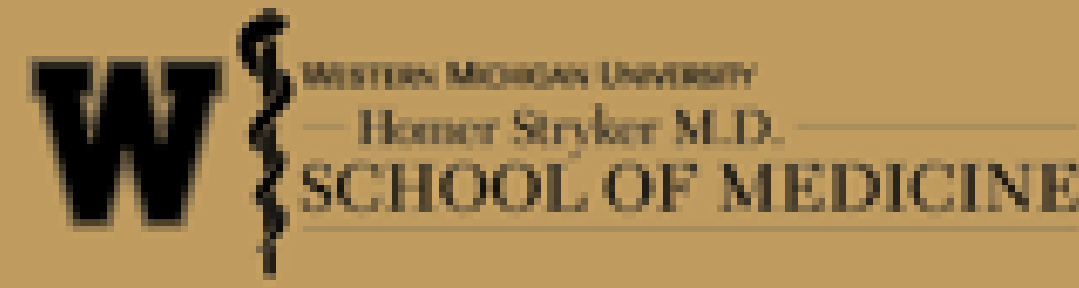


Community Medical Leadership Workshop: An introduction to physician leadership for resident physicians



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OBJECTIVES

By the end of the session, learners will be able to:

1. Define leadership in medicine
2. Employ strategies to manage conflict in the workplace and differences of opinions
3. Demonstrate effective communication skills while working with others
4. Describe the role of power in effective leadership

INTRODUCTION

The term “leadership” has been defined by many and contested, but most authors would agree that a leader inspires, motivates, and implements strategies for individuals and systems in which they work. Throughout the years, responsibilities of physicians have evolved from caring for patients to becoming leaders and advocates in their local communities.

We introduce a leadership training workshop tailored for resident physicians that follows the Leadership Practice Inventory (LPI) and Medical Leadership Competency Framework (MLCF) for the design and implementation. This workshop would allow participants to develop individual leadership attributes through medical leadership lectures and case scenario discussion.

Post Graduate Year	Internal Medicine	Medicine-Pediatrics	Orthopedic Surgery	Total
1	3 12.50	1 4.17	1 4.17	5 20.83
2	4 16.67	0 0.00	3 12.50	7 29.17
3	3 12.50	0 0.00	3 12.50	6 25.00
4	0 0.00	0 0.00	3 12.50	3 12.50
5	0 0.00	0 0.00	3 12.50	3 12.50
Total	10 41.67	1 4.17	13 54.17	24 100.00

Table 1. Breakdown of participants by post graduate year and specialty. In each cell, the top number is the frequency, and the bottom number is the percent.

METHODS

The physician leadership workshop consisted of three parts: a pre-workshop reading assignment, medical leadership lectures, and an interactive group session.

We designed two separate workshops: A first session for IM and Med-Peds residents and a second reiteration for Ortho residents. Each workshop took approximately 120 minutes. The virtual workshop began with a 60-minute lecture presentation followed by a 25-minute small group discussion with participants broken down into smaller groups.

A large group discussion comprising all participants was scheduled for 20 minutes following the small group discussion. The last 5 minutes of the workshop was reserved for closing remarks from moderators and participants. We used Kirkpatrick’s model level 1 and 2 to evaluate the success of the physician leadership workshop.

