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Introduction

General practice occurs in a wide range of settings. The work environment of a small rural practice, for example, is starkly different to an urban practice with 20 general practitioners (GPs) that operates as part of a national corporate chain. This module will describe a framework for teams and leadership that has evolved over the last 10 years.

During the early part of the last decade, most leadership discussions referenced the charismatic manager who was brought in to transform or change an organisation. There has since been increased recognition that effective leadership occurs across the organisation, rather than being merely hierarchical.

Knowledge organisations, including general practices, comprise of a range of people with different but complementary skills and knowledge. They can improve performance by providing more opportunities for individuals to make decisions and contribute. This requires flexible approaches to leadership.

Research shows organisational factors such as the effectiveness of the team process improve patient care. The UK’s National Health Service (NHS) Leadership Academy (www.leadershipacademy.nhs.uk) has developed the Healthcare Leadership Model, which draws on shared leadership. The underlying premise is that leadership is a process and a mindset that occurs outside of formal leadership positions. The model has also been developed in an environment where there is concern that an overemphasis on outcome measures has had a negative effect on the delivery of patient-focussed, compassionate care.

In Australia, the trend towards the increasing size of group practice has been prevalent for some time. The Australian Institute of Health and Welfare’s (AIHW) General practice activity 2009–10 report found 41% of GPs worked in practices with five or more GPs, while 19% were in practices of more than 10 individual GPs. Single-practitioner practices represent only around 15%.

The ownership structure will impact on opportunities for clinical leadership and teamwork. Most general practices have a mix of GP principals (owners) and employee or contracted GPs. While other health professionals work in general practice, few are practice owners. Very few younger GPs assume practice ownership in the first 10 years after Fellowship. Larger corporations typically have centralised management and decision making processes.

Research indicates a group that works well together tends to perform better than one lacking quality teamwork. Work roles in general practice evolve over time and are subject to changes in workforce numbers, funding sources, technology and legislative changes. The issue of workforce adequacy is typically linked to access. While some areas of Australia have a genuine GP shortage based on medical need, the ‘shortage’ is more subjective in other areas.

Patient access into general practice based on urgency of actual clinical need (similar to emergency department categories) is not measured. Patient perception of access is confounded by patients’ competing priorities: employer flexibility for time away from work, school hours, child care availability, distance from work to home and the practice, consumer attitudes to general practice, and the trend of instant gratification.

Nurses in general practice are currently receiving significant direct and indirect government support. While doctors and nurses have a long history of working together in primary care, nurses now seek out, and receive, more autonomy and responsibility.

This calls for new teamwork approaches in general practice.

Learning outcomes

After completing this module you will be able to:

• understand and identify group processes
• describe the characteristics of practice teams
• analyse leadership roles in general practice
• identify elements that support or impede teamwork in general practice
• outline the benefits and limitations of practice teams.
1. Groups and group dynamics

Groups occur when two or more people intentionally interact together over a period of time with a common purpose. A work group is a collection of people performing tasks for the purpose of achieving a specific outcome. They each have a role to play and are accountable for their own contribution.

There may be formal and informal structures and groups in a practice setting, particularly in larger practices.

A formal group is created for a specific purpose and has recognition as part of the reporting structure of the organisation. For example, the owners of the practice may act as the management group, which has a recognised purpose known across the practice. A formal group might be formed to prepare for an accreditation visit and be delegated with the task of reviewing the practice’s procedures manual, or be developed to undertake a plan, do, study, act (PDSA) cycle.

Informal groups form spontaneously as people work together and share common interests. Some of the staff members may meet socially and create relationships that influence how they interact with others in the practice. These relationships can be effective in providing links across the practice and improving social cohesion. Alternatively, they can lead to the exclusion of non-group members. Members of informal groups may be opinion leaders who can influence the running of the practice.

The effective functioning of a practice is dependent on both the formal and informal groups. Improving practice performance and work satisfaction requires an appreciation of the social forces that occur in your practice.

Attributes that contribute to effective group work include:

- clear objectives, describable by all members
- decision making by consensus
- members with good interpersonal skills (eg. effective communicators, able to resolve conflicts)
- group norms that encourage taking responsibility, seeking and sharing information and striving to achieve the group’s objectives
- a climate of trust and acceptance, combined with positive regard for each other.

