Medical leadership in palliative care:

a one-day seminar

A workshop for palliative care consultants to challenge us to reflect on our vision for palliative care leadership and strategy for achieving it.

Royal College of Physicians of Ireland, Dublin, 19th July 2017

Facilitated by Mary Rafferty, organisation development consultant and researcher

Convened by the National Clinical Programme in Palliative Care

Supported by The Atlantic Philanthropies

Attendees

- Brian Creedon
- Aisling O'Gorman
- Stephen Higgins
- Paul Gregan
- Karen Ryan
- Joan Cunningham
- Lucy Balding
- Feargal Twomey
- Patricia Sheahan
- Ita Harnett
- Marie Murphy
- Norma O'Leary
- Faith Cranfield
- Regina McQuillan

Introduction

This report provides an overview of a one-day seminar on medical leadership in palliative care, held at the Royal College of Physicians of Ireland, Dublin on 19th July 2017.

Dr Regina McQuillan and Dr Stephen Higgins

In 2016, The Atlantic Philanthropies (Atlantic) made a grant for a palliative care field-level study. The purpose of the grant was to document and share the collective effects of Atlantic's investment in palliative care by conducting an independent review of the field using the Strong Field Framework, which proposes the key elements that create a sustainable field.[1]

The grant anticipated that the overall report of the field-level study would be complemented by a set of case studies on major advances and accomplishments in the field of palliative care. These case studies would be prepared by the principal investigator for each Atlantic grant in the field of palliative care who are also leaders in the field.

[1] The Strong Field Framework emphasises the interconnecting importance of knowledge base, standards of practice, leadership, policy, and shared identity.

The grant proposal suggested that the case studies focus on key emergent learning in the field and was flexible about format and focus.

Mary Rafferty was commissioned by Atlantic to undertake this work.

Focus of the Work

Dr Regina McQuillan and Dr Karen Ryan, consultants in palliative medicine, considered options for a focused study. They identified the issue of leadership in palliative care in Ireland as requiring attention. Together with Mary Rafferty, author of the field-level study, they proposed a process to examine the experience of leadership in palliative care with a view to identifying enablers and barriers and to contribute to a plan for developing leadership to support the development of the field.

Drs McQuillan and Ryan, drawing from their direct experience, identified a number of key features of leadership in palliative care in Ireland:

- There is a history of effective leadership, but this has been largely focused at the local level.
- The field of palliative care has not specifically examined medical leadership to identify what form this should take to contribute to development and changes in the field.

Several issues need to be addressed if palliative care is to continue to develop. They include:

- A move towards locating palliative care in the wider health system requires proactive leadership, beyond the local/specific institutional level.
- In practice, taking up leadership in the medical domain is seen as an 'optional extra.'
- Doctors are largely motivated and enthused by direct patient engagement and see their role as primarily in relation to the patient. There is limited application of the role of the doctor in leading practice in the field beyond local organisational boundaries.
- There is little attention to or discussion of the exercise of medical leadership in palliative care. Some of this arises from professional norms and courtesies.
- Limited opportunities to make explicit the behaviours of effective leadership mean they are not recognised as medical competencies.
- If leadership capacity is omitted from routine professional discourse, it remains as tacit knowledge, located in, and held by a small number of individuals, rather than as explicit knowledge which can be examined, contested, and shared.
- There is an associated risk that leadership is seen as a personal preference and capacity, rather than a required dimension of a professional role in the field.
- If there is no focus on medical leadership, potential leaders may not recognise the personal and behavioural characteristics that are of value.
- There is a need to locate capacity and skills in medical leadership beyond personality and beyond local or institutional politics.

There is value in bringing medical leaders and potential leaders together to:

- Capture and document the experience of medical leadership in palliative care
- Identify the specific practices that enable and support leadership
- Pinpoint the barriers to developing medical leadership.

The broader field of palliative care is complex, with many individual and institutional stakeholders with differing or competing interests. In order to build capacity for engagement and to bound the discussion appropriately, it was proposed that this consideration of leadership should begin with a focus on medical leadership. This focus reduces the range of perspectives to consider. It was acknowledged that this should be seen as one part of a broader conversation with other stakeholders in the field. There is also an immediate and increasingly pressing need to address succession planning and national leadership in relation to clinical programmes.

