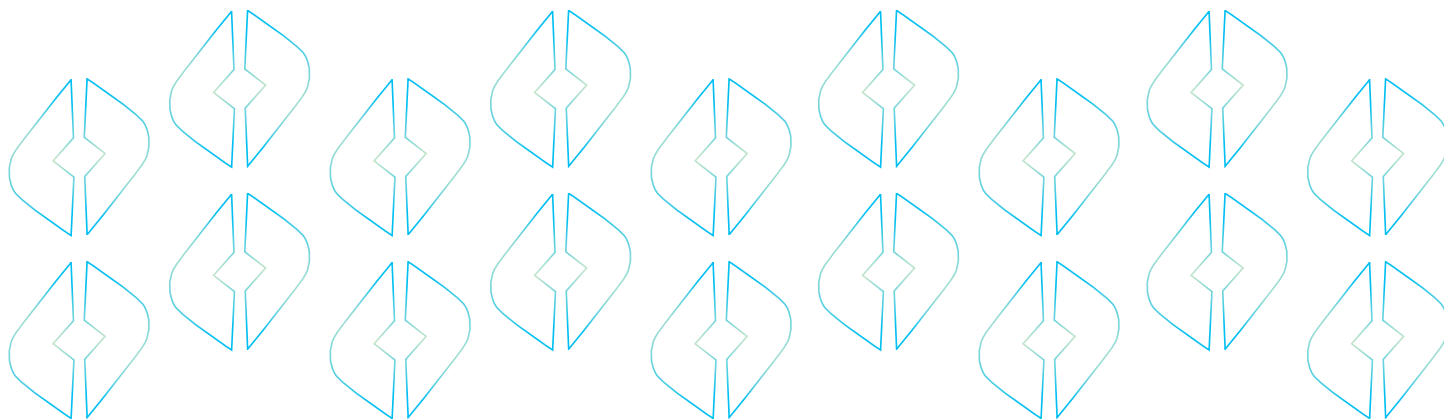# Physician Leadership Interviews Project

FINAL REPORT

November 2017

Prepared for Doctors of BC
by

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Executive Summary

A key area of focus in the first year of implementation of the Divisions of Family Practice Impact Measurement Framework was the Physician Leadership change enabler. This is defined in the framework as "*physician capacity (individual and collective) and ability to motivate and influence others, promote culture change, oversee projects, effectively lead their organization, and participate in system change efforts*".

However, little is known about how physician leadership is manifested in the divisions. As a starting point, a preliminary qualitative investigation of this issue was required. The purpose of the Physician Leadership Interviews Project was to provide insights about the physician leadership experience in the divisions, inform the development of indicators for the Physician Leadership change enabler, and inform the development of future strategies to support effective physician leadership at the provincial and divisional levels.

Twenty semi-structured phone interviews were conducted with physician leaders in 16 divisions, representing urban, semi-urban and rural/remote areas across the province. All the leaders were current or former board members. Half of the interviewees were experienced leaders, and half were leaders who were considered by their nominating divisions as "up-and-coming". Following the interviews, participating physician leaders were invited to participate in one of three webinar workshops to review and validate the findings, and provide feedback. The interviews and validation workshops were conducted between June and November, 2017.

Experienced and up-and-coming leaders typically experienced very different journeys towards physician leadership in the divisions. Several contextual factors explain this difference: maturation of the divisions over time, increased diversity of approaches to family practice within the physician community, and changes in the system back-drop that have resulted from a concentrated period of political attention to primary care reform. Leaders who became involved at or near divisions' inception (roughly between 2009-2013) generally had different motivations, opportunities, challenges, supports and community expectations than those who joined the leadership ranks more recently.

For the experienced physicians group, the motivation to become involved frequently arose from the need to organize the family physician voice in their local area. This group typically described themselves as leaders by accident. By contrast, the up-and-coming group were more likely to be motivated by a desire to help drive the changes that are going to influence the environment for their career, and more typically arrived in a division leadership role by deliberate choice.

Although both groups described having faced a steep learning curve, an analogy that seems to fit the early involvement of the experienced group is being pushed off the high dive platform. Experienced leaders described how they had very little guidance, no precedents and no mentors, and had to start with tasks for which they had no experience at all (e.g. governance tasks). By contrast, the up-and-coming group had considerably more resources to draw from to support their establishment as leaders.

Participation in the General Practice Services Committee (GPSC) Leadership and Management Development Program (referred to by most interviewees as the "SFU course" offered by Simon Fraser University) was identified as a critical milestone in the journey to leadership in the division by nearly half of the interviewees, with several others indicating they wished they had had the opportunity to take it. Several interviewees noted that the course was crucial in solidifying their identity as a physician leader.

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Interviewees described several roles they play as physician leaders for the divisions. Of these, they considered the *Influencer* role to be the most central. Leaders described how their division work is "all about relationships", but that as physician leaders in the divisions, they do not have the power to impose ideas or decisions on anyone. The analogy for the Influencer role was described by more than one interviewee as "herding cats."

Other key roles include *Conduit* (physician leaders acting as a bridge between the physician community and other players involved in the division's work), *Collaborator* (physician leaders being able to work with all the players in the system to work towards a shared vision of change), and *Transformer* (physician leaders transforming concepts, such as *Patient Medical Home* into local-level initiatives that meet community needs). Additional roles are *Negotiator, Advocate, Manager* and *Fixer.*

Interviewees described a range of competencies required to perform effectively as physician leaders. Some of these are best described as attributes: inherent qualities an individual must possess (i.e. can't be learned). The most important of these are having a vision for change, passion for the work, patience (for system change is slow) and a collegial spirit. The most important skill area is related to communication, very broadly defined. The most important knowledge area is understanding the primary care system in BC.

Interviewees noted several strategies that have been effectively employed by the GPSC, provincial office and divisions to overcome barriers to engagement in physician leadership. Provincially, the most important is the payment of sessional fees for family physicians to engage in leadership. In terms of divisional support, the most important seems to be support for physicians to participate in the GPSC Management and Leadership Development Program. Other ways in which divisions support engagement of physicians as leaders include maintaining physician engagement as a focus of existing leaders' work, formal succession planning, informal mentorship, and the ability to use division funds flexibly to enable emerging leaders to follow their passions. Interviewees suggested that a more concerted effort on the part of both divisions and the provincial bodies to encourage residents to engage in leadership would be helpful as a long-term engagement strategy.

Interviewees also noted several strategies that have been effectively employed to overcome barriers to effective physician leadership. At the provincial level, funding for highly qualified and experienced staff, knowledgeable, flexible and responsive Physician Engagement Leads (PELs)[1], flexibility of funded provincial initiatives and regular inter-divisional meetings were thought to be critical supports for physician leader effectiveness. Division-level strategies to support effectiveness include supporting physicians to take the GPSC Program and supporting physicians to attend inter-divisional meetings. Another important strategy is for more experienced physician leaders (including former board members) and the Executive Director to provide informal mentorship, especially in areas where an emerging leader lacks confidence, knowledge or skills. Two considerations for future development are to better leverage the community-of-practice of division physician leaders (particularly the 186 who have now completed the GPSC program) and to develop voluntary structured feedback mechanisms to help physician leaders identify and act on areas for improvement.

