MEDICAL LEADERSHIP MONOGRAPH
AN ONLINE SERIES BY THE MEDICAL LEADERSHIP INSTITUTE

Three Essential Skills for Today's Physician Leaders

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MEDICAL LEADERSHIP MONOGRAPHS

A Medical Leadership Institute Online Series

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Background and Context

As is so often said today, there is a healthcare "crisis." I find frequently that speakers or writers use the word "crisis" in the sense of a long-standing, seemingly intractable problem. From our medical perspective, we know that the original meaning of "crisis" is a "turning point"—where there can be a sudden change for the better or for the worse in the patient's condition.

I agree with those who say we are at a "turning point" in healthcare and those who say that physicians must play key leadership roles in helping us make changes for the better.

The changes necessary for the future of healthcare are transformational, not just incremental; for this reason, three leadership skills are essential for today's physician leaders:

- Seeing systems
- Collaborating across boundaries
- Creating desired futures

The above three skills, and indeed much of the content of this monograph, are drawn from *The Necessary Revolution: How Individuals and Organizations Are Working Together to Create a Sustainable World* by Peter Senge and his colleagues.[1] The authors argue that we are approaching the end of an era. The Industrial Age bubble, characterized by the "take, make, waste" way of thinking is coming to an end because the premise on which it is based is not sustainable—not environmentally, not economically, and not socially. What is needed now are innovative leaders and transformative strategies, not just incremental changes, so we can all work together to create a sustainable world.

While some may wonder why I chose such a source as the inspiration for this monograph, I suspect that many of you will readily see the parallels.

We have been making incremental changes to the healthcare delivery and payment system, but the era of incremental changes is coming to an end. There is widespread agreement that the healthcare system, as it is now, is not sustainable economically—and many would argue it is not sustainable in terms of the number who currently lack coverage and in terms of quality issues. Healthcare also needs innovative leaders and transformative strategies, not just more incremental changes, so that we can all work together to create a truly sustainable healthcare system for the 21st century.

We healthcare professionals are also approaching the end of an era. Our healthcare delivery and payment system were designed for a time when acute intermittent illnesses predominated. That time has passed and has been replaced by one in which chronic illnesses predominate.

1 Peter Senge, Bryan Smith, Nina Kruschwitz, Joe Laur, and Sara Schley, *The Necessary Revolution: How Individuals and Organizations Are Working Together to Create a Sustainable World* (Doubleday, 2008).

Seeing Systems

As physicians, we are trained to see systems. For example, through our study of anatomy and physiology, we learn about how the individual parts of the body function, but we also learn how these parts function as a system. That carries over to our clinical work, where we learn to focus on a "chief complaint"—but see that "chief complaint" and the treatment plan in the context of the whole individual.

In fact, over the years I have found that one of the best pieces of advice I can give new physician leaders is to use their training in clinical systems thinking to approach the non-clinical challenges of their position.

For today's physician leaders, the skill of "seeing systems" encompasses not only seeing the *breadth* of systems operating, but seeing those systems with greater *depth*.

Senge uses the metaphor of levels of an iceberg to describe four ways of explaining reality:

- The first level, the tip of the iceberg, focuses on *events*. The question asked is, "What just happened?" Those who stay at this level do little more than *react*.
- The second level of the iceberg, a little below the water surface, focuses on *patterns/trends*. The questions asked are typically: "What has been happening?" and "Have we been here or some place similar before?" At this level the emphasis is on being able to *anticipate*. However, without going *deeper*—especially in times of disruptive, transformational change—the past may not be enough of a predictor of the future to allow us to be successful using this approach alone.
- The third level of the iceberg, further below the surface, focuses on *systemic structures*. This approach is characterized by the question, "What are the forces at play contributing to these patterns and how do they arise?" The goal here is to *design* a solution. This approach is clearly deeper than just reacting or anticipating; yet it is not the deepest approach, nor the one with the greatest leverage and opportunities for learning.
- The fourth level of the iceberg, where we also focus on *mental models*, is the *deepest* level of systems thinking. In this case the question is, "What about our thinking allows this situation to persist?" By opening up our thought processes to challenge our deeply held assumptions, some or all of which may no longer be applicable, we are greatly expanding our potential solutions. We are no longer limited to trying to design the best solution to fit the current system; at this level we have the potential for an even better solution because we are willing to *transform* the current system.

Once we see systems with this *depth*, we can fully appreciate the importance of the next essential skill: collaborating across boundaries.

Collaborating across Boundaries

In our roles as physicians and as physician leaders, we all collaborate across boundaries to some degree or another. The skill we are talking about here is collaborating across even broader boundaries, not only with other healthcare providers and healthcare administrators, but also with all potential stakeholders including patients, payers, and local, state, and national governmental representatives.

