Session D5: 2020 Vision - Novel Perspectives and New Understandings in Global Medical Leadership Research

Wednesday 6th November 2019
Panel Session, Leaders in Healthcare
@LeadersHealth #LeadersHealth19 @MedicLeadership
Overview of session

Welcome & introductions
- Dr Simon Moralee (chair)

Bridging the Gap
- Professor Mark Exworthy

Panellists
- Dr Amanda Goodall
- Professor Erwin Loh
- Dr James Mountford

Learning Outcomes
- Critically reflect on the development and impact of medical leadership as evidenced by research;
- Gain a better understanding of the impact of medical leadership on global health service delivery
- Adopt new practices in their personal and professional development of medical leadership

Peer-reviewed democratic audience Q&A

Panel Responses & further Q&A
Bridging the gap
Professor Mark Exworthy
M.Exworthy@bham.ac.uk - University of Birmingham
Gap #1: Getting health care evidence into practice

- The `traditional’ gap (from lab to guideline to everyday practice)
- Gap exists in medical leadership too because...
  - Rapid rise in evidence (next slide)
  - Hierarchy of evidence seen as less applicable
  - Leaders are a diverse body of staff
  - Little formal training
  - No formal body of knowledge & `weaker’ evidence
    - Findings seen as subjective or context-specific
  - Slower to adopt & apply evidence-based principles

Walshe and Rundall, 2001
"Medical leadership" publications by year, 1969-2019

Pub Med search conducted 1.11.19 using term “medical leadership”
Gap #2: Getting health care evidence from elsewhere into practice

- Cross-national learning has been limited
- Tendency to look to the USA
  - Kaiser, Intermountain, Virginia Mason etc
  - Limited cluster of high profile organisations
  - Focus on micro-level, rather than strategic level
- Less interest in European health systems
  - But key study in Italy & Netherlands (for example)
- Crucial role for key facilitators
  - Eg. King’s Fund, universities
Gap #3: Getting evidence from outside evidence into practice

- Tendency to learn from (apparent) similar industries
  - Aviation, nuclear industry ~ QI, safety
  - Manufacturing ~ lean processes
  - Military, sport ~ teams
  - But... less so from other public services

- Translation to health care context remains crucial
  - Interplay between context, content & process (Pettigrew et al, 1992)

- Need for improved capacity & capability of leaders as ‘translators’ & ‘implementers’ of evidence
The relationship between leadership and organizational performance

Leaders should have a deep understanding of the core business of the organizations they are to lead.

Being a good manager alone is insufficient.

Evidence supporting ‘expert leadership’ comes from healthcare, universities, Formula 1, basketball, among professionals, and from large US and UK random samples.
2020 Vision: Novel Perspectives and New Understandings in Global Medical Leadership Research

An Australian Health Perspective

Professor Erwin Loh
MBBS LLB(Hons) MBA MHSM PhD FRACMA

Group Chief Medical Officer, St Vincent’s Health Australia
Clinical Professor, Monash University
Honorary Professor, Macquarie University

6 November 2019
Translational research: Valley of death

T1 discovery research from bench-top to bedside
T2 implementation research into practice, community and policy
Traditional unidirectional concept of translational research: Need to evolve to an iterative process

![Graphical representation of the research pathway from bench-to-bedside to practice.]

**Figure 3: Health and medical research pathway from bench-to-bedside to practice**

Implementation and translation

The Change Process

Good work, but I think we need just a little more detail right here!
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‘Better Health Through Research’

Researchers
MRIs, universities and hospitals

Healthcare Professionals
Hospitals, clinics and other

Investors
Governments, business and philanthropy

High Quality Health System & Outcomes
Models

Health: Patients, health professionals, Organisations, systems - pull for evidence and research, optimising data to drive quality, bringing services together

Health system priorities and engagement, accessible data driven quality improvement and efficiencies

Research underpinned by partnership; priorities Patients and Health professionals, values of front line, realities of system

Interactive and iterative research, innovation, evaluation and scale-up

Education

Capacity Building within the system
To provide the insight, leadership and governance to support SVHA in our quest to lead the world in safe, efficient, person-centred care.
The Longitudinal Investigation Of Negative behaviour Survey

St Vincent’s ETHOS Program

Australian Government
National Health and Medical Research Council

NHMRC

MACQUARIE University

AIHI | AUSTRALIAN INSTITUTE OF HEALTH INNOVATION
The RACMA Fellowship Training Program (FTP) is structured in four domains of continuous learning in formative workplace activities and summative assessment tasks that have been named:

- Health System Science (HSS);
- Medical Management Practice (MMP);
- Research Training (RT); and
- Personal and Professional Leadership Development (PPLD).