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[1] Although the PELs are now called Community Liaison Officers, most physician leaders still referred to them by their former name.

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Background

Over the past 18 months, Doctors of BC, through its Evaluation and Community Partnership and Integration teams, has been working with Divisions of Family Practice to develop a provincial Impact Measurement Framework. The Framework is designed to capture and demonstrate how divisions are making a difference for primary care physicians and, more broadly, the primary care health system. The teams are now working with divisions to develop a meaningful and reasonable set of measures for the framework.
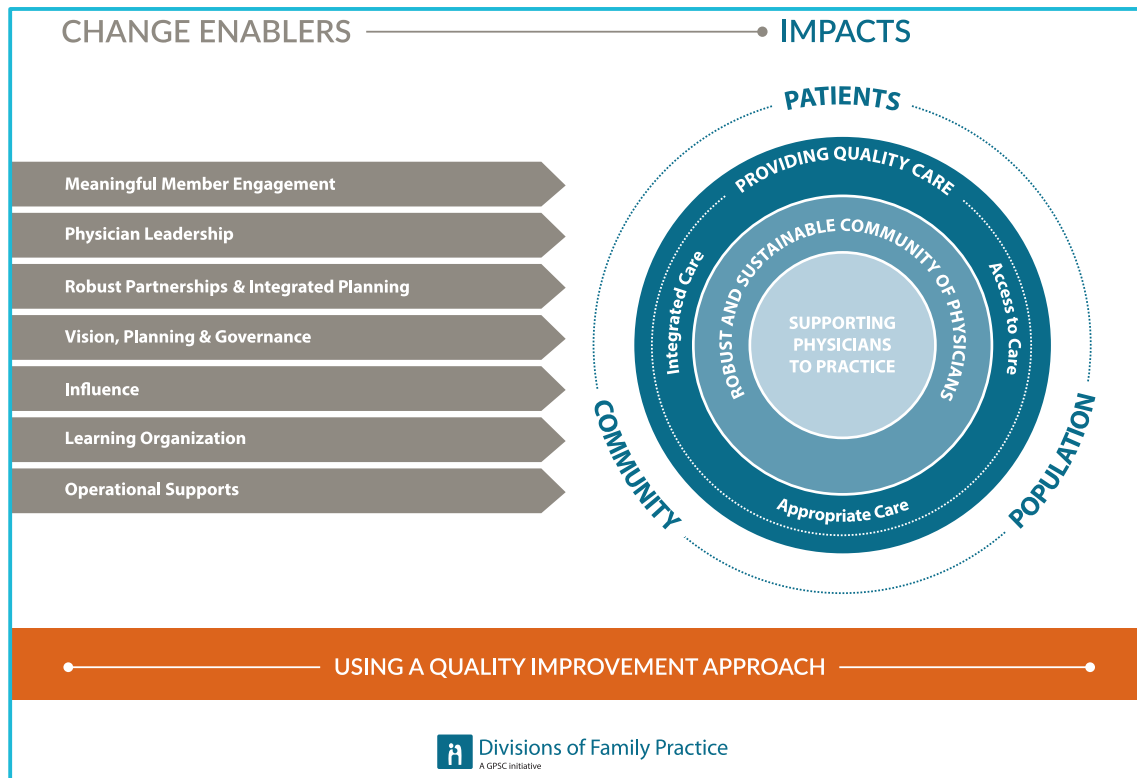

Figure 1: Divisions of Family Practice Impact Measurement Framework.

A key area of focus in the first year of implementation was the Physician Leadership change enabler. This is defined in the framework as "*physician capacity (individual and collective) and ability to motivate and influence others, promote culture change, oversee projects, effectively lead their organization, and participate in system change efforts*".

However, little is known about how physician leadership is manifested in the divisions, how divisions currently support physician leadership, what measures should be used to assess the effectiveness of divisions' support for physician leadership, and what else could be done either at a provincial level or by individual divisions to support more effective physician leadership.

As a starting point, a preliminary qualitative investigation of these issues was required. The purpose of this work was to:

➢ Provide insights about the physician leadership experience in the divisions, including their unique journeys, competencies, participation in division leadership activities and support needs

➢ Inform the development of qualitative and/or qualitative indicators for the Physician Leadership change enabler

➢ Inform the development of future strategies, programs and services to support effective physician leadership at the provincial and divisional level

Twenty semi-structured phone interviews were conducted with physician leaders in 16 divisions. At least two divisions per health authority were represented, and the sample covered urban, semi-urban and rural/remote areas across the province. All the interviewees were current or former board members. Half the interviewees were experienced leaders, and half were leaders who were considered "up-and-coming". Divisions self-selected into the process, and were responsible for nominating appropriate interviewees. Divisions also had flexibility to determine how the parameters for "experienced" and "up-and-coming" were defined.

An interview protocol was developed in consultation with the Evaluation and Community Partnership and Integration teams. Interviews were conducted by phone, and were recorded and transcribed. Interview data were coded and themed using *NVivo II* software. Following the detailed analysis, three workshop webinars were held with physicians who had participated in the interviews to validate the findings.

Findings

WHO IS A PHYSICIAN LEADER IN THE CONTEXT OF DIVISIONS' WORK?

Almost all the "experienced" physician leaders were either current or former Board Chairs or Vice-Chairs, and many were also Co-Chairs of Collaborative Services Committees (CSCs). Most began their engagement with division work at or shortly after their respective division's inception. Experienced leaders were typically very well-established in their community, and several reported starting to think about winding down their involvement in either physician leadership activities or practice or both. Most of the up-and-coming physician leaders were members-at-large of their respective division board, and had joined the division within the past three to four years. Up-and-coming leaders typically reported being either new to the community (e.g. trained out of province or overseas) or newer to practice. There was a mix of male and female leaders within each group.

THE JOURNEY OF PHYSICIAN LEADERSHIP IN THE DIVISIONS

Experienced and up-and-coming leaders typically experienced very different journeys towards physician leadership in the divisions. Several shifting contextual factors explain this difference.

Contextual factors explaining differences in experienced and "up-and-coming" leaders' journeys

Perhaps the most important contextual factor is that divisions have matured since the first divisions were formed, both individually and collectively. When many of the experienced leaders joined, the concept of divisions was still in its infancy and it was unclear how the divisions would take concrete form. There was very little provincial support infrastructure, such as experienced Physician Engagement Leads, and no division-level infrastructure. There was no division-level experience with big projects or funding, and relationships with key players at the regional and provincial level (e.g. health authorities) had yet to be established. There was no track record of division success. By contrast, by the time most up-and-coming leaders started their journey, all these elements were in place, if not locally then at least elsewhere in the province.

