To Lead or Not to Lead? Structure and Content of Leadership Development Programs

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The dictionary defines leadership as "the power or ability to lead other people." Writing in the business literature, John Kotter provides a more nuanced view: "[Leaders] don't make plans; they don't solve problems; they don't even organize people. What leaders really do is prepare organizations for change and help them cope as they struggle through it."[1] Leaders set direction, align people and motives, and inspire people. Managers are different but also necessary to complement the work done by leaders. Managers plan, organize, control activities, solve problems, and execute plans or procedures.[1–3] Similar to other industries and institutions, the healthcare system and academic medical centers need both managers and leaders to be successful.

To advance their tripartite mission, academic medical centers (AMCs) need leaders that can effectively weave education, research, and patient care into one coherent structure. Leadership development and transition planning are essential for AMCs to thrive. Recognizing this need, a number of investigators have focused on the best way to build and nurture these leaders.

In this issue, Frich et al. report the results of a systematic review of physician leadership development programs.[4] The authors searched OVID Medline for English-language peer-reviewed studies published between 1950 and 2013. The authors included articles that reported educational programs that trained physicians in leadership skills (or exposed them to leadership concepts), outlined teaching methods, and reported results. Excluded were reports without an evaluation component, that were focused on students, or were not relevant, such as building specific skills (examples: quality improvement, accounting). Included studies were abstracted to characterize the setting, educational content, teaching methods, and learning outcomes achieved. The learning outcomes from each study were classified using a modified Kirkpatrick's typology for evaluating training programs: reaction (perception and satisfaction of the leadership course), knowledge (principles and facts on leadership), behavior/expertise (on-the-job change), and system results/performance (organizational effectiveness such as costs, quality, and promotions). The latter is considered the highest level of educational outcome.

The authors identified 600 studies, 555 of which were excluded (527 lacked description or did not include physicians, 24 did not have evaluation data, and 4 articles were not available). Of the 45 included studies, 39 had been published since the year 2000; 26 included trainees, 19 included medical faculty or community practice physicians or were multidisciplinary, and 4 used a comparison group (none used a randomized design). The duration of the programs ranged from half a day to a longitudinal 3-year program. Thirteen were one-time events. Most programs used didactic lectures or interactive seminars or group work as teaching methods. The educational content spanned common topics, including leadership, teamwork, financial management, conflict management, quality improvement, communication, and health policy/strategy. Not unexpectedly, most studies reported basic learning outcomes (reaction to the program or self-reported knowledge). The highest educational outcome, system results/performance, was reported in six studies and included increased quality of care (objective or self-reported), patient satisfaction, advancing to higher leadership roles, or implementation of business plans.

In another systematic review of leadership training programs, Straus et al.[5] summarized the results of ten studies for physicians in AMCs, three of which are included in the study by Frich et al.[6–8] System results and performance outcomes, the highest level used by Frich et al., were described in three studies. In a study among 140 orthopedic surgeons, advancement in academic rank or hospital administrative rank was higher in participants (48 %) as compared to controls (21 %) within 7 years of follow-up.[9] In a before-and-after study of 32 pediatricians, only 7 % of program participants were promoted at 2 years.[10,11] Finally, in a cross-sectional study of 70 participants (29 of whom were physicians), 15 % were promoted within 3 years.[7] The authors noted that all ten studies were at high risk of bias.

Frich et al. acknowledged limitations of their study including poor quality of the existing literature and a search strategy limited to peer-reviewed publications. The lack of overlap of the included studies in the two systematic reviews could be explained by differing inclusion and exclusion criteria, target populations, or databases.

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Nonetheless, the two systematic reviews provide guidance for designing and evaluating leadership development programs. First, educational programs should have a strong study design, define the competencies necessary to succeed as a leader,[12,13] include other health professionals, and aim for system and organizational effectiveness outcomes. Second, the paper by Strauss et al.[5] reminds us that educational programs should clearly define the target population and intervention, assess outcomes blindly, and include validated instruments.[5] Third, educational programs could also include qualitative methods for evaluation (such as the case study method[14] or realist evaluation), as even if programs mitigate the risk of bias, attributing causality to specific leadership development programs would be difficult—if not impossible.

Although the scientific evidence behind leadership development programs is limited, such programs do provide a venue to develop and refine attitudes, skills, and behaviors for physicians at AMCs. What can individuals do to become more effective leaders? We discuss our experience from two perspectives, an aspiring leader and a more established one. Here we share our top five suggestions for becoming a more effective leader.

First, learn from others. For example, at the last Association of Program Directors in Internal Medicine (APDIM) national chief resident conference, one of the best sessions one of us attended was "Top 10 Mistakes of a Chief Resident," which gave great advice that has been used numerous times to avoid repeat mistakes. Regional and national conferences are a great way to gain advice from others on similar paths. Many such conferences for physician leaders are available.

Second, role model a respected leader. Take advantage of great leaders at your institution. Watch how they act in meetings, how they run meetings, how they handle conflict, and how they handle success. A first person view of a respected leader can be an invaluable asset.

Third, consulting with and reading the work of experts of leaders in other arenas can add greatly to a portfolio of leadership tactics. For example, the chief medical resident group at our institution organized a leadership "book club" with the Chair of Medicine and other invited junior faculty. The collective advice and experience of the group as a whole was richer and more helpful in tackling individual leadership dilemmas than one person's view. In his book *Contrarian's Guide to Leadership*, Steven Sample encourages readers to figure out the hill on which you're willing to die, to play toward your strengths rather than improve your weaknesses, and to surround yourselves with people who make up for your own shortcomings. Jim Collins, in *Good to Great*, reminds readers that greatness flows from having the right people in the key seats. Similarly, in *Drive*, Daniel Pink offers the insight that you need people with intrinsic motivation to help the group succeed.

Fourth, be willing to be evaluated regularly and change if something is not working well. Seek honest feedback from multiple sources on a regular basis. As Steven Sample says again in his book, everyone needs a complete and frank evaluation once a year. Leaders and institutions can use validated instruments[15,16] or one of many of the personal inventory tests available (and frequently used in leadership development programs).

Fifth and most important, practice deliberately. Any advice obtained and lessons from programs or books must be put into practice. For example, before a meeting think of a new tactic to implement—such as managing conflict and discord. If there is discord on the team, be purposeful about how to handle differently this time.

Physicians find themselves in leadership positions at some point in their career, and most have no formal leadership training or experience. The study by Frich et al. supports the belief that physician leadership programs are important for quality of care, professional advancement, and patient satisfaction. It also sheds light on the need for more programs and improved ways to measure outcomes of such programs. In addition to leadership building blocks provided by programs and courses, successful leadership development also requires motivation to improve as a leader by the physicians themselves.

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