The background features a complex, interconnected network of icons and shapes. At the top, there are several circular nodes containing icons like a pie chart, a lightbulb, a gear, and a globe. Below these, a series of human silhouettes in various shades of blue and purple are shown in profile, facing right. The silhouettes are connected by dashed lines and dotted lines, suggesting a network or flow of information. The overall color palette is dominated by blues, purples, and greys, with occasional accents of orange and yellow.

Adaptive leadership for the new #MedEd

The one hour read

Felix Ankel
Jonathan Sherbino

Adaptive Leadership For The New #MedEd: The One Hour Read

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Adaptive Leadership For The New #MedEd: The One Hour Read

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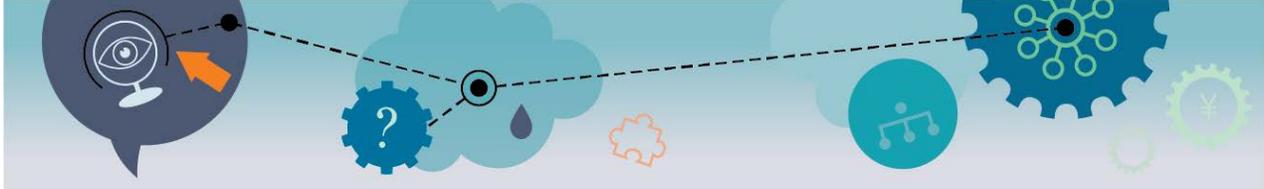
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FOREWORD
Paul Bataldan

The challenge

You are a newly minted director of a graduate medical education program. You've spent more than three decades learning how to be a good doctor, and along the way you've encountered many approaches to learning, each facilitated by leaders whose own learning autobiography seemed to inform their way of teaching. Now it's your turn. Whose work might you read for guidance or inspiration? You have some ideas about how to prepare, but what will matter for the next thirty years of health professional education? You decide to interview FF – a friend of the future.

You: I'm aware that I bring my own experiences and biases to the design challenge of this assignment. How will I know that I'm on the right track? Can you suggest some readings to guide me?

FF: I never know exactly what another person should do, but I can point to advice that helped me. For example, Stephen Brookfield's invitation to reflect on teaching and on one's own learning autobiography¹ helped me acknowledge some of my own deeply rooted assumptions. I also found David Perkins' description of the principles of teaching very useful.² His advice to eschew teaching "about" something is a provocative invitation to resist making "objects" out of the people and experiences so necessary for good professional work. He draws a memorable analogy between learning to play baseball and learning how to learn:

1. Play the whole game.
2. Make the game worth playing.
3. Work on the hard parts.
4. Play out of town.
5. Uncover the hidden game.
6. Learn from the team ... and from other teams.
7. Learn the game of learning.

You: Thanks. I know my own specialty pretty well, but I'd like to hear your perspective on the main influences shaping the future of health professional practice more generally.

FF: There are several ways of noticing and several categories for describing what is noticed. The categories that seem particularly useful to me are "systems," "service thinking versus production thinking," "digitization," and "cooperation, competition, and transdisciplinary work." Let me explain what I mean by each of these.

Systems. Fifty years ago, Ludwig von Bertalanffy³ described a general theory of systems in which he proposed the ideal of “wholeness”: multiple causal systems working interdependently, across disciplines and epistemologies, toward a common aim. C. West Churchman⁴ and Peter Checkland⁵ explored the organizational application of these ideas. W. Edwards Deming⁶ suggested that people who benefit from a system of production are actually *part* of that system. Peter Senge (a student of Jay Forrester, founder of the field of systems dynamics) connected these ideas explicitly with the idea of a learning organization.⁷ More recently, the US National Academy of Medicine (formerly the National Institute of Medicine) published a series of books and reports in its [Learning Health System Series](#), beginning with an important volume called the *Learning Healthcare System*.⁸ This report describes an approach to “help transform the availability and use of the best evidence for the collaborative health care choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and, ultimately, to ensure innovation, quality, safety, and value in health care.”

The logic of service vs the logic of production. In 1968 the pioneering health economist Victor Fuchs published a small but influential volume on the emerging “service economy.”⁹ He suggested that providing a service is different from making a product. Services always require two parties: a content expert and an expert user. A decade later, Vincent Ostrom, with his wife Elinor (who would later receive a Nobel prize in economics), published an essay in which they suggested that services were “co-produced.”¹⁰ More recently, Lusch and Vargo have suggested that we live in a world of “product-dominant logic” even as we organize, offer, evaluate, and improve services.¹¹ Osborn and colleagues have begun to explore some of the implications of this product-dominant logic.¹² Building on the work of these pioneers, my collaborators and I have explored even more explicitly what some of these insights mean for health care service co-production.¹³ The particular challenge for health professionals comes when we realize that some of the time we “make” procedures and products, which can lead us to overlook the special insights that arise from the understanding that, at some level, all services are co-produced. This interdependency has been hard for health care professionals to put into operation. Even our language trips us up: consider, for example, what the word “patient” connotes. A Dutch team has suggested we adapt the example of the late rock star Prince by thinking in terms of “The Individual Formerly Known As Patient.”¹⁴

Digitization. Much has been written about the impact of computerization and digitization on many fields, but no one has framed these challenges more eloquently for those of us in health care service settings than Robert Wachter¹⁵ and Trisha Greenhalgh.¹⁶ I encourage you to read their work.

Cooperation, competition, and transdisciplinary work. Less than a hundred years ago, we began to practice medicine in ways that suggested we knew that the days of the medical soloist were numbered. But we still persisted

in separated modes of professional formation. We were tested and certified as competent as if the professional soloist's days were of infinite duration. Fortunately, we are now beginning to acknowledge the formal structures of health care service as clinical microsystems.¹⁷ New graduate medical education programs cross disciplines and offer practical leadership development in new ways of working.¹⁸ In many ways, these approaches invite not just "multidisciplinary" or "interdisciplinary" collaboration, but also a "transdisciplinary" effort that crosses and includes multiple disciplines and epistemologies. And, finally, a word about "competition." We have habitually directed our competitive energies at one another, rather than toward the unmet needs we are trying to address. This misplaced focus for our competitiveness seems to me to diminish our efforts.

You: Thanks for this. You and the other authors of this collection offer many suggestions. Is there any piece of advice you would put above anything else?

FF: I really don't know what you should do. What I found helpful was the example of Sir Ernest Rutherford when he led the Cavendish Laboratory at Cambridge. He held regular sessions in which he limited what people could say about what they already knew, and instead focused the discourse on what they were trying to figure out. This was the laboratory that could boast of at least thirteen Nobel prizes in one of the decades under Rutherford's leadership: an amazing testimony to the power of reflecting on the questions that matter. After all, it is questioning that stimulates the work of generating, attracting, creating, and sustaining the future we desire.

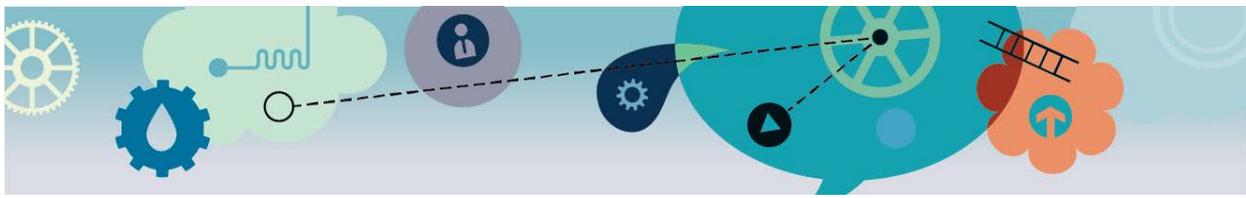
One more closing word, from the poet David Whyte:

Start Close In

Start close in,
don't take the second step
or the third,
start with the first
thing
close in,
the step
you don't want to take.¹⁹

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Introduction

Felix Ankel and [Jonathan Sherbino](#)

Do the clinician educators of tomorrow need different leadership competencies than their counterparts did in the past? In this age of increasingly complex health care, we think so. We hope that the reflections gathered here will encourage readers to take a fresh look at medical education leadership through a “systems thinking” lens.