There have also been significant changes in family practice and in the community of physicians in family practice that affect experienced and up-and-coming leaders' journeys towards physician leadership in the divisions. Interviewees reported increasing diversity within the family physician community over the past few years. They also reported changes in approaches to family practice, such as the trend towards models of practice other than full service (e.g. serial locums, walk-in clinics, GPs not working in hospitals). Interviewees also reported changes in approach that reflect younger physicians' appreciation of the need for work-life balance, and valuing of team-based care.

Finally, there have been some changes in the "system" back-drop that affect the two groups' journeys. These include a period of concentrated political attention to primary care policy since 2009, which has led to a greater need for collaboration across different parts of the health care system, establishment of relationships between new players in the system (including between the divisions and health authorities), and significant funding for primary care infrastructure and projects.

These contextual shifts affect what motivated experienced and up-and-coming physicians to get involved and stay involved, their learning curve, the nature of the work, and the nature of support available to be effective leaders.
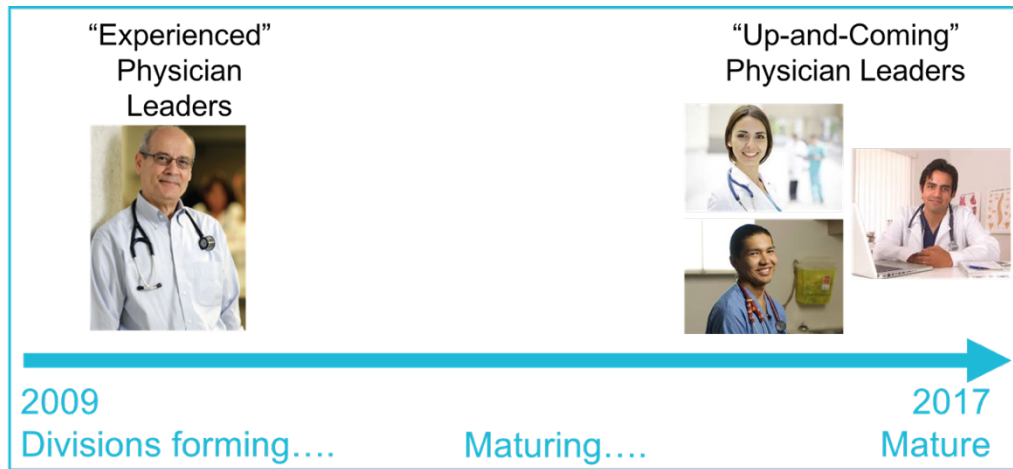

Figure 2: The journeys look quite different for up-and-coming physician leaders compared to experienced physician leaders.

How and why physicians became involved in division leadership

For the experienced physicians group, becoming involved in division leadership was in many cases an extension of their existing leadership role in the community. For example, some experienced physicians reported that a group of family physicians in their area were already self-organizing around one or more issues, and that the possibility of a division provided the means to create some infrastructure for their work. Experienced physicians' motivation for becoming involved frequently arose from the need to organize the physician voice. They talked about their decision to take on a leadership role within the division as coming from a strong sense of responsibility to patients and the profession, and a desire to drive change on their behalf. They typically described themselves as a having arrived in a division leadership position "by default" or "by accident".

We had a group of physicians, kind of a bit of an old guard in the community. We were all male and around 50 and been practising for quite a while in the community. And so, the group of us agreed to participate in starting the division. And then, you know, the first meeting was "Well, someone needs to chair this," and I happened to look up from my papers.

~Experienced Leader

I thought it would be great to be involved in making some of those changes that would ultimately affect me for the rest of my career … initially going in, I was probably just curious, and more so now than ever, I'm curious to know more about what goes on behind the scenes.

~Up-and-Coming Leader

By contrast, the up-and-coming group were more likely to have become involved out of either a desire to address a particular issue in their community, and/or a curiosity to understand the broader system. In either case, a key underlying desire was to help drive the changes that are going to influence the environment for their career. In this way, the up-and-coming group appear to have taken on leadership roles much more deliberately.

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How physicians experienced entry into division leadership

Although both groups described having faced a steep learning curve, an analogy that seems to fit the early involvement of the experienced group is being pushed off the high dive platform. Experienced leaders described how they had very little guidance, no precedents and no mentors, and had to start with tasks for which they had no experience at all (e.g. the legal aspects of setting up a not-for-profit society). The steep learning curve was associated primarily with learning about governance and the operational nuts and bolts of setting up a not-for-profit society, at the same time as trying to understand how the broader health care system worked.

By contrast, the up-and-coming group had considerably more resources to draw from, and were able to gradually assume more responsibility rather than leap straight into a Board Chair role. In most cases, by the time these leaders joined, the business of setting up the division was complete, or if not, there were plenty of models to draw from. Most divisions had had experience with developing and managing major projects, with significant funding (e.g. *A GP for Me*). For example, key relationships with the health authorities had already been established. Finally, up-and-coming leaders described being significantly supported by informal mentors, such as senior board members, former board members or the division's Executive Director. For the up-and-coming group, the steep learning curve was associated with the challenge of understanding the system well enough to feel they could make a meaningful contribution.

Figure 3: Experienced leaders leapt from the high dive platform.

Before the division started, I was asked to chair committees and things like that and I had no idea about what to do or how to manage it. I had to look up Robert's Rules … all kinds of things like that, that I really had no formal training in or understanding of.

~Experienced Leader

It probably took a good two years just to get my feet wet, in spite of having trained here and grown up with a lot of these people and having a reasonable understanding of the history. Even with that, it took me about two years to feel comfortable to speak out at meetings and take on committee memberships.

~Up-and-Coming Leader

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Steps and milestones in the journey

Typically, the experienced group started their division leadership journey by becoming a board member, often in a senior role, such as Chair or Vice-Chair.

The up-and-coming group were more likely to have started their journey by joining a committee or project working group, and then becoming Chair or Lead of a committee or project. In some cases, this group began their involvement by forming a committee or project to address an issue about which they were passionate. Typically, they moved from committee or project work to a role on the board, and then to a senior role on the board. Several who were not yet Board Chair reported that they had been approached or were being groomed for the role in the near future.

Figure 4: Up-and-coming leaders receive support from mentors.

Both groups indicated that division leadership roles are intertwined with regional and provincial roles, and there was a suggestion that there is a natural progression from leadership within the division to regional or even provincial leadership. However, this was not explored in depth in these interviews.

> *The [GPSC] Program … made me feel a little bit more empowered, like I deserved to be in the role of leadership.*
>
> *~Experienced Leader*

Also, although there seems to be a pattern of progression in leadership, it is important to note that it is not always a linear progression. For example, some experienced leaders are planning to step down from Chair positions, but plan to stay involved as committee or project Leads.

Interestingly, participation in the General Practice Services Committee (GPSC) Leadership and Management Development Program (referred to by most interviewees as the "SFU course") was identified as a critical milestone in the journey to leadership in the division by nine of the interviewees. Several others indicated that they wished they had had the opportunity to take the course. In most cases, the course was undertaken when the physician had some division leadership experience under their belt and had just become board member. Interviewees reported that the GPSC Program was instrumental in forging their identity as a physician leader, inspiring them, and giving them the confidence to perform as effective leaders.

