

Commentary: Recommendations and Remaining Questions for Health Care Leadership Training Programs

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Abstract

Effective leadership is critical for optimizing cost, access, and quality in health care. Creating a pipeline of effective health care leaders requires developing leadership competencies that differ from the usual criteria of clinical and scientific excellence by which physicians have traditionally been promoted to leadership positions. Specific competencies that differentiate effective leaders from average leaders, especially emotional intelligence and its component abilities, are essential for effective leadership.

Adopting a long-standing practice from successful corporations, some health care institutions, medical

societies, and business schools now offer leadership programs that address these differentiating leadership competencies. The author draws on experience with such programs through the Cleveland Clinic Academy to provide recommendations for health care leadership training and to identify unanswered questions about such programs.

The author recommends that such training should be broadly available to all health care leadership communities (i.e., nurses, administrators, and physicians). A progressive curriculum, starting with foundational concepts and extending to coaching and feedback opportunities

through experiential learning, recognizes the challenge of becoming an effective leader and the long time line needed to do so. Linking leadership courses to continuing medical education and to graduate credit opportunities is appealing to participants. Other recommendations focus on the importance of current leaders' involvement in nominating emerging leaders for participation, embedding leadership development discussions in faculty's professional reviews, and blending discussion of frameworks and theory with practical, experiential lessons. The author identifies questions about the benefits of formal health care leadership training that remain to be answered.

Highly effective leadership in health care is critical to address the many challenges that face health care today including cost, access, and quality.¹⁻³ Two factors compound this need, especially among physicians. First, doctors tend to be "lone healers" in focusing on their individual performance rather than that of a group or institution,^{2,3} and their selection and training favor these characteristics, potentially hampering their ability to collaborate and follow others' leadership.¹⁻³ Both leadership and followership are needed for effective teamwork, and ample evidence shows that effective teamwork is essential to provide high-quality care.⁴⁻⁶ A second factor that demands effective physician leadership is that hospitals and health

care institutions are highly complex organizations, usually characterized by many professional workforces and departmental silos.^{2,7} Because high-value health care organizations act as a unit, effective leadership requires engaging and unifying the various communities within hospitals. At the same time, leading an organization requires mastery of a toolbox of leadership styles⁸ and situational awareness of when to apply which style. Training about leadership styles and situational leadership should be a component of the curriculum for emerging physician-leaders.⁹⁻¹¹

When it comes to meeting this need for leadership in health care, a paradox exists. On the one hand, advancement to positions of leadership in medicine has traditionally been based on the candidate's academic or clinical prowess, including scientific contributions and reputation, funding, and political clout. Although these accomplishments are important, such features should be considered "threshold competencies"—necessary to gain candidacy for leadership positions but no guarantee of leadership success. On the other hand, features that distinguish highly effective health care

leaders from average leaders—so-called "differentiating competencies"—differ from these threshold competencies in important ways.⁸ These differentiating traits include technical competencies (e.g., finance, accounting, legislative issues in medicine, regulatory environment), team-building skills, communication and negotiation skills, and a commitment to lifelong learning. Perhaps the most important differentiating feature of the effective health care leader is emotional intelligence (EI),^{8,12} which has been defined as the ability to understand and manage oneself and to be aware of and manage relationships.⁸ Of the 18 component abilities of EI in one model,⁸ several seem especially important for effective leadership in health care: having a service orientation, being collaborative and adaptable, being a change agent, having vision and initiative, and developing others.

Many successful corporations, such as General Electric, Motorola, and Toyota,¹³ have long devoted resources to developing leaders in their organizations, but efforts to create a leadership pipeline in health care by enhancing differentiating competencies are only

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recent. Several medical societies, business schools, and a few health care organizations^{14–16} have recently developed programs to train health care leaders.

This commentary argues that developing a pipeline of highly effective health care leaders is essential within health care organizations and that the curriculum for developing such leaders should focus on these differentiating competencies.

The Cleveland Clinic Academy

A handful of health care organizations (e.g., Mayo Clinic, University of Kentucky, Medical College of Wisconsin, Cleveland Clinic) have developed health care leadership programs, sometimes themselves and sometimes in collaboration with business schools.^{15–17} An experience with the health care leadership development program at Cleveland Clinic provides the basis for this description of an approach that focuses on differentiating competencies and for a discussion of recommendations for health care leadership training as well as questions that remain to be answered.