Medical education is shifting its focus from knowledge as the product of learning to real-world competence as its desired outcome. As a result, value creation in medical education is shifting from institutional, positional, and informational silos in favour of fluid networks and communities of practice.¹

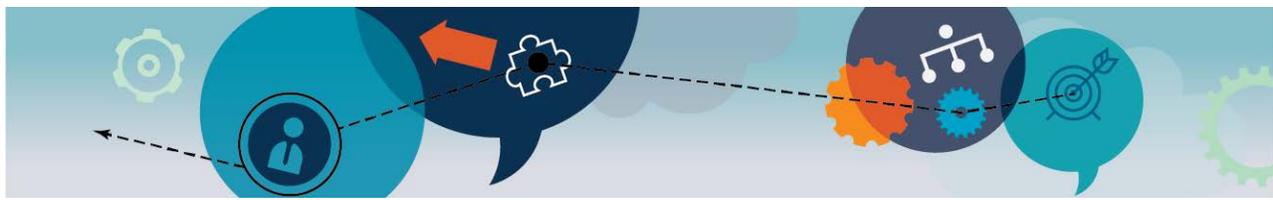
Traditionally, leadership resources for clinician educators have focused on managing the fixed [mindsets](#) of individuals and groups. For example, one case-based resource book for associate deans contains chapters entitled “Are you ready to visit the dark side?,” “Changing behavior in a culture of no accountability,” and “Trouble in Paradise: dealing with departmental dysfunction.” The challenge for clinician educators in the 21st century is to adopt a new framework for leadership while continuing to function in existing structures.

How can medical education leaders build a growth mindset within their communities? What skills do they need to manage exponential change within traditionally linear processes and hierarchical structures? How can they foster resilience, manage complexity, and navigate contextual subtleties in a world founded in organizational charts, promotion and tenure committees, and accreditation requirements? We offer case examples on how this may be accomplished.

Our hope is to contribute to the medical education leadership conversation by presenting, with case examples, concepts such as using [teaming](#) behaviours rather than simply managing teams, becoming a [multiplier](#) rather than a diminisher or micromanager, and practicing content [curation](#) rather than simply creating new content. We hope you will be inspired by these fresh takes on medical education leadership.

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Chapter 1

Developing a shared vision

Felix Ankel and Bob Englander

The challenge

As a new education leader at a medical school, you are eager to inspire change. But experience has taught you that simply importing into one context the solutions and innovations you've seen applied in another is bound to fail – particularly when there is no agreement about the need for change, and no shared vision of what the proposed change is meant to achieve. But how do you go about forging such a vision? And who will be sharing it?

As in many fields, innovation in medical education increasingly requires a shift from “old power” to “new power.” Writing about the forces of social change, activists Jeremy Heimans and Henry Timms observe that old power “works like a currency. It is held by a few [and] is jealously guarded.” New power, on the other hand, “operates ... like a current. ... It is open, participatory, and peer-driven,” and the goal is “not to hoard it but to channel it.”¹

For #MedEd leaders, the rapid pace of social and organizational change means that they will need to master specific competencies in the management of systems. They will need to be skilled in managing complexity, building organizational resilience, and enabling adaptation. The “new power” of today’s participatory approach to change also means that education leaders will need to bring multiple perspectives and interests into alignment. Thus, key to successful innovation in medical education will be the ability to align the goals, objectives, and activities of everyone involved. The first step in achieving this alignment is the creation of a shared vision.

Case example

Creating a shared vision – Bob Englander

Developing a shared vision is the first and most important step in the process of leading change. I was recently involved in a strategic planning process to develop a vision, guiding principles, and goals that would shape undergraduate medical education at the University of Minnesota Medical School for the next 10 years.

The first order of business was "to get the right people in the room." As a public institution attended by approximately 70% of practicing physicians in our state for their medical degree, residency, or both, our school has a broad range of stakeholders. For the strategic planning retreats, we invited education leaders, leaders from the major health systems with whom we share educational duties, students, patient representatives, alumni, and members of the community, including members of under-represented communities in Minnesota. Together, we started with divergent thinking, generating a list of all of the variables participants hoped to see in a vision. We then adapted a straw-man vision statement to try to include many of those variables. We ended up with the following draft statement: "Learning together to prepare physicians to meet the needs of Minnesota and beyond." Next, we opened up the statement to online feedback from our more than 3000 faculty, hundreds of staff, and 900 students scattered throughout the state. The feedback was generally positive with respect to the statement's practical goal, its emphasis on collaborative learning, and its focus on meeting the needs of the state and beyond. But respondents also felt that the statement was not sufficiently inspiring, and that it was not specific enough about the needs our existence was designed to meet.

At a second retreat we considered the feedback and came up with a new vision for medical education at the University of Minnesota Medical School: "A community, learning together, to prepare exceptional physicians to improve the health and well-being of Minnesota and beyond." The new vision inspired all the engaged stakeholders and was possible only through the collaborative delineation of values we held dear. Although the process took several months, it also made the establishment of guiding principles and goals much easier, as we all had a "north star" to point to.

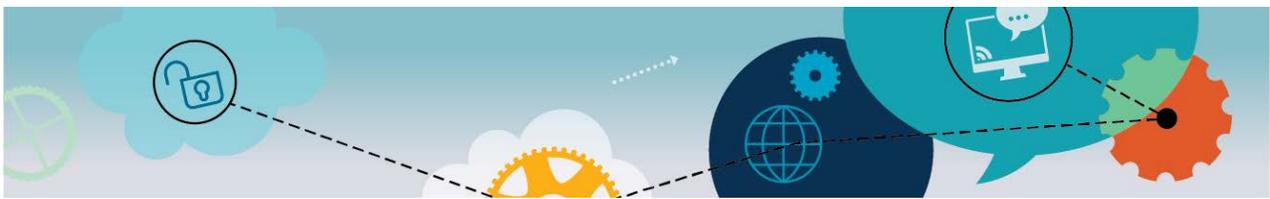
The take-home message of this case example is this: take time at the beginning to get all stakeholders aligned with a common vision that inspires them. A shared vision often leads to the organizational support² so critical to the execution of a plan.

Leadership is a discipline rather than a task, and leadership ability grows with self-reflection. The next time you find yourself without the organizational support you need to achieve your desired vision, ask yourself the following questions:

1. Did I spend enough time envisioning bold and creative possibilities?
2. Did I spend enough time enlisting others in developing a shared vision?
3. Did I use all of the "new power" available to me?

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Multiplying rather than micromanaging

Felix Ankel and Kelly Frisch

The challenge

You are a new postgraduate dean charged with producing a prepared physician workforce for the 21st century. You want to meet this challenge by leading your department from a knowledge-based to a competency-based medical education model. You plan to integrate residency training with clinical operations and to bring a deliberate focus on population health to the program. What skills will help you in this journey? Will the approaches that worked for you in the past be helpful? Or might they be counterproductive?

If medical education is a [team sport](#), the rules of the game are certainly becoming more complex. To successfully [manage complexity](#), leaders in health care need to promote a culture that is [aligned](#), empowered, and cohesive.

Effective leaders enable their teams to work “to the top of their license.” Leaders who empower their teams “[multiply](#)” more and micromanage less. “Multipliers” recognize the talent on their team, foster a productive environment, set direction, make decisions, and put plans in motion. They perfect the art of asking constructive questions and are judicious in offering opinions. Micromanagers, on the other hand, zoom in on short-term goals; they focus on winning arguments and dominating conversations rather than moving the discourse forward.¹ This approach loses sight of long-term opportunities and disengages others.

Effective leaders empower people to develop their talents and skills. “Leadership is about making others better as a result of your presence and making sure that impact lasts in your absence.”²

Case example

How a transition to a “multiplier” mindset can help educational leaders become more effective – Kelly Frisch

A few years ago, I was given the opportunity to move into a leadership role and oversee a group of managers and program associates who support graduate medical education (GME) in our health system. With over ten years’ experience in GME as an educator and leader for a residency program, I was confident with the associated processes, such as accreditation. In these previous positions, I had been a “doer” and was acknowledged and respected for getting the job done.

Shortly into my new leadership role, I was humbled by my inability to “multiply” and recognized that leadership requires a different set of skills. Despite my good intentions, my tendency to micromanage produced results but did not foster the growth and development of our team members. I needed to expand my skill set as a leader in order to empower and challenge others. I turned to several leadership resources, sought feedback, and did a lot of reflection. Since then, I have been very intentional about allowing each and every team member the space to succeed – and to potentially fail, which is also a part of growth. This transition from micromanaging to multiplying has resulted in a highly engaged, dedicated, and happy team.