The role of the GPSC Program in engaging physicians in leadership, and helping them be more effective, is discussed later in this report.

THE PHYSICIAN LEADER ROLE

Interviewees described several roles they play as physician leaders for the divisions. These roles are shown in Figure 5. As a guide, the size of the circle indicates the relative importance of the role, and the position of the circle indicates how the roles overlap. The light blue signifies the most central role, with which all other roles overlap. The dotted line indicates a tension between three related roles.

Physician leaders described their roles as *Influencers* as being central to all their work for the divisions. Other terms to describe the same function included "motivator" and "energizer". Leaders described how their division work is "all about relationships", but that as physician leaders in the divisions, they do not have the power to impose ideas or decisions on anyone. Other players in the system

Figure 5: Physician Leader Roles in Divisions of Family Practice.

often have more power (e.g. Ministry of Health, health authorities), or need to be convinced to become involved in primary care (e.g. municipalities, physicians in private practice in the community). On the other side, physicians "don't like being told what to do". Influence in this context, in the words of more than one physician, is "like herding cats".

The *Collaborator* role recognizes that to be successful, physician leaders working on behalf of divisions must be able to work with everyone in the system; they must be prepared to "leave [their] biases and expectations at the door", "come to the party", and "be prepared to give and take".

The *Conduit* role is about how physician leaders act as a bridge between the physician community and other players in the system, such as the provincial government, health authorities, hospitals and municipalities. Physician leaders seek out and listen to needs expressed by the physician community and feed these into division decision-making and to system-level conversations (e.g. work of the CSCs). They also perform the reverse function, bringing system-level conversations back to the physician community for discussion and input.

A smaller role related to that of Conduit is the *Advocate* role. This role is about physician leaders acting as advocates for family physicians both at the divisional level, and also at the more conceptual level (e.g. defending the role of family physicians in primary care). The sense in which the term is meant here is not about lobbying, but simply about loyalty to one's members as well as one's roots as a family physician first and foremost.
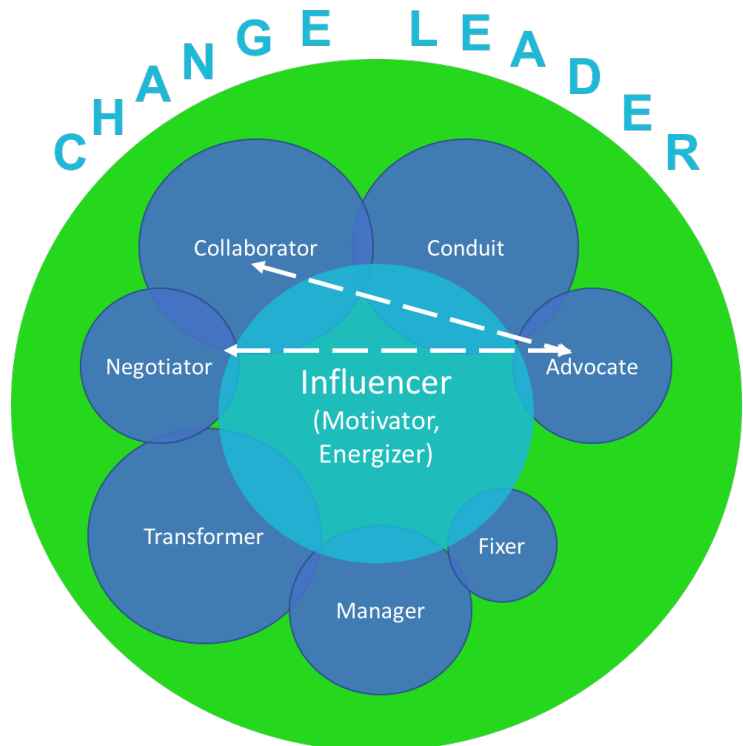
On the other side of the diagram, the **Negotiator** role is closely related to the Collaborator role, but is differentiated by a specific set of associated skills required to mediate (e.g. as Chair of a committee) between parties in situations that often involve tension or conflict. The Negotiator and Collaborator roles are sometimes at odds with the Advocate role, as the physician leader needs to balance between loyalty to their professional community (and being seen as loyal) and the give and take required for successful collaboration and the neutrality required for successful negotiation or mediation. A good example of this tension is where there has been a long and sometimes difficult history between the division and the health authority, but where both parties have reached an understanding of how to work together. In such cases, physician leaders expressed worries about being seen by their members as "selling out", but recognized that advocating too strongly for a certain course of action would damage a hard-won relationship with the health authority.

The **Transformer** role is quite distinct from the roles discussed above. This role is primarily about transforming fuzzy concepts (and funding associated with them) into practical applications. For example, the concept of the *Patient Medical Home* is still evolving, and there are many ways in which it could yet be implemented at the local level. The physician leader's role is to visualize how *Patient Medical Home* needs to look at the local level to meet local needs and work in local conditions, and then be able to drill down in ever more detail towards an initiative or project that actually gets implemented.

The **Manager** role is also quite distinct. This role involves the technical aspects associated with being a project or committee lead or board member. It includes governance, strategic planning, staff oversight and "nuts and bolts" responsibilities such as chairing meetings and writing proposals. Physician Leads were quick to point out that the extent and burden of the Manager role is heavily dependent on the quality of staff, particularly the Executive Director.

Finally, the **Fixer** role relates to physician leaders in the divisions often being the "go to" person when a problem arises. This role seems to be more important for physician leaders who are involved in system work and who often wear multiple leadership hats.

THE DAY-TO-DAY BUSINESS OF PHYSICIAN LEADERSHIP IN THE DIVISIONS

Leadership work in the divisions seems to divide into five streams: physician engagement, local initiatives, system work, operations and *ad hoc*. Naturally, there is a significant amount of overlap between the streams.

Physician engagement is about activities to empower physicians on the ground to be involved in how primary care is going to look in their communities. For a physician leader, it means meetings and events that get local physicians engaged in work that the division is doing on their behalf, get local physicians on board with system change that is coming down from the Ministry of Health or the health authorities, or gather local physicians' input on key issues. The most relevant roles here are Influencer and Conduit.

The ***local initiatives*** stream involves work on division projects, working groups or sub-committees. The work often involves taking a concept that comes from elsewhere in the system, and figuring out how to apply it locally (e.g. *A GP for Me* local initiatives, *Patient Medical Home*). Local initiatives work can also involve taking an idea arising from community needs and shaping it into something that is fundable and implementable. The most relevant roles here are Transformer and Influencer.

A third stream of day-to-day business is **system work**. This work is more outward facing than other streams (i.e. outside the local area). System work involves planning, convening and leading activity with diverse stakeholders, aimed at addressing complex issues in the primary health care system. Leaders involved in such work often represent the division at provincial round-tables (e.g. GPSC) and the CSC. The most relevant roles here are Influencer, Collaborator, Negotiator and Advocate.

