongside the people that I am trying to lead as opposed to dictating to people because I want to feel like I am experiencing the same things that they are. Which I think can be good and bad. I think good in the sense that people appreciate that you are not kind of preaching from on high and that you’re making decisions that will impact you as well as opposed to just making decisions that are going to impact other people…But I think maybe part of the flip side to that is that you’re identified less a leader potentially and more as just, I mean, you’re a colleague either way but that perhaps you’re not seen to have that same influence or same authority, I guess, because of that particular leadership style. And that may or may not be true, but that’s just kind of my impression.

Grimaldi;

> I think it just made me appreciate that there really is a lot of information out there. That people who are leaders within healthcare and within our own institution or even own department, it's a skill set but that there is background and that it's not just intuitive, that they are just a naturally good leader, I mean that there is really something behind that. And so that was really helpful for me to feel like well even though this isn't really a strong skill set of mine, this is something that I can learn and practice and become better at. …I think at least again, to give you kind of that background information and give you a reference of where to go in the future was very helpful for me.

Dr. Lauren Miller stated it provided the direction she needed for her department.

> I think I was less clear in projecting what my vision was because I didn't really have a vision. My vision was what do we do for the next 30 days as opposed to here is a vision for a year…I knew all the steps because I already could see several years into the future but I wasn't doing a very good job explaining we're doing that this year and this way to get to here next year, to get to here the next year and I really try to do a better job in explaining

that just in the way I communicate with those above me and those below me.

Miller, commenting on how the FLA has impacted her personal performance stated;

> Hopefully, they've made it better. When I walked into the FLA and looking at the two types of leaders, those that are leaders and those that are managers…I was so comfortable in the manager position, so comfortable. I love kind of the managing part. I was extremely uncomfortable in the leadership [role], and those were the skills that I was trying to take and adapt because my position is one where I already have people that manage. I don't need to manage too, and really pushing myself out of my comfort zone to try and lead, I felt more comfortable when I met with our Chair. So, I think it changed it in that respect, that I tried to move more towards leadership and less toward management and assign that to those around me. It's hard, it's very uncomfortable. It's extremely uncomfortable. When it gets really tough, I catch myself going back to management type jobs. I have a team that I've tried to empower to kind of slap me on the hand and say stop doing that. We're doing that part. You need to do the visionary and the big picture, and I'm like okay. I've tried to pick people that would remind me from time to time that that wasn't what my job was. Because it can very much be a manager type job, but I don't want

> it to be. I felt like I was getting stuck there and not doing anything to move forward.

Miller, in discussing how she is addressing the challenges faced in healthcare and her department specifically stated;

> I think related to team management, related to vision setting, goal setting I have to. Our department is going through a really difficult time right now with unknown, what's going to happen with integration…someone's got to stand up and try and be an extremely transparent communicator, vision setting, understanding of what all the rules and regulations are and how they apply…trying to be that bridge in kind of understanding the whole picture…. I think my transparent communication has been better than it was in the past because I get why that's necessary and who needs to know what and when is really important. So those fields I think I have applied quite a bit, more so than some of the other things in the course.

Lanardi found the FLA improved his performance in a job satisfaction perspective. He disclosed the FLA provided him the ability to find time in his schedule. "I'm just as busy but I've kind of cut back on things that were probably not beneficial for just me to be involved, so I've been able to kind of delegate things".

Barker stated;

"…there are places where I find the experience going through the faculty leadership classes very, very valuable, but in some places it is not". Barker found the coursework assisted his performance by helping with the "development of the physician documentation quality initiative in studying how doctors work and write documentation".

Initially, it was looked at as a research project but Barker realized the difficulty with asking physicians to sit down for hours to read through and evaluate notes would not be successful and that was "an example of something that I could use as skills from the leadership series to do", additionally "dealing with contentious issues between student and faculty" was another skill set acquired from the coursework.

He imparted;

> How do you handle that situation, especially when maybe the faculty member you are dealing with may be years in that position, technically senior to you, how do you negotiate that position, how do you get to talk and engage with this individual or alternatively, how do you engage with that individual's superiors and management?

Adult Education and Development

Many of the themes of adult development appeared in the interviews. Physicians described becoming more self-aware, questioning both their behavior and assumptions and examining new perspectives.

Comments received were:

Yordano;

"…what the leadership academy identified for us was opportunity for development…it taught you skills as it taught you partnering and mentors" and discussing his program, "…it's not about me, it's about getting the operation shifted".

"What it also taught me was to slow down and push a little less hard. Because what it showed me in terms of process is that it is about process not about pushing. So it challenged me to change my personality and to some extent I have".

Barker;

I think the sessions in negotiation and conflict resolution, managing disputes, and even some of the sessions on capital investment and organization mission really gave an insight into the disparity of ideas and how "my way or the highway" approaches to issues could be counter-productive. I think we are seeing a real live demonstration right now in Washington…They badly need an FLA session there!

Well, I guess it probably moved me from the good manager makes everybody else do the work position"…it has made him "more reflective and more broad, it has enabled me to look at

things in a much broader context…some of the experience, some of the knowledge I gained from the program helped me develop this kind of bigger picture book…what is the bigger picture, what is the bigger mission, what is the bigger intention of all of the things going on around us.

Grimaldi;

"I think the FLA course did help me further appreciate the competing interests/drivers of others behaviors/decisions".

Kyllian has personally read many books on leadership and as such he had an idea of his personality and style prior to the FLA.

I kind of modeled myself as what I think of as a servant leader model. I am inclusive, I like to invite comments, I try to get my colleagues to weigh in because these are pertinent decisions that will be made, not just during the next six months while I am in charge but for the next 10, 15 years, as well as the fact that everybody has a certain skill set, a certain perspective, and area of expertise that I may not necessarily be aware of, so I take their opinions and I think I invite free dialogue from them to weigh to the pros or cons of whatever decision we are contemplating before we execute a final decision, so my involvement of stakeholders is higher and I don't have many people to compare to but my

> predecessors so I definitely think my involvement of stakeholders is higher and I like to think about it that way because as the healthcare environment changes and the pace of healthcare accelerates I think when people are involved in the decision making and are able to see why certain decisions are made or being made and have an opportunity to weigh in, they become the change agents, they are the extension of leadership of the department to make those changes happen, and to make the changes more palatable down the road. To make them more durable. I found that has been helpful in my short tenure.
>
> I really enjoy being able to identify opportunities to have the people who have the desire, motivation, and potential in my department to rise up and take on more responsibility and be vital not only to the department but to the organization at large…So I see that as the most rewarding piece of all of this. The finance and negotiations are just problems to be solved but where I see my role is being able to sit back and identify opportunities with the different changes that are coming our way and how can we capitalize on that and be stronger.

Dr. Lauren Miller shared her transformation struggles into leadership versus management when discussing adult development.

> The sign in my office says do it because I said so, and that was my early management style. It was kind of my way…but, I'm finding more and more often that's not the best way to do it. Facilitating others ideas and being just the person that kind of has the bigger picture view and knows all the viewpoints and trying to bring those together is just much more satisfying than always having to do it my way. I like my way a lot of the time but it doesn't always work for everybody else and being very comfortable in saying well this is how I would have done it, but I realize that right now in this time and this circumstance that is not the best way to do it. It [the academy] started it. I would not have been willing to stand up in front of a group of residents and faculty and say my way was wrong or my way wasn't successful and I'm pretty darn comfortable saying that now.

Gallarde;

"I don't necessarily refer to the exact [negotiation module] framework of it but I think differently when I go into meetings now about trying to put myself in the shoes of the other person. I think about kind of what's going to lead to the best outcome".

Stewart always keeps the patient in mind first and foremost, a mantra the hospital organization lives by.

It has helped me have a better understanding of how others perceive me in my role which helps me better interact with them and get the job done for the sick patients that we take care of. It helps me maintain objectivity in difficult circumstances and listen more carefully to what people are saying and where they are coming from and approaching them. It's been helpful I think globally for me as a leader in thinking about the circumstances that we deal with on a daily basis.

…sometimes my ideas, not unusually and maybe this speaks to my leadership or intelligence, but just as often as not my ideas are not the ideas that we adopt…We form a consensus…at the end of the day we pull all of our brain fire power together and we come out with what we think is the best decision for our patients. So, I think that this course over the two years helped enable that further. I was already on my way to that but it helped move me more securely into that place. It's not about [me]; it's about sick patients with cancer. That's really the bottom line and I really believe in healthcare.

Dr. Stewart also identified a big picture perspective;

I think that what the course helps with, another aspect it is helpful with is seeing beyond yourself. So you see this bigger entity that [name omitted] will come and go. That's just the nature. That is the case for all of us. [Name omitted] obligation is

to make the most of his abilities to make a positive difference for others while he is there, that's his tenure. I think we all have a tendency to see the world through our own personal eyes and our own personal issues and such and while those are important, there is a bigger more important mission of the entire institution that's a lot bigger than [name omitted]. All of us are important as individuals but there is something bigger than all of us together.

Emotional Intelligence "Softer Skills"

The idea of a separate session specifically addressing emotional intelligence or the "softer skills" was an additional question prompted because many attendees when asked to identify those leadership qualities imparted during the sessions also indicated they either welcome the idea of additional instruction on the topic or were in need of the session.

Miller; "I personally have done a number of EI measures and always learn something about myself and ways to improve the way I interact with people".

Stewart; "For me personally, this has been a challenging concept and the more education on getting it right only has an upside. I increasingly believe this understanding is critical to optimal professional performance".

Lanardi;

I think it would be relevant yes…I think this kind of separates some of the best leaders from just effective leaders, and the best leaders you can see the group just kind of moving forward and you see they look to that person and they do anything for that person in order to achieve that goal.

Grimaldi;

I think this would be very helpful for physicians as it is not an area of focus during our training and as other providers are more "tuned in" to this terminology it is important we be able to speak the same language. Additionally, it involves a change in 'culture' in medicine to have emotional intelligence.

Gallarde speaking from the perspective of recruiting the very best candidates for the field of medicine;

"Yes, it would be helpful if focused on providing a framework for recruitment of residents and faculty colleagues, and how it relates to patient care and medico-legal issues".

Kyllian;

"Yes. Foundation of our interaction with others and for the development of social capital and the ability to influence change".

Grant took a more organized approach in advocating for the session.

> If you're going to focus you almost need to, if it's really going to be useful you have got to sort of pick what you are really going to spend time on. You maybe block these things together into some grouping, the things that are all related to strategic planning, the things that are personnel [related] and the things that are [have a] personal effect.

Yordano;

"Yes. This is critical. My thing is the emotional intelligence one I need to learn. I didn't get that out of the leadership academy or I didn't learn it yet".

Barker;

"I think leadership involves not just spreadsheets and numbers, but also people and relationships. Therefore, "soft" skills like emotional intelligence and cultural competence etc. are essential to leadership and management".

Sanders as somewhat of an outlier indicated he was "not sure". "Wouldn't be opposed, but wouldn't insist on it…"

Summary of Research Question One:

The reflections of the participants in discussing the first question indicated overall program effectiveness. Participants found the negotiation and finance modules were the most useful in providing new information they had not had

previous exposure to. Participants also identified through the modules a part of themselves they had not appreciated before from an adult development perspective. Participants were better able to read and understand what others wanted and needed and were willing to give up something in the process.

Through this interview process, participants validated they had a leadership style but the FLA assisted them with feeling comfortable with that style and confident that they could be successful outside of the FLA in their own work environments.

Participants identified a need to develop stronger skills related to EI or "softer skills" as identified in the leadership competencies. This list consist of 16 competencies are associated with strong leadership abilities.

Finally, a smaller but important theme emerged in that some participants articulated a better understanding of the organizational processes. The subjects of capital procurement and budgeting were previously looked upon as subjective and participants articulated they were able to understand the objectivity associated with those processes.

Research question two sought to discern what strategies physicians found most helpful during the sessions.

Strategies Employed

The most common strategies used were real-life vignettes, practical exercises, case study, small group discussions, and lecture.

Trent Sanders found the strategies employed were "challenging in that it moves you from just hearing the information to actually having to apply it and work through it and use some critical thinking so I thought that was very helpful".

Sanders described the lecture portion;

> …"interactive didactic" or lecture but with lots of stops, ask the audience and kind of interaction with the audience, it's not just presenting slides and I think that's effective as well. I think the biggest thing I use every day is the quality improvement stuff. But I think even if it's been awhile and I've probably forgotten some of that stuff, there are things, for example the best alternative to a negotiated agreement that we learned in the negotiation skills. I didn't learn to be a highly trained negotiator but at least I have that basic concept in the back of my mind. If I'm approaching something pertaining to that concept of that or I go into something with what I've learned with that basic understanding of what my leadership style is and how that impacts things so even though it's been several years, I think there are still things that we use from that. Again, probably the biggest thing that made me aware that I wanted to do more in healthcare leadership and so then, then started the pre reqs for the master's course and I think that's the biggest outcome for me.

Lanardi found the lecture as a lead into the group scenarios as "extremely helpful because it first obviously lecture illustrated what the principles were to utilize and then we actually put it in practices and we exercised with our colleagues to know whatever the strategy that was being taught, how to carry it out in real examples". While others found lecture less useful.

Barker thought the idea of "thirty minutes of lecture was probably less useful, and I think that's kind of been borne out by many studies of education"…"most beneficial sessions were those that had real life scenarios that had some kind of active task based learning exercises", "…clearly developed scenarios that were realistic", "…where you interact and you discuss and you do something and you could in a classroom where you make a decision"…, "…the more engaged scenarios were better".

Grant imparted;

> I think the case stories and the group interactions; those were by far the most important. I find in general lectures are not particularly helpful. I think they're useful in sort of setting things up and maybe setting up some basic definitions and making sure that people are on the same level but I think it's sort of the interactive that really makes the difference.

Miller;

"…it was very instructive for me to work a case that there was already a known conclusion so you could see the end product and then back track what went wrong".