When considering joining a practice group, find out how well its members work together by considering the attributes of an effective work group.

1.1 Group size

In view of the trend towards larger practices, it is worth considering how size can affect the way groups function. Two issues have been explored in relation to group size: how it affects interactions, and how it affects performance.4

When there is only two in a group, interactions may be constrained to avoid disagreements that could disrupt the group. Adding a third person could result in the ‘taking of sides,’ leading to disharmony. Groups of five and seven appear to be optimal for group interactions. Interestingly, as groups get larger the tendency for an individual to contribute their best effort is more likely to diminish. Social ‘loafing’ has been used to describe the phenomenon of people in groups giving less than their best effort.

Some writers have begun to apply the concept of ‘microsystems’ to general practice.5,6 A microsystem is a small replicable unit that contains the resources needed to do the work of the organisation. Using this idea, which might include practical steps such as allocating a particular nurse to work with particular GPs or pairing up GPs to work together, is designed to increase the consistency and reliability of activities and the flow of information. It can break down the overall size of the practice group.
1.2 A model for group development

The four-stage model of group development – forming, storming, norming and performing – was first proposed by educational psychologist Bruce Tuckman and is still one of the most widely quoted models regarding group development, possibly because of its simple and memorable framework.

Tuckman observed that most research on group development at that time could fit into four stages: orientation/testing/dependence, conflict, group cohesion, functional role relatedness (Figure 1).

Where a new group is formed, there will be an initial learning period during which people are seeking to learn about the others and their position within the group – the ‘forming’ stage. This learning can be formalised (eg, through a structured induction/orientation), but informal learning also occurs.

This is followed by a period of tension as people work through their expectations about roles, processes and purpose – the ‘storming’ stage. This can be a period when policies and procedures are questioned. The ‘norming’ stage is the period when the team comes together (eg, when differences about approach are resolved and the team begins to see itself as a single entity).

The ‘performing’ stage is the period of stable activity that follows.

![Figure 1. Four stage model of group development.](image)

While the Tuckman model remains a useful tool for thinking about group development, it is important to remember that a group is dynamic and can be experiencing aspects of each stage at the same time.

In most situations, a practice group has developed over time. When a new person joins the group they will be influenced to adopt the norms, which are the behaviours considered acceptable by the group. Group members have the power to produce conformity. The strength of this is determined by the degree of cohesion within the group, as well as its shared history and the personalities involved.

When joining a new practice, it can be useful to try to assess how you will function in the group in advance. Spending time to get to know people in the practice beforehand will reduce the likelihood of a clash of personalities and values. Working in a practice for a period of time before making a commitment is one way of learning more about existing group dynamics.

A cohesive group will demonstrate that its members enjoy being together, show loyalty to one another, and will have often worked together for a reasonable time, usually many years. Members of the group will generally talk more about ‘us’ and ‘we’ than ‘they’ or ‘me’. Smaller groups generally show more cohesion and communication is usually very effective in these cohesive groups.

Innovation and change can be difficult in a highly cohesive group. People may not want to create disharmony or ‘rock the boat’. A group with high levels of trust may be able to deal with controversy and confrontation.

Organisational literature suggests that healthy organisations have periods of relative stability and relative upheaval as they adjust their internal resources, structures and processes to make the most of opportunities in their environment and deal with threats to their sustainability. Seen from this context, some change is healthy and the success of effective teams is related to the adaptive skills of the team, rather than on the strength of its social norms.
2. Groups and teams

The term ‘team’ is often loosely applied and is, to an extent, a buzzword borrowed from the sports arena to motivate behaviours in the workplace. Work groups are frequently described as teams to endow the group with special characteristics that may or may not exist.

There has been interest in defining how a work group is different to a team. A work group is a collection of people working together to complete a task. Katzenbach and Smith (1993) define a team as “a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable”. Each person in a group is separately accountable for their performance.

Consideration of work groups and teams may be helped by viewing the way they function as being on a continuum (Figure 2).

![Figure 2. Work group functionality](image)

Katzenbach and Smith describe elements that promote effective teamwork, including:

- common purpose (the best teams translate that into specific performance goals)
- mutual accountability
- trust and commitment
- focus on performance to achieve goals.

