Leadership by design: intentional organization development of physician leaders

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Abstract

Purpose – The purpose of this paper is: first, to present a qualitative descriptive case study of the Mayo Clinic leadership and organization development philosophy and approach; second, to summarize a strategy for using intentional organization design as a foundation for culturally aligned physician leadership development and third, to describe the Mayo Clinic Leadership Model.

Design/methodology/approach – This manuscript is a qualitative descriptive case study of the Mayo Clinic leadership development philosophy and approach. The authors reviewed the organization design and leadership development programs of a leading healthcare institution. In the systematic appraisal, the authors sought to understand the key features and elements of team-based leadership development and the supporting organizational characteristics that guide development with the use of a customized institutional leadership model.

Findings – The authors identified four intentional characteristics of the multi-specialty group practice structure and culture that organically facilitate the development of leaders with the qualities required for the mission. The four characteristics are: patient-centered organizational design, collaborative leadership structure, egalitarian leader selection process and team-based development system. The authors conclude that organization culture and design are important foundations of leadership development. Leadership development cannot be separated from the context and culture of organizational design. Mayo Clinic's organizational and governance systems are designed to develop culturally aligned leaders, build social capital, grow employee engagement, foster collaboration, nurture collegiality and engender trust. Effective organization design aligns the form and functions of the organization with leadership development and its mission.

Originality/value – This qualitative descriptive case study presentation and analysis offers a unique perspective on physician leadership and organization development in healthcare.

Keywords Organizational behaviour, Leadership, Organizational structure, Organizational design, Organizational citizenship

Paper type Case study

Introduction

Most everyone has experienced the joy and observed the dividends of superlatively prepared leaders. Most everyone has suffered the agony of missed opportunity where struggling or failed leaders have fallen short and witnessed the attendant emotional and financial costs. Herein resides the prima facie case for investment in leadership development. Prepared leaders deliver results (Bennedsen *et al.*, 2007; Bertrand and Schoar, 2003; Dirks, 2000; Goodall *et al.*, 2011; Jones and Olken, 2005; Kahn, 1993; Kaplan *et al.*, 2008).

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It is why US companies spend over $13B on leadership development each year (O'Leonard and Loew, 2012). Building the leadership capabilities of an organization is a clear differentiator. It happens in the context of the "whole" system, unique to each organization's culture, strategies, processes and people.

As important as it is to develop individual leaders, it is perhaps even more important to develop the collective leadership of an organization, meaning all leaders, formal and informal, at all levels – committed to the same mission and moving in the same direction. Given the increasingly complex healthcare industry, the challenges and demands are too great for a small number of senior leaders.

The traditional focus on "individual leader as hero" is shifting to collective, boundaryless and connected leadership across the organization. For example, the Scandinavian Leadership Model which is characterized by respect for the individual with a strong bias toward multiple stakeholder engagement (Buus, 2014). The model includes a flat organizational structure with a high degree of delegated responsibility to create an environment that encourages collaboration (Lindholm, 2009).

Leadership is a social process to engage colleagues, individually and in teams, to face challenges, and then work together to advance mission-aligned goals. Leadership styles and approaches can vary. Servant leadership is a natural healthcare cultural match as it emphasizes building community and a patient-centered commitment to the growth of people with empathy, awareness and stewardship (Spears, 2004).

The business case for investing in leadership development is primarily the return from engaged people. Engagement is defined as the degree to which people are psychologically invested in the mission of the organization, resulting in increased discretionary effort toward the goals. "Organizational Citizenship Behavior" enhances productivity and helps institutions compete with limited resources. Organizational citizenship behavior promotes patient satisfaction, greater coordination among employees, lower turnover along with organizational adaptability and profitability (Koys, 2001; Podsakoff and MacKenzie, 1994).

Leaders have a direct impact on engagement (i.e. organizational citizenship behavior) by inspiring commitment, providing recognition, growth and development opportunities. Colleagues want to be appreciated for their work, to belong to a high-performing team, receive fair compensation and experience a sense of purpose in their work. These intrinsic motivators can be delivered consistently with coordinated leadership and aligned organization design.

Ultimately, it is all about performance. The value proposition for investment in leadership development is to deliver an incremental return from improved performance (Figure 1). When an organization and its leaders are healthy and engaged, one can see a direct correlation with improved overall performance. In healthcare this translates into improved patient care, outcomes and experience. There is a robust link between employee giving vs taking (e.g. sharing knowledge, offering assistance, making valuable introductions) and outcomes of profit, productivity and patient satisfaction (Grant, 2013). Healthy organizations are high-performing organizations that achieve maximal business success because they are aligned around a mission and vision and are able to renew and change in response to the environment. A healthy organization has five characteristics: minimal politics, minimal confusion, high morale, high productivity and low turnover (Lencioni, 2012). Leaders and organization design play a central role in achieving these organizational conditions. Each has a financial benefit to the organization and is part of the business case.

Leadership development in the healthcare provider sector probably lags a decade or more behind other business sectors (McAlearney, 2006). Organizations that prioritize

leadership development realize more impact on their business (Bassi and McMurrer, 2007; Bersin, 2007; Day and Lord, 1988; Griffith *et al.*, 2000; Menaker and Bahn, 2008). It is possible to effectively grow emerging leader talent while advancing strategy, increasing employee retention and engagement and delivering a measurable return on investment (Avolio *et al.*, 2010; Buckingham and Coffman, 1999; Cho and Wittrock, 2000; Dillworth and Willis, 2003; Harter *et al.*, 2002; Hill *et al.*, 2006; Kouzes and Posner, 2000; Lockwood, 2007; Marquardt *et al.*, 2009; Ostroff, 1992; Phillips and Phillips, 2005; Ryan *et al.*, 1996).

