



**Karolinska  
Institutet**

**Pathfinder:**  
***Duncan Neuhauser showing the way in  
the Nordic countries***

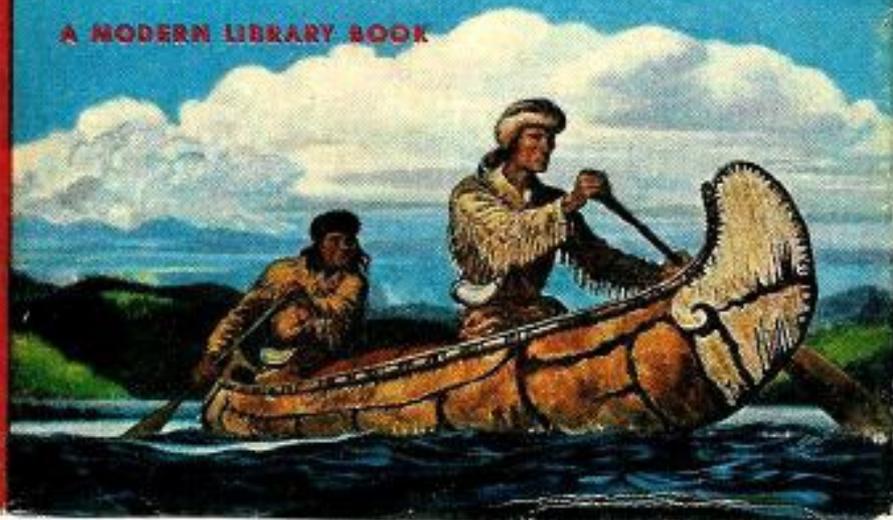
Professor Mats Brommels, MD PhD  
Founding Director  
Medical Management Centre

26 April 2024

The critics' choice—and the author's own  
favorite—of the Leatherstocking Tales, with an  
Introduction by Norman Holmes Pearson

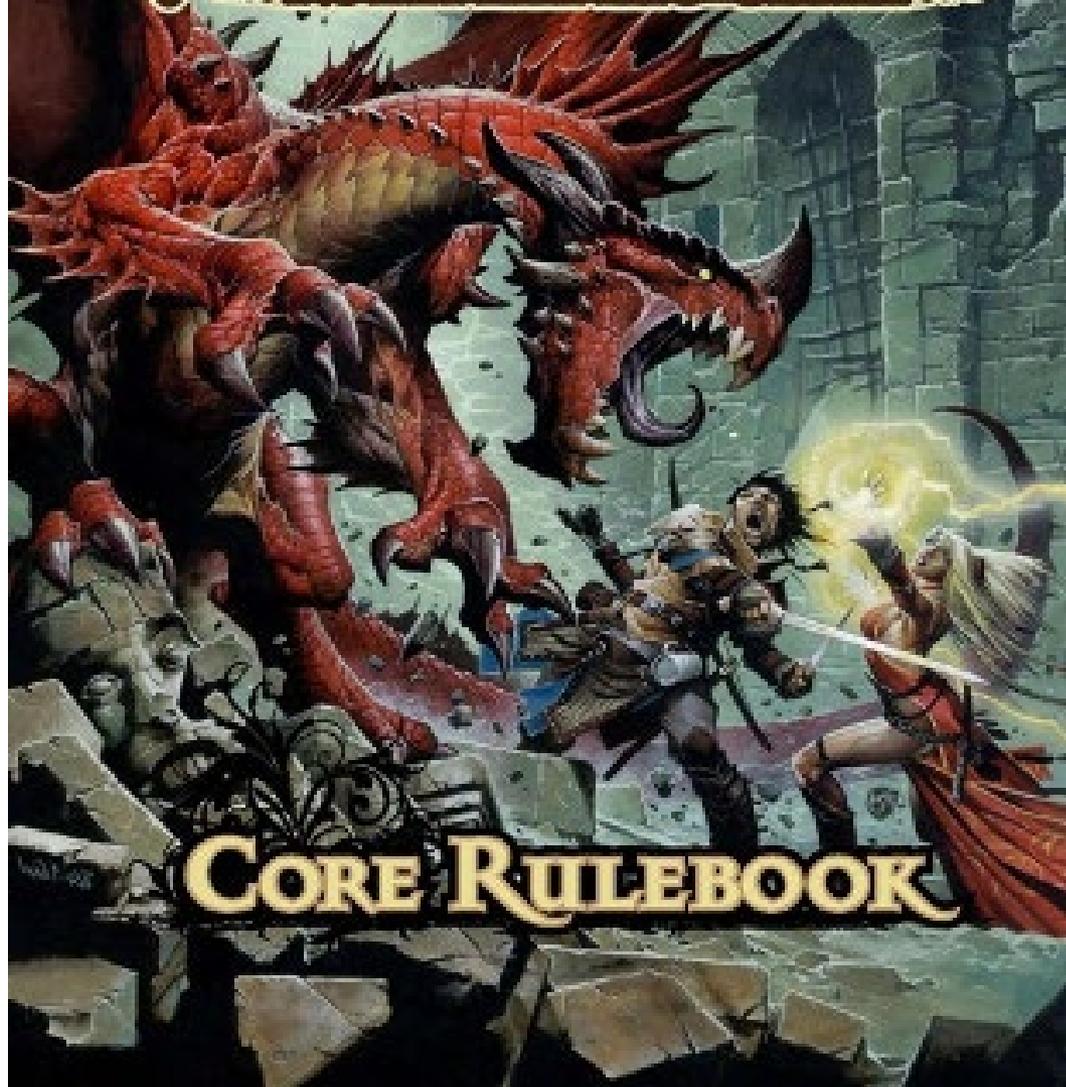
THE  
Pathfinder  
BY  
James Fenimore Cooper