However, in discussing the potential hazards to pushing the team concept too far, Katzenbach and Smith note:

‘The main issue is determining whether a team approach is the right one. Many groups that run things can be more effective as working groups than as teams. The key judgement is whether the sum of individual bests will suffice for the performance challenge at hand’.

They also observe:

‘Members may have to overcome a natural reluctance to trust their fate to others. The price of faking the team approach is high: at best, members get diverted from their individual goals, costs outweigh benefits, and people resent the imposition on their time and priorities; at worst, serious animosities develop that undercut even the potential personal bests of the working group approach.

Most of the time, therefore, if performance aspirations can be met through individuals doing their respective jobs well, the working group approach is more comfortable, less risky, and less disruptive than trying for the more elusive team performance levels’.

The question of whether general practice needs effective working groups or teams thus needs to be considered.

2.1 Groups or teams for general practice?

The manager in a typical workplace likely determines and plans the work and advises the worker on the tasks required. Within a team, however, there is a higher level of member involvement in determining the direction work should take and in the allocation of tasks.

In general practice, it might be suggested that people have well defined roles and tasks. The day-to-day work is either clinical or administrative and has become routine in that it has been repeated many times. The functional work roles – doctor, nurse, receptionist – are well defined. When the
required tasks are predictable and routine, a work group provides efficiency in getting the job done. It allows people to specialise in a task and become proficient at its performance.

However, when the work requires the group to share information, insights and views, it is necessary to adopt different roles. This is particularly true as tasks become more complex. When the work is less predictable and requires problem solving and creative solutions, a team may be more effective. In this environment the manager will relate to members as peers rather than subordinates and jointly determine objectives and the allocation of tasks.

There is a need for problem solving in general practice, characterised as a complex, adaptive system with an organism-like quality whereby the practice adapts to its environment in a relatively unique way.\textsuperscript{10}

For example, a practice may be enthusiastic about the benefits of using patient controlled electronic health records (PCEHR), but also aware of potential pitfalls. Successfully transferring information onto the PCEHR will require all members of staff to work as a team. Different members of the practice will be given roles (in part) depending on their personal characteristics. In addition to their formal group role, they will adopt team roles. This may help or hinder the team achieve its purpose.

Models for practice teams

There are some common characteristics that can be used to describe teams, including:

- interactions – task and relationship
- interdependence – unilateral and sequential, reciprocal and mutual
- structure – norms, roles and relationships
- goals – generating, choosing, negotiating and executing.

Unilateral, sequential interdependence is an archetype for the traditional GP–practice nurse group. The GP provides instructions for the nurse to perform specific tasks (eg. an ECG).

![Figure 3. Unilateral, sequential interdependence](image-url)
Mutual and reciprocal interdependence is an archetype where both the GP and nurse provide patient-focused care. The nurse’s level of decision making is increased to include more complex judgements and problem solving (eg. assess Mr Smith’s cardiovascular risks and provide lifestyle advice).

![Figure 4. Mutual and reciprocal interdependence](image)

Other practice team models include additional health professionals, who may be co-located within the practice, external, or occasionally remote.

![Figure 5. Extended practice team](image)
Tasks need to be delegated to different members based on knowledge, skills and resources for a group of people to work together effectively. GPs are typically time-poor and this resource can be supplemented through delegation. It is usually the responsibility of the delegating GP to ensure the recipient has the required skills and knowledge. Nurses often welcome the opportunity to apply their abilities across the range of competencies they possess. Campbell (1998) described tasks as having differing levels of complexity, including attributes such as:

- multiple paths to tasks
- multiple desired outcomes of tasks
- conflicting interdependence among paths and desired outcomes
- uncertainty in links between paths and desired outcomes.\(^\text{11}\)

Tasks can then be characterised as:

- **simple tasks** that have none of the complexity listed above (eg. removal of sutures, performance of an intra-muscular injection)
- **decision tasks** involve a number of desired outcomes as well as conflicting interdependence (eg. leg ulcer management requires consideration of cost, convenience, manageability, effectiveness)
- **judgement tasks** that deal with the conflicting and probabilistic nature of task information (eg. diabetes education for a 55-year-old obese male who smokes)
- **problems tasks** involve multiple paths to only one desired outcome (eg. falls assessment for an 79-year-old woman)
- **fuzzy tasks** involve most of the attributes of task complexity (eg. developing a program of care for all practice patients with cardiovascular disease).

