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Family & Community Medicine
UNIVERSITY OF TORONTO

PROFESSIONAL DEVELOPMENT

REPORT OF THE ACADEMIC LEADERSHIP TASK FORCE

Attracting, retaining and nurturing faculty for leadership and sustained excellence

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Qualitative Research Team

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Dr. Lesley Gotlib Conn, PhD, General Surgery, Research, St. Michael's Hospital

Ms. Melanie Hammond, Research Associate, University Health Network

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External Interviewees and Environmental Scan

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Mr. Fran Brunelle, Founder and President, Collaborative for Hospital Excellence, Canada Ltd. (CHEC)

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Resident Program Committee Focus Group, DFCM

Dr. Barbara Stubbs, Director Professional Development, DFCM

Dr. Helen Batty, Director Health Professions Teacher Education MScCH and Enhanced Clinical Fellowship for Future Clinical Teachers Programs, DFCM

INTRODUCTION

Leadership is essential to the success of any undertaking. For an enterprise as complex as a multi-site academic department of family medicine, leadership capability needs to be highly developed, broadly distributed and strongly supported.

The Department of Family and Community Medicine (DFCM) completed a formal strategic planning process in 2008 resulting in a Strategic Plan for 2009 to 2013: *Primary Connections: Linking Academic Excellence to High Quality Patient-Centred Care*. A key component of the Strategic Plan is to "**Attract, retain and nurture faculty for leadership and sustained excellence.**"

The Academic Leadership Task Force was struck in May 2009 to help implement this aspect of the Strategic Plan. This Report describes the progress to date and outlines a plan for embedding the priority in the ongoing activities and structures of the DFCM.

The report reflects information available at the time it was prepared. Courses and programs evolve and change continually; readers are advised to check resources such as the DFCM or provider websites for up-to-date information.

Background

The Department of Family and Community Medicine (DFCM) at the University of Toronto is North America's largest department of family medicine. At the beginning of the review period, it included over 1,000 faculty, 367 postgraduate trainees, 228 clinical clerks, 26 funded researchers and a broad array of fellows and elective students.

Throughout its history the Department has demonstrated creativity and leadership in many areas – developing practical tools for primary care practice, building a robust research agenda, developing faculty, translating knowledge, and engaging in global health. It has developed strong clinical, teaching and research programs in broad clinical areas that are key elements of primary care, such as emergency medicine, inner city medicine, palliative care, working with families and women's health. The Department continues to be at the forefront of many changes – primary care renewal and transformation of Family Medicine Teaching Units (FMTU's) to Academic Family Health Teams, growth and expansion across all educational programs, shifts to integrated medical education with new teaching sites, and advances in inter-professional care and education.

DFCM faculty require excellent leadership and team skills in order to thrive in this dynamic environment. Leadership development needs to be an explicit part of residency education in order to prepare our graduates for the clinical, organizational, academic and societal challenges of the future.

At times there has been difficulty filling leadership roles in the Department. With the expansion of the DFCM to four new teaching units in 2009 and 2010, there is a pressing need to develop and support academic leadership roles for chiefs of hospital departments of family medicine and directors of residency, undergraduate, and professional development programs at these new sites.

Informed by Strategic Planning

A survey conducted in 2008 as part of DFCM's strategic planning process revealed significant findings about faculty:

- 68% reported having a successful and rewarding academic career
- 60% reported feeling part of a team
- 57% reported interest in exploring new opportunities for academic roles or leadership roles
- 55% reported satisfaction with work-life Balance

Although it is gratifying that a majority of faculty members gave positive responses to such questions, these data identify a need for the Department to better support and advance faculty. The respondents confirmed interest and need for more comprehensive career development, succession planning, faculty development, new models for leadership, and support for promotion.

These needs led the DFCM Strategic Plan to include the strategy:

Attract, retain and nurture faculty for leadership and sustained excellence.

This is considered an "enabling strategy", in other words not an end in itself, but essential to reaching goals in research, education and enhancing clinical practice.

Specific Goals of the Strategy include:

4-1 Develop a comprehensive career development program that facilitates faculty support for various career options, including advancement and promotion, through early to senior career.
4-2 Support faculty recruitment and faculty development in the new expansion sites and in new areas of curriculum across the medical education continuum.
4-3 Foster and support leaders and leadership development.
4-4 Strengthen faculty recognition and rewards.

DFCM Academic Leadership Task Force

Responsible to the Director of Professional Development Programs DFCM, the Academic Leadership Task Force was established to develop a plan for building leadership capacity, including recommendations for mentorship, career development and succession planning. Membership on the Task Force was purposely chosen to incorporate diversity in leadership experience, career stage, academic path and teaching sites. Membership included faculty and staff members representing research, postgraduate and undergraduate medical education, as well as representatives from teaching units including Department Chiefs, residents and student leaders and other key stakeholders.

The charge to the Task Force was to:
Conduct internal and external environmental scans regarding academic leadership initiatives.
Conduct a faculty needs assessment with respect to academic leadership.
Investigate potential linkages within the University of Toronto Faculty of Medicine, other faculties and external agencies.

Explore potential residency learning opportunities with regards to leadership.
Propose a structure to support future academic leadership initiatives in the DFCM.
Explore funding opportunities.
Prepare a Task Force report summarizing recommendations related to preceding initiatives.
Begin implementation of leadership plan.

METHODS

At its initial meetings, ALTF members agreed to take an academic approach to their tasks. Specifically the environmental scans and faculty needs assessment were to be conducted as research studies. The rationale was to ground the recommendations for this report on valid data.

Specific Activities Included:

1. Conducting an environmental scan of relevant leadership literature.

2. Completing a Qualitative Research Study to gain an understanding of how members of the DFCM experience and conceptualize academic leadership.

3. Conducting a DFCM-wide survey to gain an understanding from all faculty of the current state of leadership and development needs. The survey is integrated with an assessment of the quality of work life.

4. Conducting one-on-one interviews and focus groups with faculty and external organizations to gain an understanding of resources, gaps, potential partnerships and linkages.

KEY FINDINGS

Environmental Scan

Literature and Resource Review

The leadership literature is vast, ranging from broad descriptions of leadership qualities and inspirational anecdotes to detailed studies specific to particular areas of endeavour. Many of these can be relevant to academic leaders in family medicine. However, navigating this literature to find worthwhile, targeted information is daunting.

The same diversity is true of leadership training. There is a wide variety of courses and programs available, from the very broad to the very targeted. DFCM itself has courses at the graduate level that incorporate training in leadership and managerial competencies for academic family physicians.

To address this problem, several ALTF members developed a leadership literature database and a search strategy to scan current journals to identify relevant articles.[1] The database is on the DFCM website at: http://www.dfcm.utoronto.ca/library/alld.htm

[1] Rita Shaughnessy, DFCM Librarian, lead the development of the literature database with major contributions from Dr. Flo Kim, Dr. Katherine Rouleau and Leslie Sorensen.

It includes specific instructions for use, and can be customized by the user.

The academic leadership literature database contains reference for books, articles, websites, and leadership conferences and courses. It includes links to abstracts and/or full-text articles. Some links are restricted to users affiliated with the University of Toronto. The inventory of leadership courses posted includes a mechanism to allow attendees to post comments on the DFCM's website. This is a valuable resource to inform residents and faculty at all career stages who want to pursue a leadership course and seek to understand strengths and/or connect with course attendees.

The literature is categorized under the following topic areas

- Family medicine focus
- Leader characteristics, competencies - academic
- Leader characteristics, competencies - clinical
- Leader characteristics, competencies – general
- Leader identification
- Leadership challenges, problems
- Leadership styles
- Professional development – medical school
- Professional development - programs, curriculum
- Professional development - women, academic
- Programs, courses available – external
- Programs, courses available – U of T
- Succession planning

External Interviews

External interviews were conducted with key informants in the academic and family medicine communities. The purpose of these sessions was to identify synergies and discuss collaborations around leadership programming and resources.

Dr. Susan Lieff, Director, Academic Leadership Development and the Education Scholars Program, Centre for Faculty Development, University of Toronto

Dr. Lieff provided key highlights/insights from the Faculty of Medicine's Report of the Strategic Plan Implementation Working Group: "Leadership, Recognition, and Succession Planning". Areas of overlap and for potential collaboration with DFCM's ALTF were discussed. She acknowledged the different needs for Chiefs, FHTs, PGME and Clerkship Program leaders around leadership training. However "one academic leadership program for all" reflecting diversity and valuing the importance of differences enables learning to appreciate, adapt, connect and communicate with those who are different. Key outcomes of a leadership curriculum would be greater succession planning, improved teams, resilience, skills in: self-management, time management, financial management, conflict management and negotiation. Dr Lieff suggested that a Program Committee with membership beyond the DFCM could oversee the development of a pilot that could then become self-sustaining.

Dr. Magdelena Goledzinski, Program Coordinator, Health Sector, Rotman School of Management, UofT
An exploratory meeting was held with Rotman School of Management to explore development of leadership courses with an emphasis on leadership in family medicine. Discussions involved developing customized leadership programs tailored to specific challenges leaders in family medicine face. Rotman has a menu of leadership courses that can be tailored to meet specific needs of departments and professionals and faculty from Rotman work with organizations and departments to develop "just-in-time" tailored programs for groups of various sizes. Given the number and quality of courses/curriculum on leadership available, DFCM needs to be strategic about the added value of developing its own leadership courses and is continuing to evaluate.

Ms. Jan Kasperski, CEO and Anne Duval, President OCFP
OCFP is developing a leadership program for community family physicians. The intention of the *Leadership Development Program* (*LDP*) is to provide family physicians with skills that enable and enhance their leadership locally in their own primary care teams and equip them with the knowledge and abilities to lead effectively in community-based, regional and provincial initiatives in a complex and evolving healthcare system. The *LDP* is based on group-facilitated and problem-based learning approach with content relevant to the current issues and challenges of the health care environment and focus on the development of leadership competencies for participants. OCFP members will be invited to participate in the development of an evaluation to determine the LDP program's exportability to other provincial chapters. The DFCM was invited to participate in the module development and take the concepts to pilot a module that would meet the needs of academic family physicians. The ALTF felt it would be important to provide half day support for faculty in piloting OCFP's modules as well as representing the DFCM on the OFCP Working Group. The ALTF felt that One-Time-Only funding from MOHLTC should be used for development of an academic leadership module.

Leadership Consultants
Ms. Kim Martens, Senior Consultant Leadership and Organizational Change and Ms. Ann Hawkins, Senior Consultant Strategic and Change Management, Human Resource Management
These two experts in leadership development were interviewed around potential concepts, tools and practical resources for supporting DFCM's Chiefs and Directors around leadership. They identified resources that are widely used with interprofessional teams, including Appreciative Inquiry, Communities of Practice, World Café, Polarity Management and Open Space. Ms. Martens and Ms. Hawkins subsequently facilitated a workshop for DFCM's leaders (see "Supporting Leaders" p. 13).