Senge uses a model developed by C. Otto Scharmer that describes four levels of conversations that can occur, especially when we attempt to collaborate across boundaries:

1. **Smoothing over:** This first level is characterized by *downloading*, where habits of thought dominate and you essentially hear what you are prepared to hear. This type of conversation preserves social norms and has been referred to as "terminal politeness."
2. **Speaking out:** This next level is characterized by *"win-lose" debates* and advocacy.

Both "smoothing over" and "speaking out" conversations, while they appear to be different, actually are similar in that they both can be characterized as "reenacting patterns from the past," and both work in ways that preserve the status quo. In smoothing over, groups avoid threatening issues. In speaking out, it can certainly be said that everyone speaks his or her mind; but, as Senge relates, one manager summarized it as, "We all speak our minds here, but no one's mind is ever changed."

It is at the levels of the next two types of conversation—empathetic listening and generative dialogue—when participants genuinely appreciate one another's way of looking at reality, that collaboration across boundaries can move from simply reenacting patterns from the past to enacting emerging futures:

3. **Empathetic listening:** this level is characterized by the willingness to *suspend assumptions*, balance advocacy and inquiry, and allow time for reflection of what you have heard.
4. **Generative dialogue:** this is characterized by *listening for larger questions and those connected to the future.* At this level, individuals speak about what is true for them without advocating that this is necessarily true for everyone. They also listen to other individuals' truths. Rather than a pressure to agree on one truth, a deeper understanding of the issue develops. From that understanding and trust, the foundation is built for a generative dialogue that can not merely find the best solution within the current system or constraints, but potentially find an even better solution because we are open to working together in new ways to transform the system.

A key skill in moving from "reenacting the past" levels of conversation, typified by smoothing over and speaking out, to the "enacting emerging futures" levels of conversation, typified by empathetic listening and generative dialogue, is that of *suspending assumptions*.

In my experience facilitating groups, I have found Senge's model, the "Ladder of Inference," to be very helpful—and very well received—in helping group members increase their capacity to be aware of their assumptions and increase their ability to suspend those assumptions to engage in a richer and more productive dialogue.

There are seven rungs to the Ladder of Inference. It seeks to represent the steps taken—many of which we are not always aware—as we move from observable data to taking action.

This lack of awareness of our movement up the Ladder of Inference can be a problem because, as Richard Ross[2] puts it:

> "We live in a world of self-generating beliefs that remain largely untested. We adopt those beliefs because they are based on conclusions, which are inferred from what we observe, plus our past experiences. Our ability to achieve results we truly desire is eroded by our feelings that:
>
> - Our beliefs are *the* truth.
> - The truth is obvious.

2 Peter Senge, Art Kleiner, Charlotte Roberts, Richard Ross, and Bryan Smith, *The Fifth Discipline Field Book: Strategies and Tools for Building a Learning Organization* (Doubleday, 1994).

- Our beliefs are based on the real data.
- The data we select are the real data."

The seven rungs of the Ladder of Inference, beginning at the lowest rung and moving up, are:

1. **Observable data and experiences.** This represents all "data" and experiences available as a videotape recorder might capture it.
2. **Data.** This is the "data" we select from everything we observe—in other words, it is our own subset of the observable "data" and experiences.
3. **Meanings.** Next we add meanings to the "data" we have selected based on our own cultural and personal experiences.
4. **Assumptions.** Now we make assumptions regarding the "data" we have selected based on the meanings we added to the "data."
5. **Conclusions.** At the next rung of the ladder we draw conclusions from these assumptions.
6. **Beliefs.** At this point we adopt certain beliefs about the world based on the conclusions we have drawn.
7. **Actions.** At this final rung of the ladder we are taking actions based on our beliefs.

The Ladder of Inference can also contain the "Reflexive Loop," which describes the phenomenon in which the beliefs we have adopted affect which "data" we select in the future; in other words, we often only choose to see the "data" that reinforce the beliefs we already have.

Especially when we collaborate across boundaries, one can imagine different parties coming to the table with greatly different beliefs, but each party feeling their beliefs are based on the "real data."

"Suspending assumptions" means essentially that you understand and are willing to state that your view of the situation is in fact *your* view, and not *the* view.

In terms of the model, this means you are willing to walk back down your Ladder of Inference and engage in "high-level advocacy," characterized by sharing your thought processes with others (i.e., describing the "data" you have selected, the assumptions you made, and the meaning you added to explain how you arrived at your conclusions). This approach is modeled by asking your listeners questions such as:

- Are there any additional data you think I should have considered?
- What do you think of the assumptions I've made?