Kyllian;

> Case study and built upon the case study was breaking out into small groups and actually participating in various negotiation scenarios with your peers…I think I definitely applied several elements of what I learned in the FLA in my normal course. I wanted to run [it] like a true business unit within the department to see where are the opportunities for us to grow, and are those opportunities financially feasible for the group and can we create a system where we can have the best of both worlds, both academics as well as be competitive with private practice in order to continue to retain the talent we have here. So I thought that was very helpful in creating a sound financial basis for our growth, and then being able to bring in colleagues that I thought were good additions to our group and be able to do XYZ which is expected of you from an academic practitioner point of view but also be able to make your salaries competitive with your colleagues in private practice based upon the productivity measures that we have. So I don't think I could have done that if I didn't have a better understanding of finances and strategy.

Use of strategies in practice

Physicians described the ability to apply strategies learned in their practice. Lanardi felt it probably gave him weekly insight into "some issue that we discover and I think we were very good at performance improvement. But I think just kind of developing a really good effective action plan to try and combat future instances of that, I think I'm more effective".

Kyllian;

> I wanted to create an environment within the [division omitted] that I was in charge of that is different from a typical academia practice where in typical academia you do the clinical work, you do the research and you do some teaching and that's it. It's rarely the purview of a division director to have insight into their finances or the business of running those kinds of things so I felt, which is one of the things that prompted me to go out and seek the MBA, and then participate in the FLA as well; I wanted to run it like a true business unit….

Gallarde;

> The disruptive behavior one, I think. This one and the managing conflict are probably ones that I…this is the part that I apply most in my day-to-day world more so than the financial stuff

and I think I probably did gain a fair amount out of it. I can't tell you that I can specifically remember what tools I was given but it probably just helped me to have a better framework for it. So, conflict management and managing disruptive behavior, there is a fair amount of that in my world.

Sanders;

If I'm approaching something pertaining to [that] concept of that or I go into something with what I've learned with that basic understanding of what my leadership style is and how that impacts things so even though it's been several years, I think there are still things that we use from that.

Stewart not only developed effectiveness as a leader but tied it to the organizations number one objective of keeping the patient first.

I'll remind myself, if I see myself tracking off into old habits or old ways that didn't reflect a better understanding of my role as leader and my obligations, I look back on some of those courses and it helps pull me back in the place I want to be as a leader for the program. To achieve what we ultimately want to achieve and that is taking the best care of these sick patients. So, it's helped me every single day do my job better in a more objective way.

Finally, pertaining to research question two, there was one physician, Miller, who identified that she was uncomfortable with the dynamics of the course attendees in relation to tenure. While she felt safe in the environment, as did all participants, she felt it limited her experience. Creating a safe, yet challenging environment is a part of the adult education experience and it is left to the facilitator to ensure this is provided to all participants.

> There was what I would consider a wide variation in leadership skills, mine kind of at a residency level and there were others that were running smaller divisions, like one division in medicine and there were department chairs. It was, I thought, more difficult to do group activities when we felt much more of that disparity between our own leadership skills. We could have all gravitated to a table of other people who did what we did at our level. When we had to mix and match and you were at a small group with the department chair, I then didn't feel like a leader and kind of felt like a lower person on the totem pool and just kind of deferred everything to what they were saying. I thought that course was very much supposed to be kind of similar level of experience and I'm not sure if because I went through it just at the second cohort they were still trying to pull in some more of their higher level leaders with some of their newer leaders and that was discouraging in some of the small groups when there was that big

of a leadership experience gap. Because it was much more of the "well here's what I did" and that wasn't supposed to be the point. So, I didn't get as much out of those in some of the sessions when we didn't get to more self-select our group. I still felt safe but didn't feel as contributory, more spent just listening to what they did instead of trying to explore my own what I experienced and try and brainstorm off when you're telling somebody who has 15 more years of leadership than you do what you did. So, I guess part of it can be a safety issue but I just felt that they had so much more experience that my experience didn't really matter as much. I just felt less participatory, still felt safe, listened and contributed but it kind of, for me broke apart the way the small groups should have worked when there was that big a difference, and that happened a couple of times. Over the course of the year people started to sit at tables in groups that they knew they'd be more comfortable sitting in and that certainly happened towards the end. The first, whenever you got assigned you looked for your name tag but then people did a little bit more self-selecting and moving around. You know if there was only one person at your table or two, you were told to join other tables. I would purposely look for a table with others that did more what I did, kind of leadership at an education setting as opposed to running a department and kind of self-select. I liked those, those were groups that I actually had more fun and

felt were more productive than ones that were just assigned because that's where my name tag was sitting.

Other physicians felt this diversity provided for a richer experience;

Lanardi;

"…good to have diversity of experience, in order to learn during the experiential exercises".

Stewart;

"I think the heterogeneity of the group is an advantage".

Grimaldi;

I think as safe as they could have. I mean, I have always been one of those people that I'll volunteer if I'm really comfortable with what I want to share but I don't like knowing that okay my table is next and I might have to talk. I think that that's just part of being an adult learner and that's my own personal kind of angst. But, I think in general very much so. I mean, it was very non-threatening. I think everybody was very collegial. It was nice to see people outside of the context of the clinical setting where sometimes you do feel like there is a kind of that hierarchy of "oh that's one of the senior surgeons" and maybe is intimidating in a

clinical situation but for this purpose it was kind of a level playing field.

Summary of Research Question Two

The reflections of the participants in discussing the second research question indicated participants did find the strategies utilized were effective in transferring information in a way that is suitable for adult learners. Specifically, participants indicated the case study and small workgroups were very effective, and least effective or preferred was lecture. Participants also were able to identify and demonstrate the strategies learned were able to transfer into the work environment successfully.

One participant identified a struggle in working with assigned groups in the sessions. Participant indicated she was placed in groups where physicians more senior in tenure and position were at her assigned table and she articulated this created a very uncomfortable environment whereby she felt less apt to participate and as such she acknowledged her learning potential was diminished.

This information was determined to be significant to explore further. Wlodkowski (1999) towards responsible teaching imparts as one of the five pillars, facilitators must create a safe, inclusive, and respectful learning environment. In exploration of this topic, all other participants (including those from the specific cohort) found the learning environment appropriate and verbalized the importance of the diversity of physicians as important to the overall learning environment.

Research question three was developed to ascertain if the FLA inspired participants to think about higher leadership positions.

All the physicians interviewed wear many hats each day. They are first and foremost physicians. Some are strictly hospital based, while others split their time between caring for patients in their clinics and seeing patients in the hospital. All physicians have some sort of responsibility towards student and resident education and some have hospital and or service line specific leadership responsibilities.

Most participants stated their motivation to attend the FLA was based first on the invitation by either the course co-director or their chair. But in accepting the offer, was where the motivation ensued.

The question of whether or not the FLA had influenced them regarding their own careers sparked interesting responses related to whom they are, their current responsibilities, and the direction the organization and healthcare is moving. There are strong feelings surrounding this group as they all became doctors to care for patients first. None of them went to medical school with the thought they would take on leadership positions, and for many of them, taking on more leadership responsibilities would mean a decrease in taking care of patients. The majority of this group didn't find that the FLA changed their career paths but rather the course enhanced and solidified the path they were on. Similarly, most would find giving up their entire clinical practice unsatisfying.

Career Path Progression

Sanders;

I don't know if the FLA influenced this or not but what probably happened around that time was coming to grips that it was okay to want do that. Because I think that as some point a lot of clinicians find that it is not necessarily okay to seek out management in healthcare. It's hard to explain. There's that sense of, well that's what you do if you can't practice medicine. That it's okay that you can be a good physician and pursue this. You can impact more people at a higher level by impacting the system. And so I think that is around the time I started figuring that out that I wanted to do that. And so with that I've been able to take on more leadership roles. I am the [position omitted] and ultimately would like to pursue more leadership roles, whether that's the CMO someday or as Chief [position omitted], but see my career path being in healthcare leadership.

Miller;

The leadership position I have right now is 50% of my time so I have a hard time seeing something else without feeling like I've wasted half of my clinical time for the last eight years in not getting to see patients in doing this route I almost feel like it's kind of pushed me into the area of graduate medical education, school

> of medicine kind of teaching as opposed to hospital leadership. One of the things I learned from the academy was in moving to higher and higher leadership positions what starts to take the hit is clinical and I consider where I am right now is having to make that decision. Do you back down some of the clinical in order to move forward leadership and it's a really difficult decision and one that I'm really not ready to make. I think I'm reaching kind of the end of what I can do without doing that and that's a tough decision at this point in my career.

Lanardi indicated he had looked at opportunities beyond his current position.

> Yes, I've actually looked at a couple of Chairman positions outside the University as well as in and I thought about the FLA program as far as enhancing me as a [position omitted] and then after utilizing the course I thought at a higher level. That I didn't just want to see this one program enhanced but I really sought to look at programs that have a wider footprint or penetration or array of clinical programs within it of a University or clinical enterprise.

If he had the chance to move into a leadership position full time, Lanardi stated, "Yes possibly if stimulating enough".

Grimaldi;

Yes, I would say so. I still kind of struggle sometimes with man it would be nice to just take care of patients and then go home and not have the extra 5 to 10 hours of work every week. But I think that it's just part of my nature that you identify problems and you want to help solve those. You don't want to just say, well I don't like the way this is run, and you then walk away from that. It's very natural for me to then want to help come up with solutions or work with other people to make it better. And, so I think it certainly kind of reiterated that to me. And I think too, just kind of putting me in touch with people who were already in positions of leadership within the hospital or within the medical staff so that I felt like they knew who I was and they seemed more approachable and if I heard of a committee or something that they were working on, I certainly felt more comfortable saying hey, I want to get in on that. Whereas before, I don't know if they knew who I was or didn't and so I think that's been very helpful. And, again, I think working with people from other disciplines and other departments and then seeing them in the halls afterwards, you just feel like people are more approachable and that you kind of are speaking to some extent the same language…I think to be an effective leader one must remain engaged in clinical activities or they won't be respected by their clinical colleagues (or at least will

be viewed as less vested in clinical activities which will make it difficult to get "buy in" for changes in clinical processes).

Kyllian doesn't feel that the FLA had an impact towards his career progression but would consider the possibility of leadership, although he probably would not give up his clinical responsibilities. "Depends upon the kind of role but unlikely. Clinical gives me the gratification to help people and that is what I spent most of my life training for".

Yordano's thoughts towards career path development;

> I would answer that as saying that I think I chose my career path and that it was always going to be like this. Whether or not this places me in being in a leadership role or not is something different. My director is [name omitted] and he is appropriately my director…In leadership structures you have leaders and you have lieutenants and the lieutenants provide performance to the leader. If the leader is unhappy with the performance he either does it himself or removes that person from the leadership role and places other people into leadership roles. He surrounds himself not by, what are they called, you know the people that always agree with you. You don't pick those. You pick people who sometimes challenge you, always are aligned with you and may respectively provide a difference of opinion because they see a difference of

> opinion and if you're a smart leader you will acknowledge that. One of the things I know about leadership and from [name omitted] point of view which make him a strong leader, a very strong leader is in a room when conversations are going on, he doesn't say anything. The best leader is the person in the room you don't know. He's the person who knows everything that's going on and if he has control of the influencing parties in the room then he is the best leader. He doesn't have to say a thing.

Regarding his decision on leaving a clinical career behind, it hinges on appropriate timing and succession planning.

> There will be a time when I will better serve the organization by adopting a leadership role however the organization in which I adopt this role will be one that recognizes in me a potential for them that supplants what I offer in my current position. Testament to whether I am a good leader is that my transition to the new role will be without upheaval in the organization in which I currently participate. Currently it would not be in the organization's best interest to remove me completely from my clinical responsibilities.

Grant feels the FLA coursework helped to influence his career path.

> I think it maybe helped crystalize that these are skills that I have. So I think it did help sort of crystalize that a little bit that

> this is certainly a direction. You know I didn't go through the course thinking oh my when is this over? I went through it enjoying the process and enjoying the learning. So, yeah I think it did.

For Grant the timing is close. "I am approaching the time I would consider it. I have been a clinical surgeon for many years and am getting ready to look at taking a new direction and utilizing the skills I have acquired (admin and strategic planning) in a different way".

Stewart as well doesn't believe the program changed his career path.

"I've realized the dream I set out for when I came out here"…it was to "build a fantastic national and international [name omitted] program and to be part of that process". Stewart's answer would be "no" as far as leaving clinical practice. "My greatest contribution to making life better for others is through patient care, it has become an integral part of who I am. I would consider reducing my clinic time, however".

Barker didn't approach the coursework with the expectation of his career trajectory changing or…

> necessarily to open paths or to push my career in a particular direction or to make any huge change. I did it in many ways as a personal development exercise. I wanted to gain those skills on a personal level and I was not necessarily going for a

promotion or trying to get into being the boss of some department or something. I was looking at it more from a personal development position. By the time I was going into the FLA I already had a little bit of responsibility in terms of my [position omitted]. I looked at it as a way of complimenting skills and things I was already doing but I didn't look at it as a stepping stone at all.

Barker also feels he has a

> …greater appreciation of skills in management that I may not have had prior to the sessions, but I do not think there was enough follow-up to enable me to confidently take this beyond my current management responsibilities. This may be due to the fact that I was probably doing some of the things already, though with less insight. I think I could take on more responsibilities with further mentorship or higher level skill development.

He doesn't think a role where he would give up clinical responsibilities is in sight.

> I feel that I would be throwing away three decades worth of education, training and experience. Whereas the leadership skills from the FLA are valuable, I would not be comfortable with the idea that I would stop practicing medicine, or training the next generation of physicians.

Clinical Integration

Finally, based on a response received from a physician during the interview process, all others were asked their thoughts on clinical integration. Defined by Blue Consulting Services (2012) and cited by Dye and Sokolov, clinical integration is "a myriad of efforts that have been to coordinate, or integrate, the clinical care provided to patients across providers and sites-of-care" (Dye and Sokolov, 2013, p. 102). Physicians were asked: "Clinical integration is a widely discussed topic and is very timely considering healthcare reform. Do you think it is important to have physicians visibly present in executive leadership positions and does one of those positions include CEO? Why or Why not"? While not all physicians felt the CEO had to be a physician, each agreed that physicians needed to be very involved with the clinical integration process.