Mr. Fran Brunelle, Founder and President, Collaborative for Hospital Excellence, Canada Ltd (CHEC)
Mr. Brunelle was invited to discuss the development of a self-sustaining "Community of Leadership Practice" to support and nurture leaders at all stages of their career and build successful succession planning. Mr. Brunelle proposed the "Leaders for Life" (2008) Capability Framework (LEADS Framework) as a guide in understanding and developing leadership competencies. LEADS is comprised of *Leads Self, Engages Others, Achieves Results, Develops Coalition* and *System Transformation* This Framework has been adopted by a number of organizations including Canadian College of Health Leaders (CCHL), Canadian Medical Association, Accreditation Canada and a number of others

Ms. Judith Klein, Director, Custom Programs and Joseph D'Cruz, Professor of Strategic Management, Rotman School of Management
The discussion with Ms. Klein and Professor Cruz revolved around ideas for a joint program with DFCM. They have submitted a concept paper for consideration by the Chair and DFCM Executive (see Appendix 5). A brief summary of the discussion follows.

The work of the ALTF was described, highlighting the needs assessment and environmental scan and scope of the DFCM. Joseph D'Cruz described the types of custom programs Rotman has developed with health care organizations such as University Health Network and the Department of Pediatrics at U of T. He outlined the three components of leadership development in an organization: evaluation employing self-assessment tools, mentorship and formal instruction. Ideally these are linked and coordinated. Professor D'Cruz recommends classes of about 40, which stimulates interaction and allows for work in smaller break-out groups. He recommends that to have significant impact, programs normally require 10 to 15 days of instruction, usually spread over several sessions. He indicated that some programs include web-based components, webinar and projects to be completed between sessions. We discussed how such distance-learning approaches could help to address the geographic dispersion of DFCM's sites. Ms. Klein described typical costs for Rotman custom programs, and will include these in the concept outline.

DFCM Faculty Perspective
Qualitative Research Study
A qualitative research study was conducted to gain an understanding of how members of the DFCM experience and conceptualize academic leadership. It explored enablers and barriers to effective physician leadership in early, mid- and later career stages in family medicine, and identified opportunities to attract, retain and nurture faculty members in academic leadership roles. Key findings informed the recommendations for policy and programming to be undertaken by the department, the university and other system players affiliated with our faculty. The report of this study, *Exploring and Understanding Opportunities for Academic Leadership in the DFCM* was submitted to the Departmental Executive on May 31, 2010.[2] Its key findings are summarized here briefly and the full report is included as Appendix 1.

The qualitative study yielded three broad sets of findings:

- *Tangible information*: things that DFCM can do to enhance leadership and support faculty
- *A portrait of academic leadership* that both reflects and contributes to the literature
- *In-depth constructs* that the research team uncovered and that can be explored in further study

From the research, the top priorities for action are to:
- Provide faculty development addressing fundamental topics such as:
  - What is academic leadership?
  - What are the different leadership paths?

[2] A paper reporting this research is being prepared for submission to a peer-reviewed journal.

  - How do we groom leaders in our sites? (chiefs, program directors, clinical leaders)
- Advocate for administrative infrastructure within academic teaching sites
- Raise the bar of accountability for formal leaders
- Encourage peer support and mentorship, especially for new program directors and sites
- Identify and acknowledge leaders, both formally and informally

An important finding was a lack of clarity regarding the meaning of academic leadership. Related to this, many of the study participants were uncertain of their identity as academic leaders, despite having been identified as such by peers. Indeed, mid- and late career leaders reported that their initial involvement in leadership positions had been neither sought nor desired. A recommendation arising from this work is to define academic leadership more clearly throughout the Department.

On the other hand, there is broad consensus regarding desirable qualities of an academic. These attributes are consonant with those identified in the leadership literature, and include capabilities in vision, communication, management, engagement and technical expertise and emotional intelligence. It is particularly encouraging that many of the participants identified these qualities not as ideal abstractions but by describing actual leaders in the Department.

Quantitative Faculty Needs Assessment

Building on the information from the qualitative study, a quantitative survey is underway. It will provide data assessing the quality of current leadership and support for faculty as well as an assessment of the quality of work life.

Internal Interviews

Dr. Eva Grunfeld, Director Research Program, DFCM and Dr. Paul Krueger, Associate Director Research Program, DFCM

Leadership in research at the DFCM requires individuals who are at a secure point in their own careers and able to reach out and facilitate other people. Given the highly entrepreneurial and competitive nature of research, building cooperative and collaborative relationships with teams is critical. Roles and skills needed in research include expertise with methods, content, "grantsmanship savvy" and the ability to manage projects at varying phases of development. Leadership in research to encourage people to raise the bar would ultimately benefit everyone. Strong leadership is crucial for the launch of a DFCM-wide PBRN.

Dr. Phil Ellison, Director Quality Program, DFCM Resident Program Committee Focus Group, DFCM

DFCM's Quality Program introduces quality improvement at the residency level through a 1-week program devoted to QI and change management along with other leadership components and other areas relevant to quality improvement. Following the 1-week training, residents will be involved in a team project on their unit. A challenge for leadership within family medicine is providing people with an opportunity to engage; thus rapid cycle changes provide the opportunity for team leadership, measuring results and integrating with other disciplines. Mentorship and role modeling are crucial for residents to gain skills in leading a team. Mentorship may come from family physicians as well as other professionals. For example, the IHI (Institute of Healthcare Improvement) Open School is interested in allowing students to get

involved in projects that are cross disciplinary to enable integration by engaging with people from other disciplines.

Resident Program Committee Focus Group, DFCM
The Resident Program Committee Focus group was comprised primarily of Program Directors from DFCM training sites. Findings from this group of generally mid- to late-career academic leaders included the following observations.

Before taking on a leadership position, these faculty members considered the time commitment, administrative support, potential for enjoyment, contribution to the team and remuneration. Regarding remuneration, it was noted that many leadership positions have been voluntary. Enabling factors in assuming the role include: support from peers and leaders in the team, mentorship from previous incumbents and progressing from smaller to larger leadership roles. An example from one person's experience was starting with supervision of an elective experience, then DOCH 2 and subsequently a Program Director role. Educational preparation, such as a Master's degree, provides confidence. A gradual increase in responsibility is helpful. Enablers for success in the role include: sufficient time, strong administrative assistance, good team support, good feedback and previous experience.

Ideas for ways that the DFCM could support existing and new leaders included increasing awareness of opportunities and support, encouragement for advancement, orientation to new roles and leadership development. Faculty development in leadership should be available for those considering new roles in advance of assuming a specific position. Leaders at various sites need to be attuned to the skills of team members and encourage those with leadership skills to take on leadership positions. Job sharing between a new leader and a previous incumbent enables success for roles that are highly demanding and have steep learning curves (e.g. Program Directors). Courses and workshops are helpful not only for developing specific skills but also for providing time to be creative and explore non-clinical interests. Support for taking on additional responsibility is helpful

Dr. Barbara Stubbs, Director Professional Development, DFCM
Mentoring is a proven way to promote the growth and development of emerging faculty leaders. It is an essential tool that helps faculty leaders take their leadership to the next level. Faculty leaders need to understand the key components of mentoring and how to make the most of their mentoring relationships. For instance, it helps to know how mentoring differs from coaching and other leadership activities. Strategies to support mentors and build mentorship capacity and skills will enhance DFCM's existing Mentorship Network.

Dr. Helen Batty, Director Health Professions Teacher Education MScCH and Enhanced Clinical Fellowship for Future Clinical Teachers Programs, DFCM
The goal of the Academic Fellowship and Graduate Studies Program is academic training and preparation for faculty of Family Medicine. Since its inception in 1989, its emphasis has been on teaching and education, professional leadership, and critical use of research.

All of the courses in these Programs translate well into leadership within the DFCM. For example, the *IPE (Interprofessional Education) and Communities of Practice Course* provides

practical and theoretical concepts around working in teams; the *SWOT Analysis Course* trains learners in economics and developing a business case, as well as "social" factors such as advocacy, managing change and vision; the *IPE Course* focuses on managing change and IPE teamwork. Students also take courses on Canada's Health Care System and a Policy Course. Field work opportunities offer practical applications for leadership as well as "shadowing leaders".

The *Practical Management Concepts and Cases in Leading Small Health Organizations* orients and trains learners to a number of leadership competencies. This course is very popular and limited to a small group. Opening it up to include more faculty members could meet the very high demand, but would require additional teaching resources.

In the DFCM the "Basics" model provides an excellent forum for leadership training. "Basics Leadership" could be the first step with a gradual increase in time and demand to INTAPT (Interprofessional Applied Practical Teaching and Learning in the Health Professions) and then a Graduate Program for a more in-depth and comprehensive study.

At UofT, the branding of courses and programs that refer to "Leadership" is limited to HPME and Rotman. Though the courses do not include the term "Leadership", the work in the Academic Fellowship and Graduate Studies Program prepares local and international Family Physicians to become leaders. Upon graduation many assume a number of significant leadership roles from Program Director to Vice Dean in Canada and as well as world-wide.

ACADEMIC LEADERSHIP INITIATIVES IMPLEMENTED

The Academic Leadership Task Force has been actively implementing a number of key recommendations over the past few months. The work of the Task Force can best be described as a "flowing stream" – its recommendations are being implemented and changes are occurring as members continue to research, develop tools and receive feedback. ALTF recommendations thus are ongoing and evolving.

Defining Academic Leadership

The need for widespread recognition of a definition of academic leadership became very clear in the qualitative research undertaken for the ALTF. The Task Force adopted the following definition and determined that it resonated with key informants in the Department:

"Leadership is a process of engaging *with* others to create and agree upon a vision for a program, group, or organizational entity, and of facilitating both individual and collective strategies, efforts and innovations to accomplish shared goals and objectives.

The process of leadership is not confined to those in authority positions and can be distributed such that several individuals can share in the experience of providing leadership."[3]

[3] Based on Faculty of Medicine, Report of the Strategic Plan Implementation Working Group, Jan 2009. ALTF changes are in italics

This definition can be used as a basis for faculty development, to identify emerging leaders and as a foundation for recognizing successful leadership.

Supporting Leaders

"Coaching/Peer Mentoring" Workshop for DFCM's Leaders

On June 10-11, 2010, the DFCM sponsored an Executive Retreat that included a Coaching Workshop for leaders with a view to developing a "Community of Practice". Ann Hawkins and Kim Martins, senior consultants with expertise in leadership development were retained to provide concepts, tools and practical resources to DFCM's Chiefs and Directors around being a leader. Resources discussed that are widely used with interprofessional teams include Appreciative Inquiry, Communities of Practice, World Café, Polarity Management and Open Space. Through a facilitated workshop for DFCM's leaders, faculty had an opportunity to practice these "tools" as resources for sustained communities of practice, sustained peer mentoring, problems solving and ongoing training in self-identified areas.

