Exploring and understanding academic leadership in family medicine

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Abstract

Objective To explore how family physicians understand the concept of academic leadership.

Design Case study.

Setting Department of Family and Community Medicine at the University of Toronto in Ontario.

Participants Thirty family physician academic leaders.

Methods Focus groups and interviews were conducted with family physicians from a large multisite urban university who were identified by peers as academic leaders at various career stages. Transcripts from the focus groups and interviews were anonymized and themes were analyzed and negotiated among 3 researchers.

Main findings Participants identified qualities of leadership among academic leaders that align with those identified in the current literature. Despite being identified by others as academic leaders, participants were reluctant to self-identify as such. Participants believed they had taken on early leadership roles by default rather than through planned career development.

Conclusion This study affirms the need to define academic leadership explicitly, advance a culture that supports it, and nurture leaders at all levels with a variety of strategies.

EDITOR'S KEY POINTS

• Family medicine as a discipline in Canada is in a period of rapid evolution. A time of continued innovation, consolidation, and integration is needed. Within the academic world, the discipline is engaged in expanding roles in education, research, and organization of clinical practice. Strong leadership capabilities are essential to success for academic departments in these realms. This study aimed to explore how family physician leaders understood the concept of academic leadership.

• The findings of this study lead the authors to advocate for advancement of a culture that engages and supports the development of academic leaders in family medicine. Multifaceted leadership development through formal programs, mentorship, experiential learning in progressively demanding roles, and the use of a range of resources will not only build leadership capabilities but also enhance a supportive culture.

Connaissance et compréhension du concept de leadership académique en médecine familiale

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Résumé

Objectif Déterminer ce que les médecins de famille comprennent du concept de leadership académique.

Type d'étude Étude de cas.

Contexte Le département de médecine familiale et communautaire de l'Université de Toronto, en Ontario.

Participants Trente médecins de famille agissant comme leaders académiques.

Méthodes Des médecins de famille d'une grande université urbaine comprenant plusieurs sites et considérés par leurs pairs comme des leaders académiques à différents moments de leur carrière ont participé à des groupes de discussion et à des entrevues. Les transcriptions des groupes de discussion et des entrevues ont été rendues anonymes, et les thèmes ont été analysés et traités par 3 chercheurs.

Principales observations Les participants ont identifié chez les leaders académiques des qualités de leadership qui correspondent à celles proposées dans la littérature actuelle. Même s'ils étaient reconnus comme leaders académiques par leurs pairs, les participants hésitaient à se reconnaître comme tels. Ils croyaient que c'était par défaut plutôt que suivant un plan de carrière planifié qu'ils avaient adopté très tôt le rôle de leader.

Conclusion Selon cette étude, il est nécessaire de définir de façon explicite le concept de leadership académique, de mettre de l'avant une culture en ce sens et d'encourager les leaders à tous les niveaux par différentes stratégies.

POINTS DE REPÈRE DU RÉDACTEUR

• Au Canada, la médecine familiale connaît une évolution rapide. Les innovations continuelles exigent consolidation et intégration. Dans le milieu universitaire, cette discipline prend de plus en plus de place dans l'éducation, la recherche et l'organisation de la pratique clinique. Les départements universitaires ont besoin d'un leadership fort pour réussir dans ces domaines. Cette étude voulait savoir comment les leaders chez les médecins de famille concevaient le leadership académique.

• Les résultats de cette étude ont amené les auteurs à proposer l'instauration d'une culture qui favorise et appuie le développement de leaders académiques en médecine familiale. Le développement d'un leadership aux multiples facettes grâce à des programmes spécifiques, au mentorat, à un apprentissage basé sur l'expérience dans des rôles de plus en plus exigeants et à l'utilisation d'une variété de ressources permettra non seulement d'accroître ce que leadership peut accomplir, mais aussi d'instaurer une culture appropriée.

Primary care is fundamental to effective health care.[1] This recognition is leading to important changes in the way primary care is practised and delivered. Effective leadership in academic family medicine is essential for guiding and shaping this evolution, providing the foundation in research, educating future practitioners, and implementing improvements in clinical practice.

University departments of family medicine recognize this important social responsibility. However, many face challenges in recruiting leaders for key positions such as department chairs, program directors, and chiefs of clinical units, a problem common to other academic departments.[2] Boyer proposed a model that recognizes 4 types of scholarship: discovery, integration, application, and teaching.[3] Research (discovery) and teaching are strongly recognized by academic institutions and commonly understood by faculty. In contrast, administrative roles, which entail the scholarship of integration and application, are often less valued or are avoided by academic physicians.[4] While physicians are prepared well for practice, teaching, and research, they are less likely to be prepared for the practice of leadership.[5]

By exploring what family physicians with academic appointments think about leadership, ways to identify, nurture, and sustain academic leadership in family medicine might be revealed. The literature shows that communication, visioning, strategic planning, change management, team building, personnel management, business skills, and systems thinking are critical for physician leaders in general.[6] Effective physician leaders are known for their ability to establish positive and trusting relationships and for their awareness and recognition of their strengths and limitations.[7] Studies exploring physician leadership[8,9] have included family physicians, yet little is known specifically about family physician leaders' perspectives, and even less is known about the perspectives of academic family physicians. Souba suggests that a critical examination of academic leadership is needed in order to attract leaders into academic roles.[5] This paper is unique in that it explores concepts of academic leadership specifically among family physicians in order to help shape interventions to recruit and retain more academic leaders in the future.