Case study organization description

This manuscript is a qualitative descriptive case study of the Mayo Clinic leadership development philosophy and approach. The organization is the first and largest physician-led integrated multi-specialty group practice of medicine in the world, founded 151 years ago (Berry and Seltman, 2008). Mayo Clinic has 4,100 physicians and scientists on staff, more than 61,000 employees overall, medical practices in 77 communities, 24 hospitals, $10 billion in gross revenue and the highest brand preference among academic medical centers. All of the Mayo Clinic physicians at the group practices in Minnesota, Arizona and Florida are employed and on a pure salary system.

The organization has some of the lowest physician (2.2 percent) and nurse (4.5 percent) attrition rates in the country (Berry and Seltman, 2014). Patient satisfaction is high with greater than 90 percent of patients voluntarily sharing favorable word-of-mouth feedback with others (Berry and Seltman, 2008). The 2015 All-Staff survey showed staff engagement at 96 percent (response rate, 72 percent respondents ($n = 44{,}025$)). Another measure of organizational effectiveness is external assessment of work environment. For 11 consecutive years, *Fortune* has named this institution as one of the "100 Best Companies to Work For." The list recognizes companies that have exceptional workplace cultures based on methodology using five workplace dimensions: credibility, respect, fairness, pride, camaraderie and low staff turnover (*Fortune Magazine*). Mayo Clinic performance is near the top of all major published quality indices (e.g. readmissions, complications, infections, resource use and survival rates) (Leapfrog Group, 2012) (Olsen and Dacy) despite having costs that are far below average (Wennberg *et al.*, 2008).

Mayo Clinic Leadership Model

Once established, it is important that a leadership model be integrated into all development work and human resource processes, assessments and language.

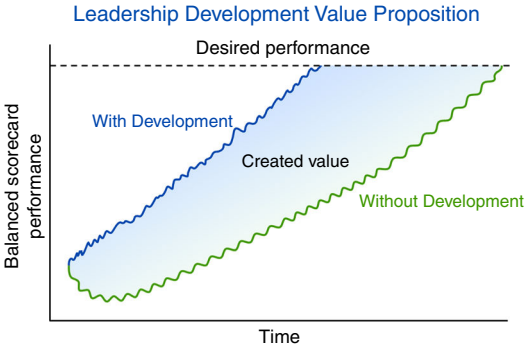


Figure 1.
The value created with successful leadership development is illustrated as the difference in balanced scorecard performance over time between a leader's performance without and with development

This builds the leadership bench and brand for an organization. The Mayo Clinic Leadership Model is a natural outgrowth of the organization's history of patient-centered collaborative leadership (Figure 2).

Instead of thinking about leadership in terms of discrete skills and behaviors, the institution identified what it wanted leaders to accomplish and be known for. They sought to answer two questions:

(1) What is our leadership brand?

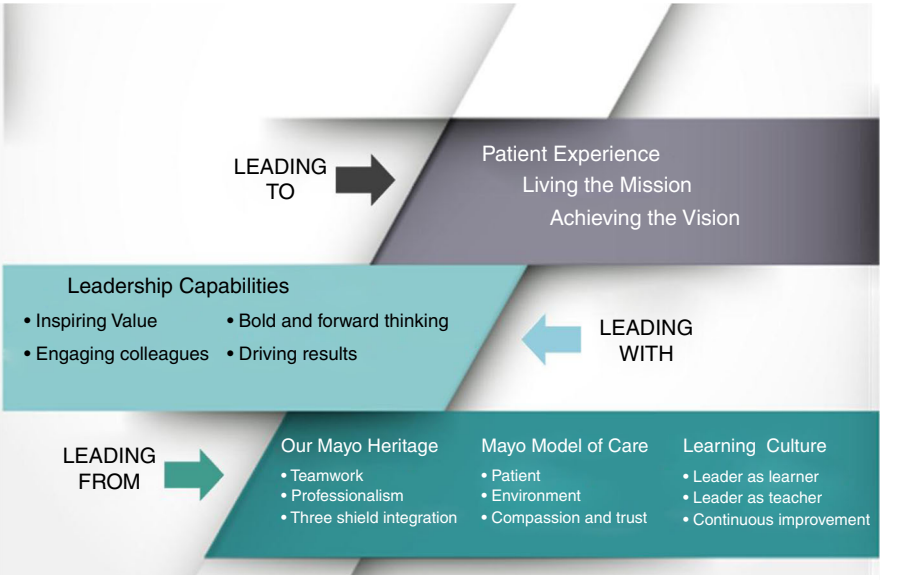
(2) What are the key outcomes of leadership?

Aligned with the importance of collective leadership capabilities, the model describes their aspirations for all leaders. They ascribe to the "leaders at all levels" framework and view all colleagues as leaders. For example, while not a formal leadership role, there is nothing more important than front-line care team leadership (Bohmer, 2013).

The leadership model provides a prescription for how Mayo Clinic leads to living its mission, achieving the vision and providing the best patient experience possible. They consciously and deliberately select and develop their leaders to inspire values, engage colleagues, think boldly and forward, and to drive results. These outcomes are ultimately obtained through the expression of their leadership brand.

