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Heart of Safety Coalition

Insights Huddle transcript

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Mitigate Leader Loneliness

Presenters: Jennifer K. Clark, MD, palliative care physician, consultant and author, Patrick Kneeland, MD, VP Medical Affairs, Dispatch Health, and Jennifer Krippner, Chief Experience Officer, Institute for Healthcare Excellence (IHE)
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Insights Huddles are a forum for leaders, learners, and advocates to share their bold voices and valuable insights. A mix between a webinar and a conversation, everyone from hospital executives to frontline clinicians are invited to set titles aside and put safety first. We share recordings of the didactic portions of Insight Huddles, and we summarize the discussions in written format. We hope this strikes the right balance between our aim to spread great ideas as far as possible and our desire to create psychologically safe forums where participants can ask questions and share stories with vulnerability. We believe that together we can spark big ideas and drive meaningful change for the safety and wellbeing of team members across our health systems.

Liz Boehm: Welcome, everyone. Thank you for joining today. My name is Liz Boehm, for those I don't know. I'm the Executive Strategist at Stryker. I manage the Coalition. Today we are recording this session and we will be distributing it out via the Coalition to members and guests and other folks who are interested in this topic because it is so critical. We have an amazing set of guest speakers today. We have Jennifer Clark, Dr. Jennifer Clark, who is a clinician, author, and consultant. She's the former CMO at Hillcrest, palliative care doctor by background.

We have Patrick Kneeland, who is a hospitalist by training, former Executive Medical Director for patient-provider experience at UCHealth. Patrick is currently the VP of Medical Affairs at Dispatch Health. Jennifer is the Chief Experience Officer at Institute for Healthcare Excellence and the former Director of Physician Development and Guest Public Relations at Maple Grove Hospital, which is where she and I met many years ago. The three of them have collaborated on research about leader loneliness. I don't know about you all, but I keep hearing conversations about leader burnout. I think this is such a timely topic.

One last comment before we jump in. I'd mentioned today's call will be recorded. Again, the reason we're here is nothing commercial. Our purpose is to advance the concepts outlined in the Declaration of Principles to improve safety for all healthcare team members. I am going to stop sharing and invite Jen, Jennifer and Patrick into this conversation. I want to start with opening up about this research, because you all just published a paper fairly recently on leader loneliness. Jen, maybe you can start by sharing a little bit about what you learned and why loneliness and how that might be different from burnout.

Dr. Jennifer Clark: Thanks, Liz. Hi, everyone. It's lovely to meet you all. I guess the most important thing is to understand the context by which this idea really came to fruition, because it's very personal for all of us. Gosh, nearly a year ago, last summer, several of us who have been involved in, re-humanizing medicine, that work, and particularly some of the work around what we've done previously in IHE had gotten together, and it was evident that there was some weightedness amongst all of us. There was a fatigue. There was definitely just a little bit of resignation, but there was really a significant amount of excitement about reconnecting together in person and had a lot of time to just think together and, frankly, feel together about what was really going on.

What is the next wave of the work that has already been done, started, gosh, now two decades, three decades ago, with quality and safety that really revealed, the onion peel as it keeps happening with burnout. Really what's the next layer? There's still something to be named, if you will around some ideas. It was on the heels of Vivek Murthy's production, I guess, or publication from the general surgeon's office around loneliness. As we were describing some of the experiences, there was so much parallel between what our own experiences were, what the loneliness was. All of a sudden there were enough c-suite people in the room to be like, "Hey, maybe this is the leadership version, the leadership manifestation of this broken healthcare system," if you will, that it was different than burnout.

It was naming what our own experiences were. We were lucky enough to have a safe space to really talk about that in an open way because when you talk about loneliness, it feels very, very personal and very, very isolating. That's what gave birth to that. I don't know if Jennifer and Patrick want to add a little bit more flavor to that story, but it really started with our own personal reflections and experiences giving rise to some language around the phenomenon. I don't know if Patrick, if you want to add anything, Jennifer?

Liz: I see they're nodding no. Jennifer, maybe, or Jen, maybe you can dig into a little, or any of the three of you can dig into what you uncovered in the research because the paper is just fascinating to dig into the prevalence, how this sort of interplay of personal needs and professional capacity starts to play off of itself and that sort of thing. Share a little bit about what you learned.

Dr. Jennifer Clark: Yes, the first question that we had to figure out was, is this burnout? Is it the same thing? We clinically just, or scientifically had to answer that question. Fortunately, our colleague, Tait Shanafelt, actually answered the question for us. There was an article that was published about c-suite healthcare, c-suite burnout, and it was really clear and evident in that science that it wasn't burnout. The things they named, though, was this idea, particularly of lack of self-care in the form of sleep was one of the big things that really led to this idea of devaluation, self-devaluation. When one doesn't sleep and have their basic safety needs met, their connection needs and the resultant isolation and loneliness that comes with it apparently appeared to be the result.

We answered that first question, is it burnout? If it is burnout, how is it different from clinician burnout and, really validating some of these ideas. Tait Shanafelt's work really demonstrated that for us. It was like, "Okay, so if it's not burnout then, and it is loneliness, then how is this really manifesting?" We started going into the psychological data on how loneliness manifests just as in humans in general. Particularly, this idea that was found in John Cacioppo's work at the University of Chicago, that loneliness is equivalent to hunger, that it is a primal psychological response to a fundamental need going unmet. As a result, it puts you in a state of hypervigilance, which then begets further loneliness.

We could see that happening in many of the people that we work with in ourselves. Then took the loneliness science and said, "Okay, how does this apply to leadership?" Surprisingly enough, when you look across all industry, we see writings about this in Harvard Business Review all the way back to 2012. It's continued to grow each year, if you pull out different data points around different industries that have looked at this. We can see it as a growing phenomenon. With Tait Shanafelt's work talking

about it not being burnout, pointing to some of the phenomenon that we see within the loneliness science, that we really think that healthcare leadership and its experience of loneliness is actually the equivalent of patient harm, clinician burnout and leadership loneliness is the trifecta, if you will, of the broken system.

Liz: Jennifer and Patrick, anything to add to that?

Jennifer Krippner: Yes, I think one thing that Jennifer touched on basically is that self-perpetuating loop of, "Okay, I'm working, I'm busy, I'm getting busier, I need to fill my day with more busyness. The busier I get, the less sleep I have, the less sleep I have, the harder it is then to be the leader that I really want to be. Then my decision-making gets compromised, my team becomes compromised, and I begin to just spiral." I think then that, you can be an N of one as a leader, and then that loneliness becomes even more pronounced. I think that's what we're finding when we're talking to people about this leadership loneliness. It's not, being a lonely leader. That's not what we're talking about.

We're talking really about a leadership phenomenon. It's really about being an N of one or an N of two in your organization. How do you create this community and this sense of community around your role and who do you have to go to create this sense of community with if you're in an organization where you're the only Chief Medical Officer, right, Jennifer? Patrick, I don't know if you want to add anything to that self-perpetuating loop thought process.

Liz: This idea of isolation, you start feeling this bad thing, so you double down on work, right? That's a big piece of your identity as a leader. Then what do you compromise? Something has to compromise if you're taking more time on work, so sleep is often the thing. That means you're unable to connect. If your sleep is compromised, you all wrote in the report as well, your team's experienced lower psychological safety. I think that's absolutely critical because if teams are feeling less psychologically safe, they're then girding against you, right? You are a risk in their environment and that becomes even more isolating. This loop is not as an individual problem, but a system problem. Similarly here, this shows the systemic nature of leader loneliness.

Dr. Jennifer Clark: Thanks, Liz. Yes, it took us a while to figure out how to craft that in such a way that it really articulated the systemic contribution to this individual manifestation of self-perpetuating loop. The three R's are involved. It's inherent, right? There are obviously key relationships that get sacrificed in all of this, oftentimes our personal relationships. Not only are you lonely at work because you're busy and keeping yourself busy and avoiding the obvious, but then as a consequence of that, the relationships that do support you outside the work environment are also sacrificed. There's further isolation in all domains of your experience. Roles, as Jennifer already talked about, by definition are isolating.

When you're an N of one, so you're the only Chief Medical Officer in the system or you're the only Chief Executive Officer in the system, it's hard to, as a consequence of your role, demonstrate vulnerability in anything. Obviously, you guys read about, and Brené Brown will tell you, vulnerability is at the heart of servant leadership and connected leadership. How do we teach people to be vulnerable, particularly when they're feeling disconnected and isolated? You have relationships that are consequence, roles that are reinforcing and then responsibilities that oftentimes puts you in opposition and create disconnection by itself just because of difficult responsibilities and roles that you have to play, decision-making being one of the biggest ones. We saw that throughout the research that there was this individual loop that is perpetuated by this system, what I call the shoulds, "You should do this, you should do that, you should be that," the should, the should, the should thing. It's this self-perpetuating loop that's fueled by the systemic issues.

Liz: I think it's worth pointing out and you all do in the paper that this isn't just for the leaders at the very top either, right? If you are elevated to a middle management position, you're often pulled out of direct peership with your friends, with your peers to a supervisory role, which suddenly means you can't have exactly the same relationship anymore, and that's isolating as well. You call out that there's not as much research around this lower level of management, but your hypothesis, if I got it correctly from the paper, is that this is across the board. Is that fair?

Dr. Jennifer Clark: Completely. As you and I've talked previously, that middle role where you have a hybrid of clinician responsibilities and you're at the frontline, but leading some of that, that's already a schizophrenic experience in and of itself, right? Where you're constantly challenged with priorities. You're pulled out of that clinical team in a way that gives you more responsibility and power, if you will, particularly in the hierarchy, that hidden curriculum, if you will, of medicine, these new leaders, particularly in those roles, become very lonely because they don't know how to navigate. We spend more time at work oftentimes than we do at home, particularly in healthcare. All of a sudden that vital connectedness that that person has now because of their new role, responsibilities, those relationships are at a consequential change and oftentimes collapse underneath that power. Sadly though, we don't see anybody writing about that yet. I think that's definitely something we want to explore and what different manifestations than what we see in the c-suite particularly.

Liz: Yes, and it also, I think, begs the opportunity for different kinds of, or additional training and support for leaders who are rising, right? There's already a fair amount of variability in what a rising leader gets in terms of training, support and what have you. It's often skills-based as opposed to relational, as opposed to self-care, as opposed to recognizing the differences of what it means to be in the organization that way. Maybe there's an opportunity for a both-and or a continuing curriculum that helps those leaders overcome that over time.

Dr. Jennifer Clark: I think that's really beautifully stated. One of the things, and Jennifer and Patrick have heard me talk about this ad nauseum, is David Foster Wallace, a famous author, gave a really amazing speech at Kent State where he talked about naming the water. The title of the speech is, This is Water. The classic picture you have in your head is a far side where you have one picture, there's an old fish swimming towards some young fish. The old fish says to the two young fish, "Hey boys, how's the water today?" The next picture is the young fish swimming away going, "What the hell's water?" I think as we are maturing in our way of practice, there's a lot of movement away from productivity as an isolated experience in our work as adults, but moving toward the mentorship model and really valuing mentoring.

I think there is something in that where we bring seasoned, well-developed leaders who have mentoring skills moving away from the productivity that's the typical part of middle life and more mature life, really bringing that, mentoring capability to these younger leaders. I think there's a way of developing that across that developmental continuum. Yes, so I think that's beautifully said, but I use David Foster Wallace's example, we're naming the water right now. It's a little bit taxing, particularly if you're not able to see it. Hopefully some of this really resonates with all of you in your experiences across your leadership career.

Liz: Yes, and that sounds like one more thing for senior leaders to take on, my friend Chip Conley's language of mentorship and mutual mentorship, I love, because those more seasoned leaders actually have a lot to learn often from the younger folks as well, whether that's a deftness with technology, whether that's how to relate to somebody of different generational status, or they're having grown up with some of the inclusion concepts that older folks, that are newer to older folks, whatever it might be, I think it doesn't have to be viewed as a one-sided transaction either.

Dr. Jennifer Clark: Yes, and I think, as we've seen in the paper, and then even in the science communities of practice, either around leadership or executive, that you can get it around, the most narrow of things. I think to your point, creating a community of practice where that sharing of learning across all paradigms is one of the major solutions that we see in the science that have addressed these more social isolating issues, particularly in higher level leadership.

Liz: Absolutely. Before we go on to solutions, I do want to spend the majority of our time on solutions, I want to just make one other connection or have you call out one other connection, because it's this link between leader loneliness and organizational languishing, right? You use this analogy in the paper that basically it's like, leader loneliness is like pre-diabetes, and it's the language, organizational language. It means that any other stress that comes onto the system, the system is no longer resilient to that stress in the same way that being predisposed to. Pre-diabetic means that COVID for example, is going to hit you harder or something like that. Can you talk a little bit about how leader loneliness leads to that organizational languishing, and then I want to shift to solutions.

Dr. Jennifer Clark: Yes, it's hard to try to find metaphors, but that one hit me smack in the face. Yes, thinking about leader loneliness and the languishing systems, it's the canary in the coal mine to a collapsing or dysfunctional system. That's the pre-diabetes of that whole situation is where it came into play and where it comes down to, and Patrick and Jennifer can really talk to their own experience in this, and it's what we were seeing is that when you are experiencing loneliness, you have a nervous system that is dysregulated, period.

