EDITORIAL INTRODUCTION

On the need for transformational leadership in the delivery of person-centered clinical practice within 21st Century healthcare systems

Andrew Miles MSc MPhil PhD DSc (*hc*)[a] and Jonathan Elliott Asbridge Kt DSc (*hc*)[b]

a Senior Vice President and Secretary General, European Society for Person Centered Healthcare; Editor-in-Chief, *European Journal for Person Centered Healthcare* and *Journal of Evaluation in Clinical Practice*, School of Medicine, Francisco de Vitoria University, Madrid, Spain & WHO Collaborating Centre, Faculty of Medicine, Imperial College London UK
b President and Chairman of Council, European Society for Person Centered Healthcare, Oxford, London and Madrid

Correspondence address
Professor Andrew Miles/Professor Sir Jonathan Asbridge, European Society for Person Centered Healthcare, c/o 77 Victoria Street, Westminster, London SW1H 0HW, UK. E-mail: andrew.miles@pchealthcare.org.uk

Introduction

We write this Editorial Introduction following the conclusion of the First Annual Conference and Awards Ceremony of the European Society for Person Centered Healthcare (ESPCH) hosted by Francisco de Vitoria University, Madrid, Spain, on 3 & 4 July 2014. The Conference proved an important event which successfully brought together a very wide range of distinguished speakers and delegates from across the length and breadth of Europe, the United States of America, Canada, Australia, New Zealand and elsewhere. Following the close of Day One of the Conference and prior to the Conference Dinner, we were pleased to confer on particularly eminent colleagues, the Society's Platinum, Gold, Silver and Bronze Medals, the Presidential Medal and the Senior Vice Presidential Medal and, in addition, to award the Society's Essay Prize and Book Prize. A full Conference Report, with the usual obligatory photographs and a YouTube videolink to highlights of the proceedings, has been included within the first *e-Bulletin of the European Society for Person Centered Healthcare*, the Society's new bi-monthly and detailed Newsletter.

The Conference generated many new and exciting ideas and the Society is currently engaged in the process of addressing these internally, with the intention of forging new and strategic partnerships through which to advance the conceptual clarification and operational implementation of more PCH-orientated approaches within day-to-day clinical practice and health service systems. Nevertheless, and notwithstanding these positive developments, the Conference raised a great deal more questions than could be answered, an observation which was not at all unexpected, given that PCH is a relatively new discourse, actively building up its aims, scope and 'ways forward'. PCH, it was noted, employs a very great number of words and terms, these often meaning very different things to very different people, whether clinicians, academics, patients, policymakers, politicians, the general public, or to governments themselves. In the absence of a common language, an effective discourse is all but impossible and the ability to move forward in any productive sense becomes negatively affected as a direct result.

Calls of the Conference on the ESPCH

For this reason, one (of the many) calls of the Conference on the Society was for the urgent construction and publication of a Lexicon and Dictionary of Terms for PCH. We are pleased to confirm here, that, in early response to such a call, the transnational writing of such an article is already very well progressed. Indeed, this major contribution to the advancement of the PCH discourse will be, subject to the usual considerations, published within the first issue of Volume 3 of the *European Journal for Person Centered Healthcare*, thereafter to be reproduced, in the interests of as wide a global dissemination as possible, as a constituent chapter of the 55-chapter seminal Society textbook: 'Person-centered Healthcare: How to Practice and Teach PCH' which is currently in preparation The Lexicon, and certainly the Textbook, will function as

major teaching resources for undergraduate and postgraduate clinical training, continuing professional development and for the Society's own educational and training courses.

A second principal call of the Conference on the Society was for much greater attention to be given to far more pragmatic considerations of how PCH approaches to care can be realized in day to day clinical practice. Here, the Conference was concerned to see the following progress: (a) A humanising of the undergraduate medical curriculum through the availability of innovations designed to ensure that students see patients as persons, not subjects, objects or complex biological machines; (b) The development of clinical methods to increase the person-centeredness of care within specific clinical specialties and for specific clinical and co-morbid conditions within those specialties; (c) The development of training courses and major teaching materials and (d) The generation of more empirical evidence (as well as evidence deriving from the qualitative exploration of the subjective experience of illness by the patient) to illustrate the superiority of person-centered care approaches - both in terms of their *clinical* outcomes and the *costs* of those clinical outcomes.

Ongoing progress of the ESPCH

As the e-Bulletin (to which we make reference above) demonstrates, the Society is already making excellent progress in addressing these undoubtedly urgent priorities. Indeed, within the Bulletin, readers will find full details of the Society's Second Annual Conference and Awards Ceremony, the major Clinical Conferences on the care of the frail elderly and of people living with HIV/AIDS, details of the forthcoming medical education Conference and details of the Society's two annually recurring intensive residential training courses: one to train clinicians in basic PCH and the other designed specifically to develop mentors and leaders for PCH. A competition for the award of the Society's first Higher Degree Sponsorship is also announced within that publication.