The fourth area of day-to-day business is **operations.** This work is primarily inward facing (i.e. within the Division), and involves all the daily business associated with the Manager role. This includes, for example, providing day-to-day decision support for division staff, particularly the Executive Director, planning, preparing documents for, attending and chairing board meetings, managing projects and budgets, and working on governance-related projects. For many in the experienced group, operations work is at present focused on making internal processes more efficient; as the divisions have matured, needs have evolved and there is a recognition that the original governance arrangements may no longer fit. Physician leaders in the experienced group also reported that they are investing significant time and attention to succession planning, recognizing that there is a need for "new blood" and for leadership to reflect the diversity of the physician community and new approaches to being a family physician.

A final area of day-to-day business is **ad hoc** and unplanned work, which may overlap with any of the above categories. This relates in large part to the Fixer role, and includes trouble-shooting, dealing with email correspondence, "hallway conversations" (and work arising from these) and responding to urgent requests for input on emerging issues. Physician leaders reported that this unplanned work often seems to add far more to the stress and workload than it should.

Figure 6: Impact of ad hoc work.

Physician leaders' specific roles affect where they spend the bulk of their time in terms of the day-to-day business of leadership in the divisions.

COMPETENCIES NEEDED TO BE AN EFFECTIVE PHYSICIAN LEADER IN THE DIVISIONS

In the interviews, physician leaders used many terms related to competencies interchangeably. These included attributes, knowledge, skills, attitudes and behaviours. It is beyond the scope of this report to define and categorize these in great depth. The following discussion is intended to provide some direction for further investigation.

Attributes

Attributes are inherent characteristics or qualities. Physician leaders expressed doubt as to whether these could be learned or taught. However, attributes are nonetheless important to the discussion about effective physician leadership, because they tell us what we should be looking for in a potential leader, as well as who is more likely to succeed.

> *If I've learned anything over time, it's that if people want to do something, they can usually figure out a way. And if they don't want to do it, it will never happen. So the desire and interest [to be involved] is at least 70 percent of it. And then the 30 percent is stuff you can teach.*
> *~Experienced Leader*

The following attributes were consistently identified by physician leaders as being critical to effectiveness. Of these, having a passion for the division's mandate and the specific work they are doing as physician leaders emerged as the most important.

Several other key attributes emerged from the interviews, presented in descending order of importance:

➢ **Vision for change**: the capacity to imagine a more effective system for the delivery of primary care.

➢ **Patience** and **Perseverance:** willingness and capacity to play a long-term game to get to the end-goal, recognizing that change is slow in complex systems.

➢ **Collegial spirit:** openness to others' ideas and to working collaboratively towards a collective vision and goals.

➢ **Personal accountability**: a high desire to contribute to system change, and capacity to follow through on commitments.

➢ **Comfort with complexity:** a level of tolerance for the uncertainties and ambiguities involved in system change.

➢ **Comfort with change**: capacity to embrace, or at least adapt to change.

It is critical to note that attributes are quite separate from knowledge and skills. The implication of this is that potential leaders can be identified early in their careers (i.e. in medical school or residency) and can be groomed for leadership (see section, "Other strategies to consider for supporting engagement of physician leaders").

Knowledge and skills

Typically, knowledge and skills can be learned, although some physician leaders felt that in some cases they cannot be taught. Knowledge and skills that physician leaders identified as being critical to their effectiveness as leaders fall into four key categories.

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➢ **Self-awareness** is about having the knowledge and skills to understand and regularly reflect on one's own leadership style, practices, successes and failures, and have the ability to adjust. Interviewees reported that this was a significant and extremely useful focus of the graduate-level physician leadership courses they had undertaken (either GPSC Leadership and Management Development Program at SFU or Physician Leadership Program at the University of British Columbia).

➢ **Communication** admittedly encompasses an enormous "basket" of knowledge and skills. However, communication was the first word that came to mind for nearly all the leaders interviewed, when asked about competencies required for effective leadership, as it is central to every role. Most of the elements that were raised under the heading of communication were expressed as skill requirements. The list below is not by any means exhaustive: it represents those skills that were mentioned most frequently in the interviews. Specific communication skills included:

- Empathy and listening skills
  - Ability to understand others' perspectives, needs, concerns, styles
  - Ability to glean and flesh out the views of others
  - Ability to "park" one's own view and fairly represent others' views; some leaders expressed this as not using the leadership role as an opportunity to stand on one's soapbox
  - Ability to encourage and model respectful communication
- Influencing skills
  - Ability to engage with a wide range of people and interests
  - Ability to motivate and energize
  - Ability to develop and sell a shared vision
  - Ability to build consensus
  - Skills in public speaking
  - Skills in dealing with the media
- Articulation skills
  - Ability to articulate an argument framed for the audience
  - Ability to parse complex concepts into simpler language

I think I'm a listener, I do listen to what people are saying. And I'm also prepared to change my mind and not have an opinion. I think that's very important. As a leader, you have to recognize when you're not right, and you can change.

~Experienced Leader

I feel like communication is a strong point of mine, just in terms of respectful communication and trying to make sure that I've disseminated the information in a clear way. But also in terms of managing very different personalities and different viewpoints, and trying to keep that all respectful and civil and trying to come to some sort of working agreement, which has definitely been an issue here in the past.

~Up-and-Coming Leader

One skill that is tough for a lot of leaders, and myself definitely included, would be motivating or engaging other members to change what they're doing. How do you really engage somebody and get them involved with whatever you're doing and keep them involved, and kind of guide them or convince them to help you?

~Up-and-Coming Leader

- Conflict management skills
    - Ability to anticipate and take steps to defuse potential conflict situations
    - Ability to manage conflict (individually and in group settings)

➢ **Management** is about the skills and knowledge needed to effectively perform in the Manager role, and perform the day-to-day business of operations. Physician leaders were quick to note that competencies required in this area are affected by the quality of a division's staff, and particularly the quality of the Executive Director. In this category, the most common skills and knowledge mentioned by interviewees were:

- Knowledge of good practice in governance
- Knowledge and skills to effectively plan and lead visioning and strategic planning at the organizational and project level
- Ability to provide effective financial oversight (e.g. read, interpret and provide feedback on financial statements and budgets)
- Knowledge of good practice in hiring, firing and managing staff

➢ **Primary care systems** is about understanding how change happens in complex systems, and having the skills to then contribute to systems change. This knowledge and skill area is vital to the Transformer, Negotiator and Influencer roles. Although the competency areas listed below are expressed in general terms, interviews with physician leaders strongly indicated that understanding the health authorities and how to influence them was one of the most critical and difficult knowledge and skill areas to master. It is also important to note that in this category, knowledge is clearly a precursor to skills. The most common elements mentioned by interviewees were:

- System knowledge
    - Understand how change happens in complex systems
    - Understand who the players are in the primary care system (e.g. committees, organizations, units, roles, people) and their acronyms

