

Towards Reconciliation of Several Dualities in Physician Leadership

Pour la réconciliation de plusieurs dualités dans le leadership en médecine



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Abstract

Leadership has a renewed focus in healthcare, and physicians are being increasingly involved in a range of leadership roles. The aim of this paper is to discuss several dualities that exert tensions at the systems and individual levels. Although oppositional, the common dualities of physician leadership are not mutually exclusive but represent a complex, dynamic and interdependent relationship, often coexisting with each other and exerting tensions in multiple dimensions. The authors contend that a dialectic understanding – instead of either/or or finding a middle ground – of the opposite poles of these dualities allows for generating meaningful leadership perspectives and choices.

Résumé

Le leadership est au centre de l'attention dans les services de santé et les médecins s'impliquent de plus en plus dans une vaste gamme de rôles liés au leadership. L'objectif de cet article est d'aborder diverses dualités qui exercent des tensions aux niveaux des systèmes et des personnes. Bien qu'elles soient opposées, les dualités habituelles du leadership des médecins ne s'excluent pas l'une l'autre, mais représentent plutôt une relation d'interdépendance complexe et dynamique; elles coïncident souvent l'une avec l'autre et exercent des tensions sous plusieurs dimensions. Les auteurs affirment qu'une compréhension dialectique des pôles qui s'opposent dans ces dualités – plutôt que de choisir un des deux ou de trouver le juste milieu – permet d'obtenir un point de vue appréciable sur le leadership ainsi que sur les choix présents.

CURRENTLY, LEADERSHIP IS A KEY FOCUS IN HEALTHCARE ORGANIZATIONS BASED on a clear articulation of the need for improvement in healthcare leadership. Driven by the necessity for better access, higher quality of care, enhanced efficiency, coordination of care, higher patient experience and overall better outcomes for patients and populations, the healthcare delivery systems are moving towards integrated care delivery models, the latter defined as, “networks of organizations that provide or arrange to provide a coordinated continuum of services to a defined population and who are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population being served.” Commitment, alignment and integration of physicians in the integrated healthcare delivery models are considered essential for success, as physicians are participants in the delivery of care and contributors to the evolution of clinical services; however, it is a complex and challenging endeavour. It requires simultaneous efforts at coupling physicians and healthcare systems at several fronts including economic, structural (formal roles in organizational leadership structures and clinical governance), process-related (e.g., involvement of physicians in quality improvement initiatives) and policy levels. There is general agreement that leadership by physicians is linked to improved physician engagement and organizational effectiveness.

This paper draws on the research and practical experiences of the authors to highlight several dualities that affect leadership by physicians. These dualities are often oppositional and none have an absolute claim on truth and sometimes may run the risk of one being regarded as more important than the other – referred to as the “inevitable hierarchization” (Baxter and Hughes 2004). Some of these dualities exert palpable tensions at systems level, while others are more acute at the individual level. The authors contend that a dialectic understanding of the opposite poles of dualities and the tension between these allows for generating a meaningful perspective and making appropriate choices for effective leadership. These dualities are discussed below.

Dualities That Need to Be Reconciled Predominantly at the Systems Level

Leadership versus management

Efforts to discern distinctions between management and leadership often resolve in overlapping purposes and roles; the former usually referring to ensuring constancy (stability) and the latter to change (pursuit of vision) (Kotter 1990). The recent trend to designate virtually all formal authority positions in healthcare structures as leaders may reflect a hesitancy to use the words managers or management. The denigration of management (Rowling 2011: 1–2) and resulting tendency to call everyone a leader, while expecting stability and consistency with expectations of adherence/compliance, may be problematic for both functions and render both less meaningful – management becomes less effective and leadership becomes merely an espoused value.