Leadership effectiveness measurement

In-depth study has shown that a key Mayo Clinic organizational attribute is the leadership product of voluntary discretionary effort (Berry and Seltman, 2008). The relationship of department chair leadership effectiveness with staff satisfaction and burnout has been documented. For every one point increase in a department chair's



Notes: The diagram depicts the Mayo Clinic Leadership Model, in which colleagues lead from a strong foundation of Mayo heritage, Mayo Model of Care, and a learning culture, lead with core capabilities and lead to the unitary goal of exceptional patient experience

Figure 2.
Leadership responsibility resides in all colleagues as well as those in formal leadership roles

composite score of 12 leadership dimensions[1] on all-staff surveys, there is an associated 9.1 percent increase in department staff satisfaction and a 3.5 percent decrease in physician burnout ($p < 0.001$) (Figure 3) (Shanafelt *et al.*, 2015a, b).

Organization design and leadership development relationship

Leadership development cannot be separated from the context of the unique organizational design of Mayo Clinic. Organization design is a fundamental driver of leadership development. Every system's design plays a central role in the delivery of the results it achieves. Effective organization design aligns the form, processes, systems and functions of the organization with the strategy and mission (Collins, 2001a, b).

There are unique organizational design features that may positively influence leadership effectiveness and staff engagement. The Mayo Clinic Model of Care is essential one of patient-centered participative management (Berry and Seltman, 2014). Participative management improves employee engagement and satisfaction. These participative management practices have been long-standing and have contributed to staff engagement and organizational durability.

Although all multi-disciplinary team members play an important role, the focus of this paper is physician leadership. The multi-specialty group practice system and the Office of Leadership and Organization Development's strategy are designed to put patients first and develop leaders using robust best practices and resources to achieve the vision.

The institution's systems are designed to develop leaders, build social capital, grow employee engagement, foster collaboration, nurture collegiality and engender trust. The multi-specialty group practice system is designed to put patients first and develop leaders using robust best practices and resources to fulfill our vision. Enduring organizations preserve their core and simultaneously stimulate progress and innovation (Collins, 2001a). The core of Mayo Clinic is: "The needs of the patient come first" (Beck and Dacy, 2003).

Leadership development at Mayo Clinic has evolved organically over its 150 year history. Leaders have played a large role in the success and development of the organization and reciprocally, that the success and development of its leaders have been in large part from the organizational structure. Ultimately, the culture and primary value ("the needs of the patient come first") have shaped the organizational design and determined the leadership brand. This mutually reinforcing dynamic demonstrates the integral nature of culture, organization design and leadership development.

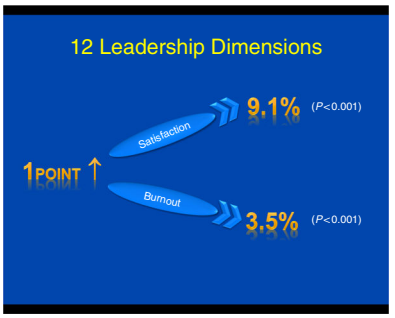


Figure 3.
Department chairs who were rated higher on the 12 leadership dimensions by their staff had employees with higher satisfaction and lower burnout

The design of the organization facilitates the enculturation, development, acceptance and ultimate success.

The leadership and organization development approach involves assessments, programs, stretch assignments/institutional projects and coaching for physicians as well as all leaders (i.e. nursing, administrators, scientists, allied health, etc.). Whenever practical and value-producing, they have integrated the development platforms to be inclusive of all Mayo Clinic leaders.

In the following sections, we describe the interrelationship, interdependency and interconnectedness of four organizational design elements with organic leader development:

(1) Patient-centered organizational design.

The patient-centered mission creates an environment conducive to developing leaders with the capability of relentlessly focussing on the reason the organization exists: to care for patients. The capabilities that accrue from a patient-centered design include servant leadership, empathy, kindness, support engendering loyalty and most of all, the daily mission that ensures that the "needs of the patient" is the only need to be considered. Physician leaders partner with administrative and nursing leaders in practice-related leadership roles and function to ensure that the strategic plan is effectively instituted.

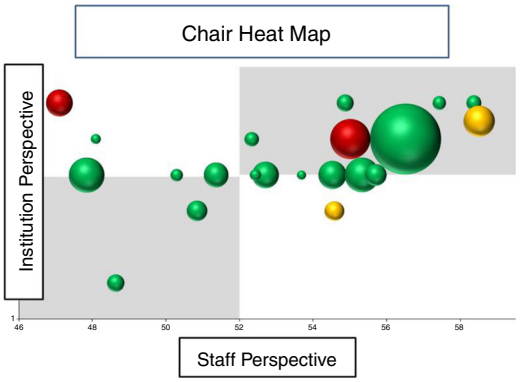
Additionally, the integrated group practice structure is fundamentally interconnected with leadership development and patient-centeredness. The group practice is constructed so that divisions, departments and medical centers have no financial conflict of interest. All departmental and site net operating income is controlled and redistributed centrally. Capital allocation for infrastructure is determined by meritorious consensus of physician-led committees. Allocation is performed without regard to department contribution to net operating income. It is driven by the needs of the patient and institutional mission.

Furthermore, Mayo Clinic physicians have no personal financial incentive to remove a gall bladder, to order a lab test, or perform a cardiac catheterization procedure. Physicians are on a pure salary system that is based on national benchmarks and set at approximately the 70th percentile. Pay is not dependent on clinical productivity, academic rank or educational commitment. The organization seeks to attract colleagues who are intrinsically motivated so their work is in alignment with the organization's commitment to teamwork and collaboration (Cho and Perry, 2012; Thomas, 2009).