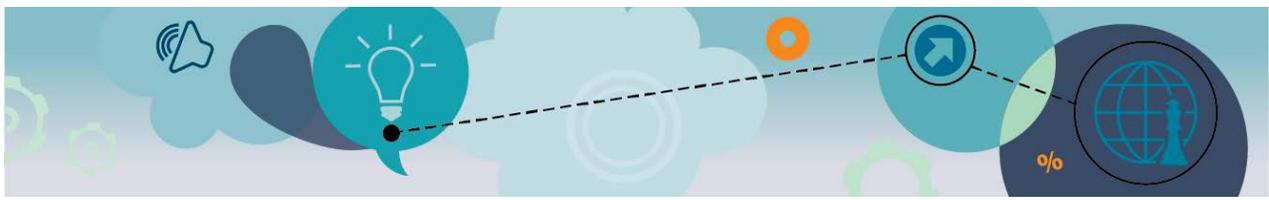
Tips for being a “multiplier”

If your team is not functioning at full capacity, ask yourself the following:

- Do you trust people enough to let go and avoid micromanaging?
- Do you let others make decisions and give them the freedom they need to develop?
- Do you let others maximize their contribution?
- Do you ensure that people receive the training and coaching they need to succeed?
- Do you ask your team what they need in order to do their work better?

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Chapter 3

Cohesion and co-creation

Felix Ankel and Meghan Walsh

The challenge

Your goal as a new education leader in a hospital is to create an optimal environment for clinical learning. You are aware, though, of tensions between operational and academic stakeholders at your institution. The operational leaders tend to view the presence of learners as impeding high-quality, cost-conscious care and as contributing to suboptimal patient experiences and outcomes. The academic leaders, on the other hand, tend to view the focus on operational metrics as a distraction from the goals of learning. How can you bridge this gap between professional cultures? Should you produce a plan and then hope others will accept it? Or should you invite the various stakeholders to join you in creating a plan?

Traditionally, medical educational programs have been developed with little input from participants outside of medical education. In this “production” model – an approach analogous to manufacturing material goods with no input from consumers – outside stakeholders were usually not involved at all or had little opportunity to provide input. This approach leads to stakeholders operating in silos, such that a great deal of energy is spent getting buy-in from disparate interests, leaving little energy to integrate education into care delivery systems. For example, elements of inter-professional teamwork, improvement science, patient experience, stewardship, and the optimization of electronic health records are often missed or added late. This lack of integration leads to an academic design that does not consider the real-world environments in which learners work.

By contrast, the move toward outcomes-based education is shifting the emphasis from “production” to active engagement and service. In the co-creation approach, all stakeholders are involved from the beginning in the process of developing programs. Participants are urged to let go of unexamined assumptions held as truths (for example, the belief that the amount of time spent in a rotation is an adequate proxy for the degree of learning) and to work together to make plans in an open and transparent fashion.

Writing about implementation challenges in outcomes-based medical education, Eric Holmboe and Paul Batalden urge a shift from a production logic to a service logic, as described in the management literature by Richard Normann.^{1,2} The implications of this transformation may resonate with medical education leaders:

1. Change is as much about letting go of assumptions as it is about creating new alternatives.³ For example, the success of competency-based medical education systems will depend on the ability of people to let go of assumptions-as-truths with respect to time-based systems as much as it will be about the ability to create new competency-based models.
2. One must have an open mind, an open heart, and an open will to let go of assumptions-as-truths. In his concept of the "[Theory U](#)," in which the "down stroke [of the U] represents letting go so that something better [the up stroke of the U] can emerge,"¹ Otto Scharmer describes the importance of emotion and loss as part of testing assumptions-as-truths.
3. Medical education is ultimately a service rather than a product; consumers (in our context, patients) play an important role in service design.⁴ Just as the future of clinical care involves the engagement of patients and shared decision-making, the future of medical education will involve "activated" learners and non-hierarchical methods of education.
4. Co-creation moves attention from "production to utilization, from product to process, and from transaction to relationship."²

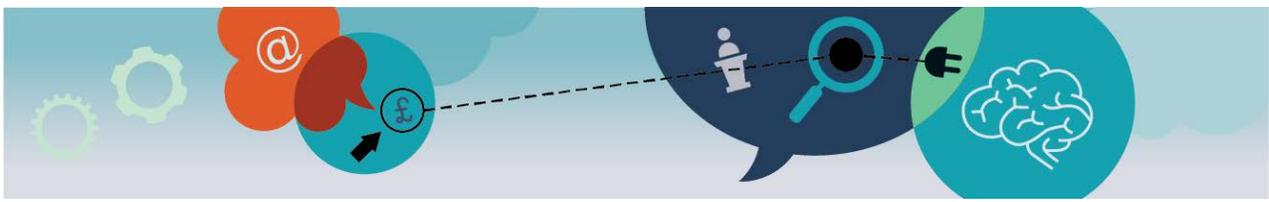
Case example

Co-creation in residency education – Felix Ankel

One example of education co-creation occurred within the Minnesota-based [Regions Hospital Emergency Medicine Residency](#). The program is part of [HealthPartners](#), the largest consumer-governed, non-profit health care organization in the United States. With supports such as a [participatory wiki site](#), continuous, transparent, annual strategic planning occurs with multiple operational and academic stakeholders. This has allowed for an adaptive approach that has helped move the focus of the residency program from rescue care to population health, from medical knowledge to improvement science, and from individual exceptionalism to a "teaming" culture focused on the patient. The residency program is now a strategic asset of HealthPartners. A next step in the co-creation process will be the inclusion of patients in educational design.

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Chapter 4

Trust networks

Felix Ankel and Leah Hanson

The challenge

You are a new #MedEd dean charged with modernizing a postgraduate medical education program and integrating it into a recently merged health care delivery system. The new organizational structure is built on existing structures that have traditionally emphasized authority and accountability and accentuated gaps between resources and responsibilities. How can you best steer change in this environment? How can you build the necessary trust networks to accelerate change?

Most health care and medical educational systems have organizational charts that describe formal structures and lines of authority. However, much of the work done in any system is influenced by more spontaneous relationships that develop into [informal networks and operate independently of the "org chart."](#) Although informal networks can be seen as potentially subversive in an organization, the opportunities they offer for facilitating communication, sharing advice and information, and building trust have obvious benefits. Recognizing the advantages of networks, some #MedEd clinician educators have formed [personal learning networks](#) to enhance competence. This discussion focuses on the dimension of trust in professional networks. An essential skill of a #MedEd leader is to build an effective trust network.

Theories behind trust networks

We tend to do our work through trusted relationships. (Geek alert: This has an evolutionary basis in our species' [eusocial traits](#) and a physiological basis in the effects of [oxytocin](#).) Health care and medical education is moving toward an [outcomes-based model](#) in which the emphasis, as discussed in chapter 3, is less on medical care and education as "products" and more on the relational logic of "service" – in which trust is needed to get the results we want.

#MedEd benefits from large trust networks. Trust networks increase the quality and speed of decisions, improve the experience of teachers and learners, and lower the costs of service. This results in high-value adaptive #MedEd value creation.

Case example

Building a trust network – Leah Hanson

I lead a neuroscience research group of scientists and clinicians spanning multiple teams within a large learning health care organization. One of the challenges I faced in bringing our group together was its loose organizational structure. Early in my leadership role, I was frustrated by a lack of progress. Why weren't initiatives moving forward? My ideas looked solid on paper, and people agreed they were the right next steps for us to take. But I knew something was missing, and it took me a while to realize the missing ingredient was trust.

I did two things that built and expanded my trust network. First, I circled back to my local team and confirmed their support of the initiatives. In doing so, I uncovered some previously unvoiced fears about the proposed changes and was able to address them. Second, my gut told me that, to succeed, I would have to strengthen my relationships across the broader organization. I reached out to other leaders and key stakeholders whom I didn't know very well with a request for a "meet and greet" session. I was surprised that everyone agreed to meet with me, making the expansion of my network much easier.

