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LEADERSHIP AND FRONT-LINE CLINICIANS

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ABSTRACT

Contemporary health care systems face increasing strain due to a variety of factors, including the growing need for care and its associated rising costs. This has motivated extensive and ongoing efforts to reform health care. The pressure to reform the health care system has led to the pursuit of new, more effective models of health care delivery. Unfortunately, these new models do not perform to their full potentials. If these new models are to achieve their intended outcomes, it will require leadership from the front-line clinicians who primarily work in patient care. Although these front-line clinicians may not see themselves as leaders and may not even have much interest in leading, their leadership is nonetheless crucial for successful health care reform. This paper examines how a physician or other clinician can exercise leadership in health care even without having a formal leadership title or role.

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INTRODUCTION

Opportunities for Leadership

Within the clinical microsystem, front-line clinicians, in particular physicians, can exercise leadership, even without the assignment of formal leadership titles or roles. It is this opportunity for leadership that formulates an important layer within the health care system that includes a group of professionals working together to serve a patient population (Spaline, 2011). The reason why this is possible is that leadership is best understood not as a position, but as an action (Open School, 2016). Any person who can take the actions that define leadership in a given context has the opportunity to be classified as a leader. In health care, front-line clinicians can be the most important leaders when it comes to successfully implementing change. One noteworthy perspective on this matter comes from the steelworker and union leader Joseph Scanlon, "who believed that the workers closest to problems were the ones most likely to identify them; find practical solutions; and, if empowered, drive these solutions through completion" (Hamid). It is true that in some cases, opportunities for leading major change within a health care organization require working with administrators and possibly combating the fears that create obstacles to real change (Hamid). This is the kind of leadership that some front-line clinicians are hesitant to exercise because the difficulty and commitment required may seem to distract them from their focus on patient care. Even physicians who prefer to stay focused on patient care can exercise leadership within the group of professionals who make up their clinical microsystem.

Exercising Leadership

Effectively exercising leadership within the clinical microsystem involves four key tasks. The first and most important of these tasks is to establish a shared goal for the group of health professionals within the microsystem. This shared goal helps to define the common purpose of the group. The second of the tasks is establishing the conditions that make it possible for the microsystem to achieve its shared goal. This typically requires striking a balance between patient-centered care and evidence-based medicine. The third task for a front-line physician leader involves monitoring performance. Clinical microsystems are complex, and therefore require careful monitoring and control to maintain quality, efficiency, and safety. Finally, a front-line physician leader must contend with the task of improving performance. The monitored tasks provide the feedback that reflects efforts

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to improve performance. A physician leader must also develop and implement clinical changes in response to this feedback (Bohmer). Physicians who carry out these four tasks are exercising leadership in a way that ultimately benefits the quality of patient care. Improvements to the quality of care are often accompanied by improvements in the efficiency of care, which ultimately reduces the rate of errors and re-admissions of patients to hospitals. These improvements are paramount to controlling costs and improving care from not only the business perspective but also the patient's perspective.

Leadership in Action

Physicians are in a particularly unique position to put health care leadership into action, as their roles in making diagnoses and formulating treatment plans are vital in health care delivery. This lends an opportunity to lead, "very little happens in the health care system without a physician's order. By virtue of physicians' plenary legal authority . . . almost all actions in health care are derivative of their decisions and recommendations" (Reinertsen et al. pg. 2). One example of how front-line physicians can put leadership into action is in the context of preventing central line-associated bloodstream infections (CLABSI). The Institute for Healthcare Improvement recommends using a tool known as the Model for Improvement. This two-part model first involves addressing three guiding questions: 1) how to set the aims for the team that is tasked with preventing CLABSI, 2) how to develop monitoring measurements to determine whether outcomes are improving, and 3) how to identify what changes are most likely to bring about improvements. The second part of the model involves implementing a Plan-Do-Study-Act Cycle. This is a scientific approach to carrying out small-scale tests of change to achieve gradual, yet significant improvements in outcomes (Institute for Healthcare Improvement). This model closely resembles Bohmer's list of leadership tasks (Bohmer). Front-line physicians who implement this Model for Improvement are putting leadership into action even if they lack the formal leadership titles held by those in managerial and administrative roles. Physicians leading in this way have the potential to significantly improve the quality and safety of care by reducing the mortality and morbidity associated with the prevalence of CLABSI. This model for improvement can be extended to other aspects of patient care.

Conclusion

Front-line clinicians have the opportunity to act as leaders who drive significant improvements in the quality and efficiency of patient care. Because of physicians' licensing that allows them the opportunity to make diagnoses and formulate treatment plans, physicians are unique to this role. Given the increasing pressures that are imposed on contemporary health care systems, it is critical that physicians take on the responsibility of leadership even if they are not designated a formal leadership role. Without this physician leadership, new models of health care delivery may never achieve their full, intended potential. Physicians can help in the delivery of the intended benefits of health care reform by defining shared goals within their clinical microsystems, creating conditions that allow the goals to be reached, monitoring, and implementing the necessary changes needed to obtain desired outcomes. This is the essence of health care leadership.

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