A MODERN LIBRARY BOOK



# PATHFINDER

ROLEPLAYING GAME



## CORE RULEBOOK

# show (someone) the way

*idiom*

to do something original that others are likely to copy:

show (someone) the way forward *Sweden has shown the way forward on energy efficiency.*

Definition of **show (someone) the way** from the [Cambridge Advanced Learner's Dictionary & Thesaurus](#) © Cambridge University Press



# Agenda

- Duncan finding his way to the Nordic countries
  - Duncan introducing
    - Health technology assessment
    - Health economics
    - Quality improvement
    - Healthcare management
  - Duncan inspiring and supporting
    - The Medical Management Centre
-

# Odin W. Anderson and Duncan Neuhauser travel to Sweden

- Odin W. Anderson (1914-2003), University of Chicago
    - Research director of the Center for Health Administration Studies
    - Professor in the Department of Sociology and the Graduate School of Business
    - Said to be father of medical sociology
  - Duncan E. Neuhauser
    - Alumnus of the Graduate School of Business, University of Chicago (and the University of Michigan Program in Health Administration; and much more)
  - Department of Social Medicine, Uppsala University
  - Nordic School of Public Health, Gothenburg
-

**Health  
Care:  
Can there  
be equity?**

**The United States,  
Sweden, and England**

**ODIN W. ANDERSON**

## Odin W. Anderson: Can there be equity?

- Review by Bess Dana and David Banta, Department of Community Medicine, Mount Sinai School of Medicine:
  - "... a rather 'free-wheeling' book .... a comprehensive review of the social, political, economic and historical literature of the three countries; and discussions of problems and issues with forty to fifty leaders in both Sweden and Great Britain."
  - "A rational defense for the pursuit of equity as a goal for health care delivery and as an objective measure for evaluating the success of a system."
-

# Health technology assessment

- Discussions started in the US in the early 1970's



- OTA 1974-1995
  - Broad view on evaluation: clinical, economic, social, ethical and legal perspectives
  - Methods development promoted by the Institute of Medicine
-

# Assessing Medical Technologies

*The National Academies of*  
SCIENCES • ENGINEERING • MEDICINE

# Assessing Medical Technologies

Committee for Evaluating Medical Technologies  
in Clinical Use  
Division of Health Sciences Policy  
Division of Health Promotion and Disease Prevention  
Institute of Medicine

NATIONAL ACADEMY PRESS

Washington, D.C. 1985

Copyright National Academy of Sciences. All rights reserved.