> Barker;
>
> Yes, I think the absence of the physician from the decision-making processes in medicine is to blame for some of the dysfunction in healthcare delivery. Having physicians as "outsiders" in the implementation of healthcare changes neglects a pool of skilled and highly trained professionals. Further, as drivers of quality, cost, and efficiency, alienating the physician probably harms the bottom line.

Miller;

I do think it is important to have physician visibility in executive leadership. When the C-Suite is comprised of leaders from the world of business/finance coupled most often with leaders in nursing, physicians can perceive that they have lost their voice in leadership. The nursing perspective, although clinical, is just not the same as that of physician. A place where this shows is work hours- nurses work shifts and most doctors do not creating conflict. The business perspective is important and I do think the CEO does not have to be a physician but there needs to be physician leadership-someone who has been in the trenches especially if they have been in the trenches of the institution so they really understand what goes on.

Stewart;

"Yes, certainly. CEO if the candidate physician is the most qualified candidate. Physicians have a unique and critically important perspective on what is in the best interest of patients that needs constant representation at the highest levels of administration".

Sanders; "I think it's very important to have physician leadership in integration at a high level. If not CEO, then at a very high level".

Kyllian;

Yes. Because physicians are the forefront of delivery of care and are the main interface for the health system with the patient. They have a lot of respect. However you want to make sure that the physicians that are put in leadership positions have the tools to succeed beyond the tools required for excellent patient care.

Grimaldi;

Absolutely imperative that physicians be visible leaders. If leaders in healthcare are only non-physicians the reality of caring for patients will not be taken into account in important decisions and decisions regarding clinical care will be made by non-clinicians without the appropriate training/background.

For clinical integration you have to find the people who can walk in those two worlds because the traditional administration in hospital and health systems walk in the business world and just don't understand the patient world. And so you need to find people who can live in both of those worlds.

Lanardi;

"Yes, need lots and varied amount of physician representation, so other Docs [capitalization by physician] feel they can trust changes and have a true voice".

Gallarde;

> I think the physician's perspective is important to have in leadership for many reasons, including advocacy for patient interest, expertise in clinical systems, and influence over fellow physicians. Specifically regarding the position of CEO, I believe the job requires a complex skill set and as such should be open to the most qualified candidate overall-this may or may not be a physician.

Summary of Research Question Three

Physicians were asked if the FLA had any influence in their future career paths. Most had a career direction in mind, but the FLA provided some validation to that. There were a couple of physicians who struggle with leadership but from different sides. One physician sees it as a struggle from a time commitment perspective in extension of her weekly hours at the hospital while the other is struggling because it pulls her away from the reason she became a doctor, her love of caring for patients.

Finally, towards the discussion of physician engagement and clinical integration, all physicians were adamant that physician presence was necessary as this change in healthcare moves forward. Their leadership presence will be necessary for success in the future as it pertains to quality and safety of patient care. Two physicians discussed their perspective as one where healthcare

organizational leaders must be individuals who have worked in a clinical capacity to fully understand the needs of patients.

Summary

Chapter four reviewed excerpts of the interviews as physicians answered the research questions. The most significant finding was that physicians identified two modules that were most useful, although other modules contained some helpful information. Physicians discussed an increase in self-awareness and how they behaved towards others. They began to identify their personal perspectives but also understand and identify the needs and perspectives of others.

Course attendees discussed the selected methods of adult education were effective in providing the information in a motivating environment that was safe, but challenging. Facilitators provided exercises that focused on topics physicians need to develop to work in leadership positions.

Finally, physicians were questioned regarding their ideas on future leadership positions and clinical integration. Most physicians expressed a reconsideration of their career paths during the interviews. There were three distinct directions they provided; some were influenced to consider higher leadership positions, others were somewhat influenced, and the remainder discussed how they were able to find clarity and balance with their current leadership positions. Most of the physicians prefer maintaining a clinical presence while also focusing on their leadership roles, however, two physicians were considering moving towards total leadership roles.

Physicians were questioned regarding their thoughts on clinical integration. Most of the physicians voiced concern regarding the need for physicians to have a strong presence in executive leadership roles citing the importance of a clinical perspective in these positions.

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Chapter Five

> …any man is justified in saying to another: "Physician heal thyself," meaning that it is his duty to himself and to All Life that he does so. And further not only is any man so justified, but when an individual tries and persists in trying to heal with a degree of power and wisdom that is not sufficient to heal, then it becomes the duty of others to say "Physician heal thyself," meaning first he should strive to increase his understanding before he attempts to heal, or can heal, that upon which he is working.
>
> Dahl (1941)

Introduction

This chapter presents a discussion on the findings of a qualitative bounded case study exploring the perceived effectiveness of an in-house physician leadership development program. A purposeful sample of ten physicians, meeting all the criteria as described in Chapter 3, shared their thoughts and experiences regarding the Faculty Leadership Academy (FLA) program in semi-structured interviews conducted on site of the university and hospital sponsoring the program.

The future of healthcare will include focus on “reducing costs, transforming the way care is delivered, increasing preventative care, improving quality, creating larger and more efficient care delivery entities, reducing unnecessary utilization, integrating community health into the system, and placing a greater emphasis on wellness” (Dye & Sokolov, 2013, p. xxv). All of these will

not only require physician involvement but must be led by physicians (Dye & Sokolov, 2013). Physicians have not been trained to oversee these types of concerns and lack the skills to lead healthcare organizations.

Discussion

Research Question One

Based on the participants' perceptions, how effective was the FLA program in developing leadership competencies and skills?

Three major themes emerged in response to this question. The first theme identified two modules which participants found both effective and beneficial. Participants indicated, two out of the eight modules presented, the Negotiations Skills and Principles and Drivers of Financial Performance provided the most useful information. Second, many participants expressed engaging in a transformative process regarding their identity as a doctor, as well as developing a more complex view of the role of a physician leader. Third, course attendees acknowledged the importance of leaderships "softer skills".

Negotiation and Financial Modules/Education Development

Both of these modules assisted physicians in developing language and skills important in physician leadership. The Negotiations module provided physicians a better understanding of how to engage people in an environment of conflicting agendas. Physicians saw this skill as important at varying levels within departments and throughout the organization. Most importantly, the

module created an awareness of their behavior in negotiations. As noted by one physician, the module made him more aware of his leadership style and how that impacted his ability to negotiate. Several physicians claimed an increased self-awareness from the negotiations module. Negotiations within an organization occur at multiple levels. Physicians noted developing a better understanding of the process of negotiations and the skills involved in this process but also indicated that while they weren't experts they were inspired to learn more about the subject. Two physicians stated they wanted more information on this topic, one found additional resources through books, and the other through an advanced course offsite. Physicians verbalized the negotiations module could assist them in handling human relations issues better from the top down and bottom up.

Physicians perceptions post course survey (Appendix B) validated this research finding. Virtually all physicians commented that they could apply the strategies of the negotiation techniques in their daily practice.

The Finance module was also highly valued. One physician, appointed to an executive committee better understood meeting proceedings dealing with finance. This physician claimed to be more confident during discussions on subjects such as capital procurement and more able to intelligently challenge certain points of discussion. Another physician has found learning the 'lingo' a significant benefit during capital pro-forma project preparations.

While some of the physicians found the content familiar and basic in these modules, other physicians identified being exposed to information and skills that medical school did not provide. Physicians once had more administrative

responsibilities in the 1920's and began to engage in coursework pertaining to leadership. As the percentage of physician led organizations steadily decreased after WWII, physicians primarily focused their educational efforts on medicine tracks only. Changes in the 21st century have brought a need for physician presence and skill in leadership roles in the healthcare industry.

One physician commented his eyes were opened to ideas not emphasized in medical school but were now "relevant to my universe and things that I could also explore more". Other physicians identified the skills and competencies learned in the FLA as "the finer points" and "immensely helpful".

Summary

This course effectively provided an introduction to negotiation and finance skills and competencies. It also provided some physicians with ideas towards seeking out other means of gaining knowledge and experience. Course Goals and Objectives (Appendix C) states participants will be able to *Apply effectively interpersonal and decision-making skills in the immediate and long-term as related to prioritizing and optimizing negotiation opportunities and Utilize financial management principles and tools to assess the financial impact of operational and clinical decisions on stakeholders (including patients) and business units across the organization system".* While there was tentative progress made towards the goals and objects, there continues to be a gap in achieving the end result.

Adult Development/Leadership Competencies

Leadership competencies such as living by personal conviction, being visionary, and cultivating adaptability (Appendix G) require a high level of cognitive complexity. Transformative learning experiences can serve as an impetus for this development.

Mezirow (1997) states "adults have acquired a coherent body of experience", these experiences are those which give us our perspective on the world or are our "frames of reference"…the structures of assumptions through which we understand our experiences" (p. 5). As part of the transformative learning process, one must make meaning out of experiences but then question assumptions based on prior experiences. When questioning those assumptions, the transformative learning process is engaged.

One physician experienced an ah-ha moment or disorientating dilemma when she described a situation as "being able to look at something less as winning and losing and more how can we come together and really come up with a solution". She questioned her assumptions of how a process had worked in the past and from her certainty of how it should always work, but found through the negotiations module she could work with the other individuals to come to a solution that would benefit all including the patient. She credited the course with this new perspective.

> Because had I not been to that, it would have never occurred to me to look at it in a kind of different perspective or ask more questions like really pointed questions like that. Because I think

> you kind of go in sometimes with your notions of the individuals you are dealing with and think well, they are kind of irrational anyway. Just kind of almost go into it thinking we are not going to come to a conclusion here or it's going to be what I want and not what they want.

Transformative experiences serve as the engine through which individuals examine multiple perspectives and question assumptions. In the cognitive development theory of Perry (1999) and Kegan (1994), these are traits of cognitively complex individuals. Kegan describes individuals at higher levels of complexity as meaning makers capable of constructing and living by personal convictions.

One physician shared his realization that he understood others and their styles, but it was still okay for him to have a different style…

> I think defining it is important but also understanding other styles but also understanding it is okay to have a different style because I think there is a sense of leaders have to fit a certain…you know they have to be a Jack Welch type, but there can be different types of effective leaders and I think that was probably one of the first times that I really kind of heard that.

One can be effective and accomplish tasks while maintaining your own style. This physician stated while he was attending the FLA he validated within himself the idea that it was okay to want to work in leadership as a physician. He had sensed negativity from other physicians when discussing leadership positions

but now was able to see within himself the opportunity as he put it to "impact more people at a higher level by impacting the system".

Summary

This course acts as a change catalyst for participants. It enables physicians to examine and think about how they view others differently after participating in the sessions. Physicians expressed a greater comfort level with competencies such as living by personal conviction, being visionary, and cultivating adaptability. Traits required include individuals to; be in touch with values and beliefs, have confidence in making difficult decisions, envision multiple potential scenarios/outcomes, and bring clarity to situations of ambiguity, possess the ability to approach work using a variety of leadership styles and techniques, be your own meaning maker, and think from multiple perspectives.

Physicians have begun to see themselves as members of a new medical community when talking about leadership, but this process has just begun. Objectives for the course state *"Articulate the culture of the faculty and medical staff and identify opportunities to improve communication, exchange information, staff support, and reporting structure so that as a leaders they feel more capable and confident in advancing the appropriate quality agenda and Utilize problem solving techniques to analyze and solve organizational related problems in multiple settings and to develop innovative pathways for addressing problems".*

This course was to a degree effective in providing the participants with the needed developmental competencies, but it is still foundational and physicians will need to continue building upon this foundation.

Emotional Intelligence – "Softer Skills"

Finally, since many of the leadership competencies, communicating vision, earning loyalty and trust, energizing staff, and building consensus relate to EI, this group recognized EI's importance, whether they identified or believed it prior to the course. Emotional Intelligence (EI) is just one of sixteen leadership competencies identified by Dye and Sokolov (2013) as those "soft skills" which truly set exceptional leaders apart. One physician agreed stating "I think this kind of separates some of the best leaders from just effective leaders, and the best leaders you can see the group…and you see they look to that person and they do anything for that person in order to achieve that goal".

Summary

Physicians began this course with varying levels of skills related to EI and self-awareness. The physicians were in agreement that this list of competencies was important for leaders to possess and as a whole all found a separate session devoted to these competencies would be beneficial. One physician did state he didn't feel it should be mandatory though.

Research Question One Summary

Participants expressed an introductory awareness of leadership skills and competencies. Since this course is foundational in its content, developing effective leadership competencies and attitudes in an eight session course over

two years is inadequate. This course served as a change catalyst for participants to begin examining and questioning their assumptions which led to greater self-awareness. EI was identified as a very important competency for successful leaders to possess. While the FLA program was effective in initiating the development process, it was not effective in meeting the overall goals and objectives as stated by course outline.

Discussion

Research Question Two

What instructional strategies did program participants find helpful?

FLA facilitators used a variety of adult educational techniques including utilization of small learning groups, case study, case story, discussion, and lecture. Numerous principles of adult education emphasize the need for adults to connect new information to prior experience and for new information to be practical and relevant to the adult's world (Kegan, 1994). Physicians who had a common workplace commented on the value of working in groups with physicians across the hospital and university. The interviews found most physicians preferred small learning groups and the case studies. This provided for "real life scenarios" and "active task based learning exercises".

Gallarde found the group scenarios helpful because of the diverse group from so many different areas in the hospital. By giving the group a common scenario to work on she articulated you were able to get different perspectives from other course attendees focused on a common problem. Instructional

strategies that follow adult education principles were utilized and appreciated by the physicians. Additionally, in a review of the course documents, a developmental perspective on teaching was utilized. (Pratt, 1998)

Developmental perspective on teaching

As mentioned in the discussion of Research question one, physicians described developing an attitude that led to a questioning of assumptions. The teaching perspective utilized by the FLA in reviewing course documents and interviewing physicians was a version of the Developmental Perspective on Teaching as defined by Pratt (1998). Pratt states "Fundamental to this perspective is the belief in the potential emergence of increasingly complex and sophisticated forms of thought related to one's content, discipline, or practice. The key to learning (and teaching) lies in finding effective "bridges" between present and desired way of thinking" (Pratt, 1998, p. 234). This method's primary commitments to the learner include:

- To learners' prior knowledge as starting point
- To desired way of thinking as end point (Pratt, 1998)

Galbraith, Sysco, and Guglielmino (1997) suggest that teachers "encourage people around them to take risks, to challenge assumptions, to question, and to consider alternative actions" (Galbraith et al, 1997, p. 15).