In most academic medical organizations, the department chair is considered an independent senior leader. At Mayo Clinic, department chairs are considered important team members whose role is fundamentally different from the traditional academic medical center. Their purpose is primarily to lead a team to execute the organization's operational plan that emanates from our single strategic plan. The chair is subjugated to the mission for the sake of the greater good of the patients and the organization. These long-standing organizational design practices result in a cultural self-selection of physicians and administrators to the institution.

In order to assess a department chair's performance they secure ratings of their performance from the perspective of the organization leadership and from the viewpoint of the staff they lead. These data are displayed in a heat map format (Figure 4).

The goal of all healthcare leaders should be to best serve the needs of the patient and those of the "greater good" for the community within which they reside. There are competing interests that challenge these two service imperatives. The financial incentives of most American physicians, institutions, departments and shareholders



Notes: Most desirable chair performance is in the upper right quadrant. The vertical axis represents the Institution Perspective with a chair rating of 1-5. Scores of 3-5 are best and signify confidence that the chair is able to deliver the organization's operational plan for their department. The horizontal axis represents the Staff Perspective from the All-Staff Survey wherein the 12 Dimensions of Leadership are assessed. On a scale of 0-60 (5 points 12 questions) the higher the score the more confidence the staff has in their department leader. The size of the sphere is in proportion to the size of the department. The sphere color represents the readiness, ethnic diversity and gender diversity of the chairs succession pool (i.e. - Green = meeting metrics; Yellow = meeting 2 of 3 metrics; Red = missing 3 of 3 metrics)

Figure 4.
Department chair Heat Map

are commonly in conflict with the best interests of the patient and the community. For instance, most physicians, institutions, departments and shareholders have financial incentives aligned with more surgery, more CT scans, more appointments and more hospital admissions, etc. The interests of surgeons and patients could be better served by free-standing surgery centers, but not those of the community or the hospital. Physician groups and patients' interests could perhaps be better served with a new MRI Imaging center, but not those of the community or the medical center (Viggiano *et al.*, 2007). Mayo Clinic strives to ensure that structure and processes are aligned with the interests of patients and the community. This is the essence of patient-centered organizational design and the type of leaders it attracts and develops:

(2) Collaborative leadership structure.

A collaborative leadership structure creates an environment conducive to developing leaders with capability to work across practice, research and education groups, departments and sites. This attribute promotes an innovative means to improve processes and patient-centered care while ensuring quality and distinction. Given the

profound pace of change, organizations need leaders who are flexible, agile and able to effectively adapt to change. Collaboration is foundational to effective leader influence for positive results. Teamwork is expected, not simply encouraged. Sharing knowledge is a requirement, not a hope (Berry and Beckham, 2014).

The following is a description of our collaborative leadership structure.

Physician leadership. Mayo Clinic is a physician-led organization. The organization considers all physicians and scientists as leaders. Except for the president and chief executive officer, all physician leadership positions are part-time. The physician-led shared-leadership model puts physicians and administrators on the same team which is unusual in medical centers and hospitals. Only about 5 percent of US hospital CEO's are physicians (2013). As medical center employment of physicians increases and delivery moves to a value-based system, that percentage is expected to increase (Stagg Elliott, 2012). Almost all Mayo Clinic physician leaders have only 10-40 percent of their time allocated for leadership responsibilities. They are expected to maintain involvement in some combination of our three-shield mission: clinical practice, education and research. This feature design militates against an "Us vs Them" culture. It also facilitates a smooth transition back to full-time practice after the term-limited leadership appointment is completed.

There are growing organizational and social drivers for physician leadership that include the complexity of healthcare organizations and the evolving healthcare environment. In addition, physician "disinclination to followership and collaboration" is another important dynamic that could offer an advantage to physician leadership (Stoller, 2008). There may be a competitive performance advantage with physician leadership (Goodall, 2011; Kearns *et al.*, 2009).

Rotational leadership. A unique requirement of physician leadership at Mayo Clinic is term limits. They administer mandatory rotations for physician and administrative leadership positions to allow others to gain leadership experience and to generate fresh ideas. They rotate practicing physician leaders and support their leadership and transitions with administrator partners. Physician leaders serve no more than two consecutive four-year terms for a total of eight years in any leadership role.

At the end of their tenure, leaders transition out of the role and either move back full-time into a combination of clinical practice, education and research or into another leadership role. There is some research to support the value of shorter leadership tenure (Luo *et al.*, 2013). This practice engenders engagement and a flatter organizational chart culture. Colleagues commonly refer to the 4,100 physicians and scientists as "vice presidents." Chairs are leaders among equals. One colleague explained: "We respect chairs, but we don't want them to act like a boss."

A common derailleur for leaders at many organizations is egocentricity. When a leadership position becomes all about the individual, instead of all about the mission, performance suffers (Seybert, 2013). Rotational leadership, along with the expectation that physicians remain active in practice, education and/or research, is an antidote for this derailleur.

Rotation of physician and administrative leaders facilitates cross-boundary thinking, collaboration and leadership development. The vast majority of US senior executives believe it is "extremely important" for them to work effectively across boundaries of function, expertise, geography, demographics, but only 7 percent of them believe they are "very effective" at doing so (Yip *et al.*, 2009). Leadership is a social process that engages and mobilizes colleagues in our community to face challenges.

Mayo Clinic is a "social community specializing in the speed and efficiency in the creation and transfer of knowledge" (Kogut and Zander, 1996). The collective approach has served them well as researchers have attributed their success to two inherent strengths – connectedness and structure – that facilitate cross-functional learning (Kotler and Keller, 2012). Fostering this capability of team leaders to collaborate across organizational boundaries is a requisite for success in this century (McGuire *et al.*, 2009). The model of rotation and leadership dyads and triads facilitate work across boundaries.