Objective

This study was designed to explore the concept of academic leadership among family physicians affiliated with a large multisite university department of family medicine. Exploring what family physicians think about academic leadership might enhance efforts to identify, nurture, and sustain leaders in the future for the discipline of academic family medicine.

METHODS

A case-study method was used to understand the phenomenon of academic leadership in family medicine. Case studies are useful when there is an opportunity to investigate a phenomenon within its real-life context.[10,11]

To be included in the study, physicians had to be affiliated with the Department of Family and Community Medicine (DFCM) at the University of Toronto in Ontario for a minimum of 2.5 years; currently in, formerly in, or considering a leadership position; and engaged in undergraduate, graduate, postgraduate, faculty development, research, or clinical family medicine at a local, provincial, or national level. To identify these physicians, an e-mail call was sent to all DFCM faculty, leaders in the Faculty of Medicine, and leaders of national family medicine organizations.

This process identified 88 individuals; a subset was invited purposely to ensure diversity of career stage (early, middle, and late), site, sex, and academic focus. The ultimate selection was also determined by participant availability. Five focus groups were conducted based on career stage (**Table 1**). We ensured that no focus group included participants who were in a reporting relationship. To achieve sex balance across career stages, the research team invited physicians who were unavailable for focus groups to be interviewed by telephone. Five telephone interviews were held using the same semistructured interview guide (**Box 1**) conducted by the same interviewer (L.G.C.). This also served as a test-of-findings process.

Table 1. Focus group and interview participants

CAREER STAGE	FOCUS GROUPS	INTERVIEWS	NO. OF PARTICIPANTS	SEX
Early (< 5 y)	1	3	6	2 male 4 female
Middle (5–20 y)	2	0	12	4 male 8 female
Late (> 20 y)	2	2	12	7 male 5 female

Box 1. Focus group and interview questions

1. When you think about academic leadership, can you envision someone within the Department of Family and Community Medicine that embodies the characteristics of an exemplary academic leader?
2. In considering your own career, what opportunities have you had to pursue academic leadership roles?
3. When in a leadership position, what are the challenges and enablers?
4. What type of leadership training would help provide readiness for academic leadership?

Focus groups and individual interviews were audiorecorded, transcribed, anonymized, and then managed using NVivo software. The transcripts were coded independently by 3 researchers (I.O., L.G.C., and M.H.M.) who negotiated the themes and content until agreement was reached across, first, all career stages and, second, within specific career stages. Ethics approval was granted by the university's research ethics board.

FINDINGS

Portrait of the academic leader in family medicine

Participants readily identified qualities of effective family physician leaders affiliated with the academic department of family medicine. **Box 2** lists common attributes with the 3 most dominant themes being vision, enabling others to succeed, and excellence in an area.

Vision. Participants described family medicine leaders in the department as individuals with clear vision.

> 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.

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

Box 2. Portrait of the academic leader in family medicine

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

Leaders in family medicine commonly challenged the status quo. Their ability to "get the message across" by "pushing the boundaries, or thinking outside the box" was regarded as instrumental.

Enabling others to succeed. Academic leaders inspired and fostered supportive environments, "assisting people to be the best that they can." Using motivation, encouragement, and guidance, effective leaders were admired for supporting the needs and interests of others. As one participant reflected, "your success is their [the leaders'] 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.

Excellence in an area. Participants also shared that academic family medicine leaders often had at least one specific niche area or "some record of achievement academically." The pursuit of a focused area of interest and the ability to apply their knowledge broadly through leadership across the discipline of family medicine was a defining feature. A participant further elaborated:

> [Academic leaders] don't just generally have to be heads of departments or whatever; it is a niche. 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.

A superb academic leader was thought to have capacity to lead within 3 portfolios "administration, education, and research," and a "really, really superb leader would have 3 out of 3."

Am I an academic leader?

Surprisingly, a common theme for participants was that they questioned whether they were academic leaders, despite having been identified as such by colleagues. An early-career physician participant reflected:

> I think that the term *academic* is problematic because it refers to research or education, right? … [A]s an academic department we [physicians] 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.