In the post course survey (Appendix B) the physicians reflected this research finding. One attendee commented "exercises were great, forced you to think through the info and application". Others said, "Very good case, will be

helpful in interdepartmental negotiations", and "great hands on application of techniques/tools".

Summary

Participants and post course survey validated that the small group sessions and case study were the most effective methods utilized. Creating a motivating learning environment was described as important. Wlodkowski (1999) discusses the need for teachers to see "learners as unique and active". Teachers must place emphasis on "communication and respect, realizing that through understanding and sharing our resources together we create greater energy for learning". (p. 8).

Exercises that are focused on learners' lives and environment provide for an educational process that is important to transformational learning. Wlodkowski (1999) also discusses the need for equitable and culturally responsive teaching, which provides a safe and challenging environment for learners to interact.

Sessions with diverse tenure and responsibilities - Strategies to ensure a safe and challenging learning environment.

Course outlines suggested consideration of Wlodkowski's model are in place, however, one physician, Miller, vocalized her concerns when she found herself in a cohort that was diverse in nature with many levels of tenured physicians in attendance. She felt at a disadvantage.

> There was what I would consider a wide variation in leadership skills, mine kind of at a residency level and there were others that were running smaller divisions, like one division in

> medicine and there were department chairs. It was, I thought, more difficult to do group activities when we felt much more of that disparity between our own leadership skills…when we had to mix and match and you were at a small group with the department chair, I then didn't feel like a leader and kind of felt like a lower person on the totem pole and just kind of deferred everything to what they were saying.

Miller expected to find her fellow resident director peers as the participants in the program as she was under the impression the course was by tenure and position within the physician community. Because of the significant gap in leadership levels she indicated she felt at a disadvantage experientially and had less to contribute to the overall task participation.

Because this interview came towards the end of the process and identified a potential area of vulnerability in the course for attendees, a further inquiry among all physicians was felt to be warranted by the researcher. Subsequent follow up was solicited from each physician. The over-whelming consensus was the opposite of Miller's viewpoint. Other physicians articulated the diverse cohorts provided for much richer learning sessions. Comments included; "It would have been even better if some of the more senior leaders in the institution actually participated as attendees", "…good to have diversity of experience, in order to learn during the experiential exercises"; and "No, I don't think tenure level matters in these session. We interact with colleagues across levels of experience in the clinical setting all the time, so I think it's probably beneficial to

earlier career folks to gain comfort level in interacting with more experienced faculty"; and one physician felt that while her own personal angst in knowing her table presented next claimed this was due to her insecurity, felt the course facilitators created a very level playing field.

Summary

Most stated that the course atmosphere was in keeping with a safe, but, challenging environment. Individuals who come to the learning environment may have levels of personal discomfort which is expected as adults take on new knowledge.

Research Question Two Summary

Based on an overwhelming margin of physicians, the FLA provides a safe, but, challenging learning environment for course participants. The target audience in the Course Outline is identified as early and mid-career faculty leadership and department chairs at the Medical Center. At times participants in a learning environment will have moments where they are uncomfortable but that would be expected in an adult learning environment. This program effectively applied instructional strategies and teaching perspectives found in adult education utilized techniques described by Wlodkowski (1999) to create a culturally responsive and equitable environment.

Discussion

Research Question Three

Did the coursework influence the participants' decision to think about a higher leadership position, and if so how and if not, why not?

The FLA represents the movement for integration of physicians into leadership roles. All of the course attendees interviewed already hold leadership positions, either within their specialty or as a leader with responsibilities to the hospital organization. They are quality directors, residency directors, department chairs, specialty program directors, and service line directors. Physicians interviewed had strong emotions about balancing clinical responsibilities with leadership responsibilities.

Most of the physicians continue to practice clinically while holding leadership positions and they prefer this dual responsibility. Finally, the subject of clinical integration and how that relates to physician roles now and in the future was discussed.

Leadership Roles vs. Clinical Responsibilities

Most people attend medical school because they are drawn to the clinical side, and this is reinforced by the medical schools because of the responsibilities associated with caring for patients. These early influences impacts physicians both consciously and sub-consciously.

Hoare states when selecting vocations or occupations, adults enter into their chosen professions with very strong conviction and develop the work-related identities associated with the chosen profession. Physician enter with the idea

that their role is all about medicine and the patient. Hoare (2006) defines identity as "the partly conscious, largely unconscious sense of who one is, both as a person and as a contributor to society" (p. 347). Hoare states this is the most complete definition for the identity concept because it is tied to "occupations and social roles in the broader culture" (p. 347).

However, the medical profession is changing, and this change will impact physicians' identity. Mandated that all Americans must have health insurance, as well as demands by insurance companies and their customers for quality of care standards and placing metrics around those for healthcare organizations to meet are impacting the medical world. What was once considered the "norm" has shifted because the nature of healthcare is changing. Hoare (2006) indicates the world in which we live today is a high-risk environment and the possibility for disruption of work identity will likely be the norm in the future. Work identity as a definition is "a personal commitment to a compelling idea and its expression in a role that inspires an unending, evolving quest of self…achieved through initial and ongoing learning in engaged and engaging work" (p. 353). Hoare goes on to discuss the amount of time adults invest in their chosen profession is significant for adults and this naturally gives adults a sense of a productive life.

> As a context for identity development, the work of one's mature years shapes many key psychosocial investments and learning opportunities. As a function of work, identity certainty increases, learning (about content, contexts, others, and the self)

> shows marked development, self-reliance grows, and career salience deepens (p. 353).

Physicians who take on more leadership and less clinical responsibility may have difficulty continuing to identify with their profession. One physician, Sanders, stated his personal dilemma with this concept during the interviews when he was asked about whether the FLA influenced his path;

> …I don't know if the FLA influenced this or not but what probably happened around that time was coming to grips that it was okay to want to do that [work in leadership]. Sanders had experienced mixed reactions in his experiences towards physicians in leadership roles. According to Sanders, physicians are critical of their contemporaries who choose to shift their focus away from caring for patients. They are skeptical of their skill set to be good doctors when they choose to direct their efforts towards leading.

Stating the opposite side, another physician, Miller, feels the academy provided a negative as far as being a physician leader; "…one of the things I learned from the academy was in moving to higher and higher leadership positions what starts to take the hit is clinical and I consider where I am right now is having to make that decision".

Miller found herself at a professional crossroad where she must make a decision on future promotions and her patients. Within the academic medical profession there are tracks physicians can take and Miller must now make a decision that is uncomfortable.

Other physicians stated they were balancing the two roles well and utilizing their leadership skills to enhance their clinical and vice versa.

Stewart found the FLA provided him with a clearer understanding of who he was in his role.

> It has made me see my role in a more broad sense than I had previously. So, it allows you to see beyond the forest and to be able to see more clearly. It has helped me have a better understanding of how others perceive me in my role which helps me better interact with them and get the job done for the sick patients that we take care of. It helps me maintain objectivity in difficult circumstances and listen more carefully to what people are saying and where they are coming from and approaching them.

Some comments found physicians who really enjoyed their clinical roles waiting to see what the future holds as far as clinical integration is concerned.

> Kyllian;
>
> I think it would depend on a few factors that are in play right now, for example, who the dean could be, what direction does clinical integration take and what would the role of the chair be in that. I am not that old and I enjoy clinical as much as I enjoy this. I really enjoy being able to identify opportunities to have the people who have the desire, motivation, and potential in my department to rise up and take on more responsibility and be vital

> not only the department but to the organization at large whether it is on the hospital side, the [specific department site omitted] management side or on the university side. So I see that as the most rewarding piece of all of this.

Summary

Most physicians enter into the medical profession to make a difference clinically caring for patients. This is the method by which they identify themselves as physicians. While there were a couple of physicians attending the FLA for a specific purpose of enhancing their current performance and positions and are not considering advancing into greater leadership roles, most of the group was interested in developing their leadership acumen further. The rest of the group looked to strengthen their skills to continue growing in their current roles and preparing and developing for future roles, and with the exception of two, all of the physicians identify themselves as continuing to strike a balance between their leadership responsibilities and maintain a clinical focus as well, citing the clinical side as the reason they went to medical school.

Clinical Integration – The role of the physician

The center of clinical integration is identifying physician leaders and giving them true appointed authority and involvement in governance, management, and developing strategy for the future. Physicians must be prepared for these new responsibilities and need to engage in educational activities designed with "active learning, developmental exercises and experiential learning" (Dye & Sokolov, 2013, p. xxx). The assumption is that physicians must

lead the quality initiatives in order to successfully navigate the future in healthcare.

The physician satisfaction survey (Appendix A) expressed this same opinion. The survey conducted in 2011 compared local results to the national averages and revealed physicians in this academic medical center wanted their voices to be heard. Of note, physicians indicated a need to have: input into strategic decisions that affect their practices, create a more open forum to communicate ideas and concerns, and better responses to feedback. In response to the survey organizational leadership developed a "next steps" process to provide leadership development-succession-planning, involve physicians in executive leadership including service chiefs, and begin development of a clinical integration concept.

Yordano commented on this idea of challenge towards allowing a more open dialogue;

> Because you're not necessarily always right and you've got to be able to get up and do that. When we look at our organization as a whole, that adaptive approach people anchor on to things and by anchoring onto things it just leads you into error.

This physician shared his interpretation about organizational behavior using a metaphor comparing the nimbleness of FedEx versus UPS. His perspective was the organizational culture of the hospital was dictating and limiting growth potential. Discussing the physician satisfaction survey, he indicated a need for increased transparency to provide individuals with

information that was meaningful, alert them to issues in performance of processes and time with data, and offer suggestions on how to approach a solution.

During one physician interview the topic of clinical integration surfaced in a unique way. The discussion centered on the traditional academic model, with promotion based on tenure and research but moved into the subject clinical integration.

> I think that my impression of the way medicine is going and academics is that you need to have a very different set of skill sets than there have been in the past. Because you're helping to run a billion or multi-billion dollar organization and to expect that being a good clinical surgeon or being a researcher is going to translate because you're successful at that is going to translate into success and it's a completely different forum, I think is fallacious. …for clinical integration you have to find the people who can walk in those two worlds because the traditional administration in hospitals and health systems walk in the business world and just don't understand the patient world. And so you need to find people who can live in both of those worlds.

The physician articulated there could be organizational structures encompassing both non-clinical and clinical leaders but he was adamant that senior leadership needed to be comprised with strong physician presence. This physician also identified that while he experienced the FLA more as foundational, it did inspire him to consider increased leadership responsibilities.

Based on this interview, the researcher felt this targeted topic warranted comment from others regarding physician presence and if indeed this included the top position in the organization.

Most of the physicians interviewed indicated the CEO needs to be the best person for the position but also were strong in support of physician leadership in key executive positions. Of note, Dye and Sokolov (2013) impart the need for physician presence in the executive offices but they also indicate that it isn't necessary for the individual occupying the CEO's office to be a physician.

Physicians cited patient advocacy, expertise in clinical systems, and influence over fellow physicians as a need for physicians in executive leadership positions. One physician spoke about the absence of physicians in executive leadership as the reason for the "current dysfunction in healthcare" "…having physicians as "outsiders" in the implementation of healthcare changes neglects a pool of skilled and highly trained professionals. Further, as drivers of quality, cost and efficiency, alienating the physician probably harms the bottom line".

Most of the comments indicated that physicians are open to diverse leadership but there is also a level of trust that will be important in the new era. Transparency will be important in their minds if clinical integration is to move forward and be successful.

Finally one physician's insights on clinical integration were aligned well with comments from Dye and Sokolov (2013):

> I think a focus on development, you know incorporating some of the elements we talked about, we as physicians have no

> clue about what it really takes and the coming healthcare environment will require people who are not only good clinically but are good leaders in order to really help the organization shine.

He went on to state that many current organizational leadership structures have great understanding in the world of finance and strategic direction but clinically these individuals lack experience in the ability to understand patient expectations and the clinical tools necessary to take good care of patients. He indicated a marriage of good management with clinical knowledge will provide organizations with "fantastic" leaders.

> Because physicians are the forefront of delivery of care and are the main interface for the health system with the patient. They have a lot of respect. However you want to make sure that the physicians that are put in leadership positions have the tools to succeed beyond the tools required for excellent patient care.

Summary

Physician leadership in healthcare is essential based on nine factors including the significant changes in the healthcare delivery system, greater emphasis on quality and patient safety, value vs. volume, newer physicians are expecting engagement in decision making processes, and the most significant factor of clinical integration. (Dye and Sokolov, 2013) The Affordable Care Act (ACA) places hospitals on notice for providing better quality to patients going forward and measures such as pay-for-performance programs will reduce reimbursements for organizations if core quality measures are not met. The

success of meeting the metrics will be dependent upon physicians' active engagement in leadership to drive results.

Research Question Three Summary

Physicians identified three directions relative to thinking about higher leadership positions; there were some who were influenced to consider higher leadership positions, some who were somewhat influenced either based solely on the FLA or in combination with other courses or outside influences, and others where the FLA provided clarity to current balances of responsibility. Many of the physicians intend to continue striking a balance between their clinical and non-clinical responsibilities while two physicians were solidly focused on elevating their careers for the future. The FLA was effective in providing course attendees a foundation for guiding them in their future decisions towards leadership.

Individuals go to medical school to become physicians and as such they identify their adult professional roles as physicians first, entering the field with the idea that their role is focused on medicine and the patient. The "norm" of identity, who we are as a person and as a member of society, for doctors is changing as healthcare changes. Physicians will need to be aware of these changes as they continue to identify themselves in the healthcare community as physicians, leaders, or both.