Leadership dyads and triads. A fundamental reason for success of physician leadership at the institution is the physician-administrator dyad. In the hospital setting the leadership partnership is most often a triad, including physician, administrator and nursing leader. Throughout the whole organization, all physician leaders have an assigned administrative partner who handles day-to-day operational management duties. The physicians lead the clinical practice, research activities, physician education programs, career development of the medical staff and ensure the needs of the patient always come first.

Fewer than 10 percent of the top 232 physician leaders have a master's degree in management, business or healthcare administration. Administrators are all master-level leaders (e.g. master degree in business administration, hospital administration, management, etc.). The approach is to develop physicians as leaders not business people. The administrative partners fill the role of "business people." Physicians bring their clinical, research and education experience to their leadership role. Physicians also have their peer relationship with clinicians for whom they will need a trusting relationship to lead change and manage personnel issues. The administrator partners have business and management expertise and a broad understanding of the institution. They lead by managing the business side of the operations, including our non-physician/scientist colleagues. The partnership allows physician leaders to successfully lead a large non-profit institution and maintain a meaningful presence in the practice, education and/or research mission.

One of the strengths of the dyad and triad partnerships is the synergistic and complementary cross-disciplinary skill sets and experiences (Berry and Seltman, 2008; Herrell, 2001; Rummans *et al.*, 2011). In general, physicians can concentrate on the patient care, education and research aspects of the integrated practice leaving the operational aspects largely to the administrative team. The dyadic partnership also allows for varying degrees of coaching, mentoring and support depending on the individual relationships and experiences. Like physicians, operational administrators also rotate.

The strong physician administrative partnership is a differentiator and one that has helped define their practice; transitions are easier if one is passing on responsibility, not giving up power. This accelerates development and creates an organizational perspective for administrators. So instead of spending a career as a cardiology administrator, operational administrators rotate between departments and services. For example, over a career an administrator may serve in orthopedic surgery, research, dermatology and systems and procedures. Many administrators also spend time in different geographic parts of the institution. This system drives the workings of an integrated multi-specialty group practice in an academic setting that has 24 hospitals in six states:

(3) Egalitarian leader selection process

An egalitarian leader selection process creates an environment conducive to developing leaders capable of effectively engaging colleagues and managing change with savoir-faire. In contra-distinction to the traditional academic medical center process of

recruiting physicians from outside their institution to leadership positions based on academic prowess and reputation, they develop and select internally, whenever possible, for leaders with capabilities per their model based on the leadership needs of the group going forward (Stoller, 2008). They do, however, expect top leaders to be top performers and have academic accomplishment with national and international reputation. They regularly give performance and development feedback to incumbent leaders and those in their succession pools using many tools, for example: 360 assessments for leadership development, peer-based performance reviews, personality, social and emotional intelligence assessments and patient satisfaction scores.

The industry best practice is to develop leaders internally (Day and Halpin, 2001). Jim Collins' research in *Good to Great* underscores the validity and business value of developing leaders within an organization. In total, 10 of 11 *Good to Great* leaders came from inside their organization. Comparison companies in his research (that vastly underperformed the *Good to Great* firms) recruited top leaders from the outside sixfold more often (Collins, 2001b). The intent is to develop internal physician leaders. This is in contrast to many academic medical centers where outside talent is more often intentionally recruited.

There is a competitive advantage to developing most leaders internally. It takes approximately three years for outside hires to perform as well as those developed internally. The direct cost of a national search is considerable. The indirect costs of a national search may be even more important and include time, morale and turnover. While there is value in bringing in new perspective from the outside, there is a higher risk of failure with recruited external candidates (Cappelli, 2013).

More than 60 percent of their physician staff had previous training in Mayo's medical school or postgraduate residency/fellowship programs before being hired. They do hire from the outside when excellent internal candidates are unavailable. They are mindful of the pitfall of becoming too insular. Every physician receives 18 trip days per year. The culture expects each physician to travel to learn and bring back and implement new ideas.

A teamwork culture depends on hiring staff that will make good teammates. Research shows that high-performance service organizations practice deliberate hiring (Berry, 1999). We hire for values and talent, not just for talent. New staff typically must pass muster on multiple interview occasions with multiple staff in various functions and roles, including an interview panel whose members ask "behavioral" questions designed to reveal a candidate's personal values (Berry and Beckham, 2014).

The selection process is designed to identify colleagues who can serve effectively as a leader among peers. They consider all physicians as leaders and therefore leader selection starts at the beginning when we hire any new staff member. Most of them will lead only the most important thing: care for patients with multi-disciplinary teams. They term physicians "consultants" to underscore their role in a team-based practice of medicine where doctors are expected to frequently consult with each other to deliver the best care to our patients.

Their orientation and onboarding process for all new physician staff is a three year enculturation endeavor and builds a foundation of beginning leadership skills. Only after three years do they formally hire physicians as permanent staff. Each new potential permanent staff is assessed with an emotional intelligence tool at the end of first year. They participate in a 360 degree assessment for development at the end of

the second year. We have required professionalism, communication, mentoring and internal executive coaching programs that support the first three years on the consulting staff.