The Gathering

Doctors working in palliative care in Ireland were invited to come together for a one-day meeting to consider issues of leadership and leadership development in the field. The program was structured to provide inputs on the development of a field with specific reference to palliative care and to highlight potential risks of a limited leadership. The workshop format was designed to allow participants to:

- Reflect on their clinical leadership role
- Explore and describe their experience of leadership in palliative care
- Interrogate the different forms of medical leadership
- Identify medical leadership development needs
- Examine options for engagement and development of medical and clinical leadership capacities.

The day was planned to identify specific actions and opportunities for leadership development.

The seminar was opened by Leo Kearns, Chief Executive Officer, Royal College of Physicians of Ireland (RCPI), who gave an overview of the current context of clinical leadership in health services in Ireland. He noted that clinical programmes came from evidence that the involvement of clinicians leads to better outcomes for patients. He acknowledged the challenges facing the clinical programmes but highlighted the imperative for the integration of clinical leadership at all levels.

He pointed to the supports for leadership development provided by RCPI. Leo acknowledged that the process of health care has become much more complex and requires attention to the connections between many dimensions. He suggested that this capacity for connection and collaboration is fundamental to palliative care and that these practices are instinctive to palliative care physicians. He drew particular attention to the influence of consultants in palliative medicine and stressed the influence of the national clinical lead. He

argued that clinical leadership should be taken for granted as a contribution to the improvement of services. Leo asserted that 'you are a leader every time you go into work. People will look to you to know where you're taking the service.' He questioned the audience as to how palliative care is 'stitched in' to other services.

Leo spoke particularly about the evidence in relation to burnout in doctors and highlighted the personal, clinical, and service risks of allowing this to continue.

Dr Karen Ryan, Mary Rafferty and Leo Kearns

Karen Ryan and Regina McQuillan spoke about the background to the day. Karen described the work of palliative care clinicians as involving core existential questions every day. She anticipated that she would one day ask herself the same question and would want to have a sense that her life had had meaning and that she had made a difference in both personal and professional areas of life. So, the issue of leadership links to being able to answer that question.

Regina illustrated leadership in concrete and varied ways, through seeking and making use of opportunities to influence policy and resources, through adopting a human rights approach to fundraising– despite the problems that this might have created– and through seeking conversations to support development of a better way for ambulance staff to manage expected deaths in the home or during transfers.

Presentation

Mary Rafferty presented an overview of field-building and the key dimensions required to develop a field:

***shared identity * standards of practice * knowledge base**

*** leadership and grassroots support * funding and supporting policy**

She emphasised the critical role of leadership and followership in building and sustaining a field, gave examples of characteristics of fields at different stages of development, and explored key palliative care competencies. She drew parallels between medical leadership competencies and those required to build a field. Mary particularly drew attention to the relevance and application of core palliative care competencies to engagement with Health Service Executive (HSE) managers and others we seek to influence.

Workshop 1 –Leadership as a professional competency

Working in small groups, participants were asked to consider the following:

- What have I done and what do I continue to do, to develop my clinical skills?
- What have I done and what do I continue to do, to develop my leadership skills?
- Is the future of the field of palliative care my responsibility, in my professional role? What am I contributing to the field at local, regional, and national levels?

There was a wide-ranging discussion in both groups, not necessarily responding to the questions but exploring the experience of leadership in role as palliative care consultant. Key feedback was shared, including:

How do I learn now?

- As you 'drift upwards,' there is less opportunity for formal learning and support
- Experience of training was having a mentor who was nurturing you, mentoring you, giving you room to grow – this stops as soon as doctors are appointed.
- No mentor ever since – sort of 'sink or swim'
- Doctors are not sure how to develop
- Limited support for learning.