---

ACKNOWLEDGMENTS

\*David Eddy, Duke University

\*Richard H. Egdahl, Boston University Medical Center

Penny H. Feldman, Harvard School of Public Health

\*Harvey V. Fineberg, Harvard School of Public Health

G.D. Friedman, The Permanente Medical Group

Clifton R. Gaus, Foundation for Health Services Research

George Greenberg, U.S. Department of Health and Human Services

Paul F. Griner, The Henry J. Kaiser Family Foundation

\*Ruth S. Hanft, Consultant

Richard J. Havlik, National Heart, Lung, and Blood Institute

Paul Jones, Case Western Reserve University School of Medicine

\*Albert R. Jonsen, University of California, San Francisco

Edward H. Kass, Harvard Medical School

Jeffrey P. Koplan, Centers for Disease Control

John Laszlo, Duke University Medical Center

\* Robert H. Moser, American College of Physicians

\*Duncan B. Neuhauser, Case Western Reserve University School of Medicine

Joel J. Nobel, ECRI (formerly the Emergency Care Research Institute)

\*Gerald T. Perkoff, University of Missouri-Columbia School of Medicine

Michael R. Reich, Harvard School of Public Health

Janet Reis, Northwestern University Center for Health Services and Policy Research

Stanley J. Reiser, The University of Texas Health Science Center at Houston

Pierre F. Renault, National Institutes of Health

J. Sanford Schwartz, University of Pennsylvania

\*Sam Shapiro, The Johns Hopkins University

Donald Shepard, Harvard School of Public Health

Herbert Sherman, Harvard School of Public Health

Jonathan Showstack, University of California, San Francisco

\*Renel A. Stallones, University of Texas Health Science Center at Houston

# History of health technology assessment in Sweden

Egon Jonsson

University of Alberta and University of Calgary and Institute of Health Economics

-----

Duncan Neuhauser from Harvard School of Public Health had visited Sweden regularly since the early 1970s, generating further interest in HTA among Swedish researchers (9). In 1973, he introduced the author of this study to key figures at the Harvard Center for the Evaluation of Clinical Procedures, among them Howard Hiatt, Harvey Fineberg, Milton Weinstein, William Stason, and Fred Mosteller. These individuals, and their new ideas about the need for broad-based assessment of health practices, had a substantial impact on later events along the road toward forming a national agency for HTA in Sweden. Duncan Neuhauser has served on the Editorial Board of the Journal since 1985.

In the early 1980s, Spri and its counterparts in Denmark (Danish Hospital Institute), Finland (Finnish Hospital League), Norway (Norwegian Hospital Institute), and later with representation also from the Ministry of Health in Iceland, initiated discussions about collaboration in medical technology assessment. Eventually a collaborative body known as NEMT (Nordic Evaluation of Medical Technology) was established and began working on issues concerning appropriate diffusion and use of technologies such as MRI, prostate cancer screening, and coronary bypass surgery. Independent of NEMT, Spri conducted several assessments of MRI at that time (28).

# Health technology assessment in Finland

**Marjukka Mäkelä**

*University of Copenhagen and Finnish Office for Health Technology Assessment*

**Risto P. Roine**

*Uusimaa Hospital District*

The Finnish Society for Technology Assessment in Health Care was established in 1987. Early adopters of the HTA idea acquired training abroad. Finland was represented on the Board of ISTAHC and arranged to hold its international congress in Helsinki in 1991. Technology assessments were produced by university groups and national research institutes, and consensus conferences flourished. Finland participated actively in European projects developing HTA, notably EUR-ASSESS.

## Networking from the Start

Finohta was established at Stakes in 1995; its task was to support and coordinate HTA-related work in Finland and to promote and mediate high-standard, multidisciplinary assessment research. Some HTA was already taking place at universities, the National Agency for Medicines, and the SII, without much coordination of methodologies or topic areas (7).