Although the process took longer than I expected, I was able to bring the group together once we had built trust. Now I recognize that the magic ingredient in any adaptive change management work is trust, and I intentionally continue to develop my trust network – up, down, and all around.

Tips for building trust networks

- **Be courageous.** We are hardwired to be suspicious. Take risks and move out of your comfort zone.
- **Be trusting.** We judge others on their behaviour, yet we want others to judge us on our intentions. Delay your judgment of others. Assume their intentions are good.
- **Be trustworthy.** Communicate transparently and be explicit about your intentions. Aim to make a difference rather than a point. Concentrate on elevating a conversation rather than maximizing your own position. Communicate in context. Keep the commitments you make. Follow through on promises.
- **Be deliberate.** Building a large trust network takes time and discipline. Engage with others; carve out time for deliberate practice in network building.
- **Be generous.** Give as much as you receive, and be the one to take the first step to repair relationships affected by distrust.

A situational awareness of how advice, trust, and communication networks underpin an organizational chart is essential in complex organizations. To optimize performance of a team, driving a person harder will not be as effective in the long term as drawing people together: an oxytocin bond is healthier in the long run than an epinephrine high.

Further reading

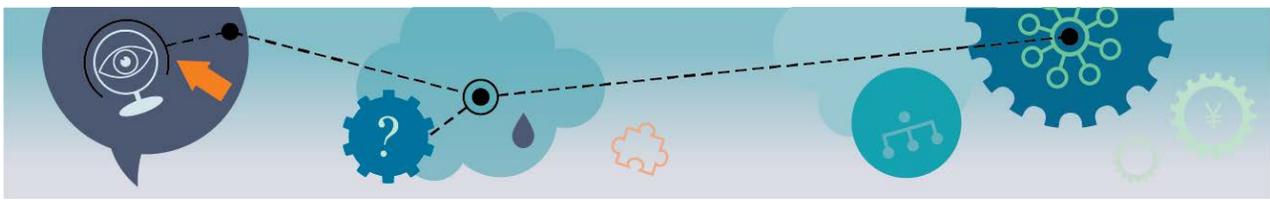
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Chapter 5

Communication networks

Felix Ankel and Michelle Lin

The challenge

You are a new medical education leader in an integrated care delivery system, charged with training a practice-ready clinician workforce for the future. In the past, a typical health professions education service in your system focused primarily on medical student and resident training, was associated with one medical school, and was delivered in one hospital. You are now poised to implement a vision for a system-wide educational approach that includes multiple hospitals and clinics with multiple health-professions schools. You would like students and their preceptors to have the skills and competencies to flourish in a team-based environment focused on improvement science, patient- and family-centered care, and stewardship. How can you develop communication networks to disseminate this vision? How can you build the necessary communication network?

The three components of effective communication networks

What is the best way to build an effective communication network? One method is to take a three-pronged approach that includes a “home base,” “embassies,” and “outposts.”^{1,2}

- **Home bases** are centralized inventories of information that networks can access (e.g., a web site, blog, or SharePoint).
- **Embassies** are external tools that can steer traffic to and from a home base (e.g., LinkedIn, Facebook, Twitter, Yammer).
- **Outposts** are analytic tools that allow you to scan the environment for communications involving your home base (e.g., Google Alerts).

In 2009, Michelle Lin, who teaches Emergency Medicine (EM) at UCSF–San Francisco General Hospital, founded the Academic Life in Emergency Medicine ([ALIEM](#)) blog to disseminate information on EM education. Her experience with this project is an excellent example of how to build an effective communication network using a home base, embassies, and outposts.

Case example

Building ALiEM – Michelle Lin

Home base: the birth of ALiEM. *When I first started the ALiEM blog, I had no intention of creating a network. My idea was simply to experiment with a relatively novel platform for information dissemination in my own academic niche. Over time, it became difficult to sustain this blog as the sole author, so I developed the team by adding a diverse group of health-professions educators with an amazing depth of and thirst for knowledge. As a result, the readership exploded from single digits to over 3,000 per day: two million site visitors per year a few short years.*

Once we saw the potential and reach of social media in delivering educational content online, we began to experiment with integrated tools such as Paucis Verbis cards. Paucis verbis – Latin for “in a few words” – was the phrase I used to describe a set of clinical cards that I had started during residency to help me remember evidence-based guidelines from journal articles, textbooks, and lectures. These pocket cards have evolved into their own website at ALiEMCards.com with over 100 digital point-of-care “cards,” covering topics such as anaphylaxis diagnosis and treatment, antibiotic selection for urinary tract infection, and dental trauma.

Despite the diverse resources, topics, and initiatives launched on ALiEM, what remains constant is our blog site. It is our home base where new projects are described, updates announced, and new educational content published. The blog is the central platform from which we keep our readers informed about us as an organization and about the field of EM. With 1.5 million views per year worldwide today, we remain humbled and grateful to be in such a position of influence and trust in EM.

Embassies: Not just one-way communication channels. *As the blog readership grew by word of mouth, and as the microblogging platform Twitter became more popular in academia, we focused on building out our embassies. We began to announce each day’s new blog content on Twitter and Facebook to expand our reach. Notably, we published our blog, Twitter, and Facebook posts at different times of day to capture readers from various time zones. This follows best practice in the blogging industry: disseminating content across different platforms to reach potentially different audiences.*

But we wondered if we could do better than using these real-time communication platforms as one-way amplifiers of our blog content. In 2013, we launched a one-year pilot series with the Annals of Emergency Medicine to host a Global Emergency Medicine Journal Club on a selected paper every 2 to 3 months.

Over the course of a week, the featured paper from the traditional print journal was highlighted and discussed on the blog site. The blog comments section allowed readers to view and participate in the ongoing conversation. Simultaneously, our journal club team monitored and facilitated Twitter conversations, tracked by the hashtag #ALIEMJC. A live Google Hangout on Air video conference was held during the week, often with the paper’s author, along with key experts and discussants. The online conversation included reflections on the paper, journal club questions, and relevant side discussions – often on comments made on the blog and Twitter.

A summary of the discussion for each journal club event was then published in the Annals of Emergency Medicine as a springboard for further discussion.³⁻⁷ For information on the basic framework on setting up a virtual journal club, see our tutorial article in the Journal of Graduate Medical Education.⁸ Although the year-long Global Emergency Medicine Journal Club project has concluded, the model continues in the annual Health-Professions Education Journal Club series, co-hosted with the Journal of Graduate Medical Education. This initiative covers topics such as resident-as-teachers and physician and resident wellness.

We have learned that embassies can do more than amplify one's message. They can also help create dynamic social bridges to bring together a virtual community of practice, whose members' common interest is to share, debate, and learn about topics of common interest.

Outposts: Analytics provide constant feedback and shape the network. *In alignment with Michael Hyatt's definition of outposts,¹ we set up Google Alerts to receive email notifications whenever ALiEM is mentioned on the web. Because they inform our impact and reach, analytic data could also be considered outposts. Tools such as Google Analytics (for blogs), YouTube Analytics (for videos), and Soundcloud Analytics (for audio podcasts) provide systems-level feedback. We are continually learning and adjusting our educational content and delivery methods on the basis of these metrics. Additionally, analytic data are reported back to our guest authors for their CVs.*

The example of our author analytics reports provided in the reference list below⁹ demonstrates the combined power of analytic data and visual design.

Communication networks: an organization's nervous system

Communication networks are part of a broader informal network of information – beyond the “org chart” – that informs the work of any organization. Many health care and educational institutions have organizational charts that describe formal structures, titles, and lines of authority. This traditional network can be viewed as the skeleton of the organization, and its predominant communication paradigm includes email and committee meetings. However, much of the work done in any system is influenced by informal advice or personal learning networks, trust networks (see chapter 4), and communication networks that complement the org chart. This web of networks can be viewed as the organization's nervous system.

Whatever their type or purpose (personal learning, building trust, or communication), networks are usually built around common areas of interest rather than titles or roles. For example, effective communication networks serve as a hub for a common area of interest by focusing on the “3 Cs”: they **C**urate information for a **C**ommunity of practice to facilitate the **C**reation of value. Communication networks often encompass multiple communication tools that are used in an asynchronous manner.