Recommendations

Advanced FLA

The FLA influenced physicians but did not provide a comprehensive impact on their leadership development. Consideration should be given for a more advanced curriculum in the FLA or an Advanced FLA. This program should contain sessions on leadership competencies including EI, and transformation leadership theory.

Quality outcomes and patient safety are the overarching focus of clinical integration; the advanced curriculum should place an emphasis on this, as well as a curriculum that looks in-depth at the direction the national government and healthcare agencies are moving. The last two areas will continue to evolve and change and as such, timely information and direction will be of importance.

Incorporated into this advanced curriculum would be at least one session devoted to emotional intelligence and a review of the 16 leadership competencies (Dye and Garman, 2006) as described by Dye and Sokolov (2013). The literature indicates physicians utilizing and mastering these competencies set them apart as exceptional leaders. Emotional intelligence (EI) is a part of this competency list. As discussed by Goleman (2004), EI is comprised of five components: self-awareness, self-regulation, motivation, empathy, and social skill. Emotional intelligence can be learned but requires motivation, extended practice, and feedback. It also requires focus on establishing new habits and dismissing old habits. Goleman indicates this takes time and effort.

Leadership Internships

Recommendation towards physician leader development internships should be explored with the ABC for physicians who are identified by physician leaders, executives, and the board of directors as physicians who are motivated and dedicated to assisting in the integration of the organization and are interested in executive positions in the future of the organization. The organization already has an established relationship with The Advisory Board Company, a healthcare consultants group instrumental in development of the FLA.

Participants and Projects

A recommendation towards a more rigorous process to determine participants is suggested. Physicians attending the course should make a concerted effort to attend each session. Further, a consideration should be made to either increase the sessions to full day or decrease time between the sessions, along with additional sessions to adequately cover course material in reasonable time frames. Comments from summaries indicated too much information was presented in the time provided. Participants should also be given information prior to course commencing of capstone projects. These projects should be organizationally tied with the goal of implementation after vetting. This may cause potential candidates to decline the invitation but will ensure those attending are there with the true intent of working towards a better quality organization.

Final Review Session

A recommendation for a final summary review session by the current cohort in conjunction with the last session of the course would be suggested.

Extending the invitation to previous course attendees may also be beneficial to determine course effectiveness from their perspectives after time has been spent in their clinical practice utilizing the skills and competencies learned. This type of review may also be helpful in establishing need for an advanced course.

Leadership Support

The researcher suggests the course co-directors identify opportunities to be the bridge for successful clinicians engaging in leadership while still maintaining their identities as physicians. Some physicians struggled with the decision to pursue leadership and the personal mental cost associated both internally and externally with their peers. This is a cultural barrier that is not easily traversed. In the medical culture, physicians who choose to move to a leadership position as opposed to continuing to practice in a clinical capacity are often negatively viewed. Mentoring would be an important addition for these physicians with physician leaders both inside the organization as well as outside of the region.

Affinity Groups

As currently structured, affinity groups are listed as an ongoing benefit of attendance. Nine of the physicians interviewed had not heard of an affinity group. This would be of tremendous benefit to course attendees. Encourage a review by course co-directors and advisors to re-implement this process going forward as a way to build a stronger physician leader base. Further it is recommended this affinity group be led by a current well respected physician leader as mentor and facilitator for the group. Mentoring as mentioned in the literature and by course

attendees would be beneficial. Important to this recommendation will be confidentiality for the group to feel comfortable in meeting and working through issues.

Recommendations for Future Research

Recommendation for the future would include surveying a future cohort after implementation of the above recommendations. A separate advanced curriculum cohort study would be of benefit to determine the variation of perceptions between foundational and advanced curriculums and perceived effectiveness.

Secondly, a survey of non-FLA physicians on their perceptions towards physician leadership development, understanding of organizational structure, and clinical integration compared to course attendees may provide beneficial feedback for future programs.

Final Thoughts

The more things change the more they stay the same is a phrase of French origin, and indicates that even as you change something, the question is: Are you really able to appreciate the impact of the change? As we entered the last decade of the 20th century and certainly as we have crossed the millennium date line into the 21st century, the changes in healthcare have had and will continue to have a palpable impact.

This frames the reason for this research. Medicine, just as everything else has been rapidly changing. The literature review chronicled in brief fashion the

history of the physician in the United States; the physician's place in our society has evolved from one of a non-favored occupation to an elite status in 2014. The job description and identity of the physician is now changing in ways those first physicians would have found unimaginable.

Physicians have first and foremost been trained to take care of the sick and they are dedicated to that mission above all other. Traditionally, they have not been trained to run big business. This dissertation discusses the perceived effectiveness of a leadership development program for physician leaders, the strategies they found most useful, and whether the program provided a platform for further consideration of advancing their leadership position. Collectively; Do physicians perceive this program provides the competencies and skills necessary for physicians to feel confident and competent in taking on leadership responsibilities?

Healthcare organizations in the United States have been primarily led for decades by non-clinical leaders. The healthcare reform acts currently taking shape will require physicians to step up and participate in the leadership model going forward. The reasoning behind discussing change is because physicians will now need to increase their visibility in executive leadership roles.

The AMC located in a major city in the Midwest, like so many healthcare organizations, is working towards clinical integration. What this means is physicians and hospitals must work collaboratively to provide the value based care patients and payers are demanding. Physicians, traditionally focused on patient care, now need a global understanding of the nuances that go into

providing that care. The FLA is positioned to provide a foundational beginning directed at elevating the level of business knowledge physicians will need to navigate the healthcare landscape in the future.

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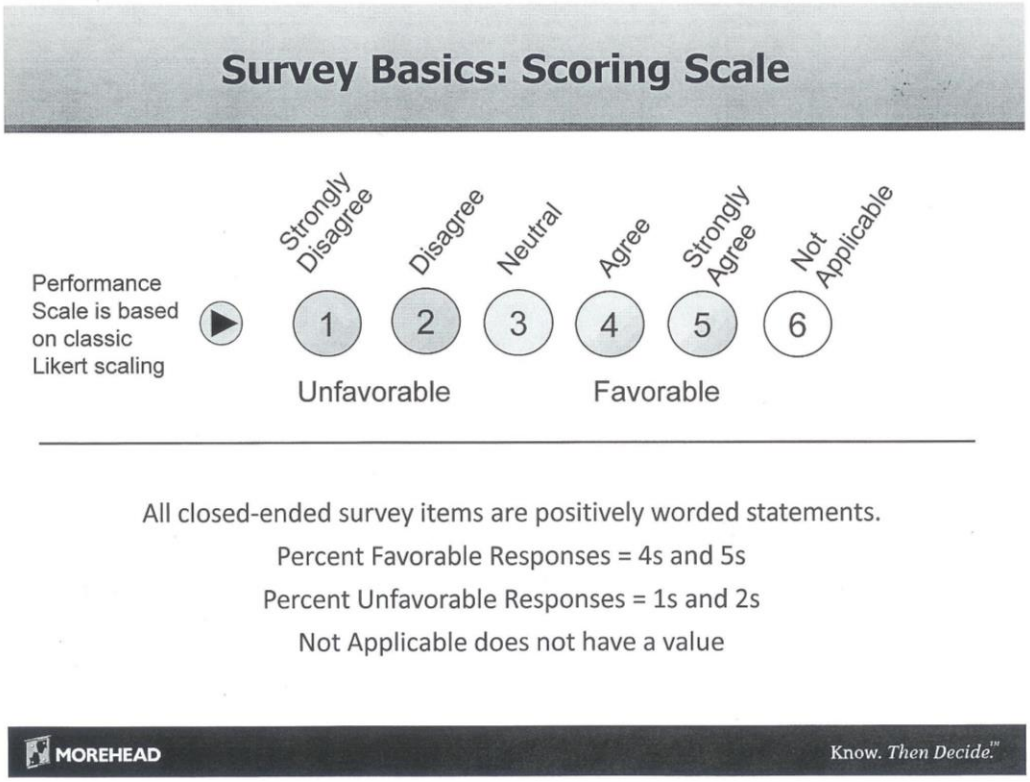
Appendix A-Physician Satisfaction Survey

Defining Physician Engagement

Engagement- The physicians' appraisal of their perceived work environment, emotional experiences, and attachment to the workplace. Physician satisfaction impacts these key engagement measures:



Appendix A-Physician Satisfaction Survey

Physician Survey Design

Morehead's Model of Physician Engagement™ + **Additional Items** tied to strategic initiatives and business objectives

8 Demographic Questions	60 Closed-ended Items	3 Open-ended Items

48 Closed-ended Items tied to the National Staff Physician Average
10 Closed-ended Items tied to the National UHC Physician Avg

MOREHEAD — Know. *Then Decide.*™

Survey Administration

Administration Period: May - June 2011

Administration Mode: Online Survey

480 Physicians Invited

245 Physicians Responded

53% Response Rate (Norm = 45%)

MOREHEAD — Know. *Then Decide.*™

Appendix A-Physician Satisfaction Survey

DETAILED ITEM REPORT

A comprehensive assessment of employee opinion survey results

Overall Organization

Item	Domain	
1. The nursing staff is responsive when I need assistance.	STF	7%
2. There is good teamwork between physicians and nurses at	STF	12
3. There is effective communication between the nursing staff and physicians regarding patient care.	STF	12
4. The nursing staff treats faculty physicians with respect.	STF	14
5. The nursing staff treats resident physicians with respect.	STF	
6. If needed, the hospital night staff is attentive to my needs.	STF	8%
7. If needed, the hospital weekend staff is attentive to my needs.	STF	9%
8. Patient care between shifts is adequate at	STF	9%
9. I am satisfied with the quality of care provided to my patients at all hours and shifts.	STF	9%
10. I am satisfied with the clinical care provided by hospitalists at	STF	7%
11. I am satisfied with the effectiveness of communication between hospitalists and staff physicians regarding patient care.	STF	1
12. Overall, I am satisfied with the performance of hospitalists at	STF	8%
13. The nursing staff at is committed to providing compassionate care.	STF	1%8%
14. Overall, I am satisfied with the expertise of the nursing staff at	STF	7%
15. Overall, I am satisfied with the performance of the nursing staff.	STF	7%

Key:

Norm 1 = Nat'l Staff Physician Avg

Norm 2 = Nat'l UHC Physician Avg

percent giving an unfavorable response
percent giving a neutral response
percent giving a favorable response

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July

Overall Organization

Item	Domain	
16. I am satisfied with the ease of the registration process for my patients.	ORG	
17. I am satisfied with the ease of the scheduling process for my patients.	ORG	
18. I am satisfied with the availability of beds at	ORG	
19. I am satisfied with the appearance and cleanliness of the patient care areas.	ORG	
20. The methods used by to communicate with physicians are effective.	ORG	
21. I receive useful information about (e.g., new services) in a timely manner.	ORG	12
22. I get the tools and resources I need to provide the best care/service for our patients (i.e., response teams, etc.).	ORG	1
23. I am satisfied with the amenities (e.g., lounge, food service) provided to the medical staff.	ORG	
24. is appropriately staffed by nurses and other ancillary staff to provide high-quality care to patients.	ORG	1
25. is a safe place for me to work.	ORG	1%9
26. makes use of new technology and clinical practices that will improve patient care.	ORG	5%
27. Once implementation is complete, I am confident the electronic medical records system will be helpful to my practice.	ORG	
28. I am satisfied with the implementation of the inpatient electronic medical records system to date.	ORG	
29. Overall, I believe my patients feel highly satisfied with the care they receive from	ORG	2%1
30. takes effective steps to remain competitive in the marketplace.	ORG	5%
31. cares about quality improvement.	ORG	2%1
32. Overall, cares about its patients.	ORG	1%9

Key:

Norm 1 = Nat'l Staff Physician Avg

Norm 2 = Nat'l UHC Physician Avg

percent giving an unfavorable response
percent giving a neutral response
percent giving a favorable response

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July

Appendix A-Physician Satisfaction Survey

Overall Organization

Item	Domain	
33. KUH cares about employee safety.	ORG	9%
34. I have adequate input into strategic decisions that affect my medical practice.	ADM	
35. I can easily communicate any ideas and/or concerns I may have to hospital administration.	ADM	
36. Hospital administration is responsive to feedback from physicians.	ADM	
37. I have confidence in hospital administration's leadership.	ADM	9%
38. I am satisfied with the overall performance of hospital administration.	ADM	11
39. Different hospital support departments work well together at .	DPT	1
40. I am satisfied with the accuracy of results and/or key information that is provided to me by laboratory services.	DPT	3%
41. I am satisfied with the timeliness of obtaining results and/or key information from laboratory services.	DPT	12
42. Overall, I am satisfied with the performance of laboratory services.	DPT	6%
43. Overall, I am satisfied with the performance of our case management services.	DPT	10
44. I am satisfied with the convenience of scheduling procedures with radiology services.	DPT	
45. I am satisfied with the accuracy of results and/or key information that is provided to me by radiology services.	DPT	6%
46. I am satisfied with the timeliness of obtaining results and/or key information from radiology services.	DPT	6%
47. Overall, I am satisfied with the performance of radiology services.	DPT	5%
48. I am satisfied with the teamwork demonstrated between the perioperative nursing staff and technical staff.	DPT	1
49. Operating rooms are well-supplied with up-to-date equipment.	DPT	

Key:

Norm 1 = Nat'l Staff Physician Avg

Norm 2 = Nat'l UHC Physician Avg

percent giving an unfavorable response
percent giving a neutral response
percent giving a favorable response

Overall Organization

Item	Domain	
50. I am satisfied with the scheduling process in perioperative services.	DPT	
51. I am satisfied with the performance of perioperative services.	DPT	
52. I am satisfied with the availability of operating rooms.	DPT	
53. I am satisfied with the interactions I have with the emergency department physicians.	DPT	1
54. Overall, I am satisfied with the performance of the emergency department.	DPT	
55. Overall, provides high-quality care and service.	EI	3%
56. I would recommend to family and friends who need care.	EI	2%
57. I would recommend to other physicians as a good place to practice medicine.	EI	7%
58. makes every effort to deliver safe, error-free care to patients.	EI	3%
59. If I am practicing medicine three years from now, I would like to be practicing at .	EI	6%
60. Overall, I am satisfied working with .	EI	7%

Key:

Norm 1 = Nat'l Staff Physician Avg

Norm 2 = Nat'l UHC Physician Avg

percent giving an unfavorable response
percent giving a neutral response
percent giving a favorable response

Appendix B-Post Course Evaluation

Office of Continuing Education

Evaluation Summary Form

In the interest of continuous quality improvement of our programs, we ask that you complete the following evaluation. Please turn in your evaluation at the end of the session.