Candidates will propose and conduct:

- A curiosity-driven qualitative or quantitative health service research project; or
- A systematic literature review (following a standardised protocol); or
- A bioethical disputation (following standardised criteria) prompted by a work-related event; or
- A substantial quality improvement investigation related to medical management practice or health service provision that is reported in a scholarly format (following standardised criteria)
communities of practice

CO-LLABORATING

COMMUNITY
Who cares about it

PRACTICE
What & how we do things together

DOMAIN
What we care about

CO-LEARNING

CO-NECTING
Thank you

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Dr. James Mountford
Editor, BMJ Leader
Director of Quality, Royal Free London FT

- James worked initially as an NHS doctor, then in consulting.
- From 2005-2007, he was a Commonwealth Fund/Health Foundation Harkness Fellow based at Massachusetts General Hospital, and at the Institute for Healthcare Improvement (IHI), both in Boston, USA.
- Before moving to the Royal Free, James was Director of Quality at UCLPartners, an academic health sciences partnership serving a population of 3 million in and around London.
- He edited one of the first books published in UK on clinical leadership: Clinical leadership – Bridging the Divide (2006)
- James has written and presented widely on topics including improvement, value and clinical leadership.
- James has recently stepped into the role of Editor of BMJ Leader.
Peer-reviewed ‘democratic’ Q&A

☐ This form of Q&A is based on an idea by Eve Tuck (@tuckeve) and Dani Rabaiotti (@DaniRabaiotti).

☐ As an audience member, please turn to the person next to you and have a conversation for 4-5 minutes about what most struck them about what the presenters/panelists said.

☐ The aim behind this is to ensure that the wider conference community helps the presenter(s): by asking a question that adds to the debate, is related to what has just been said/discussed and is a question, rather than a comment (and by implication to avoid the ‘statement question’).
Session E5: Bridging The Research-Practice Gap - producing and translating knowledge for medical leadership

Wednesday 6th November 2019
Panel Session, Leaders in Healthcare
@LeadersHealth #LeadersHealth19 @MedicLeadership
Overview of session

Framing the Session
- Professor Mark Exworthy (chair)

Making evidence useful for healthcare leaders
- Dr Donncha O’Gradaigh
Discussant - Dr Kamal Gulati

How the Other Half Thinks
- Professor Bernard Crump
- Professor Ian Kirkpatrick
Discussant - Dr Kamal Gulati

Q&A

Learning Outcomes
- Critically reflect on the development and impact of medical leadership as evidenced by research;
- Gain a better understanding of the impact of medical leadership on global health service delivery
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Mark Exworthy
Donncha O’Gradaigh
Bernard Crump
Ian Kirkpatrick
Kamal Gulati
Using Evidence - what works and why

Dr Donncha O’Gradaigh, MB, PhD, MSc
Clinical Director, University Hospital, Waterford
Evidence Based Practice, Ireland
A proposal...

Goal of decision is effective action – (in healthcare, this means “improved clinical outcomes”)

Goal of leadership is to create conditions for effective action

...so good leadership means creating the conditions for good decisions,

make information useful for decision-making (and focus less on “the gap”)
knowledge must fit context
“Mozart used the same B-flat as everyone else”

constants (descriptive, explanatory principles) + variable response

____________________

= outcome

see Davidoff, Implement Sci 2019:14; 23
Bate, Health Foundation: Perspectives on Context)
SO ... what works, and why?
Realist Synthesis

- Everything that happens occurs as a result of interaction between action, actor and context

- CONTEXT (C) triggers a MECHANISM resulting in an OUTCOME
Programme Theory from a realist Synthesis

- Evidence use as the Outcome of interest

- Working theory – the individual, in a group, with the evidence product

- Mechanisms (founded on substantive theories)
  - Making evidence Relevant, readable, reliable
  - Professional influences, the role of the expert, the role of the leader
  - Negotiating, sharing knowledge, making sense
Why groups to make decisions?