Since the Executive Retreat, a number of DFCM's Programs and Family Medicine Teaching Units have used the World Café approach to engage faculty in in-depth discussions for idea generation and consensus building. A "Community of Leadership Practice", building on concepts and ideas generated at the Executive Retreat is currently under discussion.

Chiefs' Breakfasts

Arising from an idea generated at the "Community of Practice" Workshop, Dr. Larry Erlick initiated the "Chiefs' Breakfast" as a peer mentoring and support opportunity for Departmental Chiefs at all of DFCM's academic sites. The breakfast get-togethers were launched in October 2010 and have been held approximately monthly, in the hour prior to DFCM Executive Meetings. They provide informal opportunities for interested chiefs to share problems, concerns, ideas and solutions. Although attendance is optional, participation includes most Chiefs every month. The experience to date is demonstrating that sharing perspectives from different institutions, a broad range of individual experiences and varying career stages has provided broader understanding and enhanced collaboration across sites.

Leadership Development

Community Preceptor Pathways and Leadership Development Tool

With medical student and resident expansion, the creation of the Mississauga Academy of medicine, the advent of the community-based Family Medicine Longitudinal Experience, and the move toward integrative medical education, the ALTF identified a need to orient new family physician teachers to various teaching, administrative and research opportunities that are available to them at the DFCM. These pathways are on the DFCM's website and can be accessed at http://www.dfcm.utoronto.ca/facultyandstaff/pdce/alp.htm
[Appendix 2].

These leadership pathways can be used to develop a personalized tool that will allow current DFCM faculty to assist and guide more recent faculty to utilize their existing strengths and build on areas of interest using the opportunities at the DFCM as well as the resources to facilitate their personalized academic leadership path.

Integration of Leadership Training in QI for Residents: underway
The DFCM is currently implementing a curriculum for residents that will provide all residents with basic level skills and knowledge in leadership. The QI program includes 24 hours of block teaching (followed by a project practicum). Approximately half of the block teaching deals with management and leadership issues, as applied to leading teams in QI work.

Research and Dissemination
QUANTITATIVE SURVEY
Opportunity for follow up at 5-7 year intervals

PRESENTATIONS
LIST [Appendix 3]

LEADERSHIP POSTER
[Appendix 4]

ACADEMIC LEADERSHIP INITIATIVES IN DEVELOPMENT

Leadership in residency: as part of CanMEDS roles
Building on the QI curriculum, the DFCM is in the process of developing a leadership curriculum for residency core competencies aligned with CanMEDS-Family Medicine Manager Role. As described above, the QI program provides block teaching related to management and leadership issues, as applied to leading teams in QI work. Modules supporting the achievement of enriched and enhanced leadership competencies will be developed for self-selected PGY2s and for all PGY3 Clinical Fellows. It is anticipated that these modules will include topics such as conflict management, running effective meetings and working with governance.

Enhanced Mentoring Program: upcoming fall 2011 workshop
This workshop is structured for DFCM PD Representatives and Program Directors to broaden their understanding of the benefits and underlying concepts of mentoring and to gain practical tools, tips, and strategies for mentoring success.

"Community of Leadership Practice"
It is anticipated that the DFCM Professional Development Committee will assume many aspects of accountability for identifying and nurturing leaders within the department over the long-term. A self-sustaining "Community of Leadership Practice" to support and nurture leaders at all stages of their career and build successful succession planning based on the LEADS Framework is one of the mechanisms currently under discussion to allow the DFCM and PD Committee to achieve this goal.

RECOMMENDATIONS

The ALTF mandate included not only an environmental scan and needs assessment, but also the first stages of implementation. Thus, these recommendations include actions to be undertaken in the future, as well as initiatives already underway that should be sustained.

From the qualitative study we learned that DFCM needs to:

Define academic leadership.
The ALTF proposed definition resonates with DFCM faculty. It should be promulgated to become a shared understanding.

Foster a culture that supports and celebrates academic leaders.
The Strategic Plan of the DFCM provides clear alignment of its mission, vision and values within the environment of our medical school and our social responsibilities. Purposive implementation will help to create a supportive culture for both the leaders and teams that bring these goals into reality.

The DFCM should continue to develop "communities of practice".
The "Community of Practice" Executive Retreat and "Chiefs' Breakfasts" are successful models that should continue and can serve as models for other groups.
The existing Departmental structures and organizations (committees, hospital sites, FHT's, academic programs) can incorporate "communities of practice" activities.

Recognition through awards, promotion, DFCM communications, and personal acknowledgement should continue and be developed further.

Nurture all leaders in DFCM
A supportive culture clearly has a nurturing effect on leadership (see above, Recommendation 2). This section will focus on specific activities that develop leadership capabilities.

The DFCM already has internationally-recognized programs in leadership and management in its Academic Fellowship and Graduate Studies program [Appendix 5]. Nevertheless, the qualitative survey showed that many faculty feel under-prepared for their leadership roles. The environmental scan revealed a large number of programs for health care leaders (see the "Programs Available" folders in the Academic Leadership Literature Database at: http://www.dfcm.utoronto.ca/library/alld.htm). While few of these external programs are specific for leadership in academic family medicine, they provide important opportunities to learn and interact with leaders in other specialties, disciplines and locations. Many are well-established with excellent faculty. Their limitation is accessibility: significant fees, time commitments and travel. Thus, the ALTF recommends complementary approaches to formal programs.

Develop accessible leadership programs within the DFCM
There is a need for widely accessible, low cost faculty development in leadership skills for DFCM faculty. A coherent program with distributed delivery could be developed based on the successful "Basics" Program.

Currently within DFCM there are outstanding leaders and leadership development programs; these resources provide a strong foundation for expanding and enhancing leadership development.

Develop programs with partners at the University of Toronto

Engage in ongoing discussion with Judith Klein, Director Executive Programs at Rotman School of Management.

Support senior leaders' participation in high quality external programs
Many health care institutions support senior leadership development for Department Chiefs. DFCM should encourage Chiefs to participate in such programs, especially early in their terms. DFCM should directly support departmental leaders' participation in appropriate external programs both as learners and as expert faculty.

Assess the quality and relevance of external programs for academic family physicians
Sustain the course and program catalogue as part of the Leadership Database.
Continue to develop and promote an evaluation website, where course participants can rate and recommend programs.

Regularly assess faculty needs with respect to academic leadership
The qualitative survey has informed this report and should be promulgated within the DFCM. A quantitative survey of work life and leadership is underway that will provide a comparison to the strategic planning survey and a baseline for future assessment of the impact of current initiatives.

Incorporate leadership learning opportunities into residency
Leadership competencies should be incorporated into the residency program.
CanMEDS roles provides a framework and the QI program is an ideal opportunities to incorporate relevant curriculum.
Current leadership opportunities, including site Chief residents and FRAT (Family Medicine Residents Association of Toronto) should be sustained.

The Professional Development Committee is the appropriate body within DFCM to oversee, coordinate and sustain leadership development programs and initiatives
The ALTF endorses the DFCM Mentorship program as a critical component in identifying, attracting, and nurturing academic leaders.

CONCLUSIONS

The DFCM is well-positioned to achieve the strategic goal to "***Attract, retain and nurture faculty for leadership and sustained excellence***." It has an existing core of established academic leaders. It has internationally-recognized programs for academic family physicians that incorporate key leadership and management skills. Successful expansion to a large number of affiliated community academic sites demonstrates a strong commitment to the ideals and goals of the Department.

Our environmental scan discovered a widespread sense that faculty are thrust into leadership roles with little preparation or even desire. There is a need to address an apparent gap between this sense of inadequacy and the existence of excellent leadership development opportunities, both within DFCM and in external organizations.

Progress is underway. The activities and initiatives that have taken place in the two years since the ALTF was established have already moved the Department forward. Instituting recommendations in this report will ensure sustained and enhanced strength in leadership development for current and future faculty.

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APPENDIX 1

Family & Community Medicine
UNIVERSITY OF TORONTO

Exploring and Understanding Opportunities for Academic Leadership in the DFCM

A research report for the Department of Family and Community Medicine, Academic Leadership Task Force

May 31, 2010

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INTRODUCTION

In January 2009, the University of Toronto Faculty of Medicine (FOM) released a "Report of the Strategic Plan Implementation Working Group: Leadership, Recognition, and Succession Planning." As part of its recommendations for recruiting and retaining effective physician leaders, the FOM proposed that a departmental needs assessment be conducted.

BACKGROUND

Not much is currently known about the necessary qualities and characteristics of successful physician leaders or about enablers and barriers to success in the environments in which they work (Naylor, 2006; Rogers, 2005; Souba & Day 2006). Even less is known about academic leadership in the context of Family Medicine. What little empirical research we have explores physician leadership more broadly (Taylor et. al 2008; Demmy et. al 2002) with family medicine included as one of various specialties under study. Existing research reveals that communication, visioning, strategic planning, change management, team building, personnel management, business skills and systems thinking are critical (Lobas, 2006). Schwartz and Pogge (2000) argue that interviewing and conflict resolution skills are also critical. Emotional intelligence is found to be an important physician leadership trait, characterized by self-awareness, self-regulation, motivation, empathy, and social skill. The establishment of positive and trusting relationships, recognition of one's strengths and limitations, and having a social awareness are factors suggested to help physicians be effective leaders (Serio & Epperly, 2006). Within the last number of years, academic family medicine departments across the country have had difficulties attracting leaders to take on positions like chairs, program directors and chiefs of clinical units. A cultural shift seems to be emerging to assist in the recruitment and retention of effective academic leaders. Understanding how family physicians view leadership may provide clues to help create the necessary strategies to develop the ongoing leadership required for growth of our discipline of Family Medicine.

The notion of lifestyle has certainly emerged in the literature as one area that may be deterring faculty with leadership potential to take on leadership roles. The desire for academic physicians to maintain a balance between their work and personal lives prompted Harrison and Gregg (2009) to argue that it may be time to "reconceptualize *work* altogether". Their proposed reconceptualization includes strategies to make *work* do-able – including elevating the status of academic part-time work as a viable and respected option for academic leaders.

Souba (2004) suggests that it may be a need to critically examine our understanding of leadership in academic medicine as a whole. The traditional idea of a leader as one who "wields power and stands apart" may no longer hold true. Souba argues that the challenges faced by today's academic leaders are "so complex and unpredictable that it is practically impossible for one person to accomplish the work of leadership alone." The need therefore to reconceptualise leadership may be a critical factor in attracting leaders.