# Health technology assessment

- Swedish Agency for Health Technology Assessment (SBU)
    - Founded in 1987
  - Preceded by the Nordic Evaluation of Medical Technology network in 1984
  - Finnish Office of Health Technology Assessment (FinOHTA)
    - Founded in 1995
    - Preceded by the establishment of the Finnish Society for Technology Assessment in Health Care in 1987
  - Norway 1997
  - Denmark 2001
-

# Health economics

- Egon Jonsson: head of the health economics unit at Spri (Federation of County Councils) and first (adjunct) professor of health economics at Karolinska Institutet
  - Cooperated with Duncan Neuhauser at Harvard already in the 1970's
-

## **EDITORIAL**

### *The Nordic Health Economists' Study group (NHESG) 35 years*

The first meeting in Sweden in 1980 had about 40 participants representing all five Nordic countries and with Professor Alan Williams from the University of York as a guest. Both economists and researchers from social medicine attended as well as representatives from local government and the industry. Since then, NHESG has held annual meetings in one of the five Nordic countries in a fixed rotation, and the list of participants – both from Nordic countries and from outside - has increased substantially and thereby contributed to the stated purpose to further the continuous development of health economics as a sub-discipline of economics, and to set standards for excellent research.



## Cost Containment: An Economist's View

DUNCAN NEUHAUSER, PhD  
*Cleveland*

Now I AM **NOT** a card-carrying, board-certified and fully licensed **medical economist**. In spite of this and other shortcomings too numerous to mention, let me answer a few basic health economics questions in a way that cuts through the arcane words and numbers with which economists usually surround themselves.

## WHAT DO WE GAIN FROM THE SIXTH STOOL GUAIAIC?

DUNCAN NEUHAUSER, PH.D., AND ANN M. LEWICKI, M.D.

**Abstract** The six sequential stool guaiac protocol has been advocated for screening of colonic cancer. Analysis of the expenditures involved in such a program shows that the cost of detecting cancer rises exponentially so that the marginal cost of the sixth test may be 20,000 times the average cost. The marginal cost is decreased with lower test sensitivity and in-

creased with lower prevalence of colonic cancer. This result shows that even an inexpensive test can become quite costly in terms of cases detected. The marginal cost per case detected depends on the prevalence of the condition in the population screened and the sensitivity of the test applied. (N Engl J Med 293:226-228, 1975)

# Quality Improvement

- Duncan at the Nordic School in the late 1980's: "Here is something you need to start doing!"
  - QI courses for healthcare managers in Sweden and Finland
    - Federation of County Councils (Lf) – Margareta Palmberg
    - City of Helsinki Health Services – Mats Brommels
    - Linda Headrick and Edward McEachern
  - Jönköping County the first to "fully embrace QI"
  - IHI, National Forum - Scientific Symposium – Summer Camp
  - Personal QI – Michael Bergström, Lf
  - EurIPEC - Michael Bergström and others
  - QI analysis methods possible to apply in clinical and management research
-

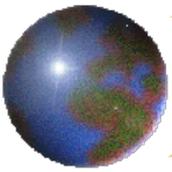
# Federation of County Councils, Sweden

## Margareta Palmberg

- QUL Award (Quality, Development, Leadership)
    - Inspired by the Malcom Baldrige Award
    - Developed with the Swedish Institute for Quality and emulating the National SIQ Award
    - Presented annually to distinguished healthcare provider
  - Healthcare Leader's Network
  - Breakthrough Series – Improvement Collaboratives
  - Quality Registries – National Board of Health
-

# Personal QI

- Cleveland/MetroHealth Workbook
  - Translated into Swedish (Michael Bergström) and Norwegian (Jane Mikkelsen Kyrkjebøe) – (and into Russian, Chinese, Turkish ...)
  - Content
    - What is QI?
    - How can I improve?
    - What's in it for me?
    - Will it take a lot of time?
    - How can it help in my daily practice?
  - Personal improvement project
-



## **Cleveland group:**

Linda Headrick  
Silvia Kashkosh  
Duncan Neuhauser  
Shirley Moore  
& MB  
Visit to Cleveland  
1998

(Michael Bergström)



(Michael Bergström)