- Representative, integrative = better acceptance and implementation
- Combining and integrating diverse knowledge, ideas, perspective of members
- Ideal performance gain occurs when each person has unique knowledge and information processing biases are addressed

Information Processing biases

- Negotiation bias
- Discussion bias
- Evaluation bias

Errors made by the group during discussion

Error made by the individual during discussion
Negotiating focus

- Information may elicit different decisions (action) depending on the context in which the information is presented (Fuzzy Trace Theory).

- Social influence – change in the decision of one due to exposure to the opinions of others:
  - Normative influence – changes in order to conform to the group, to gain approval;
  - Informational influence – changes because of information learned;
Negotiating focus (2)

- Also arises when
  - task is framed as a judgement rather than problem-solving (verdict focus versus evidence focus)
  - When there appears to be consent early, promoting early shift to agreement
  - conformity in decision-making is increased when groups are faced with complex or ambiguous data
  - energy saving heuristic
**Discussion biases - Sampling and Repetition**

- Sampling and repetition of shared information in preference to discovering unshared information
  - Because more people can quote it and participate in the discussion
  - Driven by time constraints (short conversation less likely to uncover unshared information)

- Preference-consistent information more likely to be shared
  - Motivational reasoning
  - Members wish to appear more competent, more credible, more important to the conversation, advocate for their initial position

- But the role of “expert” is significantly different (e.g. cognitive tuning)
Mindlines

- “... a view that knowledge is less a set of facts to be disseminated but a phenomenon in which knowledge is “re-created” in different contexts by different people again and again”

- Tacitly held knowledge, shared among a community of practice
Professional preferences in sampling evidence

From Kyratsis, 2014 *Health Services and Delivery Research, No. 2.6*
Evaluation bias

- Preference-consistent information is shared because
  - it is “owned” by this individual (we are more inclined to believe information we hold already,
  - we give higher “rating” to our certainty when we know that other people know this as well
  - Socially validating

- However, preference-inconsistent information is more critically evaluated (relates to gist / verbatim processing)
- if the other person says they understand the speaker’s preference, there is reduction in preference-consistent information sharing compared with when they state they hold a different preference

Conclusions

- Evidence is most likely to be used when it reflects the personal experience, values and beliefs of the user actively deliberating and seeking to persuade others.
- Conceptual or instrumental use more likely in a planning or exploratory phase.
- Time constraints (especially among managers) shift the focus to transactional issues (implementation) for which research evidence is less contextually relevant and experience is preferred.
- Knowledge brokers act as a role model for the principles of evidence-based practice.
How to create DM conditions to use evidence

- **Time**
  - Sampling bias tends to occur early in discussion
  - Too early a shift to negotiating focus

- **Task Frame**
  - Problem solving rather than evaluation judgement at early stage
  - Pool information before seeking stated preferences
  - Normalise critical appraisal—social validation then comes from appraisal skills rather than supporting preference-consistent information

- **Acknowledge expertise, engage transactive memory**
  - Avoids shift to negotiating focus and if acknowledged, expert will focus on unique information without sampling bias (M = social validation)
Leaders in Healthcare Conference 2019

Leadership

↓

Sharing and shaping knowledge, experience and expertise to fit context

↑

Effective decision process
Dr. Kamal Gulati
Consultant, All India Institute of Medical Sciences
New Delhi, India

- Consultant (Research Administration) at AIIMS, the premier medical institute in India.
- More than 20 years of experience in the health sector and has been involved in operationalising and coordinating several multicentric medical research projects funded by national and international agencies viz. UK-MRC, UK-IERI, Indian Council of Medical Research, Department of Biotechnology, Govt. of India.
- Key role in the strategic planning and execution of this first-of-its-kind cohort study in India, which comprises of both rural and urban populations.
- Research interests include medical leadership, healthcare improvement and hospital governance.
- His study on medical leadership, the first-of-its-kind from the Indian subcontinent, revealed a significant ‘Competency Gap’ and confirmed the need of medical leadership development programmes across all career stages of doctors in all types of healthcare organisations in India.
How the other half thinks: Learning from papers you will never read.
A game of two halves

• Half a career in:
  • Clinical practice
  • Clinical research
  • Public Health practice, including academic public health

• Half a career as:
  • A health service Board Director
  • A Chief Executive Officer
  • A leader and educator in the fields of
    • patient safety,
    • service improvement,
    • leadership development

• ...and latterly working from a Business School environment

BC
Ian Kirkpatrick

• Brief stint in HR management (Shell UK Oil)

• Career academic:
  • PhD in Organisation Theory, University of Wales
  • Senior (chair) appointments at Leeds University Business School, Warwick Business School and (currently) York University Management School.