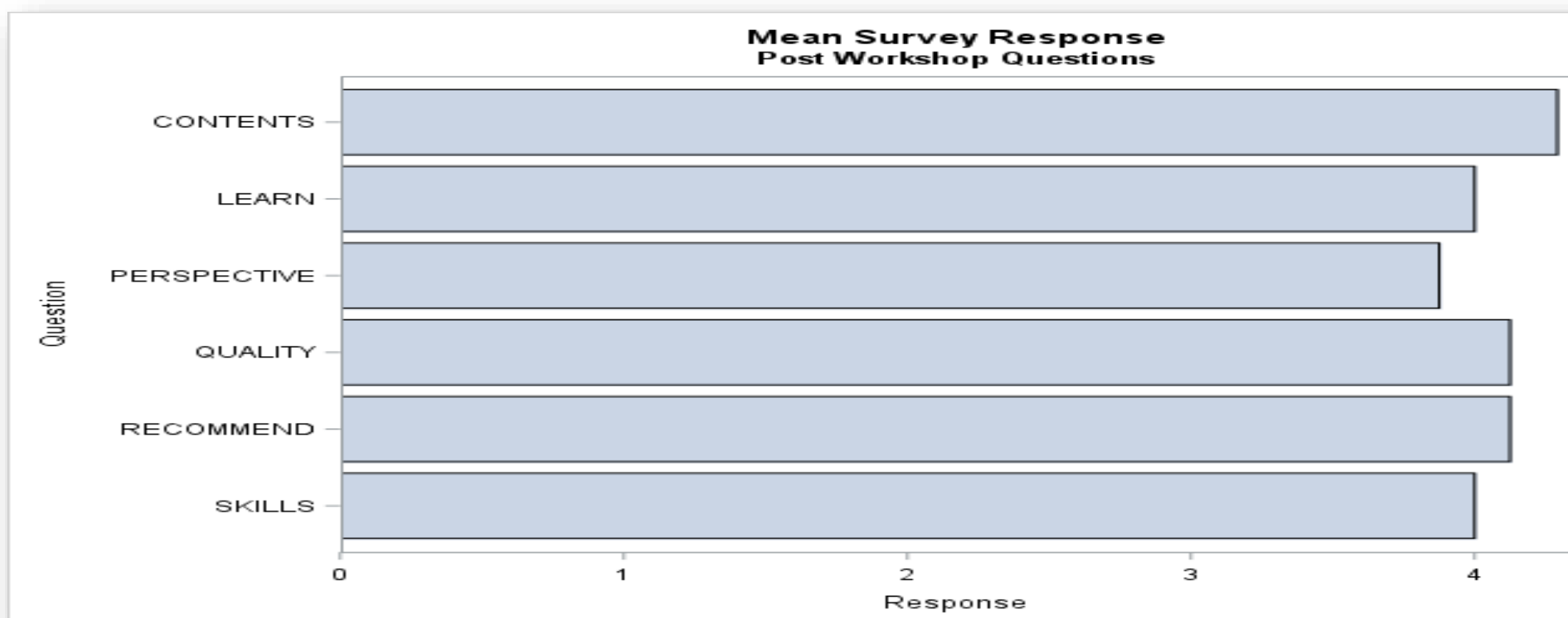


Figure 1. Summary of learner satisfaction with the workshop (Kirkpatrick level 1). Resident physicians rated the extent of agreement or disagreement with each statement as: strongly disagree (1), disagree (2), neither agree or disagree (3), agree (4), and strongly agree (5). Appendix H contains the full text of each question.