## EurIPEC

- Interdisciplinary Professional Education Collaborative (IPEC)
    - “A 1993 to 1999 demonstration project on IPE in quality improvement sponsored by the Institute for Healthcare Improvement and the Health Resources and Services Administration/Bureau of Health Profession.”
    - “In 2009, the IPEC was established ‘to advance substantive interprofessional learning experiences to help prepare future health professionals for enhanced team-based care of patients and improved population health outcomes.’
    - “This group published the first set of core competencies for interprofessional collaborative practice in 2011”. (Pesut, Headrick, Holmboe, Moore 2023)
  - A European counterpart was established in 1996 with the support of Duncan and Linda
-

# Euripec - Stockholm May - 99



(Mikael Bergström)

# Bologna 2001



(Mikael Bergström)

# New quantitative methods of QI analysis can be applied more widely in management research

- Statistical Process Control (and time-series more generally)
  - Design of experiments
  - Operations management approaches to improve service provision
-

## DEVELOPING RESEARCH AND PRACTICE

# Application of statistical process control in healthcare improvement: systematic review

Johan Thor, Jonas Lundberg, Jakob Ask, Jesper Olsson, Cheryl Carli, Karin Pukk Härenstam, Mats Brommels

---

*Qual Saf Health Care* 2007;**16**:387–399. doi: 10.1136/qshc.2006.022194

# The One-Person Randomized Controlled Trial

*Jesper Olsson, PhD; Darcey Terris, MBA; Matthias Elg, PhD; Jonas Lundberg, MSc;  
Staffan Lindblad, MD, PhD*

As with every experimental process, the first step is to clearly define the problem to be investigated. For our example, the participant had a long-standing problem with insomnia, characterized by sleep of short duration and poor quality. He previously tried short periods of various behavioral changes, but had experimented in an unsystematic manner. As a result, he did not find any factor that appeared to influence the quantity or quality of his sleep. Upon the suggestion of his fellow author, the participant agreed to undergo a systematic investigation of the effects of the various behavioral interventions, based on a simple DOE design.

# Healthcare Management

- Quality improvement
    - Systems
    - Processes
  - Managing patient processes within a system – focusing on the core task of healthcare
-

## The Karolinska Institutet President gets a crazy idea

- KI – the *medical university* – excelling in biomedical and clinical research - should also make contributions to the development of health services
  - Working group – Secretary: Johan Thor, MD MPH, a graduate of the Harvard School of Public Health, and early scholar of quality improvement
  - Proposal: to establish the Medical Management Centre
-

# Medical Management Centre

## *Mission*

- *Improve health care* as a contribution to KI's mission to improve people's health
  - More specifically, by developing useful knowledge on organising and managing health care, to promote *safe, high-quality* and *cost-effective* medical services
-

# Medical Management Centre

## *Goal*

- Establish management knowledge as an academic discipline in its own right at the medical university
  - Make a management career legitimate, visible and attractive among health professionals
-

# Medical Management *Value*

- To, through collaborative research and knowledge transfer, create space and give legitimacy to managers of professional organisations acting in a political environment
  - "We have solid evidence ...."
  - "We have a useful theory (plausible hypothesis) that we intend to test and evaluate ..."
-

## MMC: Next generation and a diversified portfolio

Health Systems and Policy	Clinical Management	Leadership and Group Counselling	Cancer and Palliative Care	Health Economics	Improvement, Innovation & Implementation	Bioentrepreneurship
	↓	↓	↓	↓	↓	↓
→ Clinical Informatics	Clinical Management	Leadership in healthcare and academia	Innovative Care	Health Economics and Policy	PROCOME: Implementation of innovative improvement programmes	Bioentrepreneurship & Innovation
→ Health Systems Safety				→ Health Economic Evaluation	→ SOLIID: Organisational learning and improvement in health and social care	

# Medical Management Centre 2002-2023

- From a modest start to on the average 50 staff, 4 doctoral students full-time and 4 part-time, 30 affiliated researchers
  - Production
    - 55 dissertations
    - Over 1,000 articles in international peer-reviewed journals, more than 200 other publications
    - € 45m in competitive research funding
-

## Duncan as a friend, mentor and supervisor at the MMC

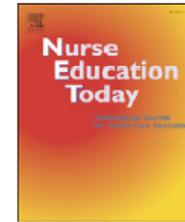
- Annual visits
  - Pep-talks with senior researchers
  - "The Cleveland Clinic" for doctoral students
  - Active participant at annual PhD student retreats
    - Commenting presentations
    - Supervising and evaluating "one-hour paper" teams (two of those papers published)
-