The progress the Society is making, while substantial and 'steady', is, of course, early progress only and there is an enormous amount to achieve over the next decade. For this reason, the President of the Society (JEA) has asked the Senior VP and Secretary General of the Society (AM) to draw up a draft 10 Year Strategic Plan, a document to be considered alongside the Society's Interim Constitution at a Meeting of Council, the date of which is imminently to be announced. Strengthening the governance of the Society is an essential pre-requisite for the Society's effective functioning in accordance with the provisions and expectations of that Strategic Plan. But will the initiatives called for and those we describe as in progress, be of themselves sufficient for the realisation of an increased person-centeredness of care within global healthcare systems? We answer definitively in the negative to this question and identify a crucial component for inclusion in any person-centered healthcare strategy if it is to have any

chance of success whatsoever: the need for transformational leadership.

PCH and its need for transformational leadership

As medicine and healthcare become increasingly reductionist and as clinicians continue to be led along a trajectory of decline - from caring professionals exercising judgement in the context of the individual case to operatives applying technical prescriptions in accordance with Government and Payer sanctioned guidelines [1-3] - it is not a question of *whether* 21ˢᵗ Century Healthcare needs to recover its humanism, but rather *how*. If this assertion is accepted, then it seems clear to us that we must ask the question '*Who*?' Who will lead the recovery of humanism and with what methods? This is a complex question and one which will be addressed within an extensive treatise on PCH scheduled to appear within the first issue of Volume 3 of the EJPCH in 2015 [4], alongside the Lexicon and Dictionary of Terms. In the interim, we invite the reader to consider what we regard to be the vital importance of a new approach to securing the development and implementation of PCH and one which has not yet been seen in this context: that of *transformational leadership*.

As we discuss in the treatise, it is, to be sure, far easier to talk of transformational leadership than to exercise it and the ability to employ such leadership depends firstly on the identification of those individuals who demonstrate the potential to become leaders of this type, then to enable their formation and then to equip them with the knowledge and methods in PCH that they will need. The change management literature (cf. 5-8], when talking of transformational leadership, is clear about the considerable particularity of the personal characteristics of such leaders. A fundamental characteristic of these leaders is that they demonstrate utter commitment to a singular task and that task is this: the transformation of that which requires transformation, whether this is a particular philosophy, institutional culture, professional practice or the 'thinking' and 'doing' of an entire system(s) at the local, national, supra-national or international level. Typically, transformational leaders combine a range of characteristics including personal authority, warmth and charisma, undoubted intellectual prowess, linguistic and literary skill, the ability to persuade and convince and an ability to 'speak the language' of all those stakeholders whose commitment is necessary to achieve the transformation, whether these (in the context in which we write) are clinicians, health service managers, policymakers, politicians or patients themselves. The literature talks of such individuals as also possessing physical (as well as intellectual) stature and of having the vigour of youth or relative youth and thus offering the broadest possible appeal and credibility to those who are required to work with and for them in achieving the transformations that have been judged necessary.

Such leaders do not and cannot work alone or in any form of splendid isolation. Indeed, the literature does not

recognise them as autocrats *per se* and such leaders do not seek to rule over others. On the contrary, their self-confidence is such that they demonstrate a developed understanding that it is through non-hierarchical team working that their transformations will be made more probabilistically likely and that they will thus eventually be rewarded by the incontestable success of their labours. These leaders are not 'old men in a hurry'. They realise all too well, having learned as much from their highly successful transformational teachers, that real change is achieved in a 'bottom up' manner, with 'boots on the ground', rather than in any form of 'shock and awe' top down imposition of a grandiose or Messianic ideological 'Declaration', such documents being typically characterised more by vivid displays of intellectually bankrupt rhetoric than clear articulations of the detailed methodological approaches necessary to transform PCH from its developing conceptual base to an operational reality. Indeed, such leaders are acutely mindful of Horace when he talks of such misguided and inexperienced endeavours: "*Parturient montes, nascetur ridiculus mus*" (The mountains heave and out of them emerges (is born) a ridiculous mouse" [9]

The astute reader, who will be conversant with the 'state of play' of PCH as we write, will know that successful transformational leaders are in desperately short supply within health services generally and certainly so within the PCH Community, yet they are needed in very significant numbers. For sure, there is no shortage of leading universities offering courses at the Master's and Doctor's level in change management and transformational leadership, among them many Ivy League universities in the USA, for example, Harvard University and others elsewhere within North America and Europe. The Society urges those institutions and the teachers of those courses, when studying health systems, to devote far greater attention to what health service systems have been put in place for – to attend to the person who is ill, who suffers and who presents for help. It seems absurdly obvious to say such a thing, but too often it is possible to see such students think of health service systems as ends in themselves, resource consuming factories, rather than as 'hospitals' in the classical sense of the word.