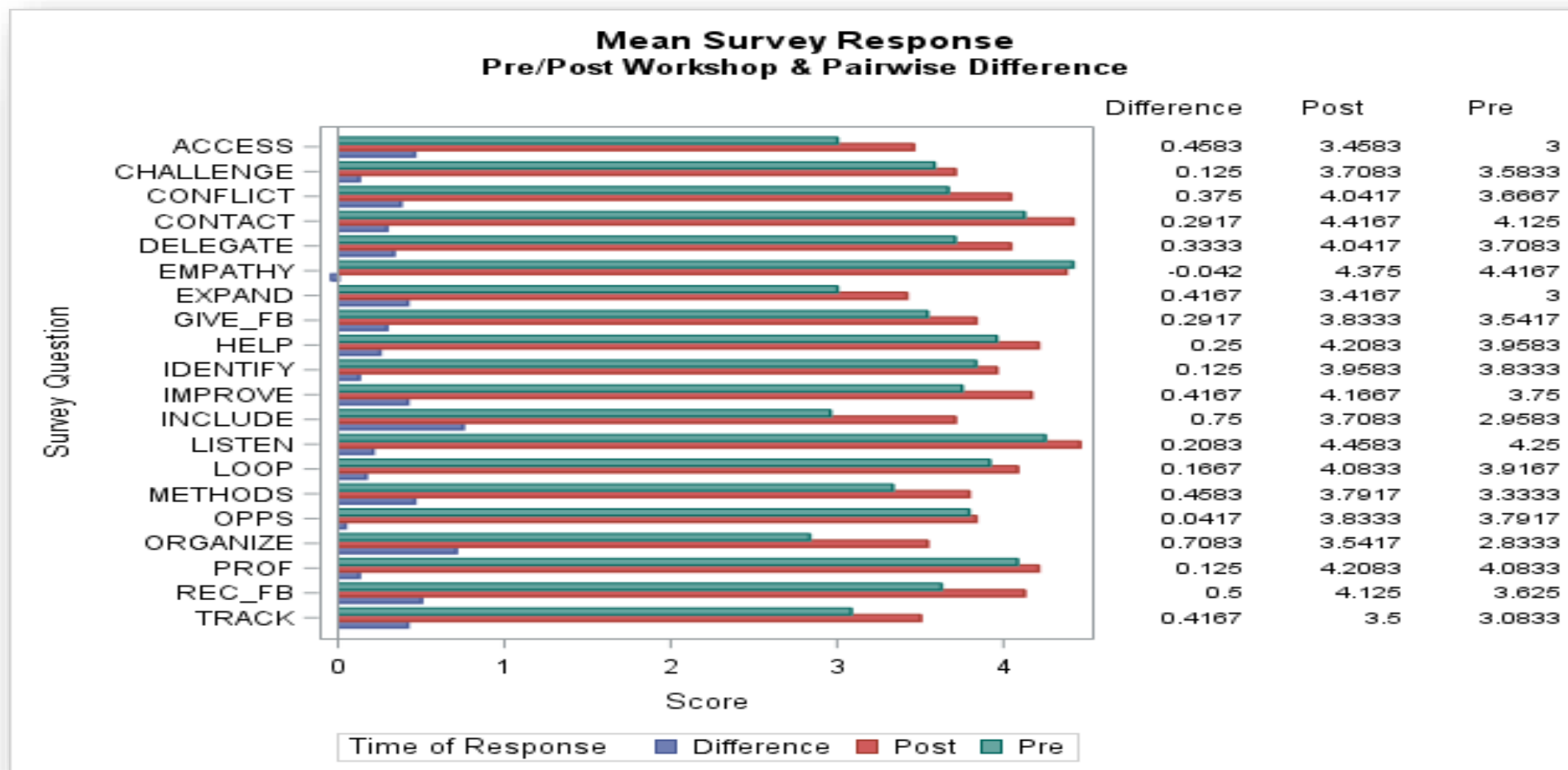


Figure 2. Frequency breakdown and pre-to-post changes for each of the Likert responses as well as a bar graph for each. Resident physicians rated their confidence level in applying leadership skills and knowledge before and after the workshop (Kirkpatrick level 2) in the following scale: Not confident at all (1), slightly confident (2), somewhat confident (2), fairly confident (4), very confident (5). Appendix H contains the full text of each question.

RESULTS

For the two leadership conferences, a total of 32 resident physicians and 14 medical students were in attendance. The final dataset contained 32 survey responses with 24 complete surveys. Twenty-four of 32 resident physician learners (75%) responded to the pre- and post-workshop leadership assessments.

Over 90% of learners were satisfied with workshop contents and will recommend this workshop to others. 83% of resident physicians agreed that the quality of the workshop matched their expectations.

The Benjamini-Hochberg procedure was used to control the false discovery rate.

Question	pval	Critical Value for FDR=10%	Critical Value for FDR=5%	Significant Difference? (FDR=10%)	Significant Difference? (FDR=5%)
include	0.001139	0.005	0.0025	Yes	Yes
organize	0.006527	0.01	0.005	Yes	No
expand	0.009152	0.015	0.0075	Yes	No
access	0.018257	0.02	0.01	Yes	No
rec_fb	0.019795	0.025	0.0125	Yes	No
methods	0.024329	0.03	0.015	Yes	No

Table 2. Critical p values for learner responses to pre- and postworkshop questions. Only statistically significant p values were shown in the table for FDR at or below 5% and for FDR at or below 10%. Appendix H contains the full text of each question.

DISCUSSION

The Community Medical Leadership Workshop (CMLW) was designed and tailored for resident physicians to introduce them to physician leadership. Our results showed that resident physicians increased confidence in their leadership skills.

Limitations to our study include sample size, single institution study, self-reported improvement measures, and time restraints and schedule conflicts in residency are other limitations that may limit participation of both residents and medical staff.

As for future work, we could potentially assess the extent of behavior change with acquired leadership knowledge and skills (Kirkpatrick level 3).

Another direction is to individually track learners’ leadership skill for improvement throughout their time in residency and to develop a longitudinal leadership curriculum tailored for residents and expand across other specialties.

CONCLUSION

CMLW intended to introduce resident physicians to leadership skills to prepare them to be more effective physician leaders. At the completion of the workshop, learners were more supportive and related to each other experiences. Our hope is that other institutions can replicate our leadership training across multiple medical specialties to help create more effective physician leaders.

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