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Health Care Leadership and mentoring

My Mentoring experience

Over a decade ago I created McCarthy Mentoring as I began to understand the importance of wisdom, experience and corporate memory in assisting people with leadership. There was no such business in Australia at the time – coaching was emerging as the new black but I saw this as skills based and I wanted to provide a more holistic approach. I had spent the best part of a decade running leadership programs especially for women and while they were fun it became clear that transferring the learning on return to the work place was not easy.

I thought systematic and incremental learning was what was needed and offered the challenge of supporting two young women into a senior leadership team in an international bank. I

developed a mentoring practice. When I asked these super bright pair what they thought they needed to assist their transition from high technical skills base to executive leadership they said independently of each other:

Women whose shoes we can walk in

I understood -----for there have been few role models for women of my age seeking and practising leadership. It has been like a documentary without the script and I could see an opportunity to find them an independent trusted adviser or mentor. I used external mentors as I believed strongly that being mentored by someone who is in charge of your promotion or pay packet has limitations. Good for understanding internal culture and how we do stuff around here but generally deficient in building trust and encouraging risk taking.

Senior leadership is not just about technical skills.

The software for new players in senior executive roles remains unwritten. The transition from technical skills to leadership can be

daunting and uncomfortable and it is at this moment that mentoring can be a powerful intervention.

A mentoring relationship is one where a wiser and more experienced person assists another person to grow and learn

In the best mentoring relationship there is mutual learning, integrity, respect and trust.

The external mentor becomes the independent trusted adviser who listens and helps the mentee hear and trust their own voice.

Health care has been slow to use professional mentoring despite the fact that it is an established management practice in preparing and supporting emerging leaders.

Too often clinicians are mentored by like people----- for as one explained to me I would have to have doctor as no one else would understand what I do.

In a sense that is the point.

Lawyers say the same but let me share my experience with the legal profession .

AAR matching, retention, return from maternity leave, partnership, clarity about roles, joining the bar and the bench

This experience is repeated with most of my clients who include banks, professional service firms including architects, lawyers and management consultants, Indigenous Arts companies, Australia's Major Performing Arts Boards, Qantas, Universities, public sector agencies and various not for Profit NGO's.

You will note that the health sector is noticeably absent.

Thinking strategically and trusting your own voice are the outcomes of effective mentoring. The evidence is clear that mentoring works

Recently I read the McKinsey **2009 journal article**

When clinicians lead by James Mountford and Caroline Webb. It encapsulates the challenges for clinicians and I quote

The health care industry faces daunting challenges. Across developed countries, cost inflation continues unchecked, and profound quality and safety problems persist. Many health systems face recruitment challenges despite large pay raises for doctors, and an increasing number of clinicians say they would advise young people against choosing careers in medicine.

So further change is needed, despite years of progress in the quality of health care around the world.

This transformation will require leadership-and that leadership must come substantially from doctors and other clinicians, whether or not they play formal management roles.

Clinicians not only make the frontline decisions that determine the quality and efficiency of care but also have the technical knowledge to help make sound strategic choices about longer-term patterns of service delivery.

The conventional view of health care management divides treatment from administration-doctors and nurses look after patients, while administrators look after the organizations that treat them. Despite accumulating evidence of the positive impact of clinical involvement in the delivery and improvement of service, health care organizations often struggle to achieve this kind of participation. To understand the barriers to clinical leadership, we conducted interviews and workshops involving nearly 100 clinical professionals.

Our research highlighted three main issues.

- **Ingrained skepticism**
- **Weak or negative incentives**
- **Little provision for nurturing**

Ingrained skepticism

We found an ingrained skepticism among clinicians about the value of spending time on leadership, as opposed to the evident and immediate value of treating patients.

Participants explained that playing an organizational-leadership role wasn't seen as vital either for patient care or their own professional success and therefore seemed irrelevant to the self-esteem and careers of clinicians.

Moreover, many participants expressed discomfort with the idea that the impact of clinical leadership is often hard to prove.