Thinking about leadership

- Leadership is not about getting on with everyone
- Look to the wider team for support, feedback, and getting a different perspective
- Good at affirmative style of management and leadership – goes with the role
- One should have several leaders in the team – to help and nurture each other, to take on different roles
- Different traits and different skills come together but requires an agreed direction

Ways of developing leadership in role

- Peer observation
- Type of reflective practice
- Mentorship, especially a longer term relationship
- Looking outside of healthcare (*there was particular interest in the experience of some participants who are accessing a mentor through a local business network*)
- Learning from other specialities for clinical skills and professional development

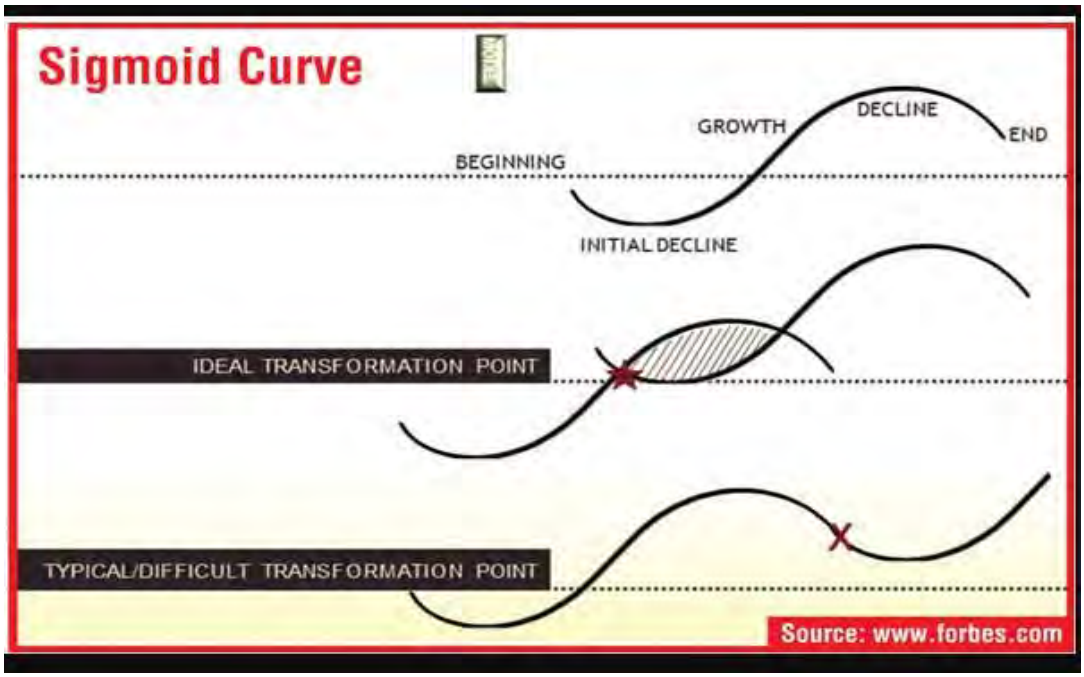
- Incorporating different perspectives
- Extending the repertoire
- Making explicit opportunities for learning.

Reflections on professional career trajectories

- Palliative care in Ireland is young and the professionals are young
- Some said they are already growing weary and jaded
- They wondered what they would be like in 10, 20, and 30 years?
- Some evidence from U.K. that consultants are not staying in palliative care

There was discussion about the need to support each other in such a small group. It is a challenge to continue to innovate and to learn collectively.

In the context of this discussion about decline and renewal, Mary gave an input on the *Sigmoid Curve*, which describes the course of all human endeavours and applies to individual careers, relationships, and field development. If you act too early on the cycle, you lose the fruits of the present life cycle. If you act too late, you may be in the downward curve and not be able to turn things around. The key to future success is to have the foresight and discipline to see the opportunities in what you are doing in the present cycle and then to make your moves while things are going well. It is against the natural order to embrace change when all is going well but, when you plan it right, it is the best possible time because you have time, resources, and morale on your side.



There was a discussion of the opportunity for the small group of consultants in palliative medicine to coalesce and to engage in collective leadership of the field. There was an acknowledgement of the need to be more unified as a group. Issues highlighted include the need to pay attention to the risks of polarisation and the opportunities for distributed

leadership and formal organisational leadership. The value of recognising and investing in alliances was identified.

Dr Marie Murphy and Dr Lucy Balding

Workshop 2–Strengths and needs in medical leadership in palliative care

After lunch in different small groups, participants worked to consider opportunities and options for action to develop leadership in palliative care. These discussions were more difficult. After a rich discussion, participants made individual contributions under the strengths in medical leadership in palliative care and needs in medical leadership in palliative care.