Case example

How ALiEM launched a Chief Resident Incubator using a 3C framework for effective networking - Michelle Lin

In 2014 our ALiEM team shifted internal communications from email to a more dynamic, real-time messaging platform called [Slack](#). This change improved the transparency of our communication and the integration of team members across our various projects. The primary "disadvantage" identified so far has been that it is practically impossible to create a traditional org chart. Anyone can drop into a project's discussion channel, listen, contribute, and leave at any time. Many of our best project ideas come from people who were not originally on the team. Our culture of trust, sharing credit, accepting doubt, inclusivity, rapid prototyping, leaning toward action, and open collaboration allows creative idea generation and efficient project management. Our communication network supports a very flat organizational structure with a collaborative working environment rather than top-down management.

In 2015, ALiEM launched the Chief Resident Incubator for all EM chief residents in the United States. Many of us in academia see the annual struggles that chief residents go through, often without a support system or mentorship outside of their local institution. Our initiative was launched to support and mentor chief residents in their leadership roles. We hoped to capitalize on our experience of building a dynamic, virtual community of practitioners to build a similar community for EM chief residents. Could a Slack-based platform create an environment that would allow them to share their experiences with and learn from their peers?

The Chief Resident Incubator was launched with over 200 chief residents, thanks in part to an unrestricted educational grant from EBSCO Health/DynaMed Plus. The project has facilitated the development of a communication network that provides education sessions, virtual mentoring, and a community of practice. Chief residents also virtually meet leaders in EM on Google Hangouts and receive direct mentorship on leadership skills. A lucky few have been able to "hang out" with former US Surgeon General Dr. Richard Carmona (former U.S. Surgeon General) and ask him questions.

The Chief Resident Incubator provides a "safe place" for chief residents to talk about issues such as career concerns, the fellowship application process, institutional policies, and developing a CV. Because the projects and conversations soon became quite overwhelming to keep up with, we recruited monthly email newsletter editors who summarized key discussion points; provided links to documents, articles, and Google Drive working documents for ongoing projects; and posted upcoming deadlines.

The Chief Resident Incubator illustrates the use of a 3-C framework for building and maintaining an effective communication network.

- **Curation.** *We collect and present high-value resources and website links for chief residents as part of their longitudinal leadership and professional development curriculum. Further, we curate our internal discussions into monthly newsletters to help them identify and remain connected with the ongoing discussions.*

- **Communities of practice.** *The EM chief residents now can gather in a safe, closed community platform to network, collaborate, teach, and share with each other within an infrastructure that also allows for mentorship.*
- **Creation of value.** *The Incubator is an illustration of social constructivist theory that knowledge is co-constructed and that people learn from one another. The products that the chief residents are creating are valuable contributions to their field. Examples include an in-service training preparation book, journal articles, and various widely read ALiEM blog posts.*

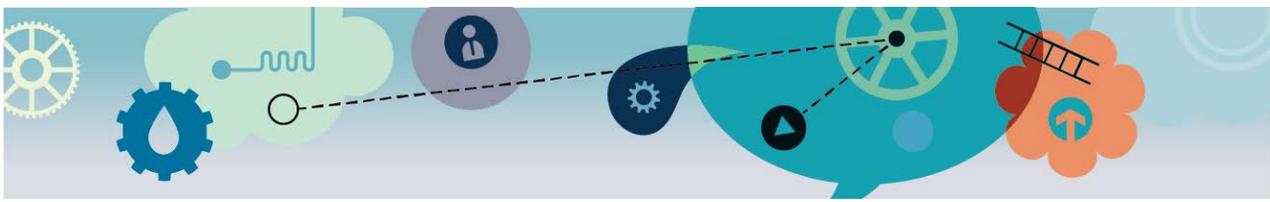
Tips for building communication networks

- Construct your communication platform. Be deliberate about the architecture of your home base, embassies, and outposts.
- Supplement bone conduction with nerve conduction. Emails and meetings will get you only so far. Supplement traditional “org chart” communication with an effective communication network, as well as with personal learning and trust networks, using multiple modalities in an asynchronous fashion.
- Incorporate the 3Cs when building effective communication networks: curation, communities of practice, and creation of value.

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Chapter 6

Creating a robust personal learning network by nurturing weak ties

Felix Ankel and Anand Swaminathan

The challenge

You are a new #MedEd leader responsible for leading medical education programs to produce practice-ready graduates. You assemble a skilled team, attend #MedEd leadership courses, and participate in national meetings. How do you develop a discipline of continuous learning and adaptation for yourself, and how might a personal learning network help?

Why build a personal learning network?

Humans are hard-wired to [learn and to network](#). (Geek alert: For this we can thank our [mirror neurons](#) and [eusocial traits](#).) Successful leaders network with people in their fields, and those who are the most successful at doing so cultivate the weak ties that lie at the periphery of their traditional professional network. The sociologist [Mark Granovetter](#) first recognized “the strength of weak ties” in a paper published in 1973¹ – long before Facebook, LinkedIn, and Research Gate existed. It is now one of the most frequently cited articles in the social sciences.

Essentially, weak ties are professional relationships without the traditional strong connection of shared work, regular communication or interactions, or direct accountability. The professional and social capital expended on a weak tie is less than that required by a strong link. At the same time, through weak ties a leader can diffuse ideas and influence across multiple networks or disciplines. Cultivating weak ties invites insights from diverse points of view and paves the way to more effective decision-making and the co-creation of successful programs.

The concept of networks is becoming increasingly prominent in medical education in our digital age. In the conceptual framework of “connectivism,” learning is viewed as a “network phenomenon influenced by technology and socialization.”² With connectivism, learning begins when the learner accesses information by means of a community of knowledge. The learner can participate in the network through discussions with others in the community,

thus adding to the net information within the group. The learner doesn't grow in isolation, but rather as part of the community. The difference in the digital age is the scale of the community as well as how participation occurs through social media platforms. A recent study shows that a major reason for the use of social media by health care professionals is the desire to stay connected with colleagues through networking.³

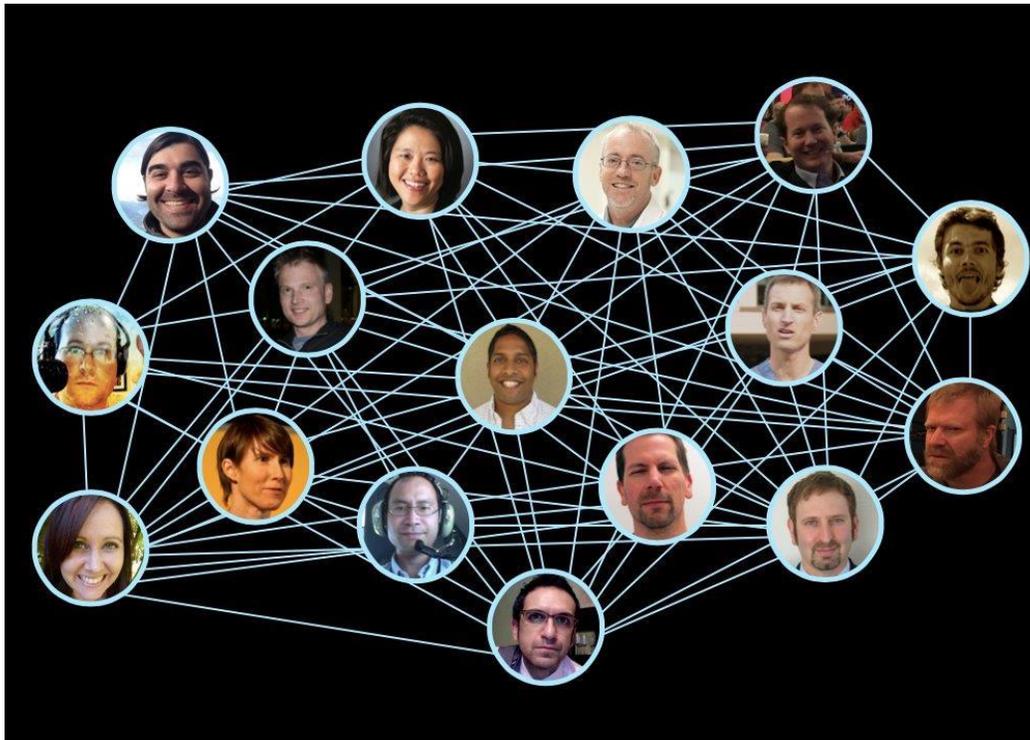
Case example

Building a PLN – Anand Swaminathan

When I started in educational leadership six years ago, I was tasked with scheduling our resident academic conference time. I wanted to overhaul our current system, but that system was the only one I knew. How could I build something different when I had no experience with anything different? Soon I realized that, with this challenge as with others, I needed a network of educators to expand my own thinking and experience. I became interested in building my personal learning network to surround myself with smart people who thought differently.