Physician leaders are selected by a democratic, inclusive and comprehensive search committee process with peer and stakeholder involvement. They support approximately 600-650 stakeholder interviews per year in order to understand department and institutional perspectives. Input is sought from every member of the department or division where the chair is transitioning. The input is gathered from one-on-one face-to-face interviews with department/division members and with key stakeholders from service line departments. Each colleague ranks their top candidates and note who they would not consider to be good contenders. This data rich process is used to select three to five candidates for a formal interview with the search committee. Succession planning data are also integrated into the process for a holistic picture of talent.

In the early days of democracy, Aristotle noted that "it is necessary for the citizens to be of such a number that they knew each other's personal qualities and thus can elect their officials and judge their fellows in a court of law sensibly" (Aristotle). Part of the success of their labor-intensive selection system is the engagement of colleagues and their judgment of the fitness of candidates. One of the most important characteristics of effective leaders is the trust that their staffs have in them.

This model of leader selection identifies leaders who tend to be intrinsically motivated. That is, they are motivated to serve a term for their colleagues and for the institution, not because it is a new career, or a large salary increase. The extrinsic motivations of career-long prestige and salary too often engage the wrong person (Cho and Perry, 2012; Thomas, 2009). They offer only a nominal salary increase for leaders. Because their physician leaders are still involved in the care of patients, research and/or education programs, they intentionally mitigate the "Us vs Them" power-distance index between leaders and staff.

The leadership pipeline. The organization has leadership pipelines for key succession pools (Charan *et al.*, 2010; Mahler and Wrightnour, 1973). They manage and track 232 physician and scientist leader talent pools and actively develop the careers and leadership skills of those in the pipeline. There are 1,675 physicians and scientists in the succession pools for these important positions. The objective is to ensure the readiness and diversity of the pipeline. This important function cannot effectively and economically be handled by a remote central team of experts (Cappelli, 2013). The Office of Leadership and Organization Development partners with the incumbent department, division and institutional leaders to accomplish this objective.

The metric for success is to have each pool populated with high-potential (ready-now) ethnically and gender diverse candidates. The annual succession review process facilitates and feeds talent metrics.

Diversity and inclusion. The organization has an intentional focus on diversity and inclusion to advance women and minorities in leadership and academic tenure. There is a solid business case that includes documented financial advantage to support increasing the number of women in leadership roles (Women Matter. New York: McKinsey and Company, 2008). People often are more comfortable with others like themselves. They work intentionally to reduce "unconscious bias" in our work (Kandola, 2009). The lack of diversity can reduce the exchange of ideas and stifle debate. Diverse groups outperform those that lack mixture because diversity generates more thoughtful processing. Uniform groups tend to feel more confident in their

performance and interactions. Dissimilar groups are more successful in finishing their tasks (Phillips *et al.*, 2010). They have a pool of high-potential women and minorities and engage with them and their leaders to ensure development plans are in place to accelerate their development and make sure they have visibility and sponsorship so their names are surfaced for search committees.

They refresh (via annual incumbent leader interviews) the readiness, gender diversity and ethnic diversity scores of all 232 physician/scientist succession pools (Figure 5).

The Office of Leadership and Organization Development partners with the Office of Diversity and Inclusion to achieve aligned metrics. This strategic priority includes:

- representation – reflecting the communities we serve at all levels of culture, background, religion, race, ethnicity, in our employees, our leadership, our clinical studies, our vendors;
- inclusion – how we create an environment and culture in which we embrace and tap into a diversity of experiences, perspectives and capabilities to generate a rich variety of ideas, options, innovations. Building the culture to value diversity of thoughts, ideas, capabilities, disagreement and divergence as highly as we value consensus and conforming is where we need to be; and
- cross-cultural competencies – how we deliver care in a way that is sensitive to and respectful of the cultural background of our patients.

Professionalism and ethics. Beginning on Day 1, staff is re-introduced to the concept of professionalism. It is reinforced through dress code interactions with patients and family members, and each other as part of the healthcare team.

Cross-boundary coaching. One of their strategic objectives is to build a coaching culture with an internal coaching practice, facilitated leadership roundtables, and coaching skills at all levels to drive leadership, team and organizational performance. Central to the plan is the training and deployment of internal leadership coaches. They have trained over 100 physician leadership coaches. The coaching practice maximizes internal resources and is closely integrated into succession management to

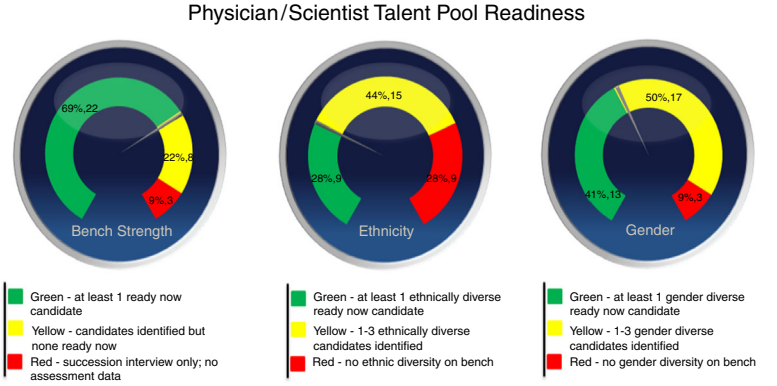


Figure 5.
Physician/scientist succession pool scorecard

Notes: Leadership development staff assess each of the 232 physician/scientist succession pools annually with interviews of the incumbent leader. Each pool is rated for readiness (bench strength), ethnic diversity and gender diversity

ensure timely development of high-potential leaders and onboarding of newly transitioned leaders (Tompson *et al.*, 2008).

