Healers in Need of Healing Cannot Heal

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The "triple aim" of healthcare—enhancing patient outcomes of care, improving population health, and reducing costs—was first introduced in the literature in 2008 and has become healthcare's Holy Grail.[1] And, unfortunately, it appears as elusive as its counterpart in mythology. This should be no surprise given that, on the average, more than half of the key players are exhibiting a range of burnout symptoms.

The desired shift from "volume to value" continues to elude us. Are the high rates of physician burnout and distress an overlooked but critical issue? A "fourth aim" to address caregiver burnout has been proposed.[2-4] But, rather than a fourth aim—an afterthought—we believe that this aim is so essential to the triple aim that it is a prerequisite. It should be the first aim.

We will continue to fall short of achieving the triple aim if we do not proactively attend to the health and wellness of physicians and not simply react to extremes of physician distress. In addition, we believe that our success in achieving all of the aims will depend on our ability to provide physician leaders with the core skills and holistic wellness to achieve such transformation.

All Physicians Are Leaders—For Better or Worse

Both formal and informal physician leadership is needed for healthcare transformation. Contrary to popular opinion, leaders are not born. They are formed. This process involves a personal inner journey, one involving the courageous development of self-awareness through a reflective process that instructs as to how one's strengths and shadows are affecting one's ability to inspire, enlist others, and create collaboration for needed change. Formal leaders need to be effective in their position to enlist collaboration in creating disruptive innovation and transformative change. But informal leaders (ie, all physicians) need to be effective in both collaborating in its creation and taking ownership by operationalizing it. If physicians are not taking ownership of their leading role, they will be barriers.

In concert with the popular definition of insanity (ie, doing the same things while expecting different results), management often continues to try to go around physicians, run over them, or "carrot and stick" them, all while getting the same negative results. One physician in a senior management position said, "I don't understand why (our) physicians can't find purpose and meaning on my agenda." He demonstrated the frustration experienced by those who attempt to lead without the necessary formation to have the skills that inspire, gain others' respect, and enlist others into collaboration.

Missing the Mark

Physicians are now being thrust in leadership positions, whether formal or informal, to an unprecedented degree. Physician leadership programs are being developed with solid material, competent faculty, and seemingly logical, well-designed curricula. Unfortunately, many miss the mark. We observed multiple instances of eye rolling during physician interviews when leadership training was mentioned. Upon probing, it became apparent that the system's program—and the entire idea of physician leadership development—had developed a bad name within the medical staff. It wasn't presented in a context that resonated with their reality. "Waste of time. I learned nothing," was the judgment of one elected medical staff leader.

This MBA-style traditional approach, which focuses mostly on management theory and practice, does not adequately address the inner transformation needed to take us from transforming processes to transforming our mental models and habits of relating to self and others.[5] The content is not sufficient because it does not address that proposed first aim of supporting the clinician experience and sustainability of the work and often does not reflect an understanding of the physician worldview and their starting point relative to leadership.

Instead, what is required is moving from what Spiegelman and Berrett call "transactional" leadership to "transformative" leadership, which have different outcomes (Table).[6] This will necessitate leaders to effectively communicate the "why" of the new initiatives they're pursuing.