This approach contrasts with "low-level advocacy," in which the speaker is not willing to share thought processes, assumptions, or data, and can be summarized as: "My belief is the truth because it is based on the 'real' data and the way the way things 'really' work—end of discussion."

You can help others suspend assumptions and encourage them to walk back down their Ladder of Inference to share their thought processes—even if they are not familiar with the Ladder of Inference model. You can do this by using what has been termed "high-level inquiry," which includes asking questions such as:

- If I understood you correctly, you are saying…?
- Would you help me understand your thought process in arriving at that conclusion?
- What data did you use in reaching that conclusion?

Contrast this approach with "low-level inquiry," in which the questioner is not trying to get the others to share their thought processes, but instead is trying to move them toward the questioner's position through "questions" such as:

- So essentially you agree with my position that….
- Given that we all have the same data in front of us, how could you possibly come to that conclusion?

Understanding the four types of conversations, being aware of our own and others' Ladders of Inference, using the tools of high-level advocacy and high-level inquiry, coupled with seeing systems, all come together in developing the next essential skill for today's physician leaders: creating desired futures.

Creating Desired Futures

Creating desired futures is not a skill that comes naturally to us from our medical education and training. On the contrary, we are trained to be problem solvers, focusing on a "chief complaint," arriving at an "assessment," and devising a "plan."

These problem-solving skills transfer well to many of the management situations we face as physician leaders. This is because healthcare leaders (as well as leaders in other types of organizations) spend much time and energy "reacting" to problems.

But just as we know that the health of an individual is not simply the absence of disease, the health of an organization or system is not simply the absence of problems.

While, as physician leaders, we must deal with the problems that come up, we must also be able to help create desired futures. As Senge puts it:

> "Ultimately, leadership is about how we shape futures that we truly desire, as opposed to trying as best we can to cope with circumstances we believe are beyond our control."

I believe that to create futures we truly desire in healthcare, we will need transformational change; we cannot get there by simple incremental changes to the current system. In its landmark report, *Crossing the Quality Chasm*,[3] the Institute of Medicine stated it this way:

> "Between the healthcare we have and the care we could have lies not just a gap but a chasm…. The committee is confident that Americans can have a healthcare system of the quality they need, want, and deserve. But we are also confident that this higher level of quality cannot be achieved by further stressing current systems of care. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Crossing the Quality Chasm described six aims for a "desired future" of the 21st century healthcare system. Healthcare should be: "safe, effective, patient-centered, timely, efficient, and equitable."

Just as we know that the health of an individual is not simply the absence of disease, the health of an organization or system is not simply the absence of problems.

While I was Commanding Officer (CEO) of Naval Hospital Pensacola, we used those six aims as part of our desired future. Both clinical and support staff bought in to this desired future and I was continually impressed at the energy and creativity that it engendered.

Of course, the energy and creativity "desired futures" engenders when compared to "problem solving" should not be surprising, as Senge explains:

> "Problem solving is about making what you don't want go away. Creating involves bringing what you care about into reality….
>
> Creating draws its energy from dreams or visions of what people truly want to see exist, in concert with accurate and insightful understanding of what is. Reactive problem solving draws its energy from crises, usually driven by an underlying emotion of fear—fear of the consequences if we fail to solve the problems."

3 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academies Press, 2001).

So what are some additional desired futures for healthcare that might draw out such creative energy from us? Let me share three, all articulated by fellow physician leaders.

Donald Berwick, M.D., M.P.P., CEO of the Institute for Healthcare Improvement, has described a desired future of the "Triple Aim"—"a transformational aim, an overarching agenda that seeks to optimize performance on three dimensions of care:

1. The health of a defined population
2. The experience of care for individuals in this population
3. The cost per capita of providing care for this population"[4]

Over 40 sites in North America and Europe are currently participating in the Triple Aim Prototyping Initiative, with the organizations functioning as "integrators" with responsibility for the overall health, experience, and cost of health associated with the population.

John Wennberg, M.D., founder of the Center for Evaluative Clinical Services at Dartmouth Medical School, and Elliot Fisher, M.D., director of the Center for Health Policy Research at Dartmouth Medical School, have documented in the Dartmouth Atlas of Health Care[5] wide regional variations in healthcare spending that are not due to differences in the prevalence of serious illness and are not associated with better care. They have described a desired future in which that variation is reduced and we begin to "bend the cost curve." They note that physicians have an opportunity to lead since they are "still almost entirely responsible for determining what treatments their patients receive and where they obtain their care." They state that physician leadership is needed at three levels:

1. "In their practices, physicians can help patients understand when a more conservative path is likely to be as safe as a more intensive and higher-cost path.
2. In their communities, physicians have the credibility to argue against the need for further growth—whether through hospital expansion, the construction of new imaging centers, or the recruitment of more specialists to oversupplied regions.
3. Physicians can support changes in the healthcare system that will help their patients and communities get the best possible care at the lowest possible cost."