The Cleveland Clinic is a physician-led, closed-staff, group-practice-based academic medical center that was founded in 1921 on the mission “to act as a unit” in providing “better care of the sick, investigation of their problems, and more teaching of those who serve.”¹⁸ Because such a setting requires highly effective physician leadership, the Cleveland Clinic began offering leadership development programs in 1990, and since then, these programs have continued to evolve.^{16,17} Today, leadership development programs are offered through the Cleveland Clinic Academy (CCA) within the Cleveland Clinic Education Institute. The curriculum and program offerings are broad, including cohort-based courses for nominated emerging physician leaders¹⁶; freestanding “a la carte” courses on a variety of leadership topics that are available to all Cleveland Clinic physicians, nurses, and administrators; leadership development workshops for all incoming chief residents; developmental coaching for newly appointed chairpersons; small-group sessions focused on leadership networking and crafting personal leadership development plans for high-potential individuals; and, most recently,

executive education programs that are available to visiting physicians, nurses, and administrators. The CCA curriculum is framed by a matrix for leadership and management competencies, which links specific leadership competencies (e.g., EI, communication skills, team building, conflict management) with the courses that highlight these competencies, thereby providing a road map for participants who wish to develop their own portfolios of leadership skills.

More than two decades of experience with health care leadership development invites reflection on several questions that may be of interest to those who are currently offering or planning similar programs: What recommendations do we have for offering such programs? What can be said about the benefits and costs of such programs? What questions remain unanswered?

Recommendations for Health Care Leadership Programs

Because leadership development is needed for all the communities from which health care leaders emerge (i.e., for physicians, nurses, and administrators), the curriculum should address all three groups. Often, courses may be applicable to members of all three together, although sometimes, because of the unique learning and training needs of each community, courses may be designed for just one of these groups.

A mature leadership development program should include three complementary experiences for emerging leaders: didactic/curricular teaching, mentorship and coaching, and experiential leadership opportunities. Emerging leaders must have the opportunity to learn the principles and competencies of effective leadership, to gain experience in leading, and to receive feedback on their leadership in a safe and developmental manner. In creating a health care leadership training program, it is ideal to offer all three components of a program concurrently, though curriculum development usually occurs first.

For cohort-based courses requiring a substantial time commitment from participants, admission to the course should be based on nomination by

current leaders. First, nomination ensures that current leaders are mindful of their emerging colleagues’ leadership potential. Nominating their colleagues for intensive training also requires current leaders to maintain an active presence as emerging physician leaders, nurses, and administrators go “offline” to participate in leadership development courses. Finally, the nomination process creates a pipeline of recognized emerging leaders from which candidates for new leadership roles can be selected.

Those developing a health care leadership program should give priority to creating a networking community for emerging leaders to reinforce relationships among classmates and to extend learning. For example, alumni functions with guest speakers can bring the whole leadership community together and can introduce members of different cohorts to one another.

To enhance interest in leadership courses, participants should receive continuing medical education credit for the courses they complete. Also, as is the case for CCA courses, it is mutually beneficial to offer participants credit toward graduate degrees (e.g., master of business administration, master of health administration) for participating in leadership development courses. The culture of academic health care organizations celebrates academic achievement, and health care organizations are populated by bright, milestone-driven individuals to whom these enhancements will appeal.

The faculty of leadership development courses should be selected to present both principles and practical applications of the topic. Creating faculty dyads of content experts, such as business school faculty with health care leaders, can ensure that participants develop a well-rounded understanding of health care leadership. This approach allows the faculty to blend pedagogic excellence and depth with, for example, the experience and credibility that only physicians can offer for teaching their colleagues.

Finally, participation in leadership development programs should be recorded and incorporated into participants’ periodic performance review process. For example, a faculty member’s

leadership course work can help demonstrate that individual's leadership goals, thereby aiding organizational succession planning. At the Cleveland Clinic, those recruiting for leadership positions and for membership on several key committees will consider a candidate's leadership preparedness (e.g., participation in the CCA's leadership development programs) in addition to his or her academic and clinical achievements.