    I would say there is a steep learning curve. Even understanding the nuances of what exactly is a CSC, and what are all the different acronyms and how does everybody play a role.
    ~Up-and-Coming Leader

    - Understand the key primary care initiatives, locally, regionally and provincially, in terms of their names (including acronyms), goals, objectives, parameters, and applications in practice
    - Understand how the players and elements fit together to deliver primary care locally, regionally and provincially
    - Understand key players' organizational decision-making structures and processes
    - Understand the history of key relationships between the local and regional parties involved in delivery of primary care (including the history of the relationship between the division and its stakeholders)
    - Understand the division's role in the system

- System skills
  - Ability to shape proposals (written and verbal) to align with structures and decision-making processes of key partners and stakeholders
  - Ability to identify a gap in the system and visualize a solution
  - Ability to visualize intended and unintended consequences (at the local, regional and provincial level) of primary care change initiatives
  - Ability to translate primary care change concepts into concrete applications that fulfil local needs and that are locally implementable

> *When you attend the meetings, sometimes listening to the presentation, it's all very higher level, theoretical kind of stuff, right? And at the end of it, you're sitting there going, okay, so what is it that we're actually doing?*
>
> ~Up-and-Coming Leader

It is critical to note that individual physician leaders could not be expected to be highly proficient in all these competency areas, and indeed, setting such high expectations for the competencies required to be an effective leader would likely be counter-productive. However, identification of competency areas may help individual physicians to identify where they have gaps, as well as to help boards identify where their collective leadership may have gaps that need to be addressed.

SUPPORTING ENGAGEMENT IN PHYSICIAN LEADERSHIP IN THE DIVISIONS

Interviewees identified several barriers to engagement of physicians as leaders in the divisions, as well as strategies that have proven useful in overcoming these barriers.

Key barriers to engagement of physicians as leaders

Not surprisingly, the biggest barrier to engagement of other physicians as leaders was thought to be **time**. This appeared to be particularly the case for younger physicians, whose time barriers included the need to concentrate on establishing themselves as new practitioners, young families, and different expectations of work-life balance than older physicians.

Interviewees mentioned that **cynicism or a sense of disempowerment** may be another barrier, noting that some family physicians continue to question whether the "system" really values what they think.

> *Physicians are a challenging group. They tend to be pretty opinionated, tend to be perpetually over-taxed and busy and stretched, and anything that you want to engage them with is initially met with "This is another ask" and another reason to put up the hand and say, "Not interested. I'm too busy. I don't have any resources left, nothing left in my tank for anything more."*
>
> ~Experienced Leader

A third key barrier may be **lack of confidence**. Interviewees noted that although many of the core skills required to be an effective physician leader are part and parcel of their everyday practice as family physicians (particularly the communication skills), some potential leaders may feel daunted by the challenges of trying to effect system change, and feel that medical school and residency has not prepared them for these types of leadership roles.

> *We're trained in medicine, and we're not really trained in how to be a leader. And a lot of doctors, myself included, find it difficult to take a leadership role for that reason. We're not used to that role.*
>
> *~Up-and-Coming Leader*

Finally, amongst some current physician leaders there was a sense of feeling **overwhelmed and burned out** by the volume and constancy of the work. In this respect, it seems that divisions have to some extent been victims of their own success: the more they are doing, the more they are being asked to do, and the more is required of their physician leaders. Some experienced physicians also reported feeling burned out by their inability to progress a particular initiative or system change over a long period of time.

Useful strategies to overcome engagement barriers

Interviewees noted several strategies that have been effectively employed by the GPSC, provincial office and divisions to overcome engagement barriers.

At the provincial level, interviewees indicated that the most important engagement facilitator was the **payment of sessional fees** for physicians to participate in leadership activities. For several, the symbolic message of their time being valued was as important as the actual compensation. Some concerns were raised about the implication of changes to the Societies Act that may prevent some of the most committed physician leaders from being paid for their time.

In terms of division support for engagement of physicians as leaders, by far the most important appeared to be **support for physicians to participate in the GPSC Management and Leadership Development Program**. As noted earlier, this was noted by many as a key milestone in the journey towards self-identification as a physician leader. From an engagement point of view, three critical aspects appeared to be the recognition of joining a community of practice, the inspiration gained from that community of practice, and the gains in confidence that come from undertaking the course.

Other ways in which divisions support engagement of physicians as leaders include:

➢ **Physician engagement as a focus of existing leaders' work**. Being visible in the physician community as a leader (i.e. role model), promotion of the division's successes and provision of constant opportunities to become involved at any level, appear to be critical elements of this.

➢ **Formal succession planning**. As noted earlier, the focus of some operational work in the divisions is to ensure that the next generation of leaders is identified and groomed for leadership. Importantly, there appears to be a focus on increasing the diversity of leadership to better reflect the physician community.

➢ **Informal mentorship**. Experienced physician leaders, along with experienced Executive Directors and past board members, are providing responsive, "just-in-time" mentorship for potential leaders that seems to be encouraging them to step up to leadership positions.

➢ **Flexible use of division funds**. Finally, divisions are being flexible in use of funds to allow potential leaders who express an interest in a particular issue to follow their passion (i.e. fund projects that will have a new physician champion).

Other strategies to consider for supporting engagement of physician leaders

The only other engagement strategy that emerged for consideration is a more concerted effort on the part of both divisions and the provincial bodies to encourage residents to engage and build skills in systems leadership. Specific suggestions included working with the UBC medical school to develop and implement curricula for systems leadership, exploring financial incentivization for residents to participate in division activities and leadership roles, supporting events aimed at residents, and including residents in formal succession planning efforts.

SUPPORTING EFFECTIVENESS OF PHYSICIAN LEADERSHIP IN THE DIVISIONS

Interviewees identified several barriers to effective physician leadership in the divisions, as well as strategies that have proven useful or could be useful in overcoming these barriers.

Key barriers to effectiveness of physician leadership

Interviewees noted that one of the key barriers to effectiveness is that not having enough time to dedicate to leadership activities. As noted earlier, as divisions have matured, the amount of work to be done by physician leaders has correspondingly increased. One physician leader noted that it is very difficult to say "no", both individually and for the division, when there are so many activities that could benefit from division and physician leader involvement.

Another time-related barrier is that physicians find it difficult to attend formal leadership training (e.g. the GPSC Program). This seems to be particularly the case for physicians in more isolated parts of the province, who must allow a full day for travel to and from a major centre and/or live in places where flights are frequently cancelled due to bad weather. Attending training is also difficult for physicians who live in small, isolated communities where it is difficult to arrange a locum.

Physician leaders also identified some skill deficiencies that impinged on their effectiveness. These relate primarily to the Influencer, Negotiator and Transformer roles, and include:

➢ **Difficulties understanding and "navigating" the system**. Although interviewees raised this as a general issue at first, through further discussion, it emerged that most of the difficulties lay in understanding and navigating the relationship with the regional health authority. Specific challenges are all those noted in section "Knowledge and Skills – Primary Care Systems", above.