As task complexity and uncertainty increases, so does the need for additional information. The patient becomes a key source of information in this situation and needs to be actively involved in decision making. Furthermore, the knowledge, judgement and problem solving skills of the GP will be required in more complex situations.

### The patient as ‘team member’

Good communication between health professionals and the patient is widely recognised to be beneficial in many ways, including:

- building trust
- viewing healthcare professionals as reliable sources of information
- following agreed management plans
- keeping appointments
- remembering medical information
- adopting healthy behaviours (eg. increased exercise, improved diet, stopping smoking)
- having greater satisfaction with their care
- being more realistic in expectations
- having more confidence in their ability to cope with illness.\(^\text{12}\)

Better communication does not necessarily mean taking more time. Improved communication may allow the health professional to use time more efficiently and result in fewer ‘door-handle’ statements made as patients are leaving a consultation. It also makes it less likely that there will be a later message requesting clarification on an issue.
The National Health and Medical Research Council (NHMRC) has put forward another principle that addresses the involvement of the patient in decision making. People clearly vary in the degree of comfort they have in making decisions regarding their management or treatment and the traditional approach delegates this decision to the health professional. A partnership approach allows for shared (informed) decision making. The informed decision making process involves the patient taking responsibility for their course of management after being given adequate and appropriate information. Enabling the patient to be involved in decision making, at the level at which they are comfortable, is important for patient satisfaction and autonomy.

2.2 Practice teams and roles

It is important that formal roles are aligned with competence and licensing arrangements. Fraser and Greenhalgh (2001), who considered the issue of ensuring individuals can adapt to change and continue to improve their performance, suggest a useful model to use when considering roles (Figure 6).

![Figure 6. Model to consider roles](source)

This model is similar to the one proposed by Donald Campbell. Other roles in the team are also important. Belbin conducted pioneering research and described nine key roles that team members can adopt. He recognised the composition of the team needs to be balanced to achieve the best outcomes. In a medical practice, it is unlikely that you will be able to select a team based on balancing people's behavioural characteristics in teamwork. You can, however, improve the way a team functions by discussing team types.
<table>
<thead>
<tr>
<th>Roles</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant</td>
<td>Creative, imaginative, unorthodox; solves difficult problems</td>
</tr>
<tr>
<td>Resource investigator</td>
<td>Extrovert, enthusiastic, communicative; explores opportunities; develops</td>
</tr>
<tr>
<td></td>
<td>contacts</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Mature, confident, a good chairperson; clarifies goals, promotes decision</td>
</tr>
<tr>
<td></td>
<td>making, delegates well</td>
</tr>
<tr>
<td>Shaper</td>
<td>Challenging, dynamic, thrives on pressure; has the drive and courage to</td>
</tr>
<tr>
<td></td>
<td>overcome obstacles</td>
</tr>
<tr>
<td>Monitor evaluator</td>
<td>Sober, strategic and discerning; sees all options; judges accurately</td>
</tr>
<tr>
<td>Teamworker</td>
<td>Cooperative, mild, perceptive and diplomatic; listens, builds, averts</td>
</tr>
<tr>
<td></td>
<td>frictions, calms the waters</td>
</tr>
<tr>
<td>Implementer</td>
<td>Disciplined, reliable, conservative and efficient; turns ideas into practical</td>
</tr>
<tr>
<td></td>
<td>actions</td>
</tr>
<tr>
<td>Completer</td>
<td>Painstaking, conscientious, anxious; seeks out errors and omissions; delivers</td>
</tr>
<tr>
<td></td>
<td>on time</td>
</tr>
<tr>
<td>Specialist</td>
<td>Single-minded, self-starting, dedicated; provides knowledge and skills in</td>
</tr>
<tr>
<td></td>
<td>rare supply</td>
</tr>
</tbody>
</table>


Individuals will act in a number of these team roles. When teams have difficulties it may be because the composition is not balanced. Improved understanding of team roles can assist in developing better teamwork in a practice. Compare this to ‘career anchors’ in Module 1 – Professional career management.