Table. Comparison of Transactional and Transformational Leadership Styles

Transactional	**Transformational**
• Clarifies issues and focuses on problem solving; prefers and makes high use of cognitive knowledge primarily	• Clarifies personal purpose and integrity through an ongoing inner journey; uses emotional, cognitive, spiritual, and experiential knowledge
• Attempts to fix what is broken	• Listens and asks honest, open questions; collegial style; attends to relational aspects
• Communicates strategy plan	• Applies appreciative inquiry, looking for what is going well and what is working
• Charts strategy course and communicates it to the team	• Facilitates emergence of strategy from the collective intelligence of the group
• Develops meeting agenda and conducts meetings according to this preset and pressing agenda; expects agreement	• Translates values into clear specific meeting practices that ensure everyone's participation and keep egos in check
• Intentionally works to avoid or circumvent conflicts and to contain contradiction	• Devotes time to bringing conflicts to light and addressing them; applies multistep conflict resolution process
• Asks: What is happening out there? What should I/we do?	• Asks: What is happening in me? How are others experiencing it? What is trying to or needs to emerge?
• Stays focused on what they perceive to be the best idea	• The leader is able to hold different points of view and integrate complex divergent ideas
• Builds alliances of interest	• Builds trustworthy relationships
Outcomes	**Outcomes**
Individuals may feel like a "cog in the wheel" and do the minimum required	Individuals feel valued, inspired, and want to be involved
Defenses remain high	Defenses are lowered
Disagreements often go underground; they may show up again in passive-aggressive or other undermining behaviors	Disagreements are worked through and resolved, resulting in team cohesion
Relationships are strained	Relationships are deepened through trust building and personal understanding of each other
Issues may be temporarily resolved, but relationships and long-term success are compromised	Issues are resolved in a sustainable way
Disengagement and cynicism	Buy in, engagement, and personal commitment

We lead from who we are, and we gain meaning from why we do what we do. If the "who we are" is burned out, cynical, and lacking in self and other compassion—and yet we feel we have to save face and not admit to it, and the "why we do it" is focused on economic transactions—no amount of academic education on leadership theory will help us engage ourselves or others in the healing process.

Ignoring Proven Principles and the Science of Leadership

Sadly, attempts to address these real challenges often ignore proven principles of leadership development and holistic personal growth. Book study is necessary, but not sufficient alone, to learn to be a healer. Information on wellness is not the same as being well, and effective leadership cannot be learned through knowledge acquisition alone. If the primary goal of a leadership academy is "teaching physicians to understand the metrics, the business of medicine, and the government regulations," it should be labeled as what it is: a management course.

There is no question that an understanding of metrics, business, and regulations is important, but this isn't what makes a leader. Absent from a physician leadership development curriculum too often is a clear understanding of what physicians are experiencing at this time and place, as well as any process for them to gain better self-understanding. Self-understanding can be thought of as one's strengths, growing edges, past and present experiences in medical practice, learned behavior and its effect on ability to succeed, and how to enlist others in a way that they call meaningful.

More foundational leadership formation is supported by the latest neuroscience research—in particular, the neuroscience of leadership. Advances in functional MRI have identified why inspiring and supportive relationships are crucial. They help to activate parts of the brain that make it possible to be open to new ideas and to be more socially oriented towards others.[7] What this means is that instead of seeing this type of leadership as "soft science," we would do well to understand how we are "hardwired" to connect. That connection matters at every level, especially when attempting to change deeply embedded patterns and immunity to change.[8]

In essence, change efforts that do not activate the parts of the brain that produce "positive emotional attractor" states (mainly through social means) and instead are based on coercive or cognitive-only methods rarely succeed in the long run.[7,9,10] In addition, this latest research also points to the ability of leaders to identify and to manage well their own internal states as being essential to the ability to influence others, as these internal states are unconsciously perceived by others. In other words, those being led pick up not only on the words of the leader but on the wholeness of the leader.

We believe that this is the fundamental reason why transformational leadership—or, as Parker Palmer and others call it, "leading from within"—is crucial at this time and place.[11,12] It will seize the opportunity to achieve the long needed integration first of the personal (ie, the "who" of leadership), then the personal with the professional, and finally the professional with the systems and environments of practice. Only then will physicians truly lead in engaging and inspiring others towards new development, new learning, adaptation, and innovation, ultimately changing the production pressure, the poor design of the work flow, and the proportion of non-value-added work towards the ultimate achievement of the triple aim. We are not going to have a cadre of effective physician leaders until we have a cadre of well and integrated physicians. And we are not going to have authentic healthcare culture transformation until we have a transformation of individual clinicians.