Contents lists available at [ScienceDirect](#)

Nurse Education Today

journal homepage: [www.elsevier.com/nedt](http://www.elsevier.com/nedt)



## Turning the tables: When the student teaches the professional – A case description of an innovative teaching approach as told by the students

Carl Savage <sup>a,\*</sup>, Shirin Amanali <sup>b,1</sup>, Agneta Andersson <sup>b</sup>, Susanne Carrera Löhr <sup>b</sup>, Zenitha Eliasson <sup>b</sup>, Hanna Eriksson <sup>b</sup>, Anette Erlandsson <sup>b</sup>, Sofia Goobar <sup>b</sup>, Jenny Holm <sup>b</sup>, Claudia Johansson <sup>b</sup>, Elin Langendahl <sup>b</sup>, Amie Lindberg <sup>b</sup>, Jennifer Lundin <sup>b</sup>, Anna Uhrdin <sup>b</sup>, Ulrica von Thiele Schwarz <sup>a</sup>

<sup>a</sup> Medical Management Centre, Karolinska Institutet, Stockholm, Sweden

<sup>b</sup> School of Nursing, Karolinska Institutet, Stockholm, Sweden

**Results:** Thirteen nursing students created three CNE courses together with sixteen nurses. Each course consisted of multiple 20-minute long web-based modules with automatic formative feedback. In the process, students exceeded course outcome-levels, journeyed from chaos to confidence and experienced new ways of viewing the group and their own capabilities.

**Conclusions:** The innovative design of the course moved the focus from student-centered learning to learning by contributing to health care. Working in a real world context, the content of the students' efforts and the skills they developed not only met course requirements, but were also aligned with the needs of the wards. This contribution was valued by the students and the RNs which enhanced students' feelings of self-confidence. Further research lies in testing the model in other contexts.

# The One-Person Randomized Controlled Trial

*Jesper Olsson, PhD; Darcey Terris, MBA; Matthias Elg, PhD; Jonas Lundberg, MSc;  
Staffan Lindblad, MD, PhD*

As with every experimental process, the first step is to clearly define the problem to be investigated. For our example, the participant had a long-standing problem with insomnia, characterized by sleep of short duration and poor quality. He previously tried short periods of various behavioral changes, but had experimented in an unsystematic manner. As a result, he did not find any factor that appeared to influence the quantity or quality of his sleep. Upon the suggestion of his fellow author, the participant agreed to undergo a systematic investigation of the effects of the various behavioral interventions, based on a simple DOE design.

# Building on insights from Quality Improvement

- Clinically oriented operations management studies
    - Lean applications in hospitals
    - Time-based activity-based costing
    - Applying complexity science to promote improvement
  - Medical leadership
    - Benefits of professionally-guided leadership
    - Qualities and capabilities of successful medical leaders
-

# Complexity complicates lean: lessons from seven emergency services

Pamela Mazzocato

*Medical Management Centre, Karolinska Institutet, Stockholm, Sweden*

Johan Thor

*Jonkoping Academy for Improvement of Health and Welfare,  
Jonkoping University, Jonkoping, Sweden and Medical Management Centre,  
Karolinska Institutet, Stockholm, Sweden*

Ulrika Bäckman

*Medical Management Centre,  
Astrid Lindgren Children's Hospital/Karolinska University Hospital,  
Stockholm, Sweden*

Mats Brommels and Jan Carlsson

*Medical Management Centre, Karolinska Institutet, Stockholm, Sweden*

Fredrik Jonsson

*Karolinska University Hospital, Stockholm, Sweden*

Magnus Hagmar

*Department of Women's and Children's Health, Division of Obstetrics and  
Gynecology Karolinska Institutet, Stockholm, Sweden, and*

Carl Savage

*Medical Management Centre, Karolinska Institutet, Stockholm, Sweden*

**Findings** – The complexity of the care process influenced how improvement in access to care was achieved. For less complex care processes (ENT and gynecology), large and sustained improvement was mainly the result of a better match between capacity and demand. For medicine, surgery, and pediatrics, which exhibit greater care process complexity, sustainable, or continual improvement were constrained because the changes implemented were insufficient in addressing the higher degree of complexity.