Beyond these recommendations, what are the benefits of offering a health care leadership development program? First, successful programs will develop a leadership pipeline of physicians, nurses, and administrators for sustained organizational success.^{14–16,18} Second, such programs can enhance participants' career and organizational satisfaction. The intensity of physicians' clinical and scientific training draws focus away from developing differentiating leadership competencies, but leadership development programs offset this by providing a dedicated forum to introduce physicians to new and frequently appealing concepts (e.g., EI, situational leadership, crucial conversations). Third, our experience suggests that the cohorts of participants who take courses together can develop a special camaraderie, which encourages ongoing collaboration and synergy among colleagues. Finally, leadership development courses can be innovation incubators for the organization. As a specific example, the CCA's cohort-based Leading in Healthcare course¹⁶ requires participants to develop an idea that they would implement to enhance institutional performance. At the first of the 10 once-monthly sessions, each participant presents his or her idea to classmates, after which, using nominal group technique, business plan teams select five to six of the most popular ideas for development. Over the rest of the course, the teams of participants work together to develop the ideas, and the teams present their fully developed business plans to the class and to organizational stakeholders during the final course meeting. We archive these written business plans to cultivate a repository of organizational ideas; an audit of outcomes of the first 49 business plans in the course showed that 61% had either been implemented or had

scuttled an idea that was found to be flawed on closer analysis after first-blush enthusiasm.¹⁶

Remaining Questions

The CCA and other leadership development programs^{16,17,19} have made great progress so far, but unanswered questions remain about the benefits of formal health care leadership training. For example, a true return on investment analysis of a leadership development program has yet to be done. Programs should conduct analyses that compare the costs of offering such programs (e.g., faculty and administrative support to arrange such programs, indirect expenses, variable costs of food, facility rental) with the revenue savings that have resulted from initiatives implemented through course projects or by course alumni. Also, to understand and assess the leadership career trajectories of course attendees, it is necessary to conduct a systematic inventory of the leadership paths and appointments of these individuals. We must further validate that these courses can meaningfully develop differentiating leadership competencies and that health care leaders with these differentiating competencies especially succeed in their leadership. Although substantial evidence from the literature on organizational behavior suggests the wisdom of this approach for developing leaders,^{12,19} empiric evidence from health care is sparse. Finally, what is the optimal method and timing of such leadership development training? The question is especially acute for physicians, whose training is already lengthy and intense. Should leadership training begin, as is generally believed,^{7,20,21} early during medical school and then continue through residency and early faculty membership? Or, should this training be reserved for later phases of graduate medical education, when clinical skills are maturing and physicians can devote their full attention to developing leadership competencies? We have not yet answered these important questions about health care leadership training, but the early successes of the CCA and other similar programs suggest that we will have a strong field of prepared leaders to address these and other

critical questions facing health care today and in the future.

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Cover Art

Artist's Statement: Flux and Efflux of the Aging Brain

I am a medical anthropologist at Pennsylvania State University College of Medicine, where I teach medical students and study Alzheimer disease (AD). As a social scientist, I seek to use my platform in academic medicine to inspire the public—not to mention the medical students I teach—to think about AD not as a “downstream” disease event that befalls older folks but, instead, as an “upstream” issue that is relevant to people of all ages. For a condition so deeply and unambiguously inscribed as a “late-life disease” in the modern mind, it will take more than facts alone to shift people to a life-span conception of brain health—one in which such social, cultural, and environmental factors as diet, physical and cognitive activity, diabetes and heart disease/stroke, head injuries, toxic exposures, and diminished social networks are relevant risk factors from the womb forward. I believe that engaging people aesthetically is crucial to instigating any meaningful change in the way our culture approaches brain health.

It is in this spirit that I created *Flux and Efflux of the Aging Brain*, which presents the organ as the complex and largely



Flux and Efflux of the Aging Brain

inscrutable entity that it is. Though rife with abstract shapes, the brain also includes elements of a water table map with snaking streams and sloping elevation contours. The symbolic “public health” meaning I intended to convey is that insults to the brain at any stage of life—whether in the form of traumatic brain injuries, an unhealthy diet, exposures to heavy metals such as lead and mercury, etc.—percolate downward into the deeper cellular reservoirs of the organ, creating conditions that can damage neurons and impair cognitive

functioning. Much like the rivers and streams in our natural environments, the brain is a fragile living system and deserves our utmost protection.

It is therefore my hope that thinking about AD as the end result of a “life-span process” rather than a “disease event” will become a gateway for a deeper consideration not only of commonsense preventive measures we can all take, but also of what it means to be a member of a community, to recognize our shared vulnerability, to have intergenerational responsibility, and to care for those more profoundly affected by brain aging than ourselves. True hope for progress against AD can emerge from strengthening our local communities to support healthy brains and bodies far more powerfully than from the exaggerated promise of a miracle remedy.

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