To inculcate in such students a deeper and working understanding that medicine must care, comfort and console as well as ameliorate, attenuate and cure [1-4], is a firm and fundamental starting point for the generation of the new leaders. From here, by networking with managers, policymakers and governments and by using the thinking, evidence and tools developed by academics and enthusiastic clinicians, such leaders can work steadfastly to build changes that are real, lasting and which produce improved clinical outcomes and patient satisfaction rates that are objectively measurable and contained or lowered in cost. The Society has made a start in identifying and equipping such potential leaders through its intensive residential course for mentors and leaders in PCH and we are in discussion with a number of universities which teach change management within healthcare systems with a view to introducing additional curricular material on PCH and its particular needs.

Conclusion

In modern health systems, the delivery of indifferent, poor and frankly inadequate care has become so commonplace as to be almost normative. Increasingly, the standards of care, having descended to the lowest common denominator legally acceptable, can be seen to descend lower than this, as the relentless rise of malpractice suits well illustrates. It seems more and more the case that modern medicine lacks the capacity to be genuinely shocked by these occurrences, viewing the scandals which result as the inevitable consequence of complex systems, escalating patient demands and diminishing economic resources. Responding to this, politicians and others, manufacture a sense of outrage and, as expected and on cue, verbalize accordingly. But little changes in reality. There are many factors which contribute to system failures and catastrophic errors, but the shift of the clinical 'gaze' away from the patient as a person, with its accompanying neglect of those needs of the individual patient which are beyond a simple mechanistic intervention in the biological dysfunction of a given disease, has a very major role to play. If such a process continues on a seemingly inexorable course, we will eventually witness not a dearth of professionalism, but its death.

Yet even given the current state of affairs within healthcare systems, we do not find ourselves nihilistic. On the contrary, we have the greatest optimism in believing that systems can and will change, however monolithic or powerful they appear currently to be. Change was considered all but impossible during the Fascist regime and likewise during the Communist era. But change came and suddenly so. Likewise, the European Working Time Directive on Junior Doctors Hours provides a further example of unexpected change and there are other such exemplars. The work of transformational leaders in changing systems, in order to increase their person-centeredness, has been made easier by the rise and rise of so called 'patient power' and a political climate which now greatly prizes patient education, advocacy and empowerment. The inherent danger associated with this phenomenon - that clinician-directed care will shift towards patient-directed care, in accordance with a consumerist model of the patient as client, can be effectively modulated *via* shared decision-making, one of many central components of the PCH approach. In this way, clinician professionalism can be preserved and patient autonomy and dignity safeguarded. A key task of transformational leaders in PCH is therefore strongly to advocate the relationship-centered approach in which the sharing of decisions is axiomatic.

In concluding, we contend that the technical application of procedures outside of the context of the patient as a person, without a proper attention to the wider illness that the multiple manifestations of the given disease precipitates, is simply not representative of good medicine. Indeed, it is a form of second rate healthcare, which is fine for second rate clinicians, until it becomes negligence - as in the hospital and care home scandals that have become all too frequently reported over recent decades. Patients

deserve better than this and should not be defrauded of their rights to adequate, if not excellent, healthcare services. We have stated before and do so here again, that adequacy and excellence in this context cannot by their nature be achieved outside of a person-centered healthcare framework. But established practices die hard and a move away from reductive, scientistic and mechanical approaches in healthcare understanding and delivery will take vision, energy, persuasion and time. It is here that the role of transformational leaders will be pivotal to PCH going forward.

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] Miles, A. & Asbridge, J.E. (2013). Contextualizing science in the aftermath of the evidence-based medicine era: on the need for person-centered healthcare. *European Journal for Person Centered Healthcare* 1 (2) 285-289.

[2] Miles, A. & Asbridge, J.E. (2014). Clarifying the concepts, epistemology and lexicon of person-centeredness: an essential pre-requisite for the effective operationalization of PCH with modern healthcare systems. *European Journal for Person Centered Healthcare* 2 (1) 1-15.

[3] Miles, A. & Asbridge, J.E. (2014). Modern healthcare: a technical giant, yet an ethical child? *European Journal for Person Centered Healthcare* 2 (2) 135-139.

[4] Miles, A. & Asbridge, J.E. (2015). Person-centered Healthcare: Theory and Practice. *European Journal for Person Centered Healthcare.* In Press.

[5] Johannsen, M. (2009). A Guide to Transformational Leadership. Available at www.legacee.com.

[6] National Defense University (2012). A Transformational Leadership Biography. Washington DC, USA: National Defence University.

[7] Wiseman, L (2010). Multipliers. How the Best Leaders Make Everyone Smarter. New York: Harper Collins.

[8] Maccoby, M, Norman, C.L., Norman, J. & Margolies, R. (2013). Transforming Health Care Leadership: A Systems Guide to Improve Patient Care, Decrease Costs and Improve Population Healthcare. San Francisco, CA: Jossey-Bass.

[9] Horace. (c. 18BC). *Ars Poetica* line 139.