

## **Leading together: Collaboration Among Senior Health Care Executives**

Mahima Mitra (University of Oxford), Sue Dopson (University of Oxford), Paul Brankin (Green Templeton College, Oxford), Timothy Hoff (Northeastern University)

### **Abstract**

Healthcare systems across the world face the dual challenge of balancing between the provision of affordable, good quality and timely healthcare on the one hand; while innovating constantly to enhance efficiency amidst increasing resource shortfalls, on the other. Their success is contingent upon the presence of strong organizational leadership that harnesses the inherent collaborative potential of both physician and non-physician executives. This study sought insight into the day-to-day experiences of healthcare leaders in the UK's National Health Service (NHS). We conducted twenty-four in-depth interviews with senior NHS physician and non-physician leaders around their experiences of working together, opportunities and challenges to effective collaboration, and identification of best practices relating to shared decision-making. The executives interviewed had job titles including chief operating officer, medical director, and clinical director. Our findings suggest that collaborative leaders in health care are not born but created through a complex interplay of personal, cultural, and structural best practices that require active attention in the everyday leadership setting. Our research has direct implications for health care practice and will be useful to health care executives and decision-makers across the UK, and health care systems internationally.

### **Introduction**

Health care systems internationally face a perfect storm of external pressures to control costs, improve quality of services, and innovate to deliver better care. Despite key differences in how their health systems are funded and structured, both the United States (U.S.) and United Kingdom (U.K.) face similar imperatives: an ageing population and increased patient demand, combined with the need for constant innovation to lower costs and improve quality. In the U.S., many health insurers report losing money in the

provision of coverage to a wider array of Americans, while hospitals continue to operate on razor-thin margins. In the U.K., despite increased funding, current reports suggest that more NHS Trusts in England are in deficit than in balance. In both countries, issues related to timely access to health services, particularly primary care and mental health, intensify (The Health Foundation & The Nuffield Trust, 2015, Merritt Hawkins, 2014).

Over the last few years, one way in which the NHS has sought to deal with the problem of rising costs has been with annual Cost Improvement Programmes (CIPs) aimed at increasing efficiency and reducing expenditure, while improving patient satisfaction and quality of care (The Audit Commission & Monitor, 2012). This approach is akin to the “Value-Based Purchasing” movement in the U.S., in which service reimbursement is tied contingently to a set of performance-based metrics, and financial incentives for producing lower-cost, higher-quality service delivery become a significant component of physician pay (Centre for Medicare and Medicaid Services, 2016). In both countries attention has now turned from the more straightforward efficiency measures to the introduction of transformational changes that push for new ‘pathways of care’ requiring less resources, while maintaining quality. These developments require significant changes in the way medical staff work; with intraprofessional teamwork, work transfer and collaboration across professional groups, greater consideration of the patient perspective, and more input from non-clinical staff and managers focused on efficiency. They also entail managing the high levels of both task and goal uncertainty among doctors, nurses, and other staff that produce greater tensions among health care workers, while undermining the esprit-de-corps required for sustaining change-oriented health care cultures.

Doctors have historically relished autonomy and preferred working free of managerial encroachment (Freidson, 1988, Starr, 1982). However, as health care contexts have evolved, many of them are increasingly asked to assume leadership roles over how medical work is organized, funded, and evaluated. Doctors are thus being asked to collaborate alongside managers in roles dealing with strategic decision-making within the organization. Underlying these changes is the notion that there is less justification for the “dual hierarchy” of separate medical and managerial leadership silos that existed in the

past, and more need for jointly-held, mutually participative models of decision-making at the senior executive level. This requires physician and non-physician senior leaders to exhibit specific psychological and behavioural skill sets, as well as supportive contextual conditions that allow such skills to be nurtured and enacted.

Given these structural and socio-psychological requirements, it is useful to consider the roots of what exists naturally as latent conflict potential between physician leaders and their non-physician counterparts, stemming from:

- Differing educational experiences
- Variation in the kinds of mentors and opinion leaders shaping early work experiences
- A very different view of hierarchies of evidence, with doctors seeing randomized controlled trials (RCT) as the gold standard for evidence, and non-physician managers being more tolerant of a mix of evidentiary bases when considering change
- Varying incentive and career structures
- The absence of opportunities and spaces for joint work and learning
- Varying proximities to direct patient care

Medical professionalism and managerialism can thus be thought of as ‘competing institutional logics’ (Reay and Hinings, 2009) that differently condition how individuals make sense of their contexts and define their identity and purpose. It is therefore important to understand how senior leadership teams comprised of both physician and non-physician executives enact leadership and decision making processes, resolve tensions and problems, and enhance their collaborative potential. These issues have not been explored much in the extant literature. Understanding these dynamics has implications not only for organizational and system performance, but also middle- and front-line management teams that rely upon co-equal participation from both the medical and administrative sides of health care delivery.