2.3 The team as a microsystem

As patients encounter larger practices and multiple medical specialists, they frequently feel their personal care needs are not being met. Clinical microsystems have been described by John Wasson et.al. as a way to improve the quality of patient care:

‘An increasing number of physicians are using microsystem principles to radically redesign their practices. Small, independent practices – micro practices – are often able to incorporate into a few people the frontline attributes of successful microsystems such as clear leadership, patient focus, process improvement, performance patterns, and information technology’.

Exemplary microsystems:

- have a patient focus as the primary purpose
- make a commitment to process improvement through the study, measurement and improvement of care
- routinely measure performance patterns and make changes based on feedback

Clinical microsystems are described as ‘the front-line unit that provides most healthcare to most people’. In the Australian context, this is general practice.
The concepts of ‘medical home’ and ‘patient enrolment’

Clinical Microsystems and medical homes share a lot in common. In terms of integrated and coordinated care, the concept of a medical home (or regular provider) is increasingly recognised internationally as an important component of improving healthcare.

Most Australians have one or two preferred GPs. While having a regular provider is well established in the Australian context of primary healthcare, patient enrolment is increasingly considered to be an important component for population health management, particularly for chronic disease management. The medical home concept promotes the regular provider as delivering integration and coordination. The RACGP articulates the view that general practice provides person-centred, continuing, comprehensive and coordinated whole-person healthcare to individuals and families in their communities.

Coordination and clinical teamwork

GPs work in close and respectful relationships to deliver accessible, integrated patient care: leading, supporting and coordinating their flexibly-configured clinical teams; contributing appropriately to external clinical teams; and engaging with diverse specialists and other sector services according to individual patient or family needs.
3. Leadership and the GP

You are educated. Your certification is in your degree. You may think of it as the ticket to the good life. Let me ask you to think of an alternative. Think of it as your ticket to change the world.

Tom Brokaw

GPs have a significant role within the practice and the community. Despite this, our medical training generally has little bearing on the role of GP as leader. Some doctors take on leadership roles through involvement in medical organisations, while others go into politics.

At a local level, GPs can be leaders in their own practices. There is significant potential to contribute to the health of patients through leadership. This is not necessarily a formal position of authority. Whether you work as a practice owner/principal or an employee, your responsibility to your patients continues. This includes the responsibility to ensure the people to whom part of your patient’s care is delegated have the skills, experience and attributes to perform the necessary tasks. It will involve ensuring communication is effective and that the patient’s care is consistent with your expectations.

Other opportunities exist for leadership through organisations such as the RACGP, General Practice Registrar Association (GPRA), Australian Medical Association (AMA), government, educational bodies and many others. It does not require a person to be ‘in charge’, but rather to seek to represent, contribute and influence.

3.1. Leadership

A good head and a good heart are always a formidable combination.

Nelson Mandela

Leading involves influencing others to achieve mutual goals. In a medical practice, leading involves influencing colleagues, staff, patients and others towards agreed objectives.

There is much written about leadership and the media and management articles usually focus on high-profile people within large organisations. This can be far removed from the usual general practice setting.

If the superlatives are removed from the leadership discussion, research has shown some key factors. There is a range of perspectives for leadership and we will draw on some of those in this discussion.

When leaders do their best work, they don’t copy anyone. They draw on their own values and capabilities.


Based on extensive studies, Boyatzis described the following as competencies for leadership roles:

- self-confidence
- the use of oral presentations
- logical thought
- conceptualisation

Collins has proposed that self-confidence also needs to be balanced with humility.

Conceptualisation involves creative or inductive reasoning and ranges from using basic ‘rules of thumb’ to simplifying complex situations to developing new models.
In their generic model for human service workers, Spencer and Spencer listed impact and influence as the most important, but not only, competencies in determining those who excel at their job. In addition, they found self-confidence to be particularly important for doctors.

Bill George lists the following in describing qualities of authentic leaders:

- understanding your purpose
- practising solid values
- leading with your heart
- establishing connected relationships
- demonstrating self-discipline.

Influence requires interpersonal understanding and is associated with the concept of emotional intelligence (EQ). EQ has been proposed as a cognitive ability that can be developed with practice. While there remains debate over whether EQ can be separated from other cognitive skills, it falls within a social skill set that can be developed.