   [Wennberg and Fisher have proposed "shared savings payments" that "should allow both physicians and hospitals to preserve their margins (net income) while reducing their total revenues."]

Arnold Relman, M.D., professor emeritus at Harvard Medical School and former editor-in-chief of *The New England Journal of Medicine*, states:

> "We must directly confront the major forces driving medical inflation: the fee-for-service payment system, the commercialization of medical care, and the excessive use of new technology and new drugs that results from the economic incentives in today's system."[6]

In writing what he terms "an open letter to my colleagues in the medical profession," Relman states that his desired future for healthcare involves the creation of "multi-specialty, prepaid group practices, and in substituting salaries for fee-for-service as the major basis of your payment."

While there are similarities and differences among these examples of desired futures for healthcare, one common element is that they all involve a key role for physician leaders.

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4 Donald Berwick, M.D., M.P.P., "The Triple Aim: Care Health, and Cost," *Health Affairs*, Vol. 27, No. 3 (2008), pp. 759–769. See also www.IHI.org.

5 Elliott S. Fisher, Julie P. Bynum, and Jonathan S. Skinner, "Slowing the Growth of Healthcare Costs: Lessons from Regional Variations," *The New England Journal of Medicine*, Vol. 360 (2009), pp. 849–852. See also www.dartmouthatlas.org.

6 Arnold Relman, *A Second Opinion: Rescuing America's Healthcare* (Persus Books Group, 2007).

Conclusion

There is a healthcare "crisis" today in the sense that we are at a "turning point" in healthcare. I believe it will result in a "turn for the better." The changes in the system will not be incremental; they will be transformational.

Today's physician leaders have the potential to play a crucial role in such transformational changes and, to do so, they need three essential skills:

- Seeing systems
- Collaborating across boundaries
- Creating desired futures

In stressing the importance of "creating desired futures" and contrasting it with "reactive problem solving," I am advocating the use of "creating desired futures" as a major component of our skill set; I am not advocating that it replace the skill of problem solving. Of course we need our problem-solving skills but, as Senge points out, the key is determining which skill is primary and which one is secondary:

> "In the process of creating what we truly want, many problems will invariably arise, and effective problem-solving skills are vital to tackling them. The distinction lies in what is primary versus what is secondary. When problem solving is primary, we focus on figuring out what's wrong and avoiding outcomes we fear. When creative orientation is primary, life becomes a journey of bringing into reality what you truly care about and addressing the many practical problems along the way. Reality is no longer the enemy—indeed, understanding and reflecting on how different problems relate to one another, how they have come about, and how different forces contribute to the status quo are essential. But working with these forces is very different from reacting to what has gone wrong."

In the words of one of our most eminent colleagues, Sir William Osler: "The future is today."

As today's physician leaders we have an extraordinary opportunity—and in my view also an extraordinary responsibility—to work together with all stakeholders to create the desired future of healthcare.

I believe that by enhancing our skills of seeing systems, collaborating across boundaries, and creating desired futures, we can maximize our contributions to this challenging and necessary endeavor.

Resources

1. Berwick, Donald, M.D., M.P.P. "The Triple Aim: Care Health, and Cost." *Health Affairs*, Vol. 27, No. 3 (2008), pp. 759–769.
2. Dartmouth Atlas of Health Care (www.dartmouthatlas.org).
3. Fisher, Elliot S.; Bynum, Julie P.; and Skinner, Jonathan S. "Slowing the Growth of Healthcare Costs: Lessons from Regional Variations." *The New England Journal of Medicine*, Vol. 360 (2009), pp. 849–852.
4. Institute for Healthcare Improvement (www.IHI.org).
5. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academies Press, 2001.
6. Relman, Arnold. *A Second Opinion: Rescuing America's Healthcare.* Cambridge, MA: Perseus Books Group, 2007.
7. Senge, Peter; Kleiner, Art; Roberts, Charlotte; Ross, Richard; and Smith, Bryan. *The Fifth Discipline Field Book: Strategies and Tools for Building a Learning Organization.* New York, NY: Doubleday, 1994.
8. Senge, Peter; Smith, Bryan; Kruschwitz, Nina; Laur, Joe; and Schley, Sara. *The Necessary Revolution: How Individuals and Organizations Are Working Together to Create a Sustainable World.* New York, NY: Doubleday, 2008.