PURPOSE

The aim of the research described herein was to explore and understand the opportunities to support and enhance academic leadership among faculty in the DFCM. How do members of the DFCM think about the concept of academic leadership? What are the enablers and barriers to effective physician leadership in early, mid- and later career stages in family medicine? Where are the current opportunities to attract, retain and nurture faculty members in academic leadership roles? The findings from this research are important to building the knowledge base on effective academic physician leadership in family medicine broadly. They can be directly used by the Academic Leadership Task Force to develop policy and program recommendations for the DFCM and for the University FOM.

Table 1. Focus Group Participants

Focus Group	*# of Participants*	*Gender*	*Career Stage*
1	3	3 male	Late
2	5	5 female	Mid
3	7	4 male 3 female	Mid
4	3	2 male 1 female	Early
5	7	4 male 3 female	Late

METHOD

A case study approach was used for this research. Case study methodology is often used when the boundaries between phenomenon and context are not clearly evident and when there is an opportunity to investigate a phenomenon within its real-life context (Yin, 1994; Robsen, 1993). With this in mind, the use of case study methodology was felt to be a good choice to begin to understand more fully the meaning and experience of Academic Leadership in the DFCM. In so doing, it was the intention of this study to uncover the "phenomenon" of Academic Leadership within the DFCM. We conducted five focus groups with a purposively selected group of faculty members who were identified as academic leaders by their peers in the DFCM (Table 1). We also conducted five semi-structured interviews with a convenience sample of participants to supplement and triangulate the focus group data (Creswell & Miller, 2000) (Table 2). All data collection took place in April 2010. Inclusion criteria for our study were:

- Individuals who have been members of the DFCM for a minimum of 2.5 years.
- Individuals who are currently or were formerly in an academic leadership role, or have/are considering doing so in the future.
- Individuals who are engaged in undergraduate, graduate, post-graduate, faculty development, research or clinical family medicine at a local, provincial, or national level.

An email call was sent out for the identification of participants among three levels within the DFCM community:

- Level A: Faculty within the organizational structure of the DFCM: Executive Committee, Department Chair, DFCM Directors (Undergraduate, Graduate, Post Graduate, Professional Development, Research, International Studies), Chiefs of Family Medicine across affiliated hospitals, and Leads of Practice Sites.

- Level B: Faculty affiliated with the University of Toronto Faculty of Medicine Deans and Vice Deans.

- Level C: Organizational Leaders external to U of T and DFCM: Ontario College of Family Physicians CEO and President, College of Family Physicians of Canada Director of Education and current President.

Our email yielded the names of 88 academic leaders. From this list we sub-divided names into three groups based on career stage. Our final numbers identified 21 early career academic leaders (defined as <5 years as an academic leader), 24 mid career academic leaders (5-20 years as an academic leader) and 43 late career academic leaders (>20 years as an academic leader). Each individual identified was invited to take part in our research. Focus groups were arranged based on career stage to ensure that participants would not participate in a focus group with a supervisor or anyone to whom they currently report.

Focus groups and interviews were audio-recorded and transcribed. Nvivo™ software was use to assist with data management. Transcripts were anonymized to protect the identity of participants, and then coded independently by three researchers (IO, LGC, and MH) by recurring themes and content, until agreement was reached. Ethics approval for this study was granted from the University of Toronto Research Ethics Board.

FINDINGS

a. What is Academic Leadership?

Defining academic leadership

Participants in this research were not entirely clear about the meaning of academic leadership. Despite agreeing to participate in the focus groups and interviews as academic leaders themselves, some expressed a lack of clarity around what academic leadership means and whether they viewed themselves in this category. Confusion stemmed from some participants seeing themselves as primarily working outside of the academic community, and others feeling that they had not come from an academic background. As stated by one mid-career participant,

"I think sometimes I'm one of them

Table 2 .Interview Participants

Interviews	Participant	Career Stage
1	1 female	Late Career
2	1 female	Early Career
3	1 female	Late Career
4	1 female	Early Career
5	1 female	Early/Mid Career

that doesn't see myself, perhaps, as an academic leader... [Clarifiying what is meant by academic leadership will] help many of us who do not come from an academic background originally [to understand] what entails academic leadership because we may be doing it without realizing it."

There was some discussion that revealed what participants currently thought about the meaning of academic leadership in the DFCM, as illustrated in this quote from an early career participant.

"I think that the term "academic" is problematic in that sense, right? Because it refers to research or education, right? That you are doing something scholarly...not scholarly, but affiliated with the university in that way. And because, as an academic department we sort of fit in the middle, because we're also involved in clinical practice, the word "academic" leadership may not really capture the clinical leadership that needs to happen, and the administrative leadership that happens. So as a department, I think that this department has been very good at recognizing those different aspects of leadership, but under the term of an "academic leader" it suggests that you're researching, right? In that way, [it] is so different from what the majority of family physician academic leaders do."

Portrait of the academic leader in family medicine

There was much consensus among participants on the qualities of an effective academic leader, generally (see Table 3). Skilled communicator, networker and problem-solver were mentioned as important characteristics of a leader. Vision, the ability to enable others, and having excelled in a focused area or niche were the most frequently discussed qualities.

<u>*Vision:*</u> Many participants believed that leaders were able to inspire others based on having and communicating a clear *vision* of their role and goals. One participant described leaders in this way:

"They have a vision of where they want to go with a committee that they're leading or areas that their leading and that vision is well articulated and creative. They inspire you in the sense that they're inspiring around their vision or where they could take the department or the committee. They make you want to work with them or want to do things because you see the power of that vision."

Another participant reflected that, *"if you [leader] don't have the vision... you're a manager."*

Visionary leaders in family medicine were viewed to challenge the status quo, "*to get the message across," "pushing the boundaries, or thinking outside the box"* moving the department and the discipline in new directions. These leaders were viewed as critical to family medicine as they influence "*the way family medicine is practiced introducing new models of care."*

Enabling others to succeed: Participants believed academic leaders have the ability to enable others to succeed in their respective roles, "*assisting people to be the best that they can*," and having "*enthusiasm and desire to see everybody else succeed.*" Through motivation, encouragement and support, effective leaders were admired for being oriented toward those around them, supporting the needs and interests of others. As one participant reflected "*your success is their success.*" Another described academic leaders in this way:

> *"I think these people [leaders] that I'm thinking of are really enablers. So they encourage people, they help give their team members skills, increase their capacity and their productivity... they're at a stage in their career where their goal is to move the organization further or a vision that they have for that committee or that organization further, or to move others' careers further, they're not completely preoccupied with their own success or career. There's an outward looking aspect to them…"*

Table 3. Portrait of the Academic Leader in FM

Visionary
Role Model
Communicator
Networker
Relationship-Builder
Organized
Supporter
Understands issues through the eyes of colleagues
Respectful
Motivator
Honest
Genuine
Enabler
Problem-solver
Effective decision-maker
Excellence in an area
Moves the department forward
Inspiring
Approachable

Excellence in an area: Academic leaders were described as having a focus or niche in which they had demonstrated excellence. "*The leader also has to have some record of achievement academically... has to have excelled in their particular career.*" The pursuit of a focused area of interest and the ability to then apply their knowledge broadly through leadership across the discipline of family medicine was an important defining feature. This participant elaborated,

> *"I think the other thing that I think has made academic leaders, they don't just generally have to be heads of departments of whatever, is a niche. You know, people find an area that they want to explore, they find a niche, and they pursue that, and I think they then can develop or generalize because they have general skills to begin with. But they find a niche, they find a question or questions that are burning or a cause and so whether somebody like [name] finding the cause of HIV disease, or [name] dealing with addiction, or [name] doing global health, that's the kind of thing that shows that leadership can see the broader picture but also take a part of what is family medicine, and push the boundaries of that."*

Another participant described the importance of being a well-rounded leader within "*administrative, educational and research*" areas in the DFCM as follows,

> *"...to be a really good academic leader you have to excel in at least the majority of those areas, 2 out of 3 I guess. A really really superb leader would have 3 out of 3..."*

b. What Enables Academic Leaders?

Mentorship

There was overwhelming agreement among participants that mentorship is a key enabler of effective academic leadership at all career stages. At the earlier career stage, mentors acted as critical role models and were seen to foster leadership potential in emerging junior leaders.

> *"I think that as I traced back to the first opportunities, and I think I can trace everything back to an individual, a mentor, who opened doors and provided opportunities for me to take which led to other opportunities which this mentor then expanded on the networking and the opportunities...I think clearly it is an informal mentorship relationship, but obviously I think the mentor saw something in me that, you know, led him to develop this relationship and why he opened these doors."*

In the mid-career stage to become a mentor and role model was viewed to subsequently embed and reinforce the identity of being an academic leader. This was noted to be an important factor for mid-career leaders to consider influencing their thoughts of becoming mentors themselves. One participant described the evolution of becoming a mentor in this way::

> *"I think being mentored yourself is a way that people become mentors. Having experience of that kind of nurturing, a supportive relationship, and then kind of pave it forward."*

The ability of mentors to connect and coach was seen as critical.

> *"I think that having somebody connect with you, identify you as somebody with potential early on, and provide some ongoing mentorship over time would have helped me along. And I didn't really have that, it's been quite fragmented to be honest, and that is why I've become very involved in the mentorship network, and actively said, 'okay, I'm going to identify a couple of people who I think have potential.' And participate quite fully in that."*

The transition from mentee to mentor was described by one mid-career participant as an opportunity to reflect on the importance of her role in supporting others in their burgeoning careers.

> *"I reflect back now and I see the vision that the mentors had in me to kind of, sort of say, "we think you can do it. We know it will not be perfect and it will be really really hard, but we see in you that you can do this." And I learned so much from that, because I now see that other people are coming to me and I have to take on that role now...now I'm the one that people are coming to and sort of saying, "okay, what do you think? Can you check my work? Can you move me forward?" and I was doing that with students, of course, but now I'm doing that with colleagues who are only a couple of years behind me, and it only literally occurred to me last week that, oh, wow! I'm that person that I used to kind of go to. And that was a pretty neat realization."*

Infrastructure

Administrative support: Participants strongly endorsed the need for competent *administrative support* to set a foundation for successful leadership in their many different academic roles. In particular, participants in educational roles at practice sites described poor or lack of administrative support as "the stuff that breaks people" and "holding me back from being able to take on more initiatives."

> *"I was just thinking about how our Educational Assistant is, and we have a phenomenal person... And that's probably the hub, right? You need support people who are extremely organized but also very capable and thoughtful about their work. And he really exemplifies that. And I think that's really key to a lot of our, those who are in leadership roles feel that they are supported. And that they can rely on, whether it's information or, in a way, sort of, an extra set of eyes that can support that."*

Funding: Funding was discussed as an important resource for leaders to run successful programs and support the members of their practice sites in professional development opportunities. Participants expressed feeling limited in their roles by having limited financial resources.