Mayer and Salovey describe EQ as the ability to process emotional information, particularly as it involves the perception, assimilation, understanding and management of emotion.

The Medical Leadership Competency Framework (MLCF) has been developed by the UK’s Academy of Medical Royal Colleges, NHS Institute for Innovation and Improvement, and other stakeholders. The following table (Table 2) is based on EQ and describes competencies that are relevant for GPs as leaders in their practice.

**Table 2. Leadership that gets results**

<table>
<thead>
<tr>
<th>Self-awareness</th>
<th>Self-management</th>
<th>Social awareness</th>
<th>Social skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional self-awareness: the ability to read and understand your emotions, as well as recognise their impact on work performance and relationships</td>
<td><strong>Self-control:</strong> the ability to control disruptive emotions and impulses</td>
<td><strong>Empathy:</strong> skill in sensing other people’s emotions, understanding their perspective and taking an active interest in their concerns</td>
<td><strong>Visionary leadership:</strong> the ability to lead by inspiration</td>
</tr>
<tr>
<td>Accurate self-assessment: a realistic evaluation of your strengths and limitations</td>
<td><strong>Trustworthiness:</strong> a consistent display of honesty and integrity</td>
<td><strong>Organisational awareness:</strong> the ability to read the currents of organisational life, build decision networks and navigate politics</td>
<td><strong>Influence:</strong> the ability to use a range of persuasive approaches</td>
</tr>
<tr>
<td>Self-confidence: a strong and positive sense of self-worth</td>
<td><strong>Adaptability:</strong> the skill of adjusting to changing situations and overcoming obstacles (resilience)</td>
<td><strong>Service orientation:</strong> the ability to recognise and meet the needs of others (patients, colleagues, staff, etc.)</td>
<td><strong>Developing others:</strong> the propensity to build the abilities of others through feedback and guidance</td>
</tr>
<tr>
<td></td>
<td><strong>Achievement orientation:</strong> the drive to meet an internal standard of excellence</td>
<td></td>
<td><strong>Communication:</strong> skill in listening and sending clear, convincing and well-tuned messages</td>
</tr>
<tr>
<td></td>
<td><strong>Initiative:</strong> a readiness to seize opportunities</td>
<td></td>
<td><strong>Teamwork and collaboration:</strong> competence at promoting cooperation and building teams</td>
</tr>
</tbody>
</table>

3.2 Shared leadership

Traditional notions of leadership are being challenged by a more recent paradigm of shared leadership. This paradigm centres on leadership being a process of influence and interaction in which all members of the team participate. This shift from leadership as a position held by a single person or small senior group to being distributed across an organisation through the process of working together is a fundamental shift. It is responsive to the demands of knowledge sectors such as health, where technical expertise rests with a range of persons.

A general practice is well positioned to utilise shared leadership when the GP-owners are receptive and interested in the input and feedback of team members and, in turn, members are engaged and motivated to contribute to and influence the practice’s processes and outputs.

The following discussion draws from the NHS Healthcare Leadership Model and translates it into the Australian context.

![Diagram of the nine dimensions of the Healthcare Leadership Model](image)


**Figure 7. The nine dimensions of the Healthcare Leadership Model.**

The core of the Healthcare Leadership Model is **inspiring shared purpose**. For an Australian general practice, this involves articulating the practice vision or the team purpose. For example, a practice may have a team working on improved management of patients with chronic obstructive pulmonary disease (COPD). As part of developing a shared purpose, it may be necessary to identify a gap between current care and best practice. While the NHS model references itself with respect to principles and values, a practice needs to engage its people with a unique value statement in order to provide inspiration and a sense of contribution to a greater good.

**Sharing the vision** is the process of communicating a ‘compelling and credible vision of the future in a way that makes it feel achievable and exciting’. The leadership task is to spread the message in an authentic and understandable manner. One effective technique is to model ideal behaviour sort (ie. actions speak louder than words).

**Leading with care** requires leaders to act in ways that support and benefit others in the team. This involves care for one’s own physical and mental health, as well as paying attention to the wellbeing of other team members.
Evaluating information is about seeking and using information to generate new ideas and make evidence-based decisions. Using the COPD example, examining practice data to collect information on smokers, the use of a spirometer, prescription of long-acting bronchodilators, immunisation rates for influenza and pneumococcal infections, and education for use of inhalers will inform better decision making. A team member such as the practice nurse or GP registrar may proactively research an area of concern and present it at a practice meeting to help influence the practice in making improvement plans.