To illuminate these issues, we interviewed senior NHS health care executives with the objective of identifying those best practices and contextual conditions that most effectively help develop successful collaborative cultures.

## The Research Design

Twenty-four semi-structured interviews were conducted with senior NHS physician and non-physician leaders. Job titles for this group included chief operating officer, medical director, and clinical director. Interviews lasted approximately 60 minutes and were guided by a semi-structured protocol containing several open-ended questions around the experiences of working together, opportunities and challenges to effective collaboration, and identification of best practices relating to shared decision-making. Interviews were digitally recorded, transcribed and then analysed using Atlas.ti, a qualitative data analysis software. Data were iteratively coded across two systematic phases that not only allowed for rich description to be captured but also a set of common themes related to the topics of interest.

## What We Found

We identified several best practices and contextual conditions which appeared to facilitate collaboration and cooperation between physician and non-physician senior executives. These are grouped into structural and cultural/psychological factors, and described next.

### Structural factors

**Time** to spend thinking about work was an important factor that significantly facilitated collaboration. Difficult to find during the course of a normal leadership day, time allowed executive pairs to get better at imperatives like joint decision-making by allowing for space to engage in conversations around strategy and long-term vision for the institution, for example. Time was also critical to communicate vulnerability among executives and helped them understand each other better. Equally important to spending time together was finding individual time to think and reflect in order to enhance one's own leadership practice.

**Proximity, whether through co-location of offices or continued interpersonal engagement over time** was identified as crucial in lowering conflict potential and facilitating joint self-reflection. Those executive pairs that were physically co-located, or went out of their way to interact personally, appeared to

report less tensions and more progress related to shared decision-making and meeting organizational imperatives. An extreme example was a pair that regularly spent a day out of the office, describing it as an investment in each other's resilience capacity for working out solutions to major challenges faced. Conversations do not just happen; space and time for reflection and discussion needs to be purposively created. Many of our interviewees were conscious of crisis talk taking over these spaces, and struggled to stop this happening.

**Access to facilitation activity** either internally or from an external source appeared helpful in building effective relationships. Some of our interviewees cited mentors and coaches, and membership of multidisciplinary action learning sets in which physician and non-physician leaders teamed up to work on an issue and share learning as being helpful for reflecting on work and working relationships. For example, coaches helped remind them of their purpose, i.e., 'what are we here to do', 'what each of us does', and 'how to close the gap' between what needed to be done but wasn't. These trusting relationships, when available, afforded safe rehearsal moments for leadership work and exploration of collaborative working. They allowed executives to make 'mistakes', and learn from them in low consequence environments. Cross-disciplinary training programmes were also cited as being helpful for understanding the actual work of the respective roles. Conflict resolution training was highlighted in a few cases as also being valuable.

**Role clarity discussions** also emerged as being important to productive relationships between physician and non-physician leaders. These involved providing specificity regarding which areas of organizational strategy or operations particular executives were most able to contribute to in their leadership role. There was also some concern that the current **reward structures** did not best facilitate collaboration among executive pairs – the mundane was rarely celebrated in comparison to the exceptional. This was important especially for the executives that were early into these complex roles, and continuously learning, unlearning, experimenting and failing. Interviewees believed that celebrating small wins in areas such as collaborative decision-making would help to reinforce progress and build confidence.

### **Cultural factors**

There were other, more cultural and psychological factors that mediated between executive relationships to make them more collaborative, mutually rewarding, and less tense. For example, executives cited that the existence of a shared deeply-held belief that both the doctor and non-physician manager were leaders and **co-equals** was important to working together effectively. Also important was nurturing the leadership dyad by valuing each other's contributions to the partnership, developing a positive working relationship, and pledging mutual support to each other during times of crisis.

As co-equals, **honesty and openness to each other's criticism** appeared in our data as important. Many executives acknowledged that some conflict among senior executives was a good thing and fully realized that if used well, 'healthy' conflict could enhance creativity in leadership enactment. Honesty and openness also contributed towards building strong, trusting partnerships between leaders which, in turn, generated confidence upwards and followership downwards.

**Articulating personal values** to each other was also cited as helping executives understand each other not simply as organizational leaders, but as unique individuals. It enabled greater alignment of individual values across the executive group that were recognized as being in common despite the difference in role or status. Some executives also reported that they were able to build strong relationships with each other partly because they had been through personal challenges that they had shared together. This sharing led to the revealing of additional dimensions to the individual, such as vulnerability in the form of exhibiting fear and anxiety, which increased the emotional bonding that occurred among executives. Said one executive, '[This has] allowed us to do things we might have been afraid to do otherwise'.