Speaker Evaluation

Did the speaker's presentation address the objectives?

1.
Scale: A Excellent B=Good C=Average D=Below Average E=Poor

2.
Scale: A Excellent B=Good C=Average D=Below Average E=Poor

Comments about the speakers:

_____

_____

_____

_____

Learning Outcomes Evaluation

As a result of attending this program, I am better able to:

3. Distinguish between harm, errors, and latent failures and identify where the most leveraged opportunities for safety improvement lie including their roles as conduits between and among members of the healthcare staff and administration.
   A=Excellent B=Good C=Average D=Below Average E=Poor

4. Describe key financial concepts--i.e., payback period and discounted cash flow in capital budgeting so as to contribute to and improve the medical center and hospital capital allocation processes.
   A=Excellent B=Good C=Average D=Below Average E=Poor

5. Identify and evaluate the barriers that hinder effective conflict management and craft optimal management strategies that achieve actionable results in reducing ongoing conflict and preventing future conflict.
   A=Excellent B=Good C=Average D=Below Average E=Poor

Appendix B-Post Course Evaluation

6. Articulate how to manage a variety of overt disruptive behaviors, as well as identify and define the subtle behaviors that negatively impact the organization.
   A=Excellent B=Good C=Average D=Below Average E=Poor

Application of content to my clinical or organizational practice (New required questions- please answer)

List one or two strategies learned at this course that you will apply to your clinical/organizational practice.

Conflict management and negotiation of conflict resolution
Management of problem behavior
Systematic review of factors "beneath the surface" in making decisions
Negotiations
Mediation strategies to help keep thing out of stalemate
Managing conflict without having to move up the chain of command
Negotiation
Conflict resolution
Realizing all sides of each story
Management skills
Conflict resolution
How to handle disruptive employees and co-workers
Become a mediator in conflict solutions
Defining goals and metrics to measure them

What will you do differently in the care of your patients? OR What will you do differently in the management of your practice?

Formally plan new programs, resources required, finances, projections
I have learned to use listening and to evaluate everyone's demands vs. needs in conflict resolution
I will be more proactive in working with others to solve problems
Inquire data of each situation prior to responding
Exercise some of the leadership skills learned into practice, i.e. financial management, negotiation, conflict resolution
Do homework – get data – before approaching conflict
Translate that systematic review to clinical and organization decision making process
Whether in a patient care of management perspective getting more detail on topics or individual interpretation of events is key to solving problems and being open to developing solutions

Barriers (Optional question)
Please describe any factors which limit your ability to use today's information/strategies in your clinical/organizational practice. Barriers may be individual (i.e. current knowledge, skills, professional performance or working relationships) or institutional (i.e. mission, operating systems, staffing, equipment, finances).

Time demands (not enough time)
Time
Institutional: relatively low physician engagement in management and decision making
Personal interaction with people unwilling to compromise
Lack of anticipated/detailed strategic planning

Content Integrity Evaluation

Evidence Based: All the recommendations involving clinical medicine and nursing in an accredited activity for healthcare professionals must be based on evidence that is accepted within the profession of medicine or nursing as adequate justification for their indications and contraindications in the care of patients. (Adapted from ACCME definition, 2007)

Appendix B-Post Course Evaluation

7. For clinical presentations, did the course provide evidence-based information? **Scale: A= Yes B=No C=NA**

If not, please specify what specifically lacked acceptable evidence. _____

Commercial Balance

The content or format of an accredited activity for healthcare professionals, e.g. CME and CNE, or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest or a commercial interest. Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company. (Adapted from ACCME July 2002)

8. Was the course free of commercial bias and balanced with respect to therapeutic options, and their risks and benefits? **Scale: A= Yes B=No C=NA**

If not, please specify why. _____

9. Please select your applicable profession:
Scale: A. Physician B. Advance Practice Nurse C. Nurse D. Other

Needs Assessment

10. My personal goals/objectives for attending this conference were met. **Scale: A= Yes B=No C=NA**

If no, please identify what you expected and/or needed.

_____

For the next program, I would be interested in attending:
a hands-on workshop on **Financial concepts**
a simulation of _____
small group discussions of case studies on **More detailed financial modeling, more small groups**
other, please explain **Any leadership topic, teaching, personal financial planning for a young family**

What has been your greatest clinical or professional practice challenge within the past year?
Handling a high volume of patients while trying to maintain an academic career and have time for my family
Mediating between residents and faculty
Time management
Management of a fellowship program
Realizing that conflict is a must – but now can deal/approach/mediate conflict before
Rapid growth and change in organizations
Dealing with a disruptive physician from outside our department

Appendix B-Post Course Evaluation

Faculty Leadership – Year I

December 2, 2010

What key learning from today will you be able to implement in your practice?

- Increased knowledge or credentialing; improving communication and culture change as an institution.
- Will I prioritize? Is it worth it? Do I know how? – Then work on removing external barriers and identifying obstacles to success.
- More active management – communicate more often in person rather than email.
- How to apply quality initiates within our department.
- Quality improvement must be a priority that is acted on and carried out in order to truly make a difference. The benefits for our patient's will only come through our own leadership and acting on it. Accountability is a must.
- Changing the culture of the organization is paramount to improving communication, effectiveness and ultimately drives out comes
- Do the right thing, provide leadership and make a difference, be willing to accept the consequences of your actions. Safety first – always. Use tool #1.
- Within our division work on developing agreed upon clinical protocols and then have monthly meeting to hold faculty accountable during a QI meeting or explain why we would deviate from a protocol.
- Barriers/Obstacle identification and overcome issues.
- Strategies to improve quality in the organization.
- Will evaluate in quality provided by service, new nurse, practitioner
- Define the problem before looking for the solution.
- Making sure all barriers are removed allowing people to work at optimal level and feel safe in choices they make.
- Make sure members of my team can bring problems to me.
- Challenges to provide quality care.
- Accountability for achieving goals.
- Establishing consensus.
- Outline expectations.
- Structured approach to problem/goal and taking time to identify key factors and barriers to achieving goal.
- The notion of removing barriers of "hill, skill and will" will be helpful in my work environment, related to creating culture of accountability.
- Quality of care, better leadership

Appendix B-Post Course Evaluation

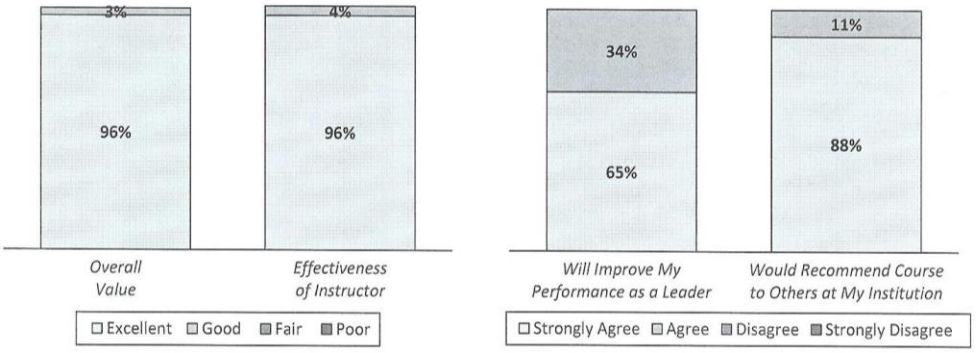
Talent Development – Leader Development

THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

September 30, 2010

Breakthrough Negotiations **(N=11)**



Participant Comments

- "Exercises were great. Forced you to think through the info and application"
- "Very good case. Will be helpful in interdepartmental negotiations. Great opportunity to get to know colleagues and communicate. Great for building relationships"
- "Give more specific "rules" of the negotiations, i.e. assumptions made that make more realistic and that don't always need to come to completion"
- "Very helpful in future negotiations with my staff and with my department chair and other departmental collaborators"
- "Excellent session – Mr. Nichols kept it interesting, interactive"
- "Great to see a structural approach to negotiation. It's not about beating the other person, rather improving your situation"
- "Very good course. Will help in future endeavors"

Appendix B-Post Course Evaluation

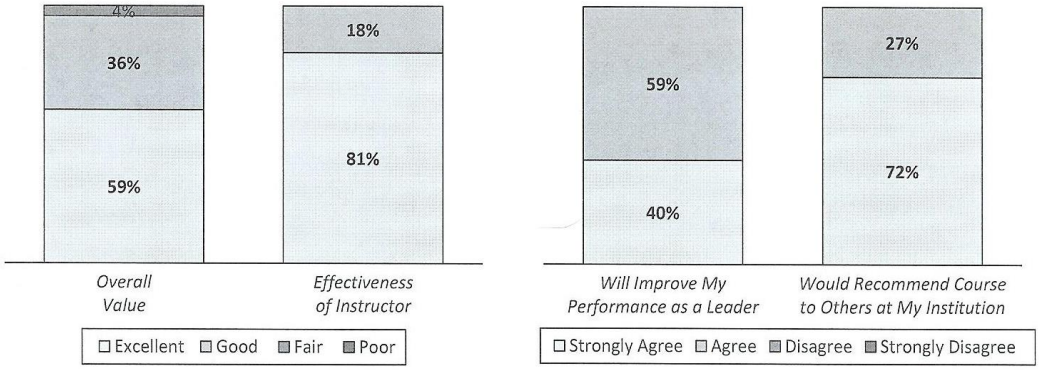
Talent Development – Leader Development

THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

December 2, 2010

Clinical Quality **(N=22)**



Participant Comments

- "Creating strong organizational climate for QI is essential to my daily work – these concepts are very helpful"
- "Make more generally applicable for scientists (non-physicians)"
- "Think – will I practice, is it worth it, do I know how? Then work on removing external barriers and identifying obstacles to success"
- "Will assess role in improving quality for new nurse practitioner"
- "Great review. I have a business background and MBA so it was not necessarily new material but well warranted. I do feel this can help realign my goals with my current practice which unfortunately I have lost some of the leadership role since I started"
- "Somewhat theoretical vs. previous presentation. Would probably suggest less information be presented"
- "Very good session. Appreciated Columbia disaster as example for discussion"

Appendix B-Post Course Evaluation

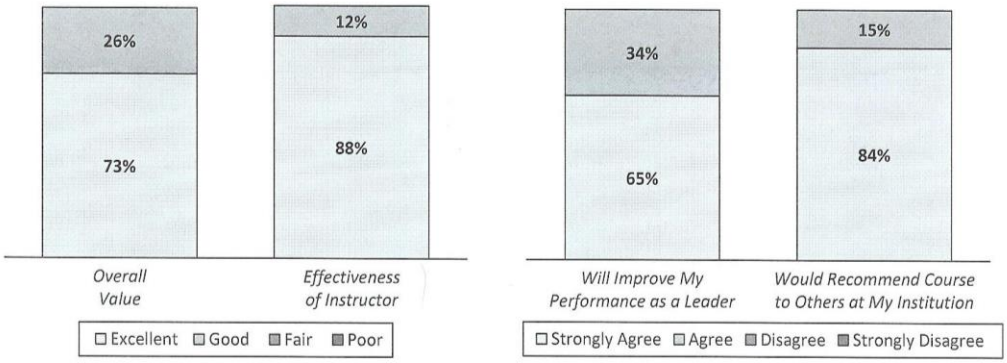
Talent Development – Leader Development

THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

January 27, 2011

Drivers of Health System Performance **(N=26)**



Participant Comments

- "Good discussion of issue. I have very little experience dealing with in my role"
- "It allows me to understand the financial impact of my decisions on health care costs, be able to be involved in decision-making with better knowledge and background"
- "Good networking, hands-on application of techniques/tools"
- "Excellent teaching tool!"
- "Clinical productivity measures, RVUs, net incomes, etc."

Appendix B-Post Course Evaluation

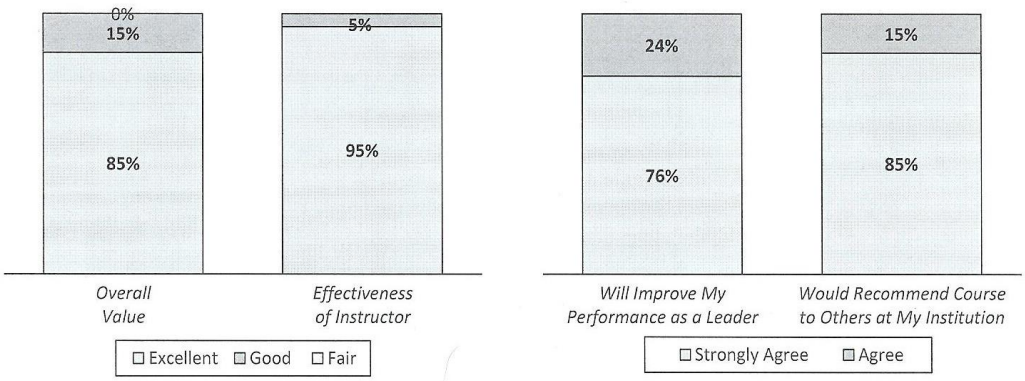
Talent Development – Physician Leadership Academy

THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

3/24/11

Problem Solving
(N=21)



Sample Participant Comments

- Fabienne did an exceptional job; very much enjoyed her.
- Really helpful to solve problems.
- Excellent course.
- Could be shorter.
- Great; concise way to identify and address solutions.

Appendix B-Post Course Evaluation

Office of Continuing Education

Evaluation Summary Form

Faculty Leadership Academy 2011-2012
Year II
October 4, 2011, December 1, 2011, January 27, 2012 & March 30, 2012

In the interest of continuous quality improvement of our programs, we ask that you complete the following evaluation. Please turn in your evaluation at the end of the session.