Every manager can and must exhibit leadership behaviours, but designating every formal hierarchical position in healthcare structures a leadership position is neither enough to elicit leadership behaviour from individuals nor required for organizational success. Healthcare relies heavily on efficient management and there is nothing wrong in labelling a position “managerial” or “administrative,” if the tasks and role expectations are in the managerial domain. An operational aspect of management that needs to be reconciled is the contentious issue of budgetary responsibility, especially in settings where a dyad leadership (joint responsibility between physician leaders and leaders with other backgrounds – nursing, technical, business, etc.) model is in place. If there is no signing authority for the budget, it may lead to perceptions of a weakened leadership (or managerial) role, although some physician leaders may be satisfied with a focus on clinical delivery outcomes.

Affirming versus enabling leadership

Leadership by physicians needs to expand in some areas and retreat from other areas. There is a vital need for increased involvement of physicians in: (a) policy – especially in the areas of quality and clinical innovation, payment policy and medical education and training (Laugesen and Rice 2003); and (b) strategic and higher-order operational decisions in healthcare systems, as it affects commitment and the decision quality (Parayitam et al. 2007). This requires that strong, value-based and assertive physician leaders become key partners with other healthcare leaders (Zismer and Brueggemann 2010).

On the other hand, in many interprofessional team care settings, physicians do not need to assume positional leadership roles; in such settings, there is a requirement for physicians to become trusted team players (Whitehead 2007). Although the principles and practices for interprofessional healthcare teams have been articulated, including the need for collaborative/shared leadership, the actual enactment of collaborative leadership remains challenging. This is because the teams are situated in traditional hierarchical healthcare structures and medicolegal systems that promote physicians’ positional power (Lingard et al. 2012a), and the existing models of interprofessional collaboration have not yet mastered the notion of

collective competence (Lingard et al. 2012b); the latter referring to a team's ability to make collective sense of workplace events, develop and use the collective knowledge base and develop a sense of interdependency (Boreham 2004).

Assuming responsibility versus maintaining legitimacy

Despite calls for increasing leadership by physicians (Mountford and Webb 2009), in some quarters of the physician community, there is a perception that physicians are already leaders by virtue of their professional and somewhat elitist status. This perception coupled with the awareness of "professional egocentricity" (NPSF 2010) together with a disdain for these imputations may result in some reluctance to step into leadership roles. However, when formal leadership is not perceived as synonymous with transactional leadership (a one-sided and autocratic role of the leader), this reticence may be overcome. Being aware of alternate leadership perspectives, such as servant leadership (leadership based on the idea of the leader acting as a servant, with the duty to serve the followers), and transformative leadership based on changing individuals by helping them reach higher levels of motivation and morality approaches may relieve the trepidation to further perpetuate fearsome stereotypes of leadership.

A second factor may contribute to hesitancy for some physicians who wish to aspire to pursue leadership careers for virtuous or even practical reasons. Their journey may be looked down upon by their peers and disparaged as a move away from the role virtues associated with the unfettered practice of medicine towards the dark side (Glabman 2006). Sometimes the frank lack of support or reliance structures for these roles (Sherrill 2005) raises sufficient warrant to dismiss opportunities. Taken together, these factors are not conducive to increased and effective uptake of leadership roles by physicians. Physicians who are not personally interested in formal leadership positions might better help their colleagues who wish to pursue leadership roles by framing their colleagues' choices as opportunities to influence healthcare at a systems level.

Dualities That Need to Be Reconciled Predominantly at the Personal Level

Influence versus accountability

It is useful to consider that physicians practicing clinical medicine co-exist in a professional community that is inherently governed "politically" – in essence, self-governed. The hospital, on the other hand, functions as a managerial, accountability hierarchy, so that all employees have managers who are accountable for what they do, and ensuring they adhere to policy. It is in the interface between these two symbiotic "organisms" that the tension emerges: a politically governed body of "state authorized," professional decision-makers (physicians) – who by virtue of their knowledge work have attributes of autonomy and "expert" power asymmetry (Pearce 2004) – and an accountability hierarchy (the healthcare institution in which