• Interests in public management and changing professional roles.
My contention today....

• Interaction with the Management and Business academic community has given me insight to a wealth of work which could, and should, be more visible to healthcare leaders.

• BUT

• It is published in places of which I was largely unaware

• Presented at fora I would not have considered attending, and

• Developed over timescales that are foreign to practitioners looking for answers, and

• Published in formats that I am not used to.

BC
Where does Healthcare Management Research come from?
Healthcare management research: assessing the landscape:

• Dispersed between health policy and economics departments (for example, HSRC, Birmingham) and/or Business/Management Schools.

• Further dispersed across core disciplines (HRM, OT, Strategy, OM) within Business/Management Schools,

• Some networks or dedicated research centres. For example, Health Services Research Centre (Manchester) - https://www.alliancembs.manchester.ac.uk/research/hsrc/; OHRN (Warwick) - https://warwick.ac.uk/fac/soc/wbs/research/organising-healthcare-research-network/
Some prominent topics:

• Leadership – antecedents, types, outcomes,

• Professional work – changing roles, identities and skill mix,

• Innovation and knowledge dissemination/translation,

• Operations management – lean systems, new technology, AI.
As a practitioner, why should I be interested?
Examples of the type of work I have valued

Professional Manager “Hybrids” and professional identity

• Extensive and insightful study of the experience of those who move into more formal leadership roles from a “professional”, often clinical background

• Individual and Organisational strategies that could help make this more of a success

Insights into Change and Change management

• Innumerable studies of the circumstances associated with the leadership of successful, or unsuccessful, change

• Directly relevant to the design of change efforts, be the focus change by patients, by practitioners, or by the leaders of systems

BC
Examples, continued

**Behavioural Psychology and Economics**

- In the context of change, the increasingly sophisticated understanding of the dynamics of decision making
- Challenges much of the conventional thinking which has been the basis for policy making
- Includes “design principles” for new behavioural interventions

**Leadership in Practice**

- Unpacking what leaders actually do, day to day, that makes a difference
- How do they create a knowledge infrastructure to support their work
And finally

Factors affecting the spread of innovation

• Why do our efforts to speed the spread and to enhance the sustainability of new ways of working seem so often unsuccessful?
• What are the elements of an innovation culture, and how can it be fostered?

Different paradigms of evaluation of complex interventions

• What alternative paradigms of evaluation should we value when looking at complex, context dependent, interventions that differ from a new drug or a new device?
• How can we learn from other sectors?
But why do they make it so difficult?
Despite my enthusiasm, working with business and management academics can be frustrating!

- They value theory far more than practice, and this has consequences
  - Every major publication needs to offer new theoretical insights
  - There is a lot of duplication “Old Wine in New Bottles”
  - The distinction between some branches of scholarship can be very fine.

- The gold standard is long form publication in a highly valued journal
  - The process of publication, drafting and review can take a very long time
  - Practitioner facing dissemination is often low priority and sometimes a distraction
  - The emphasis on theory and generalisation means that often few clues as to the relevance of a piece of work are given in the title and the abstract
What concerns Management/Business School academics?

- Primary focus on high ranking (peer reviewed) journal publications, even over research grant income (ABS list).
- Theoretical contributions over policy relevance. Healthcare organizations as illustrative cases rather than topics of substantive interest.
- But some concern with impact in the run up to REF 2021 – worth 25% of final submission evaluation.
Guiding concern: How do professionals – without formal authority - gain voluntary compliance from their internal clients (other professionals/managers) to achieve their organisational mandate?

Research focus: Two university hospital research labs (US)

Method: Comparative case study/qualitative.

Findings: One group gained authority by participating in routine (scut) work on behalf of the client, while the second group limited themselves only to ‘high skilled’ tasks and lost credibility.

Theoretical contribution: Importance of constructing relational authority in situations where expert and formal authority is limited.

**Guiding concern:** How do shared perceptions of social status influence change in Organizations?

**Research focus:** Two hospitals (US)

**Method:** Comparative case study/qualitative

**Findings:** Defender elites may undermine the legitimacy of reform alliances in hospitals by associating them with low status professions and creating perception of status threat.