Speaker Evaluation

Did the speaker's presentation address the objectives?

1.

Scale: A	Excellent	B=Good	C=Average	D=Below Average	E=Poor
	13	0	0	0	0

2. **Fabienne Moore, M.D.**

Scale: A	Excellent	B=Good	C=Average	D=Below Average	E=Poor
	11	2	0	0	0

Comments about the speakers:

_____

_____

_____

_____

Learning Outcomes Evaluation

As a result of attending this program, I am better able to:

3. Distinguish between harm, errors, and latent failures and identify where the most leveraged opportunities for safety improvement lie including their roles as conduits between and among members of the healthcare staff and administration.

A=Excellent	B=Good	C=Average	D=Below Average	E=Poor
7	6	0	0	0

4. Describe key financial concepts--i.e., payback period and discounted cash flow in capital budgeting so as to contribute to and improve the medical center and hospital capital allocation processes.

A=Excellent	B=Good	C=Average	D=Below Average	E=Poor	
3	6	2			1-no response

5. Identify and evaluate the barriers that hinder effective conflict management and craft optimal management strategies that achieve actionable results in reducing ongoing conflict and preventing future conflict.

A=Excellent	B=Good	C=Average	D=Below Average	E=Poor
9	4			

Appendix B-Post Course Evaluation

6. Articulate how to manage a variety of overt disruptive behaviors, as well as identify and define the subtle behaviors that negatively impact the organization.

A=Excellent B=Good C=Average D=Below Average E=Poor

8 5

Application of content to my clinical or organizational practice (New required questions- please answer)

List one or two strategies learned at this course that you will apply to your clinical/organizational practice.

Conflict management and negotiation of conflict resolution
Management of problem behavior
Systematic review of factors "beneath the surface" in making decisions
Negotiations
Mediation strategies to help keep thing out of stalemate
Managing conflict without having to move up the chain of command
Negotiation
Conflict resolution
Realizing all sides of each story
Management skills
Conflict resolution
How to handle disruptive employees and co-workers
Become a mediator in conflict solutions
Defining goals and metrics to measure them

What will you do differently in the care of your patients? OR What will you do differently in the management of your practice?

Formally plan new programs, resources required, finances, projections
I have learned to use listening and to evaluate everyone's demands vs. needs in conflict resolution
I will be more proactive in working with others to solve problems
Inquire data of each situation prior to responding
Exercise some of the leadership skills learned into practice, i.e. financial management, negotiation, conflict resolution
Do homework – get data – before approaching conflict
Translate that systematic review to clinical and organization decision making process
Whether in a patient care of management perspective getting more detail on topics or individual interpretation of events is key to solving problems and being open to developing solutions

Barriers (Optional question)
Please describe any factors which limit your ability to use today's information/strategies in your clinical/organizational practice. Barriers may be individual (i.e. current knowledge, skills, professional performance or working relationships) or institutional (i.e. mission, operating systems, staffing, equipment, finances).

Time demands (not enough time)
Time
Institutional: relatively low physician engagement in management and decision making
Personal interaction with people unwilling to compromise
Lack of anticipated/detailed strategic planning

Content Integrity Evaluation

Evidence Based: All the recommendations involving clinical medicine and nursing in an accredited activity for healthcare professionals must be based on evidence that is accepted within the profession of medicine or nursing as adequate justification for their indications and contraindications in the care of patients. (Adapted from ACCME definition, 2007)

Appendix B-Post Course Evaluation

7. For clinical presentations, did the course provide evidence-based information? **Scale:** A= Yes B=No C=NA
8 0 1
4- no response

If not, please specify what specifically lacked acceptable evidence. _____

Commercial Balance

The content or format of an accredited activity for healthcare professionals, e.g. CME and CNE, or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest or a commercial interest. Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company. (Adapted from ACCME July 2002)

8. Was the course free of commercial bias and balanced with respect to therapeutic options, and their risks and benefits? **Scale:** A= Yes B=No C=NA
9 0 0
4- no response

If not, please specify why. _____

9. Please select your applicable profession:

Scale:	A. Physician	B. Advance Practice Nurse	C. Nurse	D. Other	
	10	0	0	0	3- no response

Needs Assessment

10. My personal goals/objectives for attending this conference were met. **Scale:** A= Yes B=No C=NA
10
3- no response

If no, please identify what you expected and/or needed.

_____

For the next program, I would be interested in attending:
a hands-on workshop on **Financial concepts**
a simulation of _____
small group discussions of case studies on **More detailed financial modeling, more small groups**
other, please explain **Any leadership topic, teaching, personal financial planning for a young family**

What has been your greatest clinical or professional practice challenge within the past year?
Handling a high volume of patients while trying to maintain an academic career and have time for my family
Mediating between residents and faculty
Time management
Management of a fellowship program
Realizing that conflict is a must – but now can deal/approach/mediate conflict before
Rapid growth and change in organizations
Dealing with a disruptive physician from outside our department

Appendix B-Post Course Evaluation

What new information, skills, or content would be most beneficial for you as a clinician/practitioner or healthcare professional?

_____

_____

Thank you for completing this evaluation.

Appendix B-Post Course Evaluation

Analyzing Capital Investments

What items have you incorporated or utilized in your position?

Responses:

1. Deciding which purchases to make and what direction to spend limited funds.
2. Just joined a Capital Improvement Committee
3. Request capital products in a more strategic manner
4. Recognizing sources of financial capital. Analyzing investment proposals.
5. Think through as many variables/angles as possible before moving forward and prioritizing.

What challenges do/did you have for implementation?

Responses:

1. Once you decide what new program to start, you still need to find the money to start it.
2. Not applicable
3. Not in charge of these purchases.
4. Biggest challenge is lack of funding and determination of priorities and budgeting constraints.
5. Takes time!

Appendix B-Post Course Evaluation

Talent Development – Leader Development

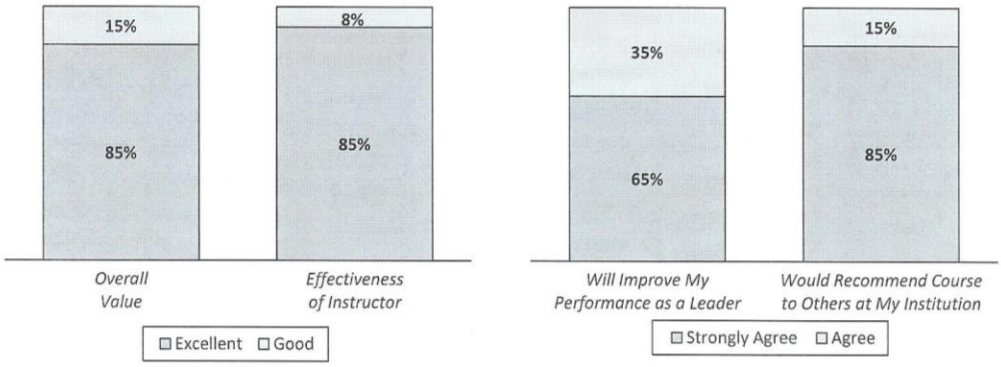
THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

10/14/2011

Clinical Capital Investing

(N=14)



Sample Participant Comments

•Very helpful to have leadership connect lessons from course to practical implementation at KUMC.

•Not as many case examples at the end.

•Very important topic and well presented

Appendix B-Post Course Evaluation

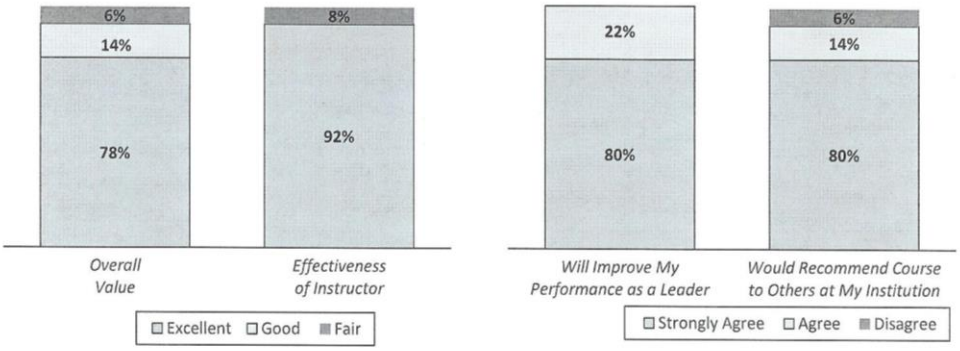
Talent Development – Leader Development

THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

12/1/2011

Managing Disruptive Behavior
(N=14)



Sample Participant Comments

•Overall an excellent presentation.
•Very helpful – we all deal with this but usually inadequately.
•Fantastic workshop. Overall very pertinent to my work. I am leaving with some new great tools – thank you.
•I will document more and work on "Changing the Economics."

Appendix B-Post Course Evaluation

Talent Development – Leader Development

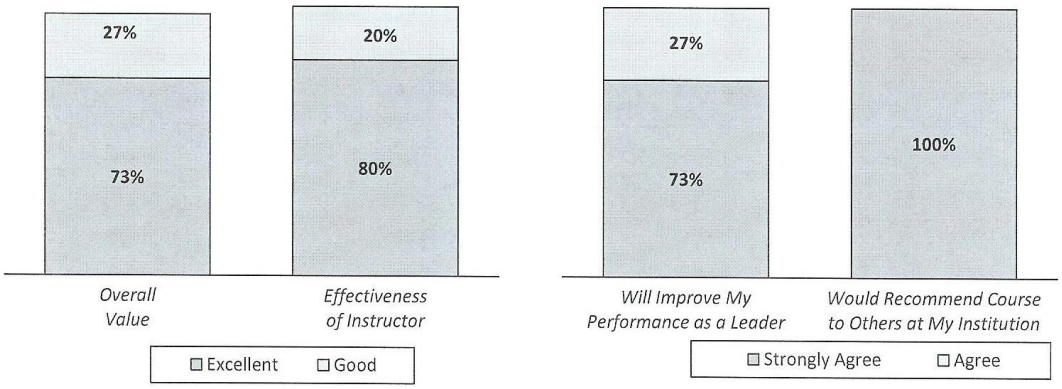
THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

1/27/2012

The Patient Safety Imperative

(N=15)



Sample Participant Comments

•The rapid response team concept has been initiated in most hospitals – what's the next iteration?

•The most pertinent topic for our practice, delivered in a meaningful, interactive way!

•Use the tools to look at the root of the problem and know how to address.

•Help triage problems that need to be further evaluated/dealt with.

•This course will hopefully increase awareness of the mechanisms & factors that come together to contribute to the events that negatively impact us and help us develop ways to reduce the frequency of the same. I would not make changes to this course.

Appendix B-Post Course Evaluation

Talent Development – Leader Development

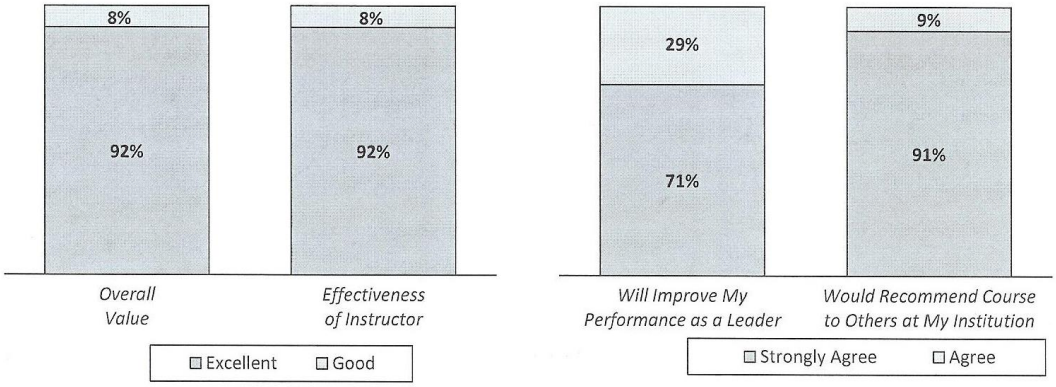
THE ADVISORY BOARD COMPANY

Individual Workshop Evaluation Results

3/30/2012

Managing Organizational Conflict

(N=14)



Sample Participant Comments

•One of the most useful sessions for me.

•Although content was not new, the exercises were helpful to engage with other participants and extend examples.

•Get the data before addressing conflicts.

•

Appendix C-FLA Course Outline/Goals and Objectives

Physician Leadership Academy I

Session 1: September 30, 2010	Negotiation Skills and Principles
Session 2: December 2, 2010	Quality Improvement Imperative
Session 3: January 27, 2011	Drivers of Financial Performance
Session 4: March 24, 20101	Problem Solving Using Analytic Tools

7:30 a.m. through 12:00 Noon

Presented by:

The University of Hospital, The University of Medical Center and University of Continuing Education

Course Co-Directors

MD, MBA, MHSA, Professor & Interim Chair, Health Policy and Management, University of School of Medicine, Director, Institute of Community and Public Health, The University of Medical Center,

PhD, Associate Dean, Professional Development and Faculty Affairs, Professor, Anatomy and Cell Biology, The University of

M.D., Vice President and Chief Medical Officer,

Overview

The objective of this program is to broaden the perspective and leadership expertise of physicians and faculty in leadership positions. Through intensive on-site coursework and mentoring from institutional leaders, participants develop the critical skills, knowledge, and perspective required to act as successful peer advocates, organizational representatives, and change leaders. This course will train the participants in four key areas: quality improvement, negotiation skills; financial management; and problem-solving in complex health care organizations.

Target Audience

This training is designed for early and mid career physician leadership and department chairs at hospital and early and mid career faculty leadership and department chairs at Medical Center.

Objectives

At the completion of this training, participants should be able to:

- Apply effectively interpersonal and decision-making skills in the immediate and long-term as related to prioritizing and optimizing negotiation opportunities.
- Articulate the culture of the faculty and medical staff and identify opportunities to improve communication, exchange information, staff support, and reporting structures so that as leaders they feel more capable and confident in advancing the appropriate quality agenda.
- Utilize financial management principles and tools to assess the financial impact of operational and clinical decisions on stakeholders (including patients) and business units across the organizational system.
- Utilize problem solving techniques to analyze and solve organizational related problems in multiple settings and to develop innovative pathways for addressing problems.