➢ **Influencing the influencers in powerful organizations.** This too emerged as an issue that relates primarily to the division and physician leader's relationship with the health authority.

> *Managing conflict.*

> *Motivating peers.*

> *Transforming nebulous concepts into practical applications.*

Useful strategies to overcome effectiveness barriers

Interviewees noted several strategies that have been effectively employed by the GPSC, provincial office and divisions to overcome effectiveness barriers.

At the provincial level, *funding for highly qualified and experienced division staff* was thought to be critical. Many indicated that they would not be able to do their jobs as leaders if not for the excellent support they received from staff. They particularly valued the business acumen of their Executive Directors.

Physician Engagement Leads (PELs)[2] have also been extremely helpful when they are knowledgeable about the division's unique needs and the provincial landscape, and are flexible, and responsive to individual divisions' needs. It was noted that the continuity of individuals in these roles has been a challenge at times, and lack of continuity significantly undermines their ability to effectively support physician leaders.

Physician leaders also identified that the *flexibility of funded provincial initiatives* has also been a factor in their effectiveness. The ability to shape an initiative to meet the needs and constraints of the local community helps physician leaders gain traction for the initiatives.

Finally, *inter-divisional meetings* provide an essential forum for physician leaders to engage with their peers, share concerns and exchange ideas about how to address key challenges or transform fuzzy concepts into practical applications. The networking value of these meetings should not be under-estimated. Leaders who had been through the SFU course found it particularly valuable to re-connect with others from their cohort or others who had been through the course themselves, as they share a common framework and language for thinking about system change. It is also important to note that regional inter-divisional meetings are in

Staff leadership is critical … his [Executive Director] training is in leadership and change management, he's a business person, that's his skill set. So we are a bunch of people who have ideas, this is what we want to do, how do we do it? And he comes back to us with ideas about how we can facilitate something that moves ahead. That's really important.

~Experienced Leader

A lot of the stuff that comes through divisions doesn't have a really strict template to it. It is nice that you're able to sort of adjust it for what's actually needed in your community.

~Up-and-Coming Leader

We do Island-wide Division CSC [Collaborative Services Committee] meetings at least bi-annually. And that is an opportunity to share, to network, to give feedback and get feedback from leaders of other divisions on the Island. That's been very valuable.

~Experienced Leader

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[2] Although the PELs are now called Community Liaison Officers, most physician leaders still referred to them by their former name.

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some ways more valuable than provincial ones, as there is more overlap in terms of the players involved in the system (e.g. a common health authority) and the issues they are dealing with.

In terms of division support for physician leader effectiveness, supporting physicians to take the GPSC Program emerged as the most critical (i.e. it was perceived as equally valuable for engagement and effectiveness).

Mirroring the provincial strategy, division support for physicians to attend inter-divisional meetings also was important.

> *It was a great opportunity to network and really gain from each other's successes and failures. As much as the formal didactic and interactions stuff was helpful, I think the community of like-minded people struggling with the same issues around engagement and change management, that was very useful.*
>
> *~Experienced Leader*

Another third strategy is for more experienced physician leaders (including former board members) and the Executive Director to provide mentorship, especially in areas where an emerging leader lacks confidence, knowledge or skills. Effective mentorship was described by interviewees as informal, responsive, and provided on an "as needed" basis.

GPSC Leadership and Management Development Program

Figure 7: The GPSC Leadership and Management Development Program strongly supports physician leadership engagement and effectiveness in the Divisions of Family Practice.

Finally, some interviewees reported that their effectiveness was significantly helped by having access to flexible, responsive support from within the division. This included, for example, organizing and funding targeted board training, as well as using staff or paid facilitators to address board leaders' skill gaps (e.g. conflict management, project management). The latter is appreciated as it can take the pressure off physician leaders who are aware they have a skill gap but do not have the time or interest in developing that particular skill to the level required. It also allows physician leaders to use their best skills rather than skills they don't enjoy using, which is helpful for sustained engagement.

Other strategies to consider for supporting effective physician leadership

Three other potential strategies for supporting effective physician leadership emerged from the interviews.

> ➢ ***Leveraging the community-of-practice of Division physician leaders.*** Interviewees who had participated in the SFU course highlighted that the networking value of the course was at least equally, if not more valuable than the content. Several suggested that there has been a missed opportunity to build on the community-of-practice through networking events or refresher courses. However, it would be risky and potentially counter-productive to limit such

> *I'm kind of sorry that after the [SFU] course, there was no real follow up. I think that, you know, we're engaging in huge change now with the Patient Medical Homes. It's going to go across the province and some re-training in change management theory and things like that would be useful.*
>
> *~Experienced Leader*

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networking events to just those who had participated in the SFU course (e.g. disempowering those who have not been able to take the course, but would benefit from being part of a community-of-practice). The opportunity could be characterized as "networking events with a learning purpose". Interviewees indicated that it almost does not matter what the topic area is (i.e. for the learning purpose), although learning that can be applied to the Influencer, Negotiator and Transformer roles were thought to be particularly useful. If there is a speaker, it could be an external "expert" but interviewees stressed that opportunities to learn from other division physician leaders would be valued. Either way, the event should allow time for structured conversation in which leaders discuss how to apply the topic content to current projects, as well as plenty of time for unstructured networking. Although interviewees recognized the value of face-to-face networking opportunities, they also recognized that time and costs are often prohibitive unless the event is anchored to an existing meeting involving multiple divisions. There was some interest in exploring the use of interactive online forums (e.g. small group webinars) for this purpose. Sessional fees would likely need to be provided to incentivize participation.

> *Developing physician leadership assessment and feedback mechanisms.* When interviewees were asked how they would assess if they were being effective as physician leaders, it emerged that almost none had had structured feedback to help them be more effective, and several had not had any feedback at all. Interviewees were keen to obtain and use feedback, but stressed that a feedback structure should not be imposed from above, onerous for the division, or off-putting for physician leaders. A competency framework that could be used for physician leaders to self-assess, or to request 360-degree feedback, could be useful.

One thing I'm definitely missing is feedback, in terms of how people feel that I'm doing, what things aren't going well, what things are going well. My tendency is to think that I'm doing everything terribly and I don't mind hearing things that I'm doing poorly. But sometimes, it's also good to hear the things that might be going okay. So I think that would be really helpful.

~Up-and-Coming Leader

> *"Just in time" virtual learning for selected topics.* There was very little consensus among interviewees as to specific topic areas for which additional training and resources would be useful. There was some interest in additional online resources related to:

- Understanding the primary care system in BC (see previous section "Key barriers to effectiveness of physician Leadership")
- Conflict management
- Reading and interpreting financial statements

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MEASURING PHYSICIAN LEADERSHIP IN THE DIVISIONS

Interviewees were challenged to identify ways in which the physician leadership change enabler could be measured. However, the interviews suggested there are two key evaluation questions:

➢ To what extent are we growing the pool of physician leaders? (engagement)

➢ To what extent are physician leaders effective? (effectiveness)

Measuring engagement of physician leaders

It is important to stress at the outset that it will be important to have a variety of measures to build a picture of engagement, supplemented by qualitative reporting. Reliance on a small number of metrics (i.e. quantitative measures) poses risks of misinterpretation.