Defining the term *academic* thus emerged as an important consideration:

> Clarifying what is meant by academic leadership will help many of us who do not come from an academic background originally [to understand] what academic leadership entails because we may be doing it without realizing it.

Identifying academic leaders

Mentorship and recruitment were highlighted as key elements that positively influenced participants' leadership experience.

Mentorship. The role of mentorship varied depending on career stage. At earlier career stages, senior mentors were considered critical.

> 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.

In midcareer, becoming a mentor was viewed as an important aspect of development, reinforcing an individual's identity as an academic leader. One participant described the transition from the one being mentored to the one doing the mentoring 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 pay[ing] it forward."

The ability of mentors to connect and coach was deemed critical. Midcareer and late-career participants believed there was a need—if not a responsibility—to actively identify, encourage, and nurture junior leaders in the department: "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."

Having local hospital chiefs and colleagues who "support you ... groom you ... coach you, [and] get you into the right position" were identified as crucial.

Recruitment.

Leadership by default: A finding shared among the midcareer and late-career participants was the recollection of taking on leadership roles "by default":

> In my clinical work it was basically my turn to do a job [leadership position] 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.

The recruitment experience for the leadership roles was characterized as having their "arm twisted." Few positive role models existed for faculty to emulate.

> I don't think we have a lot of role models out there for people who really enjoy it [leadership] 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.

DISCUSSION

To our knowledge, this study is the first to explore academic leadership from the perspective of physicians affiliated with a university department of family medicine across different career stages. The participants identified the characteristics of exemplary leadership based on their actual experiences (**Box 2**). It is relevant that these attributes align well with findings of other studies of academic physician leadership.[5,6,8,9,12]

There was a striking contrast between the facility with which participants were able to identify academic leadership characteristics and their hesitance to recognize themselves as academic leaders. When asked about their own careers, many questioned whether they were academic leaders. Our participants did not consider themselves to be *academic* leaders if they were engaged in *administrative* roles that were not specifically related to research and education. This finding resonates with a discussion paper by Fairchild et al,[4] which observes the traditional devaluing of administrative duties in the academic environment and argues for the increasing importance of administrative leadership as well as its academic relevance.

Many universities have adopted Boyer's model that recognizes 4 types of scholarship: discovery, integration, application, and teaching.[3] Boyer recognizes knowledge application and leadership as scholarly work.[3] University departments of family medicine need to clearly define *academic leadership* in an inclusive way that incorporates all aspects of scholarship. The scholarship of integration and application are central to effective clinical leadership. Greater clarity will help departments to identify, mentor, and support leaders who can advance the discipline.

This study also reveals how perspectives on leadership evolve throughout career stages. The early-career academic physician leaders identified the need for mentors to provide encouragement. Midcareer academic leaders recognized the importance of mentorship in

building confidence and competence. The late-career academic leaders valued their roles as mentors and the opportunity "to give back." This cycle of academic leadership involving differing roles over time seems to have developed naturally within the DFCM.

A surprising finding was the recollection by midcareer and late-career leaders of being put into leadership situations "by default." These experiences affected many of their views related to leadership. Negative beliefs and experiences of senior family medicine leaders can negatively influence potential younger academic leaders, influencing them to avoid rather than embrace leadership opportunities. A culture of "leadership by default" is concerning for any enterprise.

Fostering a supportive culture

Within the literature on leadership, *culture* has been defined as a collective phenomenon shared by people who live or have lived within similar "social environments."[13-15] These social environments shape individuals' beliefs and values. *Culture* has been further described as a set of shared images, values, and modes of speech to which individuals attach their understandings.[16] Language is a critical link to describe "what is" and "what can be"[17] and it enables meaning making. For family medicine, the lack of a definition of *academic leadership* is problematic. Creating a culture within family medicine that supports academic leadership requires departments of family medicine to use clear language to describe what constitutes academic leadership and to value it explicitly.

Limitations

Our recruitment strategy was limited to a single university, representing a specific population of faculty in family medicine, and therefore might limit the generalizability of our findings. Further studies involving more settings can help to test for unique or different understandings of academic leadership with context specificity.

Conclusion

The findings of this study lead us to advocate for advancement of a culture that engages and supports the development of academic leaders in family medicine. Our findings affirm the need for physician leadership development initiatives to incorporate role models and mentors.[18] The results lend research support to the recommendation from Bogdewic et al[12] that departments of family medicine should consider multilevel and multifaceted leadership strategies across the continuum of a physician's career. This should start in medical school, continue through residency, and be advanced within practice. Multifaceted leadership development through formal programs, mentorship of all types, experiential learning in progressively demanding roles, and the use

of a range of resources will not only build leadership capabilities but also enhance a supportive culture. This study affirms the need to define academic leadership explicitly, advance a culture that supports it, and nurture leaders at all levels with a variety of strategies. 🍁

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