> *"For a lot of initiatives I have found that your limits of leadership are sort of tested by having to do things with less and less resources, specifically money...It's, while it's not the only factor, it certainly is a huge thing, like, we've mentioned a number of time already, is that you do have to follow the money in a lot of ways. So, what leadership is being compensated for, and also what resources, what monetary resources those leaders have to play with. Because the bigger the pot you have to play with, the easier your job is going to be."*

Interest and desire to improve an area of family medicine

Participants across the career stages described having a strong interest in a particular area of family medicine and a willingness to get involved to make improvements in that area. As one undergraduate program director explained, *"I wanted to elevate that experience so that more people would choose family medicine."* Personal desire to make positive changes in education and research were enablers for some participants. One late career participant explained the following,

> *"I think the important thing is that we got into these positions because they were areas of interest for us, and then we became leaders. What really bothers me now is when I see new grads going into leadership training programs, because I don't think that's the way it's done, I don't think that you train the leader first, and then put them into a position. I think they have to have an interest in what they're doing first, and then they rise to the top to become leaders."*

Another late career participant added,

> *"My first opportunity for leadership came about 3 months after I became a staff physician at [hospital] and I had an idea around a family medicine ward and I became director of that family medicine team which was the first in the city...it was an idea that I had been having as a resident that we could make things better, teaching better for family medicine residents. So it's partly making your own opportunities."*

Interest in an area and a willingness to get involved was most strongly expressed by early career participants among whom there was more of an enthusiasm for initially getting involved in a leadership activity. One such participant stated,

> *"I was interested because having just come out of residency there was a lot of things that I would liked to have seen changed and improved upon and so that's sort of where my interest in pursuing that more formally came from."*

c. Identifying and Nurturing Academic Leaders

Our third set of findings revealed important generational differences among participants, identifying and nurturing academic leaders for effective recruitment, retention and succession planning.

Identifying eager early career leaders

Mid and late career participants felt there was a need, if not a responsibility to actively identify junior leaders in the department, to encourage them, nurture them, and allow them to explore new opportunities on their own terms. *As one stated:*

> *part of our role since we're older is to identify people who are obviously showing potential and letting them run with it, no matter how old they are or how inexperienced they are."*

Another participant encouraged the DFCM to begin "*identifying faculty at an early age, identifying potential leaders.*" Having a supportive Chief within one's department and colleagues who "*support you, they groom you, they coach you, [and]get you into the right position" allows for the identification of up and coming leaders.* In this way, the pool of eager and interested up-and-coming leaders would remain plentiful despite the lack of a formal structure in place to recruit people.

One early career participant described her trajectory into teaching in a leadership role which exemplified the significance for early identifying and nurturance.

> *"I think that for me it started back in medical school, and when I was a medical student I was very interested in alternative medicines and wanted to spend some time with a chiropractor, and I went to my Vice Dean and I said, "I would like to do an elective with a chiropractor." And she said, you know, "it's all well and good to learn about what other providers are doing, but that's not medical education. And so you can't do it as part of your medical training." And I said, "I don't agree with that." And she said "you know what, why don't you do a medical education elective and why don't you do some research about why it should be medical education, and why don't you write a proposal about why we should have this in our curriculum?" And it was taking a student who didn't know anything and wasn't even thinking education, and took the enthusiasm of it, and created an opportunity by framing it as something that would be legitimate....And so it starts with little opportunities like that, which then got me interested in teaching..."*

Experiences of mid- and late career leaders

Among many mid- and late career participants, initial involvement in leadership activity was neither sought out or necessarily desired. This was noted to be a critical difference from what was heard among early career leaders. These participants described taking a leadership role because there was no one else who was either willing or able to do it.

> *"I realize you're trying to be positive and focus on opportunities, but in my clinical work it was basically my turn to do a job that was perceived as onerous and people had burned out and left because of that. It was kind of like my turn. Which doesn't mean it wasn't, you know, it doesn't have some possibilities, but it certainly wasn't something I initially identified as a good opportunity."*

Another agreed with this and noted that leadership positions were often taken up by "default." As one participant reflected:

> *"I think my leadership roles were by default. Nobody else wanted to do them."*
>
> Yet another said, *"all my leadership roles have been massively arm-twisted so I have very sore arms."*

In light of the shared experiences of these mid- and late career participants, it was felt that more positive role models who had experienced fulfilling leadership positions were needed.

> *"I don't think we have a lot of role models out there for people who really enjoy it and are doing it because they choose to or they've been asked to. My experience is it's more of a "who is going to do it?" And that is an opportunity to switch that around."*

Nurturing leaders differently at different career stages

Among early career participants, there was a sense that significant reinforcement of one's leadership role was needed to help individuals form and establish their identity as an academic leader. Being directly told by others that, *"listen, you're a leader"* was believed to be necessary to achieve this. As elaborated by one such participant,

> *"I think being a leader, especially for junior faculty, it's a very hard thing to understand, to accept, to get... with leadership, there is still that, what do you call that, the impostor syndrome. There is still that impostor syndrome that persists as junior faculty. So I think that, for junior faculty, to really encourage them in that [leadership] role you need to continue to solidify that identity as a leader."*

Another participant effectively likened the socialization process to that which happens as young physicians.

> *"I think in physician culture we are socialized to think of ourselves as leaders. I actually think physicians are trained to think of themselves as the leads – the leads of team, the one who is most responsible for the patient, the buck stops with me. We are socialized to think that way as physicians. And I wonder whether that socialization and that kind of leadership, when you identify yourself as that kind of leader, if that's the kind of leadership that is then needed in academic medicine."*

Leadership positions that were compatible with other academic interests and a work-life balance were viewed to be more desirable by mid-career leaders today than in

the past. For instance, we heard from participants who believed that the younger generation of leaders had a different set of expectations from their roles that needed to be met.

> *"I think that there's a change in the work style of people that are in medicine now and I think [it's] probably for the good that people are wanting to have more balance in their lives. And I think that the leadership positions need to be sensitive to that and adapt to that. I think that the, a number of us in my [late] stage of life are seen by the younger faculty as burnt out and living a work-life that they see as not very feasible and not what they want....So I think that sort of looking at some of the leadership jobs and making them more doable and more compatible with other life interests and wishes would be a great idea."*

One mid-career participant shared the following about needing to have leadership opportunities fit well with the demands of having a young family.

> *"We all are taking care of families, we all are, and I know that's a big deal in any job, but I have, I mean, not turned down but I've had people encourage me to apply to positions that I have not applied for because if I didn't have kids I'd be great at the job. But I have kids. So I can't do that job now. Maybe in 15 years, when they're a little more self-sufficient."*

Finally, late career leaders expressed appreciation for the opportunities presented to them reflecting on their many accomplishments, and supporting junior colleagues, instilling a sense of pride and fulfillment in them. In this way, there was a continued nurturance of the roles and contributions of these individuals. Accordingly one participant reflected, *"One of the most exciting things for me in the last 20 years of my career is being able to watch other people succeed, succeed well, and beam while they're doing it."* Later he added, *"Sometimes my job description is to be in the room and do nothing except appreciate the work of somebody else. That's about like 20% of my job description or something like that, somebody is paying me to go and be impressed by work that somebody else is doing that is truly wonderful. It's an unbelievable perk to leadership. Who else gets that?"*

Another late career leader emphasized the satisfaction experienced when the entire team which one is leading is recognized.

> *"...recently with the team we developed a list of our accomplishments and grants and publications and some of the external markers, or the concrete markers of our outputs, which was quite impressive and we purchased a couple of glass cases to showcase some of our publications and put up some of our posters so the whole effort has been to really showcase the success and celebrate our successes as a team. So that was a example of something that I kind of had a vision for and worked towards with the team and enabled to have happen and I think has accomplished what we wanted which was to celebrate our successes. To both encourage and celebrate our successes as a research group."*

RECOMMENDATIONS

This study provided a unique opportunity to hear the stories of academic leaders who shared their experiences and thoughts about academic leadership generally. From this research a number of key recommendations can be made for future consideration. Three are highlighted for discussion:

1. Define academic leadership
2. Foster a culture that supports and celebrates academic leaders
3. Nurture all leaders in DFCM

1. Define academic leadership

As noted by many of the participants it was unclear what was meant by the term "academic leadership." Although identified by others as "academic leaders," some did not see themselves as such. The term "academic" had connotations of research which did not resonate with all who participated yet there was acknowledgement that the DFCM did a good job in recognizing leaders of all types. With the opportunity for reflection based upon this study the Academic Leadership TaskForce (ALTF) is encouraged to consider the following questions:

- How can academic leadership be defined in a way that is understood, resonating with all members of the DFCM?
- What behaviours would an academic leader demonstrate in order to be identified?

Three distinct areas in which physicians may focus leadership interests exist in academic Family Medicine: research, education and administration. Fairchild et. al (2004) discuss the field of **a**cademic **p**hysician **a**dministrators and **l**eaders (APALs) as unique and "traditionally shunned by academics in medicine." Administrative work, they argue, has traditionally been viewed as less valuable than other areas of academic medicine (i.e. research and education). Certainly, our participants were challenged with trying to understand if they were academic leaders if they didn't engage in research or education but were engaged in administrative roles, particularly outside of the University. APALs, Fairchild et al believe, require support in all areas of leadership yet the the type of support required may be unique to the area of leadership engaged upon (research, education, and/or administration). In thinking about opportunities for leadership in Family Medicine, it is important to distinguish and acknowledge that the three areas of leadership foci exist and each may require unique and individualized types of support, yet the question of the similarities across may need to be examined in creating professional/faculty development opportunities.

The literature on academic leadership for family medicine is limited. The opportunity to define this area is timely for the discipline. The definition of leadership adapted from the *University of Toronto Faculty of Medicine Strategic Plan Implementation Working Group: "Leadership, Recognition and Succession Planning"* is:

"Leadership is a process of engaging with others to create and agree upon a vision to inspire and motivate for a program, group, or organizational entity, and of facilitating both individual and collective strategies, efforts and innovations to accomplish shared goals and objectives. The process of leadership is not confined to those in authority positions and can be distributed such that several individuals can share in the experience of providing leadership."