The first task for measurement of engagement is to define who is a leader in the context of divisions. The process of recruitment of physician leaders for this project (i.e. division-defined) suggests that a physician leader in the division must be either a board member or Chair / Lead of a project, sub-committee or working group. The indicator here would be **number of current physician leaders**.

The interviews suggest it is important to differentiate between established leaders (e.g. in leadership roles for five or more years) and emerging leaders (e.g. in leadership roles for four or less years). The indicator here would be **number of established leaders** and **number of emerging leaders.**

Interviews suggest we should also be monitoring the **number of potential physician leaders**. This would be more challenging to define, but could be based on participation in a committee, project or working group, possessing the attributes listed earlier in this report, and / or whether potential physician leaders have been targeted through succession planning.

Vacancy, retention and turnover rates form another dimension of engagement. Indicators here could include:

➢ **Number and percentage of physician leadership roles that are filled.** Careful interpretation would be needed here, as some roles may only be created or retained if there are individuals to fill them.

➢ **Percentage of physician leadership roles that turn over.** Again, careful interpretation would be needed, as turnover can be both positive and negative.

➢ **Percentage of physician leaders who continue in a leadership role after their initial term ends** (i.e. stand for a second term).

Engagement of new leaders is also important to measure. An indicator for this could be **number of non-leaders newly appointed to leadership roles.** It would be important to measure this in conjunction with figures about turnover and retention. Interviewees suggested that there is likely a "sweet spot" between continuing to engage experienced leaders, and ensuring there is "new blood" in leadership

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roles. Another way to do this would be to monitor and report on the _median_[3] _and mode number of years physician leaders have been engaged as (a) board members, and (b) other leaders._

Interviews suggest that it is also important to measure whether the physician leadership reflects the local physician community. Two potential indicators here would be:

➢ _Number and percentage of the family physician community engaged as physician leaders in the Divisions._

➢ _Representation of key physician community demographics in division leadership roles_ (e.g. ethnicity, age groups, gender, new-to-practice, new-to-community).

Another dimension to measure is progression. This includes progression within the division, but also progression to leadership roles outside the division; interviewees reported that roles in the division often act as stepping stones to regional and provincial leadership roles, and felt that this should be considered a positive impact of the division's work. Indicators could include _number of leaders who have progressed into more senior leadership roles,_ and _types of leadership roles outside the division._ Some work would be required to define a ladder of progression, but could include, as a starting point, progression from committee / project lead, to board member, to Board Chair.

Another area suggested by the interviews is to monitor participation in the GPSC Physician Leadership and Management Development Program or UBC Sauder School of Business Physician Leadership Program, and monitor graduates' progress as leaders, as signs of engagement. Indicators could be _number of individuals who have completed the GPSC or UBC Program, number and percentage of graduates (from each Division) in leadership roles_, and _at what level_ an individual has progressed (see previous paragraph).

Finally, interviewees felt that physician leader satisfaction is a critical indicator of engagement. Multiple indicators are possible here, but an over-arching one could be _percentage of physician leaders who are satisfied or very satisfied in their role as a physician leader in the division_ (e.g. Likert-type scale).

Measuring effectiveness of physician leaders

Interviewees found it extremely difficult to identify ways in which physician leadership effectiveness could be measured. A key issue is that it is difficult to isolate effective physician leadership from the overall effectiveness of the division.

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[3] Mean is not suggested, as the figure could be skewed by a small number of people who may have been in leadership roles since Divisions' inception.

Some potential areas for consideration include:

➢ *The number of physician leaders who complete the SFU or UBC physician leadership training programs*, and *number and percentage of graduates (from each division) in leadership roles*, and at *what level* (as above, "Measuring engagement of physician leaders"). The rationale for this is that these courses are viewed as supporting physicians to be effective.

➢ *The number of leaders who have progressed into more senior leadership roles* (as per engagement) could also be an indicator of effectiveness. A caveat to this is that election to more senior roles could simply reflect an absence of more effective or qualified leaders prepared to take on the roles.

➢ *Physician community and key stakeholder satisfaction with division leadership* could also be an indicator of effectiveness.

It is perhaps more valuable at this stage to consider different approaches to measuring physician leadership effectiveness. One way to do this would be to firstly measure the division's impact in key areas (as per the Impact Measurement Framework), identify specific areas or projects where impact has been either strongest or weakest, and then qualitatively explore the role that physician leadership (as distinct from other factors) contributed to those impacts. The measurement strategy would focus on establishing contribution by exploring the counter-factual (e.g. for any division outcome, what was the contribution of physician leadership – or lack thereof – to that outcome? What would have happened in the absence of physician leadership?). This measurement strategy would have the added benefit of generating learnings about the role of physician leadership, and how it can be strengthened to enable change.

Implications

Upon reviewing this report, the Community Partnership and Integration Team met to discuss its implications. The points that follow summarize the key themes from this discussion.

➢ This research report needs to be "given life" by creating opportunities for presentation and discussion with different groups of stakeholders both internally and externally. There is an opportunity to engage physician leaders in further discussion of the implications.

➢ The findings of this research should be used to inform the next round of implementation of the Impact Measurement Framework.

➢ There is a need and opportunity to explore how residents could be encouraged to begin the physician leadership journey early in their career, as many of the qualities required to become an effective leader are attributes (i.e. inherent qualities) rather than acquired knowledge or skills. Additionally, it was recognized that residents may bring valuable and unique perspectives, knowledge and skills of their own to the leadership table.

➢ There was some interest in using the research findings (particularly the roles and competencies) as a foundation for developing a physician leadership competency framework that could be used as a structure for voluntary self-reflection, self-assessment or feedback. However, the consensus was that further developmental work is first required to understand the nuances (the "art") of effective leadership. One key area for exploration is how the diversity and strength of physician leaders' relationships (both at the individual and divisional level) contribute to effectiveness.

➢ There was some interest in developing tools or processes to help with orientation of new physician leaders, particularly to accelerate their understanding and ability to navigate the health system in their new role.

➢ There was some interest in developing a webinar series to engage the physician leader community-of-practice. The webinars would be in the form of small group, informal "hosted conversations", facilitated by physician leaders, to encourage sharing of practice and experience on leadership topics. Physician leaders could present a scenario or issue they are wrestling with or have successfully overcome, and engage the group in discussion about effective strategies.

➢ There was consensus that it is too early to develop quantitative indicators to measure physician leadership effectiveness. Qualitative exploration of this dimension of physician leadership is required. After an initial period of qualitative measurement, it may be possible to develop quantitative measures in addition to qualitative measures.

➢ Case studies may be an appropriate and powerful means of exploring and reporting on effective physician leadership.