**Theoretical contribution:** Importance of status dynamics for understanding micro-processes of change
So how do we find the middle ground?
Some modest suggestions....

• For those from the practitioner world..

• Be open minded

• Broaden your search strategy

• Make connections with your local Business Schools

• Seek out “popular form” precis of the work, in in-house journals and “White Papers”

• Look for impact studies and, especially where work has been funded by the Research Councils or NHS R&D the research reports, which are often more accessible

BC
‘The sub-panels will assess the ‘reach and significance’ of impacts on the economy, society, culture, public policy or services, health, the environment or quality of life that were underpinned by excellent research conducted in the submitted unit. This element will carry a weighting of 25 per cent.’

https://www.ref.ac.uk/media/1092/ref-2019_01-guidance-on-submissions.pdf
Why the NHS can lead the world in AI technology
27 March 2016
By Panos Constantinides and Simon Rasalingham

A recent Lancet editorial pointed out that "In the span of a few years, I trained radiologists will assess more than 10 million images; a dermatologist will analyse 200,000 skin lesions; and a pathologist will review nearly 100,000 specimens."

Advances in deep machine learning and artificial intelligence (AI) means a lifetime of work cannot be done in days, rather than decades - AI takes just 33 milliseconds to scan and diagnose images.

Such a saving in time will not only free-up clinicians to get on with what they are good at - saving lives and treating patients - it will also save healthcare organisations millions of pounds.

For instance, the UK’s National Health Service (NHS) currently outsources the diagnosing of X-rays and images to several companies, who employ hundreds of people to pore over them and send them back, which can take a week or more.

Instead of hundreds, behind AI - a deep-learning medical software company - trains on several NHS hospitals. It employs four data scientists and diagnoses thousands of images every month, giving doctors an instant diagnosis. Moreover, if the trials succeed, this can be rapidly scaled across the whole NHS with the addition of only a handful of staff.

And this is just in radiology. AI technology can be applied across so many areas. According to recent data from CB Insights, a venture capital database, the number of startups coming the healthcare AI space across the world has increased by 85 per cent from 2012 to 2017.

What the NHS needs is more managers

December 14, 2018 9:32am GMT
Updated December 14, 2018 11:51pm GMT

How do you reduce elderly patient falls?
01 March 2019

This research and more will be on show at the Chartered Association of Business School’s Annual Research Conference on March 20 at the University of Edinburgh, which will be showcasing how business school research is delivering a positive impact on society.

By Greene Currie

As a business school academic it is not often possible to say that your research led directly to lives being saved. However, this was one particularly positive outcome of research conducted by myself and colleagues Nicola Burgess and James Hayton into knowledge diffusion and brokering in the English NHS.

In fact our work helped prevent more than 100 hip fractures and saved 60 lives according to the NHS Trust we worked with.

A research project in which we demonstrate how it is possible to overcome many of the barriers that prevent the spread of good practice from frontline services to other parts of an organisation and, in doing so, really make a difference.

In an ideal organisation, knowledge about good practice and good practice innovation would make its way from wherever it originates, often at the frontier of service provision, to the parts of the organisation where it is useful. Unfortunately, this is rarely the case. And, unlike a ”frontline”, there is no centralised point of control that can ensure that the whole organisation implements the good practice.

This project considers how organisations can prevent the ”trickle-down” of practice innovation and how it can make a difference to patient care.
For the academic community...

• Offer opportunities for engagement, eg Organisational Health Research Network

• Consider the place of practitioner facing journals in the hierarchy of “esteem”

• Consider lobbying for “implications for practice” boxes in mainstream journals, as we have now in specialised clinical journals

• Make the case for a regular feature, in mainstream practitioner facing publications of “highlights from…” the business and management academic literature, in an accessible form, with a declarative title and informative summery

BC
Dr. Kamal Gulati
Consultant, All India Institute of Medical Sciences
New Delhi, India

- Consultant (Research Administration) at AIIMS, the premier medical institute in India.
- More than 20 years of experience in the health sector and has been involved in operationalising and coordinating several multicentric medical research projects funded by national and international agencies viz. UK-MRC, UK-IERI, Indian Council of Medical Research, Department of Biotechnology, Govt. of India.
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Audience Q&A