**Originality/value** – The variation in process performance and sustainability of results indicate that lean efforts should be carefully adapted to the complexity of the care process and to the educational commitment of healthcare organizations. Ultimately, the ability to adapt lean to a particular context of application depends on the development of routines that effectively support learning from daily practices.

# BMJ Open Time-driven activity-based costing for patients with multiple chronic conditions: a mixed-method study to cost care in a multidisciplinary and integrated care delivery centre at a university-affiliated tertiary teaching hospital in Stockholm, Sweden

---

George Keel ,<sup>1</sup> Rafiq Muhammad,<sup>1</sup> Carl Savage ,<sup>1</sup> Jonas Spaak,<sup>1,2</sup> Ismael Gonzalez,<sup>1</sup> Peter Lindgren,<sup>1</sup> Christian Guttman,<sup>1</sup> Pamela Mazzocato<sup>1,3</sup>

**Results** This modified TDABC analysis costed outpatient care for patients with multiple chronic conditions. The approach accounted for the difficulty of conceptualising care cycles. The estimated total cost, stratified by resources, can be reviewed together with existing managerial accounting statements to inform management decisions regarding the multidisciplinary centre.

RESEARCH ARTICLE

Open Access

# Make it complicated: a qualitative study utilizing a complexity framework to explain improvement in health care



Marie Højriis Storkholm<sup>1,2</sup>, Pamela Mazzocato<sup>1</sup> and Carl Savage<sup>1\*</sup> 

Situation	Problem universe	Response	Locus of responsibility	Kind of work	Decision-making process
Simple	Ordered with clear causality	Requires implementation	Manager	Technical	Sense Categorize Respond
Complicated	Ordered with clear causality but little oversight	Requires analysis	Manager and staff	Technical and adaptive	Sense Analyze Respond
Complex	Unordered without clear causality	Requires learning	Staff more important than manager	Adaptive	Probe Sense Respond
Chaotic	Unordered, unstable	Requires action	Manager	Technical	Act Sense Respond

# BMJ Open Medical leadership: boon or barrier to organisational performance? A thematic synthesis of the literature

---

Mairi Savage , Carl Savage , Mats Brommels, Pamela Mazzocato

Savage M, et al. *BMJ Open* 2020;**10**:e035542. doi:10.1136/bmjopen-2019-035542

# Healthcare benefits from clinically qualified managers

- **Quality of care** (Ham 2003, Lega *et al.* 2013, Sarto & Veronesi 2016, Clay-Williams *et al.* 2017)
- **Management of operational and financial resources** (Spurgeon *et al.* 2011, Dickinson *et al.* 2013, Veronesi *et al.* 2016)
- **Staff work satisfaction, retention, performance, and reduced burnout** (Menaker *et al.* 2008, Shanafelt *et al.* 2015)
- **Psychological safety, respect, and shared goals** (Wholey *et al.* 2014)
- **Approval and support for political reforms** (Martinussen *et al.* 2011)
- **Adoption of information technology** (Ingebrigtsen *et al.* 2014)

# From medical protectionism to management through medicine

## Medical protectionism

- Safeguard physicians' role, identity, influence
- Going over to the “dark side”, concerns about losing credibility among clinical peers
- Struggling heroes “working against the odds or as righteous victims struggling in the face of adversity”
- Use managerial strategies to protect their autonomy and avoid control

## Management through medicine

- Ensure that management decision have positive impact on care and clinical outcomes
- Expert knowledge is integrated through openness, trust, respect and cooperation
- Leadership as a collective decision-making process where clinicians can enhance their identities

# From command and control to participatory leadership practices

## Command and control

- Bureaucratic, policy-driven and hierarchical workplaces
- Decentralisation that results in role ambiguity and makes physicians rely on their status
- Sense of powerlessness from:
  - Being held accountable for (externally imposed) performance measures with no authority, staff, budget, time etc
  - Values conflict
  - Lack of peer support

## Participatory leadership

- Inclusive leadership behaviours:
  - Soliciