Can we dance together? The dyadic leadership model in physician quality improvement

The dyadic leadership model supports physicians and operational leaders to work in partnership to co-develop projects that address health care system problems and to translate learning into action and sustainability.

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ABSTRACT

Background: The Interior Health Authority Physician Quality Improvement initiative implemented a dyadic leadership model in 2018. The model pairs medical and operational partners to foster a culture of learning, trust, and shared vision. Successful dyadic partnerships facilitate alignment of core values, develop collaborative relationships, demonstrate transparent communication, value complementary competencies, and model mutual respect.

Methods: The rapid review methodology and survey design are published in a white paper titled "Dyadic Leadership Model—Why It Works." This article discusses the dyadic leadership factors supported through the rapid review and survey. Participant impact statements from the survey results support the discussion.

Conclusions: The dyadic leadership model has become the expectation of new participants in the Interior Health Authority Physician Quality Improvement program. Feedback from cohort alumni has expressed the strength of the dyadic partnership. This model has become a core component of the program, as it provides valuable links between medical and operational partners.

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In 2018, the senior executive team of the Interior Health Authority (IHA) supported the Physician Quality Improvement (PQI) initiative, with the goal of increasing physician involvement in quality improvement activities. Supported through a collaboration between the Specialist Services Committee and the IHA, the PQI initiative operationalized a dyadic leadership model wherein participants are provided with quality improvement education, training opportunities, and expertise from coaches and consultants. A core component of the model is the dyadic partnership that matches medical leaders with operational leaders to learn quality improvement through project work. For the purposes of this article, the term *medical leader* refers to a physician dyad partner. These individuals are committed to building a partnership in which they share a passion for a project idea and the quadruple aim vision: improving the provider experience, improving the patient experience, achieving better outcomes, and reducing the per capita cost of health care.

The dyadic partnership is not a new concept in health care, and there has been a resurgence in implementing this model in high-performing health care organizations worldwide, including in Canada, the United States, and Germany.[1] Although the dyadic partnership has become more common in health care, there is limited understanding of the physician and operational experience as dyadic partners.[2] This raises questions about how to optimize the dyadic partnership. This article explores the key leadership factors in the dyadic partnership and how it supports physician engagement in quality improvement activities.

In March 2021, IHA PQI leadership commissioned a white paper on the

emerging dyadic leadership model. The white paper, titled "Dyadic Leadership Model—Why It Works," outlines the findings from a rapid review process and survey results from IHA PQI alumni.[3] The paper describes the program's current state, outlines the dyadic leadership model, synthesizes dyadic participant experiences, and identifies opportunities for improvement.

Context

Over the past 5 years, the IHA PQI program has exponentially increased the number of dyad partnerships enrolled. The Institute for Healthcare Improvement's quadruple aim underpins the program; the four components are improving the provider experience, improving the patient experience, achieving better outcomes, and reducing the per capita cost of health care.[4] To achieve this, resources are provided to ensure the medical leader–operational leader dyads can access quality improvement coaching and expertise, data analysis, administrative support, education, and funding to support their project. To enroll in the program, physicians residing in the Interior Health region complete an application identifying their area of interest and specific goals, which is followed by an interview. Physicians are matched with counterpart operational partners, typically from the same geographic area and specialty. The PQI steering committee adjudicates the applications. Physician participants are compensated for project time and for attending nine training sessions.

The IHA PQI program brings the practice context to the foreground, creating an opportunity for medical and operational partners to work together with their team to identify a need, co-develop a plan to address the need, and trial strategies to translate the learning into action and sustainability. The program offers the dyad a structured environment for reciprocal knowledge sharing, consensus building, and co-creation toward actionable solutions. Pairing medical and operational partners to apply quality improvement to a common goal facilitates positive and sustainable change. To this end, dyads are encouraged to complete a partnership agreement. The agreement challenges them to think about how they will work together, including how to address decision making, competencies, values, goals, and accountabilities. Additionally, to set up IHA PQI dyads for success, they complete a strength deployment inventory. The intention is to learn about their own and each other's strengths and to gain insights to communicate effectively, navigate conflict, and promote collaboration. Moreover, throughout the learning process, the dyads begin to speak a common language, and their shared learning accelerates solutions to the problems that arise. This shared learning ensures that interventions are tailored to the specific context and that local teams are engaged in decision making and co-creating solutions for sustainable change.

Dyadic leadership factors

Dyadic leadership factors are key aspects in the dyadic partnership that support leadership development toward more effective and relational collaboration. The authors chose five key factors integral to leadership success, supported by the literature and by impact statements from survey participants. The five key factors are common core values, collaborative working relationships, clear and transparent communication, mutual respect, and complementary competencies.[2,5-9] What is unique is how these factors guided the authors to think about the dyad partnership as a dynamic and multifaceted medical and operational dyad in the IHA PQI program. This uniqueness is illuminated in the dyadic experience related to these and other factors.

Common core values

Our values are lived through our actions and reflect our organizational culture.[10] When dyads share common core values and a collective vision, it helps motivate their behavior toward a collaborative culture; as a result, there is a greater likelihood that the project will succeed. Historically, medical and operational leaders have had distinct core values.[11] These distinct values sometimes create tension and hinder collaboration and trust.[6,12,13] For example, physicians value autonomy, while operational administrators value interdependence of organizational structures.[12] Having common core values was identified as an essential element of the IHA PQI dyadic experience, as it provided an opportunity to work with "other highly motivated staff looking to make positive changes for patient care" and "[to collaborate] with a physician champion for improved quality of care" [impact statements from survey participants].

Collaborative working relationships

At a base level, a collaborative working relationship can be described as a PQI dyad working together effectively, sharing responsibility to reach their project goals.[14] Health care organizations are using the dyadic leadership model to break down traditional silos to allow operational and medical leaders to work together toward shared goals.[8] A traditional siloed approach perpetuates isolated thinking and tension in the working environment. Alternatively, shifting dyads toward a joint working relationship emphasizes collaboration, co-creation, and sustainability of the quality improvement change initiative **[Figure]**.[15,16]

Senge describes collaborative relationships as a learning environment akin to a systems-thinking culture capable of continuous growth and change.[17] The idea of systems thinking highlights the importance of pooling collective intelligence and developing a shared vision. Systems-thinking insights and collective intelligence emerge as the dyads collaborate and co-create throughout the experiential learning in PQI. Specifically, the dyadic partners better understand each other's culture, strengths, and perspectives; build trust; encourage learning; and provide new opportunities to use evidence to improve decision making.

Example: Palliative care team. One dyad set out to improve morale and decrease compassion fatigue and burnout among members of a palliative care team. Their

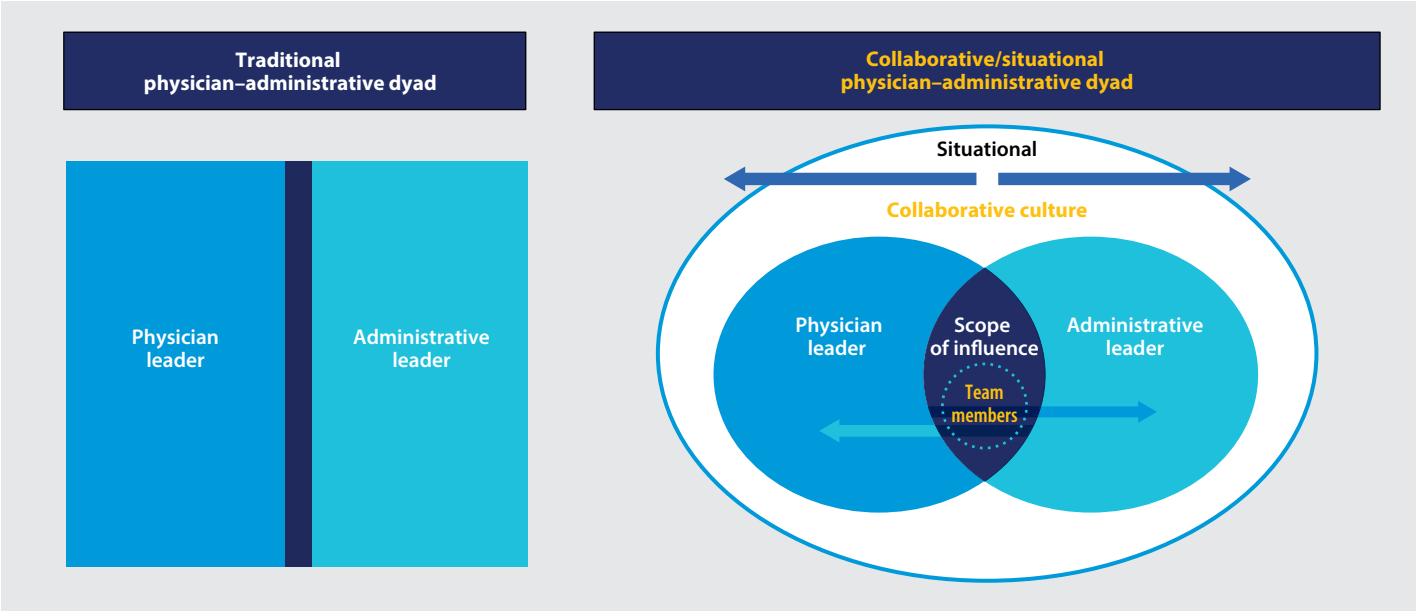

FIGURE. Traditional versus collaborative teams. Figure concept from Oostra.[16]

work together was successful beyond expectations, decreasing sick time taken by palliative care team staff members by almost 50%. The positive outcomes strengthened the partnership; several years later, they continue to trust and respect each other's expertise. They also continue collaborating on this project to spread joy at work, which carries over into promoting a culture of excellence and a supportive environment for patients and care providers. Their project's purpose remains the same—to promote an environment where staff enjoy coming to work, make fewer errors, take less sick time, and provide better patient care.

Clear and transparent communication

Effective, clear, and transparent communication is essential to the PQI dyad, as it supports positive learning experiences and successful project development. Additionally, transparent communication is necessary to ensure the dialogue between dyadic partners is respectful, timely, and intentionally focused on problem-solving rather than being task driven.[14] IHA PQI alumni describe problem-solving as the ability to "build bridges between management and physicians" and engage in "dialogue, bridging gaps in communication with other health care providers, [and] learning about barriers involved in doing so" [impact statements from survey participants].

Example: Handwritten notes. One of the PQI dyad projects addressed the need for improved communication between hospitalists, nurses, and allied health professionals. The need was identified due to challenges reading and interpreting handwritten notes and varying documentation styles. As a result, the dyad and interdisciplinary team developed and implemented a physician electronic note template, reducing the use of handwritten progress notes by 40%. Moreover, 90% of hospitalists agreed that electronic progress notes help them with complex discharges, and 100% agreed that e-documentation and the template improve handovers. This example shows the need for better communication and that intentionally collaborating with multidisciplinary partners elevates dyad problem-solving abilities, provides a platform for creative solutions, and can yield desired outcomes. The overwhelming support from alumni survey results underscores effective, clear, and transparent communication as a prominent factor in driving positive outcomes in their PQI project.

Mutual respect

Mutual respect is a positive feeling, specific action, or conduct toward another person.[12] The underlying premise of mutual respect is that each person is a professional specialist and their contributions to the dyad are equally valued. A PQI alumni survey participant described valuing each other and mutual respect: "We can't do this work without a dyad; it's that simple."

The reciprocal relationship and joint accountability between dyad partners are key characteristics critical to addressing potential conflicts and contradictions during the project.[18] A safe, respectful space must be created to reach the project's potential. To create a safe environment for dyads to succeed, there must be respect for each other and the team to face failure enthusiastically rather than as defeat.[19]

Complementary competencies

The dyadic leadership model incorporates complementary competencies or roles. When operational and medical leaders work in a dyad, each at the top of their skill set, capabilities, and competencies, it can allow a maximum return on their time and effort.[6,20] Complementary competencies are necessary because health care is a dynamic

and complex system; one leader does not have the capacity to be good at everything required. Moreover, an alumnus explained that being in a dyad "amplifies the ability to engage stakeholders in a multidisciplinary project" [impact statement from survey participant].

The IHA PQI program highlights the importance of complementary competencies by encouraging dyads to complete an IHA PQI dyad agreement before their project begins.

Example: Shared learning. Implementing the dyadic leadership model in the IHA supported collaborative relationships, clear and transparent communication, and shared vision between medical and operational partners for quality health care outcomes. Interestingly, each dyad partner wanted to learn more about each other's competencies during the project. They gained valuable insights through self-reflection and conversations to develop a more significant relationship to support the partnership throughout the project. By increasing physicians' knowledge of and experience in health care operations, they are better equipped to co-create solutions that support sustainable change. Additionally, physicians get a sense of partnership and belonging within the organization, which can facilitate integrating physicians and alleviate burnout.[13,15] An alumnus described complementary competencies as follows: "The power of the dyad is being able to make change much stronger together" [survey participant].

Summary

The IHA PQI program, with support from the Specialist Services Committee, plays a critical role in spreading the science of improvement throughout the Interior Health region. The dyadic leadership model provides a way for physicians to engage in the health care system meaningfully and effect positive change in patient care. The model of medical partners paired with operational partners was introduced as a change idea at the program's inception and has become expected by new participants. The overwhelming success of this change has demonstrated considerable benefits for the dyads, patient care, and the organization. The IHA PQI dyadic model activates people's agency on an interpersonal level with the hope and anticipation of increasing connectivity, trust, and innovation throughout the organization. ■

Competing interests
None declared.

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References

1. Clouser JM, Vundi NL, Cowley AM, et al. Evaluating the clinical dyad leadership model: A narrative review. J Health Organ Manag 2020;34:725-741.
2. Campanelli SM. The lived experience of healthcare leadership dyads: Perceptions of agency [doctoral thesis]. Maine: University of New England, 2019.
3. Waida E, Harper C, Harris D, et al. Dyadic leadership model—Why it works. 2024. In press.
4. Bodenheimer T, Sinsky C. From triple to quadruple aim: Care of the patient requires care of the provider. Ann Fam Med 2014;12:573-576.
5. Cortese DA, Smoldt RK. 5 success factors for physician-administrator partnerships. 23 September 2015. Accessed 23 August 2022. www.mgma.com/articles/5-success-factors-for-physician-administrator-partnerships-2.
6. Vremes C. A tale of two leaders: Dyad leadership model in healthcare organizations. 4 October 2018. Accessed 23 August 2022. www.semanticscholar.org/paper/A-Tale-of-Two-Leaders%3A-Dyad-Leadership-Model-in-Vremes/a561fef21fc2bb47a76854b02d5b4355a3c3c693.
7. Young R. It takes two: Can dyad leadership provide a durable pathway in healthcare's brave new world? Cardiovascular Business. 30 January 2017. Accessed 17 November 2022. https://cardiovascularbusiness.com/topics/patient-care/it-takes-two-can-dyad-leadership-provide-durable-pathway-healthcares-brave-new.
8. Buell JM. The dyad leadership model: Four case studies. Healthc Exec 2017;32:32-40.
9. Saxena A. Challenges and success strategies for dyad leadership model in healthcare. Healthc Manage Forum 2021;34:137-148.
10. Swensen S, Mohta NS. Leadership survey: Ability to lead does not come from a degree. NEJM Catalyst. 17 August 2017. Accessed 23 August 2022. https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0407.
11. Zismer DK, Brueggemann J. Examining the "dyad" as a management model in integrated health systems. Physician Exec 2010;36:14-19.
12. Sanford K, Moore SL. Dyad leadership in healthcare: When one plus one is greater than two. Lippincott Williams & Wilkins; 2015.
13. Swensen S, Pugh M, McMullan C, Kabcenell A. High-impact leadership: Improve care, improve the health of populations, and reduce costs. Institute for Healthcare Improvement. Accessed 8 June 2023. www.ihi.org/resources/white-papers/high-impact-leadership-improve-care-improve-health-populations-reduce-costs.
14. Clark RC, Greenawald M. Nurse-physician leadership: Insights into interprofessional collaboration. J Nurs Adm 2013;43:653-659.
15. Doctors of BC. Doctors of BC strategic framework – Better. Together. Making a difference for BC doctors. 2018. Accessed 24 August 2022. www.doctorsofbc.ca/news/doctorsbcstrategicframework.
16. Oostra RD. Physician leadership: A central strategy to transforming healthcare. Front Health Serv Manage 2016;32:15-26.
17. Senge PM. The fifth discipline, the art and practice of the learning organization. Perform Instr 1991;30:37.
18. Saxena A. Challenges and success strategies for dyad leadership model in healthcare. Healthc Manage Forum 2021;34:137-148.
19. Clausen C, Lavoie-Tremblay M, Purden M, et al. Intentional partnering: A grounded theory study on developing effective partnerships among nurse and physician managers as they co-lead in an evolving healthcare system. J Adv Nurs 2017;73:2156-2166.
20. Schwartz SK. Adopting dyad leadership in practices. Physicians Practice. 12 March 2016. Accessed 24 August 2022. www.physicianspractice.com/view/adopting-dyad-leadership-practices.