You're in a hypervigilant state. Your ability to creatively think and innovate goes down, way down in manifestation. Decision-making becomes analysis paralysis, ruminating, up waiting, whatever it happens to be. Major decisions don't get made, and much of the work is in the letter of the law and not the spirit of the law. As a result that the things start getting backed up and put downstream, and all of a sudden, the system has an insult like COVID or some financial hit or something.

Liz: Cyber security, who knows?

Dr. Jennifer Clark: Yes, oh yes, cyber security. That, all of a sudden takes a very fragile, what is the fragilely held together, almost a house of cards system, and it collapses it. We saw some of that post-pandemic and said, "Okay, what happened in those systems? What were the things?" Some of that was in the loneliness that we saw in the leadership because they left shortly thereafter, or, in and around that. That's so, what is the other thing that we saw is this massive, exodus of leadership that actually pointed out in one of his online webinars or something on IHI. Try to figure, add that into it. That was part of what we were seeing. Patrick, do you have anything do you want to add to that piece of that?

Dr. Patrick Kneeland: Not specific with that, no.

Liz: Okay, is there anything different you want to add, Patrick?

Dr. Patrick Kneeland: I was just going to weigh in on some earlier comments around the nature and some of the research. One piece I think that's really important, as important as it has been when we're talking about burnout amongst clinicians and nurses. This is impacting people who are showing up to work and are in their positions that they're in for all the right reasons, showing up to do their best work, care deeply and passionately about the outcomes that their leadership is impacting. I think that's a really important element around this as well.

I think at times, as folks progress into leadership roles, there can be a perceived distance from the clinical frontline to the levels of leadership around what's really in their heart. I think what we know and what we've seen in the leadership is part of the conundrum here is people care so deeply about

their clinicians that work in their organizations, et cetera, that it's part of what drives, at times a sense of despair in terms of really meeting those outcomes. I just wanted to pull that thread through as well.

Liz: Yes, I think it's interesting to note that I think a lot of frontline folks feel like leadership aren't dealing with the kinds of life and death or morally distressing kinds of decision-making that the frontline people see because they're seeing the direct impact on patients more closely. The leaders are, particularly leaders who have come out of any clinical or who are staying connected to the frontlines, they have that same cognitive and emotional load and the moral distress of the consequences of making decisions within finite resources that they know have an impact on their teams, they know have an impact on patient-family experience and all that stuff. Is that fair?

Dr. Patrick Kneeland: Totally agree with that.

Liz: Let's look at what we do about this, right? If this is a systemic challenge, if this is something that is like burnout, something we need to address with system change, what are some of those system changes? What are you seeing organizations do or even play with? I know this is still somewhat emerging. Where do people go with this?

Dr. Patrick Kneeland: Yes, maybe I'll pick up the thread first and ask for inputs. Again, my own foray into this work in general started with work early on in my career on quality and safety, quickly realizing that frontline folks, physicians, nurses, et cetera, who are showing up burned out are not going to be able to help improvement efforts. Similarly, leaders who are experiencing elements of burnout and loneliness, it just impacts our ability to execute in all levels and wanting to turn attention to solutions that actually foundationally support the human experience of the workforce, including leaders and even executive folks around this work. I think, we've honed in on, and again, citing the research in the paper around on at least three domains that are really important to think about when we look at solutions.

One is efficiency. To the earlier point, we can't be sending, asking people to spend five hours at night working on not being lonely or being more relational with other leaders across the country, et cetera. That efficiency, both in terms of the individual experience, but also the organizational design has to be part of the solution. Can't be yet another add-on. The second is empathy around which we, when we say that in this context, we mean the ability to connect and engage in the work. Again, not socializing after work or whatnot, but really how do we build into the work that ability to experience each other as human beings? Then third is energy and how do we promote elements of interaction that actually promote, enthuse, and sort of renew what's limited energy.

Listening to an Adam Grant podcast recently, the organizational psychologist, he was talking about leadership with Yo-Yo Ma, actually. Yo-Yo Ma, one of his comments was talent and talented people are somewhat infinite. I think we see that in our colleagues, but energy is not. The ability to really make sure that energy is being renewed and thoughtful in terms of those outcomes and actual solutions is really important. If we think about it in those three buckets, efficiency, empathy and energy, there's some concrete things that sort of jump out around what are some of the solutions.