I started with the traditional route of network building: going to conferences, meeting other educators, and building relationships. The problem with this approach was that it required expensive and time-consuming travel without any guarantee that I would cross paths with the educational leaders I needed to meet. After a couple of years I concluded that this old-school approach wasn't going to work. If I wanted to build a robust network of educators with similar goals and unique perspectives and ideas, I would need to embrace connectivism.

I quickly discovered the virtual network that naturally developed with the Free Open Access Medical Education (FOAM) movement.⁴ Travel, geography, and time were no longer barriers. Unfettered access became simple. I now have a robust, heterogeneous personal learning network that allows me to collaborate with people around the globe.



Tips for building a personal learning network

Although technology has influenced the scope and size of personal learning networks, the fundamentals of network-building remain the same.⁵ Consider these five key principles.

- **Be authentic.** Pursue what you love. As Steve Jobs said, “The only way to do great work is to love what you do.”
- **Be courageous.** Don’t be afraid to get out there. Take a risk and get involved. This means emailing leaders you respect, approaching them when you see them at conferences, and getting involved in a learning community. Technology makes access easier.
- **Be deliberate.** Build relationships with people you like working with. The best output comes from people who enjoy working together.
- **Be generous.** Give back as much as you take. Say yes when your network asks for help on projects, edits, or advice, and help junior leaders when they come calling.
- **Look for weak ties.** Seek out people outside of your discipline and your institution. Engage with people who connect more than one network or discipline.

By following these steps, you’ll find yourself with a robust personal learning network that will challenge you to constantly improve.

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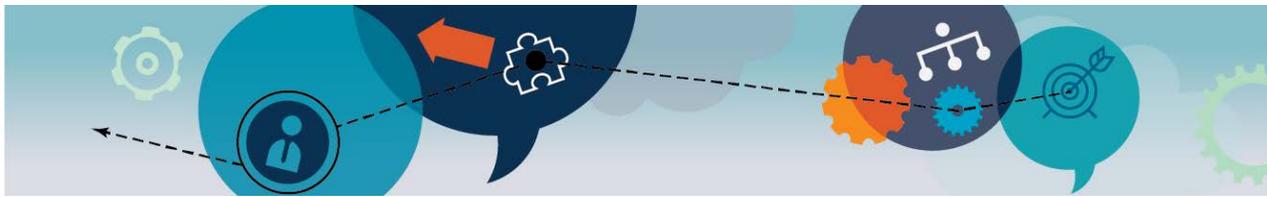
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Chapter 7

Identifying and communicating clear values

Felix Ankel and Michelle Noltimier

The challenge

You are a #MedEd leader charged with integrating health professions education into a health care system. The new system will require the alignment of nurse practitioner and physician assistant training. As you work toward this goal, how do you ensure that the new education program has, and fosters, the attribute of [resilience](#)?

Health professionals are burning out, learners are burning out, and educational systems are burning out. The classic signs of burnout – emotional exhaustion, detachment, and a low sense of accomplishment – are prevalent among [medical students](#) and [doctors](#).

What portion of burnout is attributable to the capacity of the individual to handle stress (“the gene code”) and what portion is related to the capacity of the system to handle stress (“the zip code”) is a subject of debate. (For a deeper discussion of this concept see Daniel Cabrera’s excellent article on resiliency: [part 1](#) and [part 2](#).)

Resilience is the capacity to recover from stress. In the current climate of health care and health professional education, resilience is indispensable. So what makes an education program resilient? In our view, resilient programs have four key attributes, the first of which – having clearly defined values – is discussed in this chapter. The next three chapters will cover the other key characteristics: interconnectedness, flexibility, and the practice of systematic reflection.

Explicit values: the cornerstone of resilient educational systems

A key to a resilient medical education program is the establishment of clearly defined values explicitly communicated to system stakeholders. Clarity grounds culture, facilitates connections, allows us to bend to internal and external stimuli, and stimulates systematic reflective practice. In the absence of clearly defined values, external support functions such as measurement and finance sometimes fill the void and become the de facto values. They

increase system stress and may inadvertently crowd out key de-stressing values such as civility and transparency.

There are several ways to approach the identification and clarification of system values that, ideally, will lead to action. For example, you can try any of these three processes:

- **Sorting.** Assemble a group of program stakeholders. Distribute a list of values. Many sample core values lists that can be used to spark discussion can be found online. (For an example, see [here](#).) Pare the values down to 10 or so and discuss them. Reflect further to pare the values to three or four.
- **Creating.** Assemble a group of program stakeholders. Reflect on and brainstorm important values of the program. Repeat in two or three iterations to identify the most important.
- **Modelling.** Look at the larger context in which your educational system resides, such as your hospital, health system, or medical school. Model the program values on those that are important in this larger context.

The case example below illustrates how the third method, modelling, can provide a foundation for building a resilient educational program.

Case example

Using modelling to identify and clarify education program values – Michelle Noltimier

I come from a clinical and operations background with experience working as a nurse, clinical educator, and manager in two level 1 trauma centre emergency departments. Both emergency departments have a culture that values education and training as a way to enrich the clinical environment and strengthen patient care.

Over the past year I began a journey of constructing a resilient educational system for nurse practitioners (NPs) and physician assistants (PAs) using the values of our health system in Minnesota, [Health Partners](#). These values – excellence, compassion, partnership and integrity – resonate with our stakeholders and with me personally.

Excellence. Any successful work that is produced is usually the result of a team of many individuals. Creating a resilient educational system for PAs and NPs requires the input of many to deliver the best product. We use our relationships across the system to create and nurture a [community of practice](#) to produce excellent outcomes using the talents of all.

Compassion. I feel fortunate to work for a health system in which compassion is one of four explicit values. I have been lucky that part of my role involves providing part-time clinical care to patients in the emergency department as a staff nurse. I am reminded how

important is it to place the patient and the learner at the centre of any educational design. Compassion for patients and for co-workers makes the work rewarding and provides for [deeper connections](#) with our educational and clinical teams.

Partnership. The relationships and connections I have made along the way have been the most rewarding part of my work. Partnership moves interactions beyond a merely transactional level into relationships built on [trust](#). Partnership takes these relationships and connections to the next level because it requires commitment on both sides and a willingness to work together to achieve meaningful outcomes. I have been amazed at how committed and engaged my collaborators have been. I am energized by those around me and am excited about what we can create together.

Integrity. Creating trust and establishing relationships with leaders, educators, schools, and trainees throughout our system was a priority. My goal was to understand the needs of our system and its various stakeholders and to establish a process to move the work forward. This required listening to others, honouring my commitments, and staying connected through regular communication.

Tips for building resilient education programs

When building educational programs, consider the following:

- Identify three or four clearly articulated values for your educational program.
- Incorporate these values in explicit communications, describing the [content](#) and [people](#) of your education system.
- Use these values to [co-create](#) a revised education system that has the resilience to address the competing pressures of today's health care environment.



Chapter 8

Using a co-leadership model to increase the density of connections

Felix Ankel and Jeanette Augustson

The challenge

You are a Dean that has moved from a traditional university medical school role to a health system that is integrating #meded and clinical operations. Medical education in the health system is led by a MD-operations leader dyad model. How do you thrive in this model? How do you use this model to maximize value to the system?

Co-leadership models have existed since republican Rome.¹ For 400 years, the Roman leadership model was a dyad consisting of a patrician (noble) and a plebian (commoner). Physician-administrator dyad leadership teams date back to 1908, when Will Mayo, MD, and Harry Harwick recognized that [joint leadership](#) is more effective than single leadership in integrative health care delivery.