Coaching is an excellent leadership development method to help leaders ascend the learning curve to execute rapid changes in day-to-day operations (Kumata, 2005; Tompson *et al.*, 2008). An internal coaching practice increases focus on developing others and managing performance, increases sharing and utilization of knowledge, leads to more participative and transparent decision making, and makes learning and development a top priority (Anderson *et al.*, 2008). Coaching has been shown to result in improvement in relationships, teamwork, job satisfaction and improve overall productivity, employee satisfaction and customer satisfaction (ManpowerGroup Company, 2012; McGovern *et al.*, 2001; Phillips and Phillips, 2005). The internal coaching practice is integrated with other leadership development programs to ensure the highest level for success and a positive measurable impact on the bottom line (Bersin, 2007; Coutu and Kauffman, 2009; Eby *et al.*, 2008; Gentry *et al.*, 2008; ManpowerGroup Company, 2012; Lester *et al.*, 2011; London, 2002; McCauley and Van Velsor, 2004; McGovern *et al.*, 2001; Olivero *et al.*, 1997; Tompson *et al.*, 2008; Underhill *et al.*, 2007).

At best practice companies, internal coaching strategies are now a key component of a coaching culture (e.g. General Electric, IBM, 3M and Intel). Organizations that are effective at training managers to coach employees have higher levels of employee productivity, employee engagement and financial performance (Bersin, 2007). Ultimately, coaching creates stronger, more agile teams and better business results:

(4) Team-based development system

Successful teamwork requires leadership to engage colleagues in ways that create shared meaning and purpose. A team-based development system creates an environment conducive to developing leaders capable of effectively leading staff in a consensus-driven organization that aspires to a highly engaged workforce. Team-based collaboration drives the establishment and spreading of best practices, and holding oneself and others accountable to metrics for patients and colleagues.

Formal development, orientation and onboarding programs. The Mayo Clinic approach to leadership development was benchmarked with 11 of the top 25 organizations recognized as world leaders in other business sectors, wherein leadership and organization development is a top priority (Kowitt and Thai, 2009). The development offerings whenever feasible involve multi-disciplinary teams, where the primary development activities are group based, experiential and interactive. The leadership offerings are made available to all staff. Most programs like professionalism and emotional intelligence are required. The intent is to build teams, develop leaders and deliver a return on investment from action learning. For example, a recent Department Chairs Team Program had nine teams doing strategy-aligned work with results in 90 days. Humans learn best through experience, problem-solving and when the learning is of practical and immediate value. The most important development is delivered not by a teacher but by experience.

Because focus on the collective over the individual is fundamental, they emphasize the experiences with interdisciplinary, inter-department and inter-site action learning teams. Action learning is a methodology that has been around for more than 50 years. Action learning is not a training program, but rather an approach to development and performance. The basic premise of action learning is that leadership development and learning will be accelerated when doing real work solving the complex business

challenges (Raudenbush *et al.*, 2003; Revans, 1982). Action learning improves collaborative and shared leadership skills and strengthens divergent and assimilating capabilities of participants (de Hann and de Ridder, 2006). You cannot learn to be a great leader in the classroom. Experience is the best teacher.

Quality academy. Another leadership development program offered and required of leaders is the quality academy fellows program through which they recognize team-based excellence and accomplishments. Today they have more than 42,000 colleagues certified as bronze, silver, gold or diamond fellows. The silver certification requires an examination documenting competency in basic process improvement science and completion of a team-based quality improvement project. They require all leaders to be certified as a quality fellow. In total, 27 courses are offered within the Quality Academy. The academy covers a multitude of topics ranging from the overall strategy to more specific approaches/tools including lean, six sigma, change management, failure modes and effects analysis, project management, and champions training, among others.

A number of careful studies have now demonstrated that companies making a serious commitment to the disciplines and methods associated with quality improvement outperform their competitors. There is now little doubt that when used properly, system engineering-based value creation work produces significant value to both organizations and their customers (Swensen *et al.*, 2012). Quality Academy work develops leaders while improving the care of patients or the processes that support that care.

Resiliency. Finally, in order for leaders to function optimally on teams, they must be resilient. They look beyond the basics of their leadership model to have and support highly functioning leaders. Professional burnout is a serious healthcare organization and leadership issue. The professional burnout rate among Mayo Clinic physicians has decreased seven-points in the last two years and is now at 32 percent. This contrasts with the current national benchmark all US physicians of 43 percent (Shanafelt *et al.*, 2015a, b).

Burnout manifests as a combination of emotional exhaustion and depersonalization. Burnout impairs the quality of care physicians provide and their professionalism (Shanafelt, 2009; Shanafelt *et al.*, 2003). Professionalism and patient-centeredness are at risk with physicians who are burned out. A burned-out leader is an ineffective leader and one who puts the organization at risk. Leaders must build a firewall from the burnout-inducing demands for themselves and for the colleagues they lead (George and Baker, 2011).

Eradication of burnout is the job of leaders. Healthcare systems operate more effectively and efficiently when physicians are satisfied with their professional environment (Beckley, 2003). Physicians' satisfaction with their leaders is closely associated with the frequency with which leaders are perceived as exhibiting specific transformational leadership behavior (i.e. idealized attributes, idealized behavior, inspirational motivation, intellectual stimulation and individual consideration) (Menaker and Bahn, 2008).

The approach to burnout is to address the five drivers (i.e. drivers: work load, work efficiency, work-life integration, autonomy, meaning and purpose) in four contexts (i.e. organization, work unit, leader, individual). After the drivers have been mitigated as much as possible, they address opportunity to improve resiliency. The institution looks at resiliency as the balanced health of these five elements: cognitive, social, emotional, physical and spiritual.