### **What Can We Learn from These Senior Executives?**

Leaders need reinforcement and support as their context, including their followers, can sometimes 'eat them alive'. Good leadership is about providing direction and creating energy. Our small-scale study suggests that executives can nurture their potential by investing in each other as individuals but also as collaborative decision makers, away from the local stressors of their contexts. Conversations about

organizational and situational analysis are important, of course. However, these need to be complemented by an equally-weighted dialogue identifying leaders' individual beliefs, the crucible moments of their professional journeys, their personal values and aspirations, and their collective leadership strengths. It is our contention, therefore, that change and implementation work will be more likely to progress if leaders invest in these conversations to build a shared understanding and resilience with each other.

It is also important to acknowledge the different sensemaking frames and incentive structures that physician and non-physician leaders operate within when analysing problems and making decisions, both separately and together. Professional development programmes often do not adequately recognize these factors in the provision of either medical or managerial training. Multi-professional training programmes that develop the softer interpersonal competencies alongside management acumen are more likely to enable executives to venture out of their core knowledge communities to other knowledge domains, and grant access to more experiential knowledge derived from a variety of contexts. The finances for facilitating coaching and action learning are hard fought-for and diminishing. Yet, this contrasts with the external consultancy spend on operational and strategic improvements, which has increased from £313 to £640 million between 2010 and 2014 (Knapton, 2014 December 9). Perhaps it is time to recognize and creatively explore the value of tapping into the psychological and cultural capital of leader dyads.

### Key Messages

- Collaborative leaders are not *born* but through engaging in a process of reflection, reframing and engagement, a collaborative leadership approach can be shaped. Structural factors such as time, co-location, external facilitation, and more appropriate rewards systems help create them.
- Time and space are critical to the materialization of a number of best practices for senior executives, but they are not easily achieved. The way work is organized and incentivised will have a key role to play in making these attainable.
- Senior executives must exhibit high levels of emotional intelligence to better understand themselves and others. Acknowledging and embracing the different foundations of training and

knowledge for each party and sharing emotional states such as anxiety and uncertainty with peers contributes towards developing a shared understanding of, and empathy for, each other's role.

- Fostering a senior leadership culture that enables high degrees of creative tension and openness to criticism generates the kind of conflict that is productive in moving to higher quality decision-making.

**Ethical Approval:** This study was approved by the Research Ethics Boards at the University of Oxford (SSH\_SBS\_C1A\_15\_051) and the Institutional Review Board at the Northeastern University (IRB#15-09-21). All procedures were performed in compliance with relevant laws and institutional guidelines as provided by the review boards above.

**Acknowledgments:** We would like to acknowledge the help received through PB's organization, Oxford Executive Coaching Ltd., to identify the first leaders interviewed, as well as the majority of the following group.

**Competing interests:** We would like to declare the following conflicts of interest: (i) this study was funded by the Templeton Education and Charity Fund; (ii) PB is Director of Oxford Executive Coaching Ltd. where he coaches senior doctors and managers in the NHS and other organizations.



## References

- CENTRE FOR MEDICARE AND MEDICAID SERVICES. 2016. MACRA [Online]. Centre for Medicare and Medicaid Services Available: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html> [Accessed 15 September 2016].
- FREIDSON, E. 1988. *Profession of medicine: A study of the sociology of applied knowledge*, USA, University of Chicago Press.
- KNAPTON, S. 2014 December 9. NHS spending on management consultants doubles under Coalition. *The Telegraph*.
- MERRITT HAWKINS. 2014. *Physician appointment wait times and Medicaid and Medicare acceptance rates* [Online]. Irving, Texas: Merrit Hawkins. Available: <http://www.merritthawkins.com/uploadedfiles/merritthawkings/surveys/mha2014waitsurvpdf.pdf> [Accessed 15 September 2016].
- REAY, T. & HININGS, C. R. 2009. Managing the rivalry of competing institutional logics. *Organization studies*, 30, 629-652.
- STARR, P. 1982. *The social transformation of American medicine*, USA, Basic Books.
- THE AUDIT COMMISSION & MONITOR. 2012. *Delivering sustainable cost improvement programmes* [Online]. London: Monitor. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/285845/CIP\\_final\\_18\\_Jan\\_v2\\_0.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285845/CIP_final_18_Jan_v2_0.pdf) [Accessed 15 September 2016].
- THE HEALTH FOUNDATION & THE NUFFIELD TRUST. 2015. *Closer to critical?* [Online]. London: QualityWatch. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/285845/CIP\\_final\\_18\\_Jan\\_v2\\_0.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285845/CIP_final_18_Jan_v2_0.pdf) [Accessed 15 September 2016].