physicians have been granted privileges to practice). Engaging physicians is critical to achieve organizational goals and is one of the expected “tasks” of physician leaders. Physician leaders simply do not have the same types of “positional authority” over physician clinicians that hospital managers have over their subordinate employees. For this reason, physician leaders must “earn” personal and political authority to generate commitment among their physician “peers” to work efficiently and to high standards, and “apply” that personal and political capital when necessary through personal persuasion and mobilizing peer pressure. This is best done using appropriate influence practices rooted in positive psychology (study of what makes individuals and communities thrive) and appreciative inquiry (systematic inquiry on what works when a system is at its best and using “positive questions” to shape the future) and by avoiding coercion (Silversin and Kornacki 2000). In some instances – when persuasion, peer pressure and collaborative negotiation have failed to bring about the appropriate behaviours – there is also an appropriate place to “resort” to more well-chosen formal tools such as peer-review, privileges and credentialing to ensure accountability by staff physicians (Pronovost and Marsteller 2011).

Promoting effectiveness versus nurturing colleagues

For effective leadership, the centrality of the relationship with “followers” has long been known and recently reiterated in the healthcare settings (Grint and Holt 2011). The leader’s task involves balancing the “demands of efficiency and the need to nurture human spirit” as “the employees today are less likely to put up with a workplace that emphasizes efficiency at the expense of meeting human needs” (Helgesen 1990: 234–35) – this was true in 1990 and is true today, especially with the new workforce generation. This is not easy because leaders need to push people out of comfort zones and manage their emotions on the journey forward (Heifetz and Laurie 2001).

The phenomenon of “conundrum of accountability” for the physician leaders arises with colliding conflicts between the fiduciary and strategic demands owed by physician leaders to their organization and the promises, and the psychological contracts, interests and expectations of their constituents (Merry 1991). These dual affiliations and often opposing demands may make a physician leader ineffective; consequently, the organizations suffer by having a physician who neither provides effective leadership nor is fully engaged in direct patient care. The physician leader, therefore, must have the self-awareness and self-confidence to recognize that the greater good is, at times, superordinate to the autonomy of the individual physician clinician (Kraines 2010).

Clinical practice versus administrative work

Physician leaders need to balance their clinical practice with time devoted to leadership work because of two reasons. First, clinical practice is an integral component of “physician identity” that imparts a unique perspective for mindsets and psychological health. Second, it is generally

believed that continued involvement in clinical work is necessary for maintaining credibility with physicians (Holmboe et al. 2003). Physician leaders who continue to engage in clinical practice need to pay particular attention to the “advocacy” role because of their “visibility” and consequent role modelling as well as the work they need to do at the systems level. Although physicians are aware of the need for advocacy at both individual patient and system levels, the actual balance of the “agency” (acting in the interests of the individual patient) and “activism” (changing social conditions that impact the populations) in practice settings requires additional work.

The administrative roles for most physician leaders are situated in clinical and academic domains and to some degree in public and political domains. Further, physician leaders in academic health centres are expected to deliver on clinical as well as academic missions. This requires physician leaders to work across multiple inter- and intra-organizational boundaries, including the fault line between universities and hospitals/regional health authorities. This cross-boundary work across the fault lines is challenging due to differences in the clinical and academic settings in organizational cultures, organizational processes around decision-making and accountability mechanisms.

Balancing clinical and administrative work requires not only personal time management but also an ability to utilize appropriate mindsets (often referred to as wearing my other hat), e.g., “agency” with “activism,” short-term gains with long-term goals and, in the educational settings, remaining patient-centred and learner-focused.

Discussion – Reconciling Dualities

A reconciliation of several common dualities in physician leadership is conducive to increasingly meaningful and effective leadership by physicians. Although oppositional, the common dualities of physician leadership are not mutually exclusive but represent a complex, dynamic and interdependent relationship. Further, it is not necessary to find a middle common ground between these dualities. A dialectic emphasizing that both “poles” are important – “the coexistence of diametrically opposed elements” (Levine 1971), accepting that both are true at the same time, in a both/and manner, adds a third approach to reconcile these dualities (Coser 1971: 184).