Table 4. Email Responses to Proposed Definition of Academic Leadership

Summary
9 Positive Responses

Participants thought that this definition seemed to encompass their perspectives (see Table 4). Yet there continues to be an opportunity for simplifying the language and perhaps shaping a definition that builds upon demonstrable attributes and behaviours. The participants shared many of the same types of leadership behaviours (found in Table 3) that are found in the existing leadership literature. Of particular note was that leaders need to be able to demonstrate excellence in a particular area as a key defining principle. They were also adept in communicating a vision and gaining momentum from others to carry out the vision. Finally, the attribute of humility emerged where leaders genuinely celebrated the successes of others and considered them just as important if not more than their own personal successes. The ALTF could look to the literature on physician leadership and the voices of family physician leaders to consider opportunities of enhancing the definition of academic leadership for the DFCM's purposes. Whether the DFCM adopts the FOM definition of academic leadership or builds upon it is a decision that the ALTF may need to make.

Once a clear definition is developed and behaviours shared, the communication strategy to promote academic leadership will be critical. It will become the foundation for creating a supportive culture for academic leadership in DFCM.

1 Negative Response 2 Undecided
"My understanding and experience of academic leadership is captured by the definition. It is completely captured; the definition is quite extensive."
"The primary thing that I would add is that leadership could/should involve mentoring and the development and advancement of others in the pursuit of that longer-range vision."
"I think it is an awfully complex definition. I think leadership is about engagement with others for the purpose of transformation. 'Others' could include individuals, groups or organizations."
"Definition OK with me but would add for established leaders being approached by younger faculty, the Dylan quote: "The vagabond who's rapping at your door is standing in the clothes that you once wore."

2. Foster a culture that supports and celebrates academic leadership.

Culture has been defined as "the way things are done around here" (Schein, 1993) Culture can be seen through language used, its leaders, structures, policies, practices, resources, tools, behaviours. These factors are considered artifacts that provide evidence of the underlying organizational culture. Some have defined the culture of an organization as reflects the underlying beliefs and assumptions that guide action, and are learned and shared by members of groups as they strive to achieve the organization's goals and fulfill its purpose (Evans, 2009: 2). With this in mind the ALTF may want to reflect upon the following questions:

- What are the underlying beliefs and assumptions that will guide the type of academic leadership we hope to demonstrate and nurture within DFCM?
- What would a strategy look like to advance a culture supportive of academic leadership that will be transcendent across all members and organizational structures within DFCM?
- What is the level of accountability for advancing this culture and how would this be evaluated for success?

From the voices of participants, there was at times a sense of cynicism amongst those who have held leadership positions in the DFCM for a long time. The senior career leaders shared an underlying belief that leadership was often thrust upon them feeling compelled to accept leadership roles by default versus by keen interest. This type of belief and assumption related to academic leadership is one that shapes the type of culture that prevails in DFCM for

leadership. It would be wise for DFCM to consider reshaping the beliefs and assumptions with a focus on highlighting the positive and rewarding components that relate to academic leadership and to remind leaders of how they have made a difference. In this positive light, a shift in culture can occur to support and nurture academic leaders.

It is noted in the literature that organizations are systems that are comprised of components that when consistently structured and managed, cause them to operate effectively. Where multiple systems operate within the same organization knowing the component parts and how they interact with each other is important for organizational efficiency (Tushman & Nadler, 1997). Further, Tosti and Jackson (1994) write that organizational alignment is achieved when:

- the ***mission, vision and strategy*** fits its environment;
- strategic **goals** and **values** are mutually supportive;
- objectives are derived from **strategy** and supported by **management practices**;
- **people's activities** and objectives are congruent with the mission, vision and strategy; and,
- **systems, structures and policies** support activities and **behaviours**.

For DFCM, it may be very helpful to consider how its mission, vision, strategies, goals and values created for its educational imperative align with its hopes for academic leadership. How can this alignment be seen in the management practices, activities conducted by members, structures, policies and accepted behaviours within the DFCM?

3. Nurture all leaders in DFCM

Building upon a culture that supports and celebrates academic leadership, the opportunity to nurture all leaders (early, middle and late-career) seems only natural. Early career leaders in the department identified the importance of having mentors and role models with whom they could identify and aspire to emulate. Middle career leaders struggled with identity issues, requiring reinforcement to help convince them they indeed were leaders. Many wished that they had coaching to assist them in developing their leadership skills and the notion of mentorship and support emerged strongly. Late career leaders began to reminisce about the rewards of being a leader through mentoring others, often seeing this phase of their careers as an opportunity to give back. Yet many of these same leaders spoke of their experiences negatively perhaps again speaking of the nature of how these leadership positions were thrust upon them with few supports provided while in their positions.

Within a department that is hoping to nurture academic leaders, learning from the experiences of the participants, it would be helpful for the ALTF to consider the following questions:

- How can we identify new and emerging leaders in the DFCM and provide them with the peer support and professional development to ensure that they succeed in becoming the leaders they and we hope they will be?
- How do we support middle career leaders and ensure that their identities are reinforced listening to their needs and addressing them with confidence?
- How do we have others learn from the late career leaders within the DFCM to capitalize on their wisdom, encouraging others to see the difference they have made in Family Medicine and foster a culture of future catalysts in our discipline?
- How do we build upon the strong programs that already exist within the department (mentorship, professional development, faculty development, etc.) to strengthen the area of academic leadership as a key area of focus?

Our participants provided some key ideas in the area of professional development, identifying particular topic areas that would be helpful (Table 5). They also shared their hopes of coaching while in new positions and mentorship with those experienced. Finally, they reinforced the need to consider the administrative supports which would allow them to be successful in the leadership roles they have come to accept. This included fostering opportunities for professional development and coaching for administrative assistants and ensuring leadership positions are posted with administrative needs considered and provided. One participant reported,

> *Having worked with a terrific Admin Assistant, it's like magic. Everything is smoothed over and you can get on with your life. And if you don't have that, it's hell.*

Another echoed the key importance of strong administrative support, stating,

> *That infrastructure, that kind of support, that's the stuff that breaks people, the lack of that…just to know that when you ask for something to happen, it's gonna happen. It can be as simple as having coffee in the meeting [or] to make sure that the people that you need to be emailed are emailed.*

Limitations:

There are several limitations to our study, including a small sample that may represent a specific population of Academic Leaders in Family Medicine, and therefore limit the generalizability of our findings. However, it should be noted that our recommendations echo the existing literature on Academic Leadership (Souba 2004; Harrison and Gregg 2009; Demmy et al 2002), thus suggesting robustness of our findings.

Table 5. What Can the DFCM do?

1. Provision of education/faculty development • **What is leadership?** • **What are the different leadership paths?** • **How do we groom leaders in our sites? (with a focus on what Chiefs can do)**
2. Advocacy for administrative infrastructure across all types of leadership roles including research, education and administration. Particular attention to be placed on this when instituting new leadership roles.
3. Raising the Bar of Accountability for formal leaders e.g., Who is overseeing the Chiefs to ensure they are meeting the DFCM's expectations of them?
4. Encouraging Peer Support & Mentorship • **Especially for new Program Directors** • **Assisting leaders new clinical sites** • **Supporting administrative assistants across the DFCM**
5. Identifying & Acknowledging Leaders (other than the award nomination process) Fostering ways to reinforce the celebratory aspects personally, professionally and academically that leaders gain

This research extends insight on Academic Leadership in the context of Family Medicine and suggests some strategies to support and nurture existing and future leaders in the DFCM. There is opportunity for future studies to build upon and validate this work by continuing to explore the needs of existing leaders in the DFCM by means of survey feedback, or further qualitative and quantitative research methodologies.

Conclusion:

There is an ongoing critical demand for academic leaders within the discipline of family medicine. The success of DFCM and indeed the future of the discipline of family medicine lies in the beliefs and assumptions made about academic leadership which will either deter or entice leaders to step forward. The research conducted in this study affirms the need to advance a culture that supports academic leadership ensuring that all know what academic leadership is and interest is fostered for many

to want to become leaders. The emerging possibilities are exciting and the ALTF's work is hugely important for the future of our discipline.

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APPENDIX 2: ALTF PRESENTATIONS AND WORKSHOPS INVENTORY TO DATE

1. June 19, 2009; Vaughan Estates – DFCM Academic Retreat; "Attracting & Nurturing Academic Leadership"; David White, Jordana Sacks, Sharonie Valin, Susan Lieff

2. April 21, 2010; DFCM - Research Team Meeting - Exploring the Understanding and Opportunities Related to Academic Leadership in the Department of Family and Community Medicine"; Dr. Ivy Oandasan, Melanie Hammond, Lesley Gotlib Conn

3. April 24 and 25, 2011; Vaughn Estates – DFCM Annual Retreat and Rosser Day; "Academic Leadership Networking Breakfast"; David White and Leslie Sorensen

4. April 24, 2010; Vaughan Estates – DFCM Rosser Day Workshop; "Acknowledging and Supporting Academic Leadership in Family Medicine – A Round-Table Dialogue"; Florence Kim, Katherine Rouleau, Leslie Sorensen

5. June 11, 2010; Knightsbridge Conference Centre – DFCM Executive Retreat: "Academic Leadership Task Force Research Summary"; David White, Jamie Meuser

6. November 4, 2010; Vancouver, B.C. –Family Medicine Forum; "Exploring the Understanding and Opportunities Related to Academic Leadership in the Department of Family and Community Medicine"; Florence Kim, Melanie Hammond

7. October 26, 2010; DFCM –Strategic Plan Implementation Committee; "Academic Leadership Task Force Status Report and Preliminary Recommendations"; David White

8. November 16, 2010; Seattle, Washington – North American Primary Care Research Group (NAPCRG); "Applying a 'Complex Intervention' Research Framework to a Strategy to Improve Academic Leadership in Family Medicine - Workshop"; David White, Leslie Sorensen

9. December 21, 2010; DFCM– Executive Committee; "Academic Leadership Task Force Status Report and Preliminary Recommendations"; David White