Productive dyads allow for continuous reflection, better decisions, and more effective problem-solving. Cognitive biases sometimes become prejudices that push others away, decreasing potential connections and opportunities for collaboration. Effective dyads help mitigate the co-leaders' [cognitive biases](#), particularly "anchoring" and "confirmation" biases. Dyads also help the co-leaders calibrate each other's emotional state when faced with conflict-prone situations. This results in an approach that moves the mindset up the Senn Delaney "mood elevator"² from judgment and defensiveness to creativity and resourcefulness. This new mindset allows for more efficient [trust network](#) development. Ultimately, effective dyads perfect a system of [reflection-in-action](#)³ that allows for continuous adaptive learning.

Our experiences in working in dyads, described below, show how this leadership model can increase the density of connections within systems and serve as a foundation for building resilient educational systems.

Case example

Diversity of thought and skill – Jeanette Augustson

A couple of years ago I had my first experience working in a dyad leadership model. Initially, this was an opportunity to lead through a partnership in which each of us brought different skills and strengths to the task. My strengths included planning, communication, and implementation. My partner had a wealth of expertise in the programs we were leading, as well as strengths in strategy and vision development. Together, we complemented each other with our diversity of thought, skills, and experience.

As our partnership evolved, I saw our leadership become much more than two people with complementary skill sets working together on common goals. First, I found that I was approaching challenges and opportunities in a more thoughtful, elevated manner. Through dialogue with my dyad partner—benefiting from his experiences and observations as well as my own—I was more confident that my decisions and actions were on point. Second, my own awareness about my leadership style and strengths increased. In certain situations, my partner was leaning on me for strengths I hadn't recognized in myself before, and I likewise leaned on him.

Finally, our effectiveness in working with others to accomplish our goals increased. We both had professional networks and relationships that we brought to our common efforts. I also believe that as others saw us working in partnership their trust and support grew, since they recognized that we were applying our combined skills and expertise to a challenge. It is this density of connections that elevated and accelerated support for our efforts.

Case example

Fostering communication and partnership building – Felix Ankel

I came into a dyad leadership structure after decades of being in a typical singular leadership design. My focus had been on developing and fostering expertise that focused on medical knowledge and individual exceptionalism rather than the Institute for Healthcare Improvement's [Triple Aim framework](#) and teaming behaviour. In my new environment, I felt confident in my content knowledge and methods of information transfer. I felt less confident in my ability to construct an educational narrative and [communication](#) platform that was understandable to a heterogeneous group of stakeholders, many of whom had only peripheral engagement with medical education.

My dyad partner had a wealth of experience in areas such as planning, finance, human resources, and board relations. Initially, we invested a great deal of time and energy in a "dyad boot camp" that accelerated our on-the-fly learning. Both of us attended all meetings and worked collaboratively on all projects, which allowed us to prepare together, observe together, and reflect together. Soon, we were able to divide up our responsibilities and speak for each other.

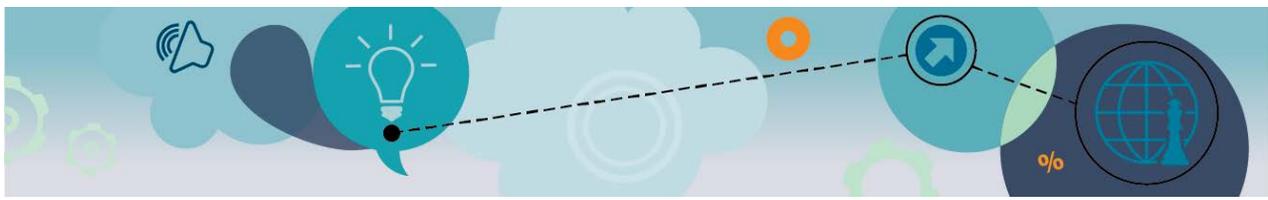
The dyad model and up-front immersion allowed me to become a quick study in the cultural norms of an integrated health care system. I learned the new language, leadership, management, and communication styles of a large organization and became more effective. The melding of both of our networks also increased the density of our education connections, both within and outside our system, and facilitated rapid partnership building.

Tips for effective leadership dyads

1. Be “present” in the partnership: actively listen, consult, reflect, and make decisions together.
2. Have clear roles, responsibilities, and rules of engagement.
3. Reflect on your own strengths and the areas for which you may want to lean on your dyad partner.
4. Share your professional networks and foster shared relationships.
5. Make it a personal goal to ensure your dyad partner is successful; you will have the most influence on his or her experience of the work.
6. Remember that dyads reflect the goals of the system they are leading, not the desires of two individuals.
7. Educate others on the dyad leadership model, which may be tricky for others to navigate.

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Chapter 9

Bending the system to accelerate change

Felix Ankel and Nico Pronk

The challenge

You are a vice dean in a medical school with a long track record of educational success. Medical school chairs have built departments with outstanding regional and national reputations based on first author publication and grant funding metrics. Recent regional mergers are changing the relationship between the medical school and the clinical learning environments housed in the local health systems. How will you help medical education leaders adapt to this change? How will you build “bending” competencies into your team?

Challenges to bending and adapting

Educational programs stick to the status quo for many reasons. Program directors and faculty who are comfortable with established practices might be reluctant to initiate change. External accreditation and compliance standards are typically interpreted in a conservative fashion. Moreover, hierarchical organizational structures favour [perfectionism](#) and often succumb to what Freud called “the illusion of central position”: the assumption that current experience reflects appropriate norms. Such conditions are not conducive to innovation or an enthusiasm for rapid prototyping (which also requires acceptance of rapid failure).

Clinicians have minimal tolerance for error – or for competing points of view, unless those views are backed by compelling data. In academia, committees promote faculty on the basis of their volume of peer-reviewed publications and grants, which are surrogates for academic reputation. These forces ensure that the interpretation of external data is constrained by an inward-facing lens that stifles program innovation and creativity.

A “culture of central position” results in medical education programs being produced and “[perfected](#)” without input from diverse stakeholders. This “[production model](#)” (see chapter 3) often leads to small technical improvements, but it does not address the adaptive transformation needed to train the clinicians of the future to work in the environment of the future.

Shifting your perspective

Human capital refers to an organization’s human resources – including their health, expertise, and functioning. The ability of an organization’s culture to “bend” with the

evolving and emerging needs of its environment has a profound impact on performance. Medical education leaders benefit by developing competencies that will help them adapt to, and remain relevant in, rapidly evolving health care environments.

One technique is the A-B-C-D method devised by the influential American psychologist [Albert Ellis](#) (1913–2007). The **A**ctivating event is one that causes stress (e.g., learners being removed from a subspecialty clinical service). The **B**elief is the immediate thoughts or assumptions about the event (e.g., that the residency does not value the training provided by the subspecialty service). The **C**onsequences are the emotions or behaviours that develop in response to the belief (e.g., anger and hostility toward the residency director). **D**isputing involves challenging one's initial belief by coming up with alternatives (e.g., learners are removed from the service because of national duty hour restrictions, and not for reasons related to the value of the training of the service).

Education leaders who can instill perspective-shifting competencies in their team will help educational programs bend, adapt, and maintain resilience in a rapidly changing world.

Case example

A (non-medical education) case study – Nico Pronk

Over a ten-year period I studied the journey of a medium-sized manufacturing company in the United States.¹ In 2003, the company's Minneapolis location had a diverse workforce of about 500 employees, among whom more than 30 languages were spoken. The company's performance was floundering, and a new CEO was brought in. The CEO decided to focus on the company's workers as its main asset and set out to create a culture of health and safety that reflected clear values, ethical leadership, support for worker well-being, and organizational performance. In the process, the company built a culture that reflects an organizational capacity to bend and adapt and provides a context in which the company's human capital can thrive.

Health and well-being. *The manufacturer built a platform for worker health and well-being that was designed to go beyond individual programs and address needs holistically. Support from leaders was enhanced by access to a range of benefits, including an on-site medical clinic, pharmacy, and health-coaching services; sponsored retirement savings programs and financial counselling; profit-sharing for retirement; "work/life pursuit" time; company matching for volunteers; a policy of promoting from within; and tuition reimbursement*

Education. *The company created a leadership and development track to support managers and supervisors in optimizing all aspects of employee and organizational health and well-being. All executive, mid-level, and front-line leaders participate in this ongoing program, which includes training in social and emotional intelligence, leadership effectiveness and authenticity, goal setting and coaching, and intrinsic needs assessments.*

Motivation. Year-round communications that bring recognition to the services and experiences of the employees and transparency around the company's performance in the market optimized employees' energy and motivation to bring their best selves to work every day. The notion of pursuing a "human-centred" culture means not only paying attention to physical health so that employees can be at work, but also addressing the issues that matter most to them and their families. Through the introduction of "stay" interviews, coaching, and mentoring programs, the voice of the employee is loud and clear.

