

Leadership Development in Ophthalmology: Investing in the Future of the Profession

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Over the last two decades, there has been widespread acknowledgement that the medical professionals of today and the future require a much broader skill set than just good clinical knowledge and expertise. These additional skills and competencies have been formally articulated by medical societies and organisations, for example the CanMEDS framework outlined by the Royal College of Physicians and Surgeons of Canada¹ and the Core Competencies of the Accreditation Council for Postgraduate Medical Education (ACGME)². Healthcare organisations around the world have reiterated that effective leadership should be present at all levels, whether it is a clinical or academic field³.

Leadership, an intangible concept with many definitions, has been described as a “process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task”. Leadership is about defining a vision for individuals, and setting values that are inspiring and lead the organisation in a strategic direction⁴. There is a growing body of evidence that medical leadership plays a critical role in the effectiveness of organisational change in the health sector⁵. Clinicians are not only equipped to make calculated choices but also have the ability to make cutting edge decisions to establish the competency and excellence of healthcare⁶. One study demonstrated that medical institutions with higher contribution in management had about 50% more score on crucial performance drivers compared with institutions having very little clinical leadership⁷. Physicians who are involved in development of their leadership skills are usually motivated to manage the important steps in patient

management, build better knowledge and poise to start a transformation that is positive and endorse improved alignment of the team⁸. In ophthalmology, leadership is required in the clinical setting, both in direct patient care, which includes leading and managing teams, as well as at the institutional level of hospitals and health care organisations. Educational leadership is required for education and training as well as academic research. Organisational leadership is required for ophthalmic societies, through which advocacy efforts aimed at governments and healthcare decision-makers can be highly effective.

Concepts of leadership have evolved from the “Great Man Theory”, which implies that great leaders are born and not made, arising when there is a great need, to an acceptance that leadership consists of definable skills that can be developed through experience, observation and education³. Despite the widespread recognition of the need for and value of clinician leadership, as well as the benefits of training clinicians in these skills, most medical and surgical curricula remain focussed on clinical knowledge and skills, with less emphasis on teaching and assessment of non-clinical professional competencies, including leadership. Ophthalmologists, having not been trained in leadership skills, may be reluctant to take on leadership roles: they have undertaken years of training for their clinical role, so many assume that months or years of training are needed before being able to be a competent leader⁶. As a result, opportunities to influence positive change may not be fully realised.

Recognising this shortfall, the ophthalmic profession has been pro-active in investing in

leadership development. This drive started in the United States through the American Academy of Ophthalmology, which launched its Leadership Development Program in 1998, with the goals of identifying individuals with the potential to become leaders in ophthalmology, providing orientation and skills to allow potential leaders to promote ophthalmology locally, nationally and internationally, and facilitating the promotion of program graduates into leadership positions locally, nationally and internationally⁹. Since then, leadership development programs (LDPs) in ophthalmology have expanded around the globe, with programs run by supranational and national ophthalmic organisations, including the Ophthalmological Society of Pakistan.

To maximise their effectiveness, programs should be based on adult learning principles¹⁰, acknowledging that participants are independent and self-directing, have experience that provides a rich resource for learning, value learning that integrates with the demands of everyday life, and prefer immediate, problem centred approaches. Leadership programs usually incorporate a combination of methods to train and assess leadership skills³.

These may include:

1. **Mentoring:** off-line help by one person to another in making transitions in knowledge, work and thinking;
2. **Coaching:** a shorter-term, goal-oriented process aimed at performance enhancement in specific areas;
3. **Networking:** providing a wide range of contacts, perspectives and information;
4. **Stretch assignments:** the individual is required to work outside their comfort zone to learn new skills, knowledge or behaviours;
5. **Action learning:** joint problem solving of issues that arise in the workplace, during real-life projects or by observing and working with others;
6. **Multi-source or 360-degree feedback:** views of peers, managers and other team members about leadership skills and competencies are obtained, collated and fed back to the individual, preferably by an accredited professional trained in this process.

Although the ophthalmology LDPs around the world vary in structure, content and length, all cover the key aspects of leadership: self-awareness,

awareness of others, communication skills, management skills, governance and advocacy, using a combination of the teaching methods outlined above. A key component of the programs is the requirement for participants to complete a self-directed project, the topic of which should be related to leadership, not clinical ophthalmology, and which fulfils the purpose of a stretch assignment. Although some components can be learnt through reading or online study, much of leadership is experiential, which makes face-to-face interactive learning essential. This also creates opportunities for networking, as well as the creation of a community of practice¹¹, where learning takes place through joint enterprise, shared repertoire and mutual engagement. In contrast to training, which teaches proven solutions to known problems, development is geared towards the future and involves learning the skills to tackle as yet undefined problems¹². LDPs are constrained by finite timelines and resources, but aim to prime participants for a lifelong journey of learning and self-transformation.

Whilst ophthalmology leadership development programs are now well established, there have been challenges to overcome, and challenges remain. It is known that clinicians may be sceptical about the value of spending time on leadership and there is discomfort with the difficulties proving its impact. Clinicians may have established views of what constitutes robust evidence – rooted in evidence-based medicine for clinical interventions – and are less familiar with qualitative research methods, which they may regard as fundamentally ambiguous, even weak⁶. Evaluation needs to be undertaken, not only to assist in continuous improvement of the programs, but to ensure that individuals and organisations can be convinced to invest in leadership development. Adequate financial, human and time resources are required to ensure these programs are sustainable.

Kirkpatrick's framework provides a structure through which to approach evaluation of the impact of LDPs¹³. The framework evaluates effectiveness at four levels: reaction (satisfaction or happiness), learning (knowledge or skills acquired), behaviour (transfer of learning to the workplace) and results (impact on society). Surveying participants for their reaction to participation has revealed widespread enthusiastic satisfaction and strong acknowledgement of the need for such programs. In terms of demonstration of learning through transfer to the workplace, there have been hundreds of ophthalmology LDP graduates around the world assuming leadership roles in their

clinical and medico-political organisations, and it is through them that new LDPS have been established. Whilst most participants would have been selected into LDPs for a demonstrated aptitude for leadership, many have reported accelerated progression to positions they would never have previously considered.

The most powerful lens through which to evaluate effectiveness is the impact on society. Ophthalmologists strive to improve access to the highest quality eye care in order to preserve and restore vision for the people of the world¹⁴. Many LDP projects have directly achieved this. More difficult to measure is the indirect benefit to patients and the community from engagement of younger ophthalmologists earlier in their careers and providing them with the opportunity to accelerate the development of vital leadership, management and advocacy skills that they will continue to apply throughout their entire career. There are opportunities to add to the momentum of what has already been achieved by embedding the teaching, learning and assessment of leadership skills in undergraduate and postgraduate medical and surgical curricula, as well as creating career pathways for clinicians that acknowledge, value and reward leaders. There is a well-established literature on leadership; in the same way that medicine and surgery have benefited from lessons learned from the aviation industry to improve quality and safety, there is much to be gained from collaborating with other professional groups, including business administration, from which much of the leadership evidence base has been developed.

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