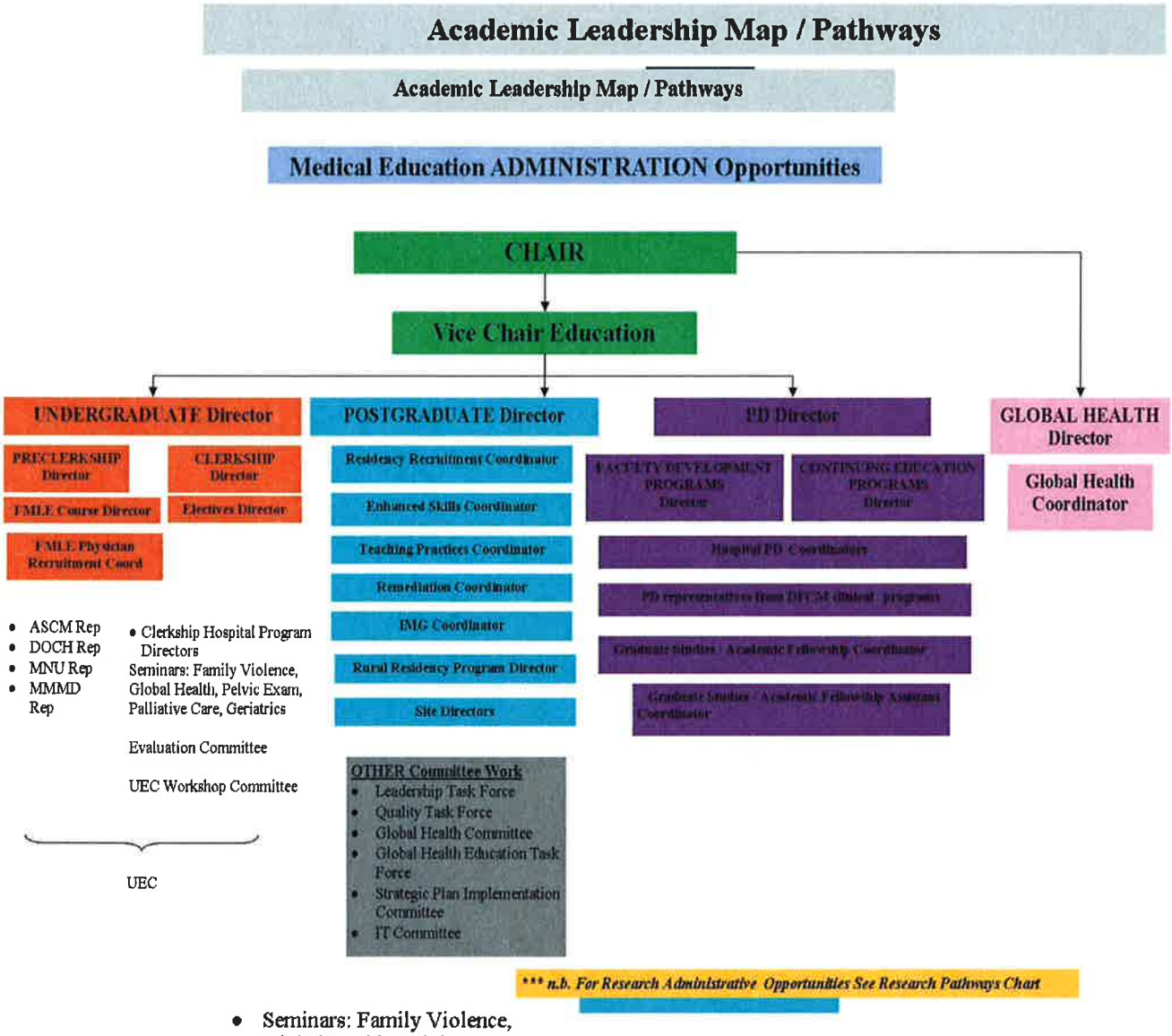
10. April 16, 2011; Vaughan Estates – DFCM Rosser Day Poster Presentation; "Advancing Academic Leadership in Family Medicine: Strategies, Resources, Tools"; Leslie Sorensen, Rita Shaughnessy, Laura Surdianu

11. November 15. 2011; Banff, Alberta – NAPCRG; "Measurement, Questionnaire Design and Survey Implementation to Explore Factors Impacting Leadership and Work Life in Family Medicine - Workshop"; David White, Paul Krueger, Leslie Sorensen, Florence Kim, Jeff Kwong, Viola Antao

12. November 12-16, 2011; Banff, Alberta – NAPCRG; "Exploring The Factors Impacting Leadership And Work Life In Family Medicine – Research in Progress Poster "; David White, Paul Krueger, Leslie Sorensen, Florence Kim, Jeff Kwong, Viola Antao

13. November 2, 2011; Montreal, Quebec – FMF; "Exploring the Factors Impacting Leadership and Work Life in Family Medicine – Research Day Poster"; David White, Paul Krueger, Leslie Sorensen, Florence Kim, Jeff Kwong, Viola Antao

APPENDIX 3: ACADEMIC LEADERSHIP PATHWAY MAPS



- Seminars: Family Violence, Global Health, Pelvic Exam, Palliative Care, Geriatrics

Academic Leadership Map / Pathways

↓

RESEARCH Opportunities

↓

RESEARCH Director

↓

Associate Research Director

Clinical Scientists (New title for Research Scholars who have ≥50% protected research time)

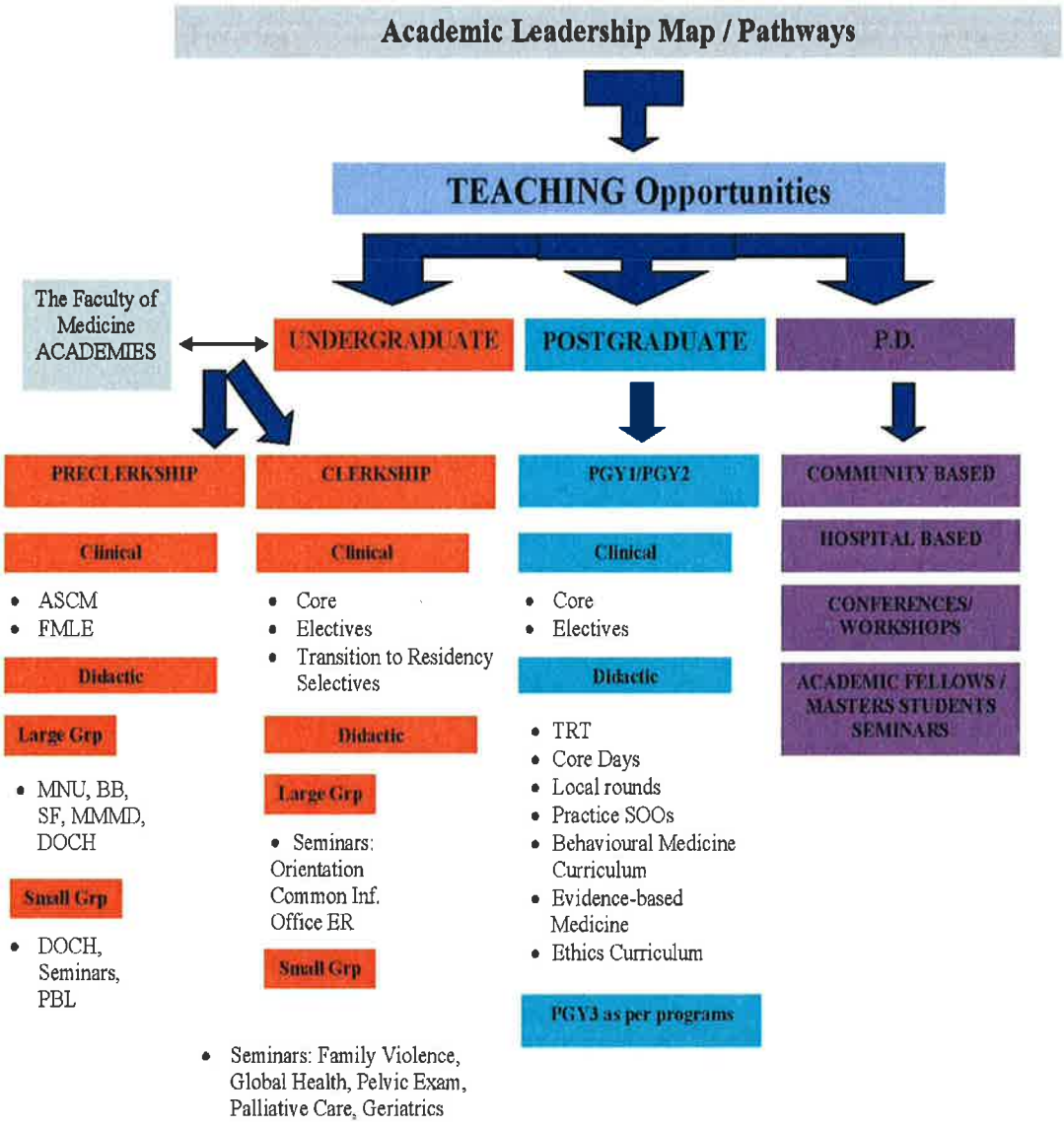
Clinical Investigators (New title for Research Scholars who have <50% protected research time)

New Investigator Award (New opportunity for DFCM faculty who are within 5 years of completing their highest academic degree and are interested in becoming "Clinician Scientists (i.e. having ≥50% protected research time). Preference will be given to those with a research PhD or equivalent. Funding will be made available for up to three years contingent on successful annual reviews and available funds. The purpose of this award is to provide protected research time for recent graduates to become more experienced and more competitive (in terms of obtaining new investigator awards and peer reviewed grants) family medicine researchers.)

Family Medicine Research Fellowship (New opportunity for those who hold an academic appointment (or equivalent) in the DFCM and are enrolled in a research degree program. Preference will be given to those enrolled in a PhD program. The maximum duration of each award is five years if enrolled in a PhD program and two years if enrolled in a Masters program. Up to two fellowships will be awarded based on the quality of candidates.