Why did these changes matter?

Having the ability to bend and adapt as a company is important for health and well-being, education and expertise, and motivation. The reverse is also true: a focus on human capital is as important for an organization's ability to bend and adapt as any other factor. Hence, maximizing the capacity to bend is a leading indicator of a culture of health and safety.

Companies recognized for their cultures of health and safety tend to outperform the market by as much as 5% to 17%, as measured by the average Standard & Poor's 500. Over the decade it took the company described above to build a positive culture, the rate of employee turnover declined from 15% to less than 1%. (The industry average is 13%). Employee surveys indicated that 93% of employees gave their best effort each day and that 91% put in extra effort as needed. Such results support the conclusion that the benefits of taking a long-term view include building **resilience** among people as well as in the organization as a whole.

When building resilient educational programs, consider the following:

- Beware of the limitations of perfectionism. Embrace rapid prototyping and rapid failure. Champion human-centred design.
- Beware of the illusion of central position. Design your programs from many points of view. Embrace criticism as providing energy for creativity and innovation.
- Maximize your cognitive-bending practice. Consider embedding the ABCD approach into your program for maximal resilience.
- Recognize the value of investing in human capital,² especially the health, well-being, and education of your people.

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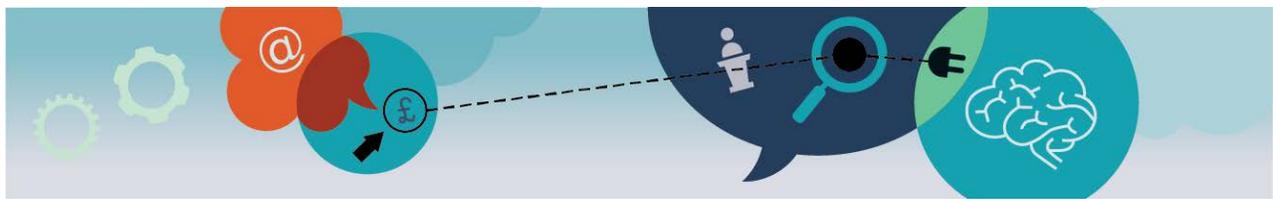
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Further reading

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Chapter 10

Reflective practice and learning organizations

By [Felix Ankel](#) and [David Abelson](#)

The challenge

You are a #MedEd leader charged with integrating health professions education within a health care system. You are trying to guide the educational enterprise from a knowledge- and time-based system to a competency-based one. You attempt to create assessment tools and faculty development opportunities for preceptors who are increasingly burning out because of operational stressors. Enrolment numbers and class sizes are increasing, which necessitates increased clinical capacity for rotations. How do you maintain direction? How do you systematically incorporate reflective practice to maximize your potential as a learning organization?

Humans have a hard-wired desire to create trust, learning, and communication networks (Geek alert: This is because of [oxytocin](#), [mirror neurons](#), and [eusocial traits](#)). The quality of these networks is influenced by the relational competencies of the individuals in them. [Peter Senge](#), a visionary on the topic, [described a learning organization](#) as “a group of people working together collectively to enhance their capacities to create results they really care about.”¹

Viewing the functioning of a learning organization as relational allows us to consider whether the four relational practices developed by Koloroutis and Trout – attuning, wondering, following, and holding – can be used to advance learning organizations.²

Understanding the four relational practices

The four relational practices espoused by Koloroutis and Trout for individuals might be summarized as follows:

- **Attuning** is the practice of being open, aware, and present in the moment. It usually includes “tuning in” to an individual or situation. Attuning is the most foundational of all of the practices; without it, the other practices are not possible.
- **Wondering**, the practice of discovery, is grounded in curiosity and genuine interest in others. Wondering prevents us from making assumptions, rushing to judgment, or disconnecting from people prematurely. We become more scientific when we wonder: we resist reaching conclusions too quickly, we welcome and even seek new data, and we imagine possible explanations beyond the apparent ones.
- **Following** is the practice of attending to the rhythm and flow of a person’s words as much as to their content. Following means focusing on what an individual is teaching us about what matters most to him or her and allowing that information to guide our interactions with that person. It requires consciously suspending our own agenda.
- **Holding** is the practice of creating a safe haven for healing in which people feel accepted and are treated with dignity and respect. We hold someone when we do what we said we would do. We hold when we remember the things people tell us and, perhaps, act on them. We hold when we listen without defence or retort.^{2,3}

Case example

Applying relational practices to a learning organization – David Abelson

As CEO of a large health care organization, I incorporated relational practices into health care delivery operations. Below I describe these relational practices through an operational lens and show how attuning, wondering, following, and holding can catalyze learning organizations. The discussion is adapted from the “Care Delivery Design” chapter of my book Advancing Relationship-Based Cultures, co-edited with Mary Koloroutis.⁴

Attuning as an organizational practice entails taking regular pauses in the day-to-day urgency of work, taking the time to recognize our responsibility to design health care delivery that first does no harm and aspires to do great good. We built these important pauses into leadership team meetings.

Each monthly management meeting began with a patient or family member attending the meeting and telling his or her story. These narratives gave the executive team a sense of reverence for the importance of their mission in caring for people, and the importance of continuously improving the design and implementation of health care delivery. The stories also put some of the most practical ideas of what patients and their families want and need into the consciousness of those designing care.

Attuning means addressing with humility the unknowns, unknowables, and unintended consequences that accompany changes in a complex and interdependent system. Most

design changes, no matter how well planned, result in unintended consequences. Humble attunement involves constantly asking how we know that a change is an improvement: What more do we need to learn? What more do we need to improve?

Wondering as an organizational practice entails asking questions about how the organization is doing and how it can do better. Following involves translating what we learn into actionable assessments using a variety of methodologies, including focus groups, surveys, and standardized data collection of key processes. The practice of [appreciative inquiry](#)⁵ inspires another sort of questioning, which is equally based in wondering and following. In appreciative inquiry, questions are aimed at uncovering what is working well within the organization and how to make more of it happen.

The practices of wondering and following need to be built into the rhythm of organizational processes. A SWOT analysis as part of strategic planning is a process of wondering about organizational Strengths, Weaknesses, Opportunities, and Threats. Selecting annual improvement projects begins with wondering about what we can learn by looking at any measurements of current performance. Leaders should have regular monthly, weekly, and daily dashboards that gauge the organization's progress along various metrics to make the practice of wondering practical and expected.

Holding, as an organizational practice, entails viewing all individuals involved with the organization – patients, families, employees, suppliers, referring physicians, community members, and more – as partners. It means holding individuals harmless when processes fail. At the same time, it means holding people accountable for personal ownership of results, improving imperfect processes, and leading within their zones of responsibility and authority.

All the partners in the organization hold by doing what they say they will do or what people expect them to do in order to produce the promised, wanted, or expected result. Leaders hold by cultivating a positive and [psychologically safe](#) environment in which people are able to flourish in their roles and experience pride in being part of a health care community that serves the noble cause of human caring.

A learning organization counts on the effectiveness of relationships. Even the processes and structures are created and refined by people working in relationship with each other. Thus, the quality of relationships is paramount in the success of any organization. The four relational practices provide a conceptual and practical framework for creating and advancing quality relationships at an individual, group, and system level.

Tips for incorporating systematic reflective practice

When building resilient educational programs, consider the following:

1. What is your discipline of systematic reflection? Incorporate "space between the notes."
2. [How attuned are you with your educational operations? How can attunement help you unlearn?](#) Invite a student or educator to share his or her story at the beginning of every senior educational meeting.
3. [Do you use wonder and following for strategic and annual planning?](#) Integrate appreciative inquiry into planning.
4. [How do you hold the relationships within your program? How do you balance accountability and psychological safety?](#) Be deliberate in building your [trust](#), [learning](#), and [communication](#) networks.
5. [How do you develop the four practices of attuning, wondering, following, and holding into your day-to-day leadership practice?](#) Incorporate systematic reflective practice to maintain a resilient educational program.

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