Dr. Patrick Kneeland: In terms of those three, the main, certainly the mentorship idea and facilitating and getting formal spaces for folks to connect both within the organization, but also across organizations, cohorts like this one that's online right now, participating around that mentorship and sharing the wisdom of the group in a formal way, certainly part of that solution. Two is really, I think, we talk about the technical skills related to do these jobs. Most people have those skills by the time they are moving up the chain into leadership roles.

Sometimes those need to continue to be developed, but those relational skills oftentimes looked at as the soft part of what we do. We tend to think of those as being more core to what we do. There's tangible ways to give skills, particularly for connectivity to leaders or teams of leaders to practice with each other. Continue to hardwire those specific skills. Then third is really around building those skills and that ability to connect into system design, so that human-centered design, and actually solving some of the organization's most complex problems with each other in a way that actually preserves and renews energy rather than feeling like it's so overwhelming and that some version of nihilism is what we're left with.

I'll stop there and see if Jennifer, either of the Jennifers, have anything to add when we're talking about solutions here.

Jennifer Krippner: Thanks, Patrick, for outlining that. I think it was a good recap of where IHE's solutions were really centered around the thought process around leadership loneliness as we came up with the paper, and really thinking about framing it not from a deficit-focused issue or problem, but really thinking about it as from how are we going to move forward as a connected leader and as a connected leadership team. Really thinking about it from efficiency, empathy, and that energy perspective, really how do we move forward in a way that's different than before. Thinking about it from a connected leadership standpoint in framing it from a place of thriving and connection and community and just wanting to frame it that way versus from a place of loneliness. Curious as to, Jen Clark, or anybody on the call, from what you've heard so far, and Liz, maybe have you take it from here, too. Love to get some insights on some of the solutions that you're seeing or hearing.

Liz: Jennifer, one of the things I'm remembering, and this was probably 10 years ago at Maple Grove Hospital, was that you had an all-leadership huddle. I think it was once a week with literally all the leaders getting together in a room. It was a way of two things. One was to eliminate all of the one-on-one-on-one-on-one-on-one, meetings. I don't know that we thought about this, or at least I didn't recognize this at the time, that idea of everybody in the room together. There's something valuable and powerful in that. Sometimes there are specific practices that can hit both the efficiency, the empathy, all three now, and the energy piece of it by being thoughtful about how leaders get together or don't get together, whether it's always transactional, whether it's always sort of committee-focused, that kind of thing. I was just remembering that the energy in that room was very positive when I was there.

Jennifer Krippner: Yes, it's that intentional practice, Liz, around building those always events of, "When are you going to get together, how are you going to get together," and then creating a way that builds that community so that when you do share information, that you have started to build that trust and the respect of your people that you're leading with. I think that's really important. Thanks for remembering and for noticing, but it has to begin with an intentionality.

Liz: I want to say a huge thank you to Jen, Jennifer, Patrick, for doing the research, for putting this out there, for being brave enough to enter into this conversation while this is still such an evolving space where you don't have all the answers. It's much easier to talk about something that's clear-cut and what have you. To all of you for joining in and recognizing, and as Jenn said, putting the name to something that all leaders are grappling with, managing in some way, shape, or form. We will be following this up with a recap as usual. You should feel free to share it because the more we can get people into this conversation, the more we'll start to have answers to some of those questions. Thank you all. Thank you, Jen, Jennifer, and Patrick. We thank you all for being committed to your own and your team's safety and wellbeing.

Thank you to all of our Insights Huddle speakers and participants. We don't share the discussion portion of Insights Huddles publicly, so we can foster a safe environment where participants can be candid and share vulnerable and valuable experiences. Insights from the group discussion are summarized in the recap with supporting resources. If you have questions about this topic or have an idea for a future Insights Huddle to help improve the safety and wellbeing of team members, email us at heartofsafetycoalition@stryker.com. You can also sign up to join Insights Huddles live on the Heart of Safety website. The views and opinions expressed in this Insights Huddle are those of the speakers and do not necessarily reflect the views or positions of Stryker. Thank you for looking after the safety and wellbeing of healthcare team members.

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About the Heart of Safety Coalition

The Heart of Safety Coalition places care team member safety and wellbeing at the heart of healthcare. This national community of leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systematic and individual change. The Coalition works to advance the Heart of Safety Declaration of Principles, which intersects health justice, physical safety, and psychological and emotional wellbeing to accelerate transformation. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at www. HeartofSafetyCoalition,com.