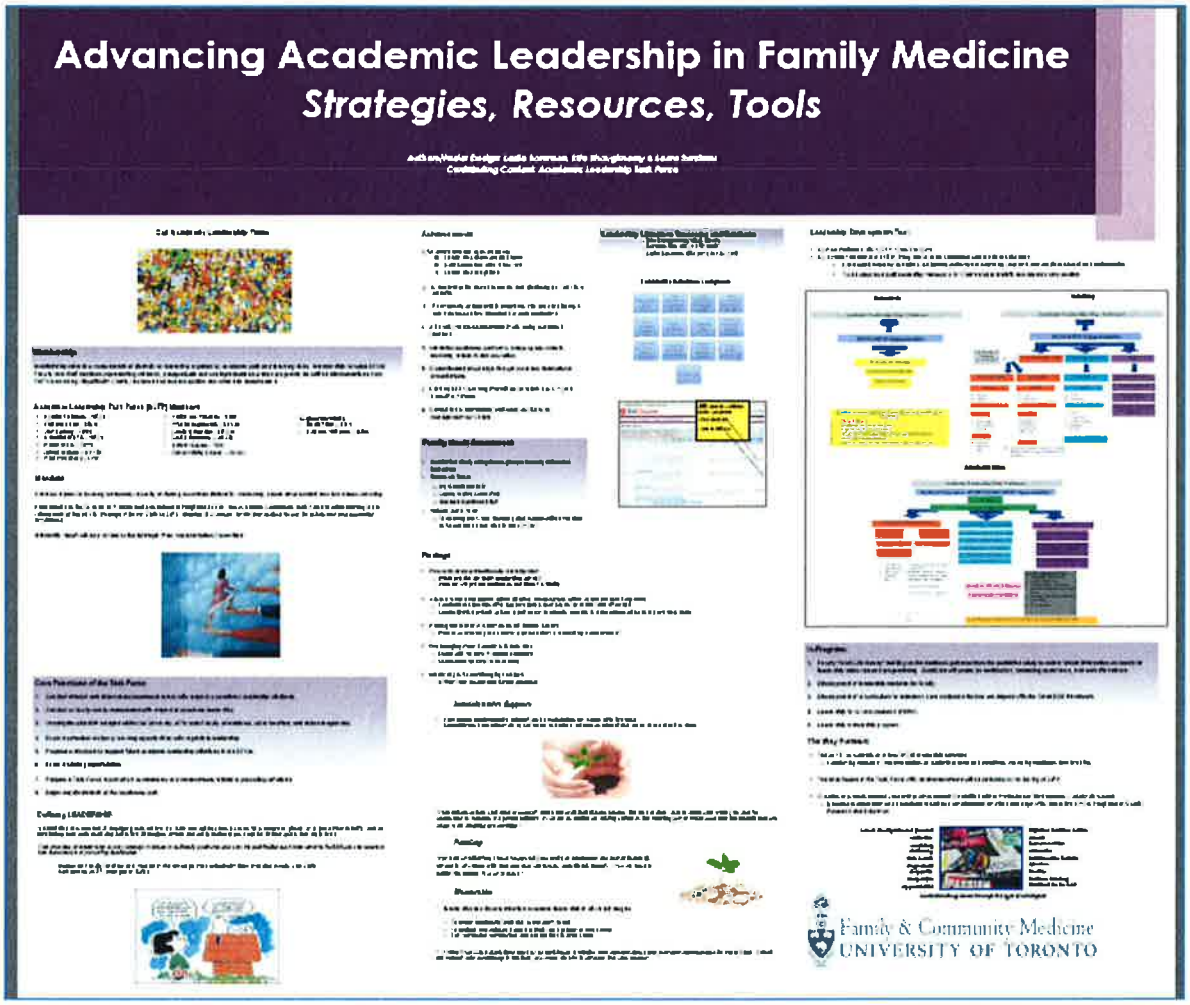
Available Resources to Faculty Family Physicians Wanting to do Research:

- Biostatisticians
- Qualitative Research Expertise
- Expertise in Research Design
- Administrative Support for Ethics Approval Processes
- Advice re: Funding Sources
- Access to other Faculty with Similar Research Interests
- Mentorship Resources:
  - A) DFCM Staff
  - B) Research Program website
  - C) DFCM Research Rounds
  - D) Internal Grant Review Process
  - E) DFCM Research Travel Fund


Academic Leadership Map / Pathways
TEACHING Opportunities
The Faculty of Medicine ACADEMIES
UNDERGRADUATE
POSTGRADUATE
P.D.
PRECLERKSHIP
CLERKSHIP
PGY1/PGY2
COMMUNITY BASED
Clinical
Clinical
Clinical
HOSPITAL BASED
• ASCM
• FMLE
• Core
• Electives
• Transition to Residency Selectives
• Core
• Electives
CONFERENCES/ WORKSHOPS
Didactic
Didactic
Didactic
ACADEMIC FELLOWS / MASTERS STUDENTS SEMINARS
Large Grp
Large Grp
• TRT
• Core Days
• Local rounds
• Practice SOOs
• Behavioural Medicine Curriculum
• Evidence-based Medicine
• Ethics Curriculum
• MNU, BB, SF, MMMD, DOCH
• Seminars: Orientation Common Inf. Office ER
Small Grp
Small Grp
• DOCH, Seminars, PBL
PGY3 as per programs
• Seminars: Family Violence, Global Health, Pelvic Exam, Palliative Care, Geriatrics

Last Rev

APPENDIX 4: LEADERSHIP POSTER



Rotman School of Management
UNIVERSITY OF TORONTO

APPENDIX 5

Concept Paper

Leadership Development Program for Department of Family and Community Medicine

Executive Programs (EP) at the Rotman School of Management, University of Toronto, has prepared this paper as an outcome of discussions with Dr. David White and Leslie Sorensen of the Department of Family and Community Medicine (DFCM. It is intended as the basis for further discussions leading to development of a formal proposal, if requested by DFCM.

Competencies for Leaders in Family Medicine Teaching Hospitals

DFCM is the largest Department of Family Medicine in North America with 14 hospitals providing a range of undergraduate and graduate training through over 900 faculty members, most of whom also have heavy clinical workloads. Chiefs and program leaders in these hospitals have often been appointed to leadership roles with limited or no prior formal management training or preparation for leadership. They have usually been chosen for their clinical skills and academic accomplishments in teaching and research.

That, however, is an inadequate preparation for the leadership responsibilities they face. Competencies in leadership and management are very different from clinical competency. These leaders need to develop the following broad competencies:

Personal Leadership Skills: These are critical skills for the new world of health care. The recommended Rotman approach to health care leadership focuses on setting and communicating a direction (visioning), creating supportive conditions for those whom they lead, developing commitment to the vision (aligning) and appealing to the values of stakeholders (motivating).

Management of Change: A systematic approach to managing change and a process for working with individuals and groups both inside and outside the hospital is essential - to deal with the human aspects of change as well as its technical components.

Emotional and Political Intelligence: Self-awareness is a critical asset for an effective health care leader. Rotman proposes a range of assessments that which will aid participants in developing their personal leadership agenda.

Application of Managerial Tools: Rotman employs a range of tools for planning, organizing and measuring performance. We have embedded these tools in our approach to Integrative Thinking.

Recommended Leadership Program

For DFCM, Rotman recommends a leadership program of 12 days of classroom based activities. The program would be delivered in six, two-day modules, at six week intervals - an optimal format for busy physicians with leadership responsibilities and clinical and research commitments.

Each module will be sufficiently long to provide meaningful learning, while allowing participants to return to their hospitals for the rest of the week. We do not recommend holding classes on weekends as most of these leaders are already handling heavy workloads.

Each cohort would ideally consist of approximately 45 participants from the 14 hospitals and the university. A mix of chiefs, program leaders, portfolio directors and potential leaders is recommended.

The program would be developed and delivered in partnership with the Department of Family and Community Medicine and the Rotman School of Management, University of Toronto. Rotman would commit to assisting DFCM to obtain CE certification of the program from the College of Family Physicians of Canada.

Value proposition

The payoff to the participating hospitals and to DFCM will be two-fold. Firstly, participants will develop competencies in health care leadership and management needed to deal with the rising demand for services while faced with resource constraints. Secondly, during the program, participants will develop a network of collaborative relationships that will aid in the implementation of DFCM's strategic plan.

The payoff to the participants will be their enhanced ability to lead and manage, and increased confidence in their leadership capabilities. They will establish a strong network of peers during the program that will provide them ongoing peer support and resources.

Upon completion of the program, participants will receive a certificate of attendance from Rotman and DFCM.

Fees:

The price for the design and delivery of the leadership program is estimated at $205,000 (plus HST) for a cohort of 45 participants. This includes all instruction, materials, facilities and meals during the six, two-day modules. Assessments are additional and estimated at $25,000.

This fee also includes group coaching; individual coaching fees for participants will be negotiated, as required.

Three examples of Rotman Executive Programs' impact

The following cases have been selected to provide DFCM some overviews of Rotman's successes in the health care field.

1. *The Leadership Academy* for the Ottawa Hospital (TOH)

TOH is a leading academic health sciences centre in Canada, recognized for outstanding patient care, education and research. The hospital provides services in English and French to 1.5 million people in Ottawa and Eastern Ontario.

Rotman Executive Programs designed a customized leadership development program targeting front-line supervisors, managers, directors and senior managers.

The objectives:

- To provide participants with actionable management tools aligned with TOH's vision, values and leadership competencies
- To guide participants in the application of management tools in the Healthcare environment
- To stimulate participants to adopt a proactive approach to championing improvements in their organizations
- To improve TOH's ability to attract, develop and retain potential and proven leaders

We delivered the program in partnership with the Telfer School of Management of University of Ottawa. Pre-course materials were posted on a dedicated portal. In addition to class lectures and discussions, the program included collaborative team projects, business simulations and role playing.

The results:

The Leadership Academy has become one of our most popular programs and has been named one of the best programs for healthcare leaders by Accreditation Canada. We are currently in the fifth offering of the program since its launch in 2006, and are working with TOH on planning the sixth offering to commence in the fall of 2011.

2. Leadership Development Program (LDP) for the Scarborough Hospital (TSH)

TSH is Canada's largest urban community hospital and a leader in advocacy, research, teaching and learning. Serving a community of close to one million people, TSH has more than 3,400 staff, 700 physicians and 600 volunteers.

TSH has been confronting two workforce challenges endemic to the healthcare industry: 1) a disproportionate percentage of the healthcare workforce approaching retirement age, creating an urgent need for succession planning, and 2) changing population demographics, placing greater demands on the system.

The objectives:

- To provide its current and future leaders with leadership insights and actionable tools,
- To teach and practice personal, strategic and organizational leadership skills needed to implement the organization's vision of providing the best healthcare in a changing global community

The Leadership Development Program was developed in close consultation with senior TSH leadership. The program addressed conflict management issues, leading and team building, coping with change, time management and communication. There was a strong focus on patient and staff service in every module of the course.

Participants completed projects during the course of the program. A typical project was to formulate a plan for making a significant improvement in operations at TSH and laying out a 60-90 day road map for implementation. Ten hours of professional one-on-one coaching followed for all participants.

The Results:

We have just completed the second offering and have started planning with TSH for next year.

3. *Joint Physicians and Directors Leadership Development Program (LDP) for* Trillium Health Centre (THC)

THC is one of Canada's largest academically-affiliated health centres, with highly-specialized regional programs, serving the changing and diverse needs of the communities of Mississauga, West Toronto, Halton, York and Peel. Housing a model ambulatory care centre and the largest free-standing day surgery centre in North America, Trillium serves over one million residents.

THC's brief to Rotman was to design a program that would build the leadership capacity of physician leaders and clinical and non-clinical directors.

The objectives:

- To create a culture of excellence and enable THC to achieve its strategic goals through focused development of leadership competencies.

Rotman's sessions equipped participants with the skills and competencies to immediately apply what they learned to existing challenges within their organization. One of the key features of the program was the Preceptor Project Presentations. Participants were required to identify possible changes or improvements at THC which could be achieved through a practical application of learning in the program. They presented their findings and analyses to their sponsors and the senior executive team about the particular need, the proposed change and plan of action, and the expected results once change was implemented. These action learning projects contributed to an early return on investment.

The Results:

After the successful completion of the inaugural program this spring, with overwhelming positive response from the participants, Trillium and Rotman are planning for the next offering of the Joint Physicians and Directors Leadership Development Program. This second offering will also address the integration of operations of Trillium and its partner, the Credit-Valley Hospital.