Strengths in medical leadership in palliative care

- Understanding of human factors!
- Integrity
- Patient focus/patient centred/maintaining patient as the focus of care
- Well-developed skills and training, used clinically, that can be utilised in leadership
- The National Clinical Programme for Palliative Care is respected and valued by external bodies (HSE, RCPI etc)
- Openness, willingness, and capacity for collaboration
- A mix of personalities and skills
- Early consultants interested in service development and comparatively fast development
- Local /service leaders focused on doing a good job locally

- Advocating for just division of service resources
- Collegiality
- Committed group
- Can openly dialogue and share different views /practices.

Needs in medical leadership in palliative care

- Develop research leadership in palliative medicine
- Greater understanding of structures and influences on the development of services
- Media skills/media savvy
- Reward leadership
- Build alliances with medics and managers outside the speciality
- Visibility in mainstream medical leadership, e.g., medical council, RCPI, and clinical directorates
- Develop skills in leadership with the same dedication clinicians have put into developing my clinical knowledge and networks
- Unity/collaboration
- Support development of clarity around role of voluntary hospice.
- Maintaining the speciality of palliative medicine
- Mentoring colleagues and trainees to be ever more effective leaders
- Support colleagues to engage in all regions
- Enhance public voice/public engagement
- Build on established national relationships
- Repair broken relationships with engagement
- Learn to influence colleagues.

Next Steps

Following on, participants identified actions that can be taken individually and collectively to build on the work of the day.

As consultants in palliative medicine, we're going to ….

- Be more collegiate and invest in this – e.g., schedule more 'catch-ups' as a group
- Discuss clinical director role within the group – seek more clarification re: governance
- Develop standards/benchmarking to compare and improve what we do
- Continue to develop the supportive environment of the Irish Palliative Medicine Consultants Association to share problems and common situations
- Make 360° feedback part of normal practice
- Be truly open to benchmarking of our outcomes across services
- Consider the role of palliative care medical/clinical director in the model of care
- Get media training to play to our strengths as a group
- Seek−relentlessly− equality of provision of services nationally
- Become more cohesive with other relevant care bodies – social work, CEOs etc.
- Become more entwined with other medical specialities in a role-supportive way

- Be less shy about things we do well
- Seek to generate evidence/proof that we are clinically effective and clinically efficient
- Re-engage with others in alliances e.g., the Irish Hospice Foundation and CEO group
- Carry on these discussions to continue to motivate each other and strengthen our cohesiveness
- Improve involvement in undergraduate and postgraduate programmes to improve standards of future palliative care
- Re-establish medical involvement in the Irish Association for Palliative Care
- Create the opportunities for alliances to be strengthened or developed.

As a consultant in palliative medicine, I'm going to ….

- Find out more about the 'real' decision-making forums!
- Work to build relationships with the Irish Hospice Foundation
- Consider clinical leadership
- Consider formal mentorship
- Slow down, think more. Allow time for change to happen.
- Devote more time explicitly to leadership when teaching trainees
- Review weekly schedule to reduce some clinical time in order to allocate more time to building local relationships
- Get more involved with local HSE structures
- Look at my time and see how I can reconfigure it with management opportunity
- Timetable regular semi-formal meetings with peers within organisation
- Formalise links with local voluntary organisations – extend olive branch to begin with
- Seek honest feedback about my clinical practice, about my leadership style and effectiveness
- Observe other colleagues' practice
- Foster links between out of hours medical GP service and emergency department service to improve care of patients – develop 7-day service locally and out-of-hours advisory service
- Continue to develop local relationships and with key stakeholders locally and nationally
- Do a leadership course with nurse colleague
- Approach management in a similar way to my clinical encounters, to be more effective for my service/patients
- Incorporate a piece about palliative care leadership/development/reflection in the clinical academic group.

Review of the day – what went well

• Size of the group • Active participation • Openness to challenge and different perspectives	• RCPI as venue • Space and time • Space to develop ideas • Wider participation

• Locating the big existential questions and concrete examples early in the day • Very young group • Hungry for this opportunity	• Met a need – people are struggling to work with the HSE • Focus on the future and on the field development

Dr Karen Ryan and Dr Faith Cranfield

Dr Aisling O'Gorman and Dr Patricia Sheahan