Appendix C-FLA Course Outline/Goals and Objectives

Faculty Leadership Academy II

Session 1: October 14, 2011	Clinical Capital Investing
Session 2: December 1, 2011	Managing Disruptive Behavior
Session 3: January 27, 2012	Towards a Higher Standard of Patient Safety
Session 4: March 30, 2012	Mediating Medical Staff conflict

Presented by:

Course Co-Directors

, MD, MBA, MHSA, Professor & Interim Chair, Health Policy and Management
School of Medicine, Director, Institute of Community and Public Health,

PhD, Associate Dean, Professional Development and Faculty Affairs, Professor,

Overview

The objective of this program is to broaden the perspective and leadership expertise of physicians and faculty in leadership positions. Through intensive on-site coursework and mentoring from institutional leaders, participants develop the critical skills, knowledge, and perspective required to act as successful peer advocates, organizational representatives, and change leaders. This course will train the participants in four key areas: capital budgeting and clinical investment; managing conflict; managing disruptive physicians; and structuring for proactive patient safety improvement.

Target Audience

This training is designed for early and mid career physician leadership and department chairs at hospital and early and mid career faculty leadership and department chairs at Medical Center.

Objectives

At the completion of this training, participants should be able to:

- Describe key financial concepts--i.e., payback period and discounted cash flow in capital budgeting so as to contribute to and improve the medical center and hospital capital allocation processes.
- Articulate how to manage a variety of overt disruptive behaviors, as well as identify and define the subtle behaviors that negatively impact the organization.
- Distinguish between harm, errors, and latent failures and identify where the most leveraged opportunities for safety improvement lie including their roles as conduits between and among members of the healthcare staff and administration.
- Identify and evaluate the barriers that hinder effective conflict management and craft optimal management strategies that achieve actionable results in reducing ongoing conflict and preventing future conflict.

Appendix C-FLA Course Outline/Goals and Objectives

Planning Committee

MD, Associate Professor, Director, Division of Otology/Neurotology, Director, Audiology/Vestibular Rehabilitation Laboratory,

MD, MSPH, Chief of Staff, Center for Environmental and Occupational Health,

, MD, MBA, MHSA, Professor & Interim Chair, Health Policy and Management, School of Medicine, Director, Institute of Community and Public Health,

MD, Professor and Chair, Department of Family Medicine,

MD, Senior Associate Dean, Clinical Affairs, Professor and Chairman, Director, Division of Head and Neck Surgery,

, MD, Professor and Chair, Department of Pediatrics, Director, Center for Child Health and Development,

PhD, Associate Dean, Professional Development and Faculty Affairs, Professor, Anatomy and Cell Biology,

MD, Vice President and Chief Medical Officer

CPMSM, CPCS, Director, Medical Staff Services,

PhD, Project Manager, Continuing Education,

Accreditation

Physicians: The Center Office of Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Medical Center Office of Continuing Medical Education designates this educational activity for a maximum of 16 *AMA PRA Category 1 Credit(s)* ™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Faculty

is currently a Director of the Advisory Board Academies, a division of The Advisory Board Company in Washington, DC. The Academies serve leaders at multiple levels of health care, helping them to improve their management skills and maximize their leadership abilities as they guide health care providers in the delivery of superior patient care in the hospital setting.

is a faculty member for the Academies and is responsible for teaching classes and conducting workshops at leading hospitals in the United States

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Privacy Policy

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We occasionally use mailing lists that we have leased. If you receive unwanted communication from it is because your name appears on a list we have acquired from another source. In this case, please accept our apologies.

Faculty and Planning Committee Disclosure Information

Disclosure of Relevant Financial Arrangements

As a provider accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the American Nurses Credentialing Center (ANCC), the
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The following presenter does not have any relevant financial relationship with any commercial entity producing healthcare goods or services related to the content of the activity.

The following planning committee members do not have any relevant financial relationship with any commercial entity producing healthcare goods or services related to the content of the activity.

Appendix D-Invitation to Participate

Dear Dr.

By way of introduction, my name is Kim Smith, and I work here at the hospital as the Assistant Director of Radiology. I am currently in pursuit of my PhD in Educational Leadership. Dr. Lee Norman has recommended you as an individual who would be able to assist me in my research project which is a focus on Physician Leadership in the 21st century. Healthcare is a very complex environment requiring many different skill sets. I have found in the literature that physician leadership is more important now than it ever has been in helping manage the difficult landscape ahead. Success depends on physicians possessing the advanced knowledge and skill sets/competencies necessary to succeed in leadership roles and the FLA along with other in-house and national programs globally are providing guidance.

The dissertation is a qualitative case bound study and will focus on the faculty members who have actively participated in the two-year FLA program. I will be conducting interviews with ten physicians to understand their perception of the relevance of the FLA program and the impact of the program on their desire to seek higher leadership positions.

Historically and culturally, physicians have not played a major role in earnest of leading healthcare organizations since World War II, so it will be important to the study to allow participants the opportunity to describe their life experience in healthcare.

The interview will take no longer than 90 minutes to complete however, my goal is to complete it in approximately one hour. It would be a privilege to interview you regarding the above project, and I would be happy to meet with you at your convenience and in a location to which you feel most comfortable.

All interviews will be conducted by me only, and all interviewees will be listed in the dissertation with a pseudo identity. All participants will be asked to sign a consent letter at the time of the interview, as I will be providing some basic statistics (non-identifiable) regarding each person in the dissertation.

The favor of a reply is requested so interviews can be set up. Again, thank you very much for taking time out of your busy schedule to consider this opportunity.

Regards,

Kimberly A. Smith, M.S., R.T. (R)

Appendix E-Interview Questions

Interview Questions

1. What were the most important competencies/skills you learned in the FLA?
2. What strategies did you find helpful?
3. How have these changed your personal performance?
4. What motivated you to attend the FLA?
5. Did you apply what your learned why/why not?
6. How has the FLA influenced your personal leadership style?
7. How has the FLA influenced your personal career path?
8. What are your recommendations towards program enhancements?

Follow up questions:

1. Would you have preferred a session where tenure level was equal? Why or Why not. If yes, did you feel this held you back in participation?
2. Do you feel the FLA assisted you in gaining a higher adult developmental level perspective? Why or Why not? (Developmental level refers to your view of issues, so for example a basic look would be
    i. Child
    ii. Adolescent
    iii. Adult where my opinion is the best
    iv. Adult+ where I can appreciate your opinion, but feel mine is still preferable

Appendix E-Interview Questions

v. Adult++where I absolutely understand your perspective and can abrogate mine to yours

3. Do you feel the FLA gave you the basic skills to prepare you confidently to take on greater leadership responsibilities? Why or Why not?
4. If you had the opportunity to take on a leadership role that would mean totally giving up your clinical responsibilities, would you? Why or Why not?
5. Clinical integration is a widely discussed topic and is very timely considering healthcare reform. Do you think it is important to have physicians visibly present in executive leadership positions and does one of those positions include CEO? Why or Why not?
6. Would you find a session on the softer skills like emotional intelligence of use? Why or Why not?
7. Dual Degrees – If you could have, would you have done a dual degree?

Can you briefly describe your career?

Years in medicine

Training – Traditional, Military

Specialty

Leadership positions held

Appendix F-Consent to Participate

KANSAS STATE UNIVERSITY INFORMED CONSENT

PROJECT TITLE: **Leading for the 21st Century: A Qualitative Study Focused on Educating Physician Leaders in Understanding the Challenging Landscape of Administrative Practices in Healthcare**

APPROVAL DATE OF PROJECT: ____ **EXPIRATION DATE OF PROJECT:** ____

PRINCIPAL INVESTIGATOR: CO-INVESTIGATOR(S): **Dr. Sarah Jane Fishback**

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS: **785-532-5554**

IRB CHAIR CONTACT/PHONE INFORMATION: **(785) 532-3224**

SPONSOR OF PROJECT: **N/A**

PURPOSE OF THE RESEARCH: Physicians have traditionally been trained in clinical science only. The field of healthcare has rapidly changed over the past century and now physicians need and want to participate in leadership roles within organizations. Dissertation focuses on a hybrid program developed for an acadamic medical center in Kansas to provide the needed competency skills necessary to assist physicians in a leadership development process.

PROCEDURES OR METHODS TO BE USED: **Semi-structured interviews**

ALTERNATIVE PROCEDURES OR TREATMENTS, IF ANY, THAT MIGHT BE ADVANTAGEOUS TO SUBJECT: N/A

LENGTH OF STUDY: **2 months**

RISKS ANTICIPATED: **None**

BENEFITS ANTICIPATED: **The information provided in the interviews will check program effectiveness, and recommend measures that improve effectiveness of the program.**

EXTENT OF CONFIDENTIALITY: **The participants will be given a pseudonym, and researcher/recorder will be the only one knowing participants real names.**

IS COMPENSATION OR MEDICAL TREATMENT AVAILABLE IF INJURY OCCURS: **N/A**

PARENTAL APPROVAL FOR MINORS: **N/A**

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled. I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form. **(Remember that it is a requirement for the P.I. to maintain a signed and dated copy of the same consent form signed and kept by the participant**

Participant Name: _____

Participant Signature: _____ **Date:** _____

Witness to Signature: (project staff) _____ **Date:** _____

Appendix G-Leadership Competencies

Leadership Competencies

Living by Personal Conviction – You know and are in touch with your values and beliefs, are not afraid to take a lonely or unpopular stance if necessary, are comfortable in tough situations, can be relied on in tense circumstances, are clear about where you stand, and will face difficult challenges with poise and self-assurance.

Possessing Emotional Intelligence – You recognize personal strengths and weaknesses; see the links between feelings and behaviors; manage impulsive feelings and distressing emotions; are attentive to emotional cues; show sensitivity and respect for others; challenge bias and intolerance; collaborate and share; are an open communicator and can handle conflict, difficult people, and tense situations effectively. Emotional intelligence may often be labeled EQ, or emotional intelligence quotient.

Being Visionary – You see the future clearly, anticipate large-scale and local changes that will affect the organization and its environment, are able to project the organization into the future and envision multiple potential scenarios/outcomes, have a broad way of looking at trends, and are able to design competitive strategies and plans based on future possibilities.

Communicating Vision – You distill complex strategies into a compelling call to march, inspire and help others see a core reason for the organization to make change, talk beyond the day-to-day tactical matters that face the organization, show confidence and optimism about the future state of the organization, and engage others to join in.

Earning Loyalty and Trust – You are a direct and truthful person; are willing to admit mistakes, are sincerely interested in the concerns and dreams of others, show empathy and a generally helpful orientation toward others, follow promises with actions, maintain confidences and disclose information ethically and appropriately, and conduct work in open, transparent ways.

Listening Like You Mean It – You maintain a calm, easy-to-approach demeanor; are patient, open minded, and willing to hear people out; understand others and pick up the meaning of their messages; are warm, gracious, and inviting; build strong rapport; see through the words that others express to the real meaning (i.e., cut to the heart of the issue); and maintain formal and informal channels of communication.

Giving Feedback – You set clear expectations, bring important issues to the table in a way that helps others hear them, show an openness to facing difficult topics and sources of conflict, deal with problems and difficult people directly and frankly, provide timely criticism when needed, and provide feedback that is clear and unambiguous.

Appendix G-Leadership Competencies

Mentoring Others – You invest the time to understand the career aspirations of your direct reports, work with direct reports to create engaging mentoring plans, support staff in developing their skills, support career development in a non-possessive way (will support staff moving up and out as necessary for their advancement), find stretch assignments and other delegation opportunities that support skill development, and model professional development by advancing your own skills.

Developing Teams – You select executives who will be strong team players, actively support the concept of teaming, develop open discourse and encourage healthy debate on important issues, create compelling reasons and incentives for team members to work together, effectively set limits on the political activity that takes place outside the team framework, celebrate success together as a unit, and commiserate as a group over disappointments.

Energizing Staff – You set a personal example of good work ethic and motivation; talk and act enthusiastically and optimistically about the future; enjoy rising to new challenges; take on your work with energy, passion, and drive to finish successfully; help others recognize the importance of their work; are enjoyable to work for; and have a goal-oriented, ambitious, and determined working style.

Generating Informal Power – You understand the roles of power and influence in organizations; develop compelling arguments or points of view based on knowledge of others' priorities; develop and sustain useful networks up, down, and sideways in the organization; develop a reputation as a go-to person; and effectively affect the thoughts and opinions of others, both directly and indirectly, through others.

Building Consensus – You frame issues in ways that facilitate clarity from multiple perspectives, keep issues separated from personalities, skillfully use group decision techniques, ensure that quieter group members are drawn into discussion, find shared values and common adversaries, and facilitate discussion rather than guide them.

Making Decisions Effectively – You make decisions based on an optimal mix of ethics, values, goals, facts, alternatives, and judgments; use decision tools effectively and at appropriate times; and show a good sense of timing related to decision making.

Appendix G-Leadership Competencies

Driving Results – You mobilize people toward greater commitment to a vision, challenge people to set higher standards and goals, keep people focused on achieving goals, give direct and complete feedback that keeps teams and individuals on track, quickly take corrective action as necessary to keep everyone moving forward, show a bias toward action, and proactively work through performance barriers.

Stimulating Creativity – You see broadly outside of the typical, are constantly open to new ideas, are effective with creativity group processes (e.g., brainstorming, scenario building), see future trends and craft responses to them, are knowledgeable in business, and societal trends, are aware of how strategies play out in the field, are well read, and make connection between industries and unrelated trends.

Cultivating Adaptability – You quickly see the essence of issues and problems, effectively bring clarity to situations of ambiguity, approach work using a variety of leadership styles and techniques, track changing priorities and readily interpret their implications, balance consistency of focus against the ability to adjust course as needed, balance multiple tasks and priorities such that each gets appropriate attention and work effectively with a broad range of people.