One way to address this problem is to be far more systematic about gathering stories- told authentically and compellingly by those who participated in or observed them- that highlighted the value of great clinical leadership. By “making heroes” of clinical leaders of all types, both in formal management and frontline roles, organizations can create a stronger bank of role models and spark a sense of possibility. Health care organizations need to build a solid, credible evidence base to show the importance of clinical leadership.

While approaching the topic as though it were a clinical trial is difficult, organizations should track measures of clinical-leadership development and correlate them with their impact on quality and costs. To create this kind of evidence base, health care organizations need, at a minimum, basic performance data for making meaningful comparisons.

Weak or negative incentives

It became clear there were weak or even negative incentives for clinicians-especially doctors-to take on service leadership roles.

Leadership potential generally isn't a criterion for entry into the clinical professions and often isn't a major factor in promotion.

Nor is there a well-defined and respected career path for those with an appetite for formal leadership roles- in stark contrast with well trodden clinical and academic tracks.

Peer recognition is low or nonexistent, and often there are financial disincentives for doctors taking on organizational-leadership roles.

Policy makers and organizations must **retune incentives**. Correcting these problems is important not only for direct financial reasons but also because of the wider signals that incentives send about the value and prestige attached to clinical leadership.

Where it flourishes, clinicians in formal leadership roles typically receive a small premium over colleagues who focus solely on direct patient care.

Too great a financial premium, however, would make patient care less attractive and damage what ought to be the peer-to-peer relationship between leaders and other clinicians.

As people come to appreciate the link between performance and enhanced clinical leadership, health systems can also encourage it indirectly by finding appropriate ways to reward organizations that perform well and by creating meaningful consequences for those that don't.

Little provision for nurturing

We found little provision for nurturing clinical leadership capabilities.

Organizations generally lack meaningful processes for **finding, inspiring, and stretching those clinicians who possess the greatest potential as leaders. Leadership and management training is frequently absent from core curricula for undergraduate or postgraduate trainees and for the continuing professional development of clinicians.**

Any effort to encourage clinical leadership has to include support for professional development.

Health care organizations must define what they want from their clinical leaders-what skills and attitudes they hope to encourage, whether there are differences across professions or roles, and where the need to develop leadership is greatest. They can then target their efforts wisely and help clinicians identify and overcome any shortcomings.

I would add to this that being mentored by non doctors and dare I suggest consumers would be transforming and could model a new way to deliver health services.

Currently I chair headspace which is one of the leadership successes of the Australian General Practice Network. It has a young executive team all of whom have mentors to help retain them and build their capacity.

It is a work in progress.

Headspace is an exciting leadership initiative which aims *to promote and facilitate improvements in the mental health, social wellbeing and economic participation of young Australians aged 12-25 years.*

It was launched in 2006 after a consortium of AGPN, Orygen Centre of Excellence at UOM, Australian Psychologists Association, The Brain and Mind Research Institute persuaded the Australian government of the need to address the mental health issues of young people and the evidence around early intervention. It is currently funded by the Australian Government Department of Health and Ageing under the Youth Mental Health Initiative Program.

There are thirty youth friendly multidisciplinary centres providing services to young people across Australia provided at a community level by a consortium of services.

All **headspace** Centres have at their core

- a primary care component that includes general practitioners,
- allied health staff,
- drug and alcohol workers and
- mental health practitioners.

The **headspace** website provides information and support to 60,000 young people and families every month.

The **headspace** Centre of Excellence provides evidence and best practice information in youth mental health for workers.

Conclusion

The soft stuff of health care is the hard stuff and keeps being neglected. Investing in health governance when Health systems

are screaming for visionary and bold leadership at every level seems a no brainer. Emerging leaders probably need mentors as well as leadership courses.

One to One mentoring is not a new concept. Mentor was the close friend of Ulysses who before setting off to Troy asked Mentor to care for his son Telamachus and prepare him to succeed his father as the King of Ithaca.

The concept informs today's ideas of mentoring.

The idea of apprenticeship,
the passing of wisdom and experience and
the generosity implicit in taking an active interest in the
growth and development of a younger person.

What Ulysses asked of Mentor for Telemachus is what we
seek in mentors today.

Thank you.