For the purpose of this article, dialectic thinking refers to the ability to arrive at a reasonable approach to resolve contradictions. Developing a “dialectic” thinking requires deep self-awareness and awareness of other perspectives to create and maintain a balance between these two dynamics (Basseches 2005). This internal reconciliation allows the leaders to frame and facilitate interpersonal and organizational discussions in a dialectic language. This sets the stage for reconciliation of dualities and at the very least is a respectful acknowledgement of “different truths,” even if no agreement is reached; this by itself is a powerful step in establishing trust with and among groups – the very basis of effective leadership. Reconciliation of the dualities may sometimes involve ensuring that the decisions and actions are consistent with upholding both “truths” through a wider perspective, which accommodates both “realities.”

Alternatively, reflections and deliberations of the different “truths” may lead to emergence of new realities. A couple of examples illustrate this reconciliation.

Both strategic and operational decisions in organizations (e.g., creating integrated delivery models or achieving financial and quality targets) almost always require working across intra- and often inter-organizational boundaries. It is well-known that human interactions are influenced and often determined by the identity of individuals and groups – the manner in which the individuals classify themselves and others into social categories (Hogg and Terry 2000). It is further complicated by the observations that individuals have multiple simultaneous identities and their relative importance varies with time and context. A general approach to solving system-wide issues is by creating a superordinate identity (Gaertner et al. 1999) – essentially a larger tent under which multiple groups and individuals can come together to work towards a common goal. Although this approach has merit, it is not always successful (physician engagement is still a work in progress), as the groups sometimes perceive this as a loss of identity of the subgroup to which they belong. This requires that while a superordinate identity is being created, careful attention is paid to preserving and protecting group identities and that the larger collective work is not perceived as “subsumation” of individuals and groups. Specific recommendations for cross-boundary work – creating intergroup safety, fostering intergroup respect, bridging groups to develop trust, developing intergroup community, integrating group differences to generate interdependence and bringing groups together in emergent directions (Ernst and Chrobot-Mason 2011: 81–220) – allow for implementation of decisions to achieve organizational goals through a dialectic approach.

Patient advocacy – the “agency” component referred to above – by physicians offers an opportunity to apply dialectic thinking. Instead of advocating for an individual patient at all costs (thesis), as the resources are finite (antithesis), the concept of distributive justice – socially just allocation of goods in a society – allows for a meaningful allocation of resources for realistic outcomes, i.e., the best we can do for the patients given the resources we have so that other “individual” patients who are later in the queue can be appropriately cared for (synthesis). The recommendations in the relatively recent Choosing Wisely Canada initiative – endorsed by many national societies – allow for an evidence-based appropriate use of resources for diagnosis and management (Levinson and Huynh 2014). Physician leaders can become role models in their individual clinical practice and exhibit leadership by ensuring adoption of this framework throughout the organization, increasing the likelihood of attaining financial and quality-of-care goals.

Conclusion

Physician leaders are constantly balancing and adjusting to the ever-moving landscape of medical knowledge and have the additional task of successfully managing and leading in healthcare organizations. Adopting a dialectic approach to leadership dualities at both the individual and systems level enhances leadership by physicians. At the individual level, the leaders need to develop and apply a dialectic mindset and commit to life-long leadership development. At the

systems level, the dialectic approach would involve: (a) valuing managerial roles and reflecting these in organizational designations, (b) actively including physician leaders at strategic and operational levels in healthcare organizations, (c) incorporating collective competence principles in organizational development for both interprofessional teams for patient care and for leadership teams, (d) screening for appropriate mindsets in the selection of leaders and managers, (e) ensuring protected time for physician leaders' clinical practice, (f) managing the physician community for leadership "cultivation" and (g) educating senior leaders in healthcare settings and on what makes physician leadership unique.

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