Connecting our service is about understanding the practice’s internal and external linkages and how to complete tasks by utilising this understanding. A patient with severe COPD who needs home oxygen can be referred to a local respiratory specialist with a letter, or a practice nurse could make the call to facilitate a booking for a six-minute walk test prior to the appointment. In a larger practice, a senior GP may be able to influence a management decision if co-opted by a focus group to be a champion for their group for the purchase of a new spirometer.

Engaging the team requires the recognition that all members are able to contribute worthwhile perspectives and insights that add value to the overall work of the team. People become disengaged when solutions and plans are implemented if they have not had the opportunity to contribute or if their suggestions are ignored.

Teams need to accept responsibility for results. Holding to account addresses the need for clear performance goals and to receive feedback on results. When team members are committed to the team goals they will care about the outcomes they achieve. It may be necessary to manage poor performance and address reluctance to change. Inevitably, some team members are happy to coast along and leadership requires addressing people who lack commitment. Balanced feedback is important.

Developing capability requires leaders to contribute to the ongoing development of knowledge and skill for themselves and the team. The team can take the learning experiences gained from one project on to others, building the ability of the group as well as the individual team members. Team processes that are fine-tuned via problem solving will then be useful in future activities. Taking this into a strategic context, the team can analyse the skills and technical knowledge required for the future and support team members to acquire them (or co-opt new team members).

The final attribute of leadership in the NHS model is influencing for results. Becoming proficient at sharing information and presenting well reasoned arguments enables leaders to influence others towards assisting the team achieve its objectives. This may involve building support for an idea or proposal by engaging other stakeholders and key persons in the practice. It is important that this is done in a transparent manner to ensure there is no breach of trust.
3.3 Women in leadership

Do women have difficulty attaining leadership roles and how is this relevant to Australian general practice?

Women are still substantially underrepresented in leadership positions in Australia. The 2012 Census of Women in Leadership in Australia revealed:

- 9.2% of executive key management personnel (KMP) positions in the ASX 500 were held by women
- 60% of ASX 200 companies did not have any female executive KMP (Figure 8).

ASX 500-listed companies with women directors delivered significantly higher return on equity (8.7% over five years) than those without.

63.1%  
ASX 500  
Companies have no female executive KMP

The intake of medical students is shifting the gender balance such that the number of female doctors is increasing (Figure 9). In 2009, 39% of GPs were female, a rise of 6% over a 10-year period. While 57% of doctors younger than 30 are female, 86% of those older than 65 are male.

It is now common for women to take on senior GP leadership positions, as exemplified by the current and past presidents of the RACGP, Dr Elizabeth Marles and Dr Claire Jackson, and Dr Vasantha Preetham (2006–08) before them.

Practice ownership in primary care is still more common for men than women. A 2012 American Medical Association study found 59% of male primary care physicians were practice owners, compared to 57% of women. It is likely that Australian figures are similar. Ownership is gradually becoming more focussed in large and smaller corporate groups, which provides fewer opportunities for women to own a medical practice.
3.4 How do women make a difference?

Research tells us about the dynamics of the discussion in the boardroom and the quality of decision making when women are present. It also tells us the range of issues canvassed increases and includes usefully different perspectives from female board members. Boards with women also are more likely to ensure best practice in terms of board evaluations, codes of conduct, conflict of interest guidelines and looking more closely at executive remuneration arrangements.