Mayo Clinic researchers have demonstrated that team-based work is an effective and proven approach to reducing burnout (West *et al.*, 2014).

Discussion

Social capital

In the last several decades there has been a dramatic downward shift in the percent of US company value that can be attributed to tangible assets (Barrington and Silvert, 2004). The traditional forms of capital (financial, operational and customer) can be replicated. Most organizational value in the twenty-first century is intangible and not easily replicated. We live in a knowledge economy today and so we need governance and a model of leadership that is appropriate and compatible.

The intangible assets manifest as social and intellectual capital. Securing the future of an organization necessitates effectively harnessing commitment and growing social capital. Social capital is the goodwill, trust and interconnectedness available to organizations that accrues from the capability of employees to work together for common purposes. Intellectual capital is the collective knowledge of the individuals in an organization and is best leveraged with optimal social capital. Trust in leaders is fundamental for organizational health and success (Bennis and Nanus, 1985; Dirks, 2000).

Mayo Clinic structure and culture engender boundarylessness, the cultural encouragement to cross-conventional organizational borders to seek help from those whose expertise is needed. Boundarylessness opens up the organization, removing walls to enable talent and knowledge to converge where needed (Berry, 1999; Tichy and Sherman, 1993).

Leadership development is, therefore, focussed on the development of social capital. It is no longer sufficient to develop individual leader behaviors and competencies. It is imperative to also develop broad leadership capabilities related to values, influence, interpersonal relationships, team dynamics and social networks. Formidable organizational capital is a primary source of sustainable competitive advantage for a company. Leaders are, therefore, the primary force multiplier for differentiation.

Organizational democracy

Organizational democracy is a systems approach to amplify the possibilities of the community as a whole. Its application is associated with higher levels of innovation, superior employee involvement, commitment and satisfaction. Organizational democracy executed properly results in enhanced performance (Harrison and Freeman, 2004; Manville and Ober, 2003). The Mayo Clinic model of team-based organizational leadership is a modern rendition of organizational democracy (Hansen, 1989; Manville and Ober, 2003).

Mayo Clinic has 267 institutional committees. Economists and social scientists have developed elaborate formulas to express the trade-offs of efficiency, effectiveness, accuracy, consensus, expense, speed and engagement of committees. The optimal group size for decision making is ~7(+/−2) members (Kang, 2004; Koh, 1994). The committee system organizational purpose is to support a culture of consensus decision making. Committees are also vehicles for communication and graduated development platforms for leaders. The committee system engenders collegiality and collaboration and is one of many manifestations of organizational democracy. One of the most important functions of leaders is to engage colleagues. Approximately half of American employees (49 percent) do not feel valued at work (American Psychological Association, 2013).

It has long been recognized that committees may slow organizational decision making. One of the few criticisms of demokratia by Aristotle and Plato related to the

slowness of decision making (Hansen, 1989). The slower speed of decision making in general is outweighed by the merit of the quality of the decisions, the value for collaboration, the power of physician engagement, the inherent change management and the interwoven leadership development.

Transformational leadership and servant leadership

In many ways the Mayo Clinic model of Intentional Organization Development of Physician Leaders is a unique blend of two philosophies: transformational leadership and servant leadership. With servant leadership one observes community-building behaviors of listening, empathy, awareness and stewardship (Ebener and O'Connell, 2010; Hunter *et al.*, 2013; Jenkins and Stewart, 2010; Liden *et al.*, 2014; Parris and Peachey, 2013; Sendjaya and Pekerti, 2010).

The organizational design of the multi-specialty group practice in this case study engenders transformational leadership. Transformational leadership is about organizing around a collective purpose in order to engage group members in the mission and vision of the organization. Transformational leadership is intended to intentionally and positively transform colleagues through the strategy, processes, systems, culture and structure of the organization (Grant, 2012; Wang and Howell, 2010; Parolini *et al.*, 2009).

The organization in this case study organizes its systems and structure around promoting collectivism while hiring and developing individuals who exhibit civility, community-building skills and are socially and emotionally intelligent. In other words, this organization is intentionally designed with a blend of transformational and servant leadership.

Conclusion

The success of the organization has, in large part, been from the performance of its leaders. Reciprocally, the success of the leaders has been in large part due to the culture and organizational design. Both are designed to promote the attributes of transformational and servant leadership. Organization design is not simply structure and reporting charts. It is about the design and alignment of systems and processes that drive the culture and determines their leadership brand.

There is clearly further research work that needs to be done. Next steps could include inquiry to better understand healthcare provider participative management dividends and potential relationships with professional burnout. The inter-relationships of transformational and servant leadership could also be studied explicitly.

The approach of the organization featured in this case study is to integrate robust and innovative leadership development programs and resources into the multi-specialty group practice institutional design. The physician-led integrated group medical practice systems are calculated to develop leaders, build social capital, grow employee engagement, foster collaboration, nurture collegiality and engender trust within an organizational democracy. The organization system is planned to put patients first and custom develop leaders by design using intentional organization development to fulfill its vision.

Note

1. 12 leadership dimensions:
   Holds career development conversations with me.
   Inspires me to do my best.
   Empowers me to do my job.

Is interested in my opinion.
Encourages employees to suggest ideas for improvement.
Treats me with respect and dignity.
Provides helpful feedback and coaching on my performance.
Recognizes me for a job well done.
Keeps me informed about changes taking place at Mayo Clinic.
Encourages me to develop my talents and skills.
I would recommend working for this leader.
Overall, how satisfied are you with this leader.

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