The Burn-Out Epidemic

All of this leads to the question: Why are physicians generally so ill prepared for the expanded role they need to play in this transformation of healthcare? As alluded to above, the majority of physicians today are burned out, cynical, and overwhelmed. The recent Medscape Physician Lifestyle Report places physician burnout at a higher prevalence and greater severity than just a year ago, with the highest

prevalence at 53% and greatest severity of 4.3 on a 5-point scale, depending on specialty.[13] This is consistent with a recently published article that placed mean physician burnout in 2014 at 54%, with a specialty-specific range between 39% and 71% and with every specialty's prevalence increasing since 2011.[14] The consensus is that physician burnout has reached a critical, if not epidemic, crisis level. In addition, in a recent survey in the United States, 60% of physicians reported that they were considering leaving their practice, and 70% reported knowing at least one colleague who left their practice due to low morale.[2]

Why is physician wellness of crucial importance as we face this unprecedented change in healthcare? For starters, physicians have tremendous influence, and they are often looked upon as de facto team leaders. They possess the ability to collaborate in essential teamwork or to undermine those essential processes. Indeed, physicians are more than just cogs in the healthcare machine. They are the key influencers for good or bad. Just think of the power of the physician's pen, order entry on an electronic health record (EHR), or the reality that they are on the front lines and responsible for critical points in the care of the patient. Therefore, they have the ability to undermine an initiative because they are emotionally and physically maxed out, do not understand the meaning of it, do not experientially see how it will be helpful, or have not been meaningfully enlisted so they are too detached.

Without addressing the issue of burnout and all of its causes and working toward a culture of wellness for caregivers and patients alike, we are not going to have the foundation we need to achieve the much needed triple aim. After all, what could be more patient-centered than ensuring that those who provide care are not only clinically competent but emotionally well? But let's be clear: Addressing burnout is not just a matter of addressing how many hours one works, how many bureaucratic tasks one has to weed through, how many barriers one has to jump through in order to care for patients, reducing the number of clicks on an EHR, or providing better pay. While these are necessary components, any comprehensive approach must include addressing the damage that may have been done by physician training and the ongoing effects of medical and organizational culture.

The Hidden Curriculum

Medical training includes a hidden curriculum from which physicians often learn such things as valuing expertise and reductionism over whole-person care; embracing independence and invulnerability as opposed to teamwork, collaboration, wholeness, and compassion; and saying nothing in order to survive rather than expressing concerns when deviations from care quality occur, when communications with patients are inadequate, or when team members are treated with disdain, disrespect, or dismissal.

Many physicians carry emotional scars from the tension of these opposing experiences. At best, the formal curriculum of medical training often lacks any process for gaining the emotional intelligence skills of self-awareness and self-management, with most of the feedback focused on the mastery of the technical and cognitive skills of becoming a physician rather than the intra- and interpersonal skills necessary to be a healer. This education system takes young students who score higher on important measures of emotional wellness than their equivalent peers pursuing other academic endeavors and statistically ends up lowering their emotional wellness (compared with their peers) by the end of medical school.

The culture of medical practice must also change if provider wellness is to be effectively addressed. The present system produces a suicide rate that is the equivalent of losing an entire class of medical school students every year; a culture that advocates self-sacrifice at the expense of self-care; a culture that aspires to and talks a lot about teams, collaboration, and interprofessionalism but often invests little time or resources in the development of these; a culture that often models leadership as a command-and-control function; a culture that can drive physicians to ignore their own humanity and disconnects them from their

own experiences, which is the very self-awareness they need to function in a high-complexity environment.

Additionally, the current dysfunctional and overly stressful healthcare work environment must change. This environment is a byproduct of the gradual shift in healthcare from a service to a business model without accounting for the complex, highly intimate relationships involved in physician-patient relationships. We cannot afford to reduce clinical work to transactional tasks that focus on productivity and efficiency at the cost of these very relationships and at the same time hold the aim of improving care quality and the patient experience of care as a desired outcome.

Indeed, this rapidly changing healthcare environment, with increased demands, regulations, mandates, payment models, and care delivery structures, is also contributing to this burnout. These alone have caused many compassionate, dedicated physicians to exceed their burnout threshold. Given all of this, it is no wonder that the medical infrastructure is cracking under the weight of the accelerated change and the resulting stress on individual physicians. We are demanding more from a group of professionals who are not prepared for the pressures that require skills that in many ways are just the opposite of how and for what they have been trained.

But Physicians Are Not Victims

Nevertheless, we reject the notion that physicians are victims. Instead, they are often co-creators of this unfortunate reality. They are co-creators by: (1) continuing to accept the "status quo" and expecting that the leadership of our healthcare systems and our political structures will fix the problem; (2) buying into the professional drive that leaves important parts of themselves out of their professional and personal lives; (3) perpetuating a culture of "silent suffering" and denying their own humanity; and (4) ignoring self-care as imperative to calibrating themselves in order to sustain this most meaningful, but most stressful work.

It is therefore not difficult to see how we will fail in our efforts to achieve the triple aim if we do not enlist the power of both formal and informal physician leaders in their clinical leadership and administrative leadership roles. Those physicians already in leadership positions have the opportunity and responsibility to focus attention on physician health and wellness and promoting development of professional identities that integrate biopsychosocial spiritual needs. Their own leadership development must provide them with the skills that will help transform current frames of reference from individualistic to interrelated, from managing others to enlisting mutual collaboration, and from posturing, often driven by insecurities and fears, to risking the power of vulnerability.

Then, and only then, can physicians lead the transformational change of which we are in desperate need. What we are doing now is the equivalent of building a house on sand. It is imperative that we address the issue of physician burnout, not to mention the physicians who are merely in survival mode. We must invest in the formation of leaders with inner capacity that will allow a questioning of long-standing frames of reference that are no longer useful (ie, reactivity, competition, individualistic goals, invulnerability) and create the conditions for a new frame of reference (ie, interdependence, interrelatedness, team work, vulnerability, inspiration, respect).

Leading from Within

Ultimately, we believe that the goals of excellence in healthcare and the transformation necessary to achieve it will not be possible without a re-examination of who is leading the transformation and how we are preparing them and supporting them on their leadership journey. So how is this transformative leadership, this "leading from within," really developed? To begin with, we must acknowledge that leader development is not an "event" that takes place over a weekend conference or even a yearlong program. Leader development is an ongoing formation process that requires deliberate, consistent, and explicit

implementation and dedicated organizational support and is continually grounded in the *who* and the *why* of leadership. It involves a commitment to the inner work of leadership—creating regular space for reflection, contemplation, developmental dialogue, and feedback.

These leaders are invited and supported to seek their ongoing personal wellness as an ethical imperative and take a holistic view of wellness that includes not only the physical but also the mental, emotional, spiritual, relational, and communal. They cultivate a high degree of self-awareness and awareness of others, engage often in open and honest questions and deep listening, hold tension in ways that respect a diversity of realities, and inspire trust by their integrity. Their development involves a commitment to a purposeful process that is more than a classroom or educational program or formal curriculum, though each of these can be components of this process.

The process should be developed, implemented, and facilitated by an interdisciplinary team that understands the physician worldview, principles of adult learning, and dynamics of behavioral science. It should be highly experiential, take advantage of small-group dynamics and collegial relationships, incorporate the physician's individual context into the process, create a safe space for learning that acknowledges the vulnerability involved in transformative learning, and provide ongoing mentoring and professional coaching. It must focus on the emotional wellbeing and personal integration of individual physicians as a foundation from the very start. The important management aspects of the business, structure, finance, and regulatory environment of healthcare can be taught in parallel to this process but should not be viewed as more important than true leadership development.

We realize that this is *not* a minor tweak of the first generation of physician leadership development. It is a major advancement over what is presently being offered. Implementing such a process will require true vision on the part of the present group of senior physician and healthcare leaders. To do otherwise will mean that achieving the triple aim will likely continue to exist more as an aspiration than reality; and the blind search for this Holy Grail will set up patients, clinicians, and leaders for frustration and disappointment.

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