Insync Surveys’ 2010 Gender Agenda: Unlocking the power of diversity in the boardroom found that board members on gender-diverse boards believe they:

- add more organisation value through the quality of their decision making
- feature Chairs that are more effective in several ways
- feature directors who act with greater integrity
- are more vigilant about the connection between management’s remuneration packages and performance
- require better documentation of roles and responsibilities.
Table 3. The 10 most important issues in the professional and non-professional lives of women GPs (in ranked order, beginning with the most important)

<table>
<thead>
<tr>
<th>Professional life</th>
<th>Non-professional life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving job satisfaction in general practice through mental stimulation, challenge and a variety of work</td>
<td>Making time for self-care to avoid stress, guilt, ‘burnout’ and ill mental health</td>
</tr>
<tr>
<td>Balancing professional and non-professional life by drawing boundaries to protect oneself, one’s family and other interests</td>
<td>Having time to nurture a quality relationship with a partner</td>
</tr>
<tr>
<td>Managing time to allow for successful participation in all aspects of professional and non-professional life</td>
<td>Having time to spend with children in order to take care of them and to share life experiences</td>
</tr>
<tr>
<td>Having a strong sense of self-esteem and self-image, leading to autonomy and control over one’s professional life</td>
<td>Managing time to allow for successful participation in all aspects of professional and non-professional life</td>
</tr>
<tr>
<td>Having the option of flexible hours and part-time work to allow fulfillment of multiple non-professional roles</td>
<td>Having time and ability to engage in social contact and foster friendships</td>
</tr>
<tr>
<td>Having sufficient income to cover professional expenses and provide financial security</td>
<td>Finding a balance between one’s own career and that of one’s partner</td>
</tr>
<tr>
<td>Receiving fair remuneration for medical services and work performed</td>
<td>Providing a focus for family life and all the requirements and activities of the family</td>
</tr>
<tr>
<td>Juggling the complexities of competing priorities in one’s professional life</td>
<td>Having time for non-medical interests that allow for a range of life experiences</td>
</tr>
<tr>
<td>Having the ability to train and retrain (after time out of the workforce) in a flexible part-time program in general practice that caters for the individual needs of women GPs</td>
<td>Having sufficient income to pay for private expenses, such as childcare, mortgages and personal requirements</td>
</tr>
<tr>
<td>Having a voice and a share of power in decision-making about issues affecting women GPs</td>
<td>Balancing professional and non-professional life by drawing boundaries to protect oneself, one’s family and other interests</td>
</tr>
</tbody>
</table>

References

Resources

- Kilmartin MR, Newell CJ, Line MA. The balancing act: key issues in the lives of women general practitioners in Australia. MJA 2002;177(2):87–89.
Activity 1. Identifying effective work groups and attributes

Consider the ideal attributes of a group at each of the stages proposed by Tuckman. This can be for an administration group or a clinical group of staff. These attributes should contribute to the overall goal. Examples of attributes have been provided for an administration group (eg. receptionists, practice manager and business manager).

- **Forming** (orientation, testing) eg. diversity of skill, communication
- **Storming** (resistance) eg. ability to interpret, maturity and direction
- **Norming** (group cohesion) eg. consistency and behaviour
- **Performing** (meeting functional role) eg. interdependency
Activity 2. Defining and developing teams and groups

Consider a task, objective or problem, then work through a series of questions to determine whether it is best for a team approach or group approach.

<table>
<thead>
<tr>
<th>Define the task/objective/problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Define the complexity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the task non-routine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this the first time the problem/task has occurred?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the task require special skills and knowledge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the task involve many levels?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the task require information to be shared across many people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are different insights required and views sourced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are tasks complex?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If most answers were **Yes**, it would indicate a high degree of complexity
  Usually involves problems and tasks that are not routinely performed by staff and therefore require a special set of skills and knowledge to reach the objective. For example, upgrading a practice’s IT system.

- If most answers were **No**, it would indicate a low degree of complexity
  Usually involves problems and tasks that are routinely performed by staff, giving them the knowledge needed to complete what is required. For example, ordering stock. In these situations a manager will usually delegate the task. Not all tasks have clear indicators as to whether it is better to form a group or a team. In most cases, past experience will be used. This may involve talking with staff as well as patients.

<table>
<thead>
<tr>
<th>Individual attributes/skills and competencies required</th>
<th>Relevant role(s) that may be adopted</th>
</tr>
</thead>
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<td></td>
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</table>
Activity 3. Leadership development programs

For further development of your leadership skills, enrol in a program such as those offered by:

- Australian Institute of Management  www.aim.com.au
- Women and Leadership Australia  www.wla.com.au
- Leadership Victoria  www.leadershipvictoria.org/programs
- Australian Rural Leadership Program  www.rural-leaders.com.au
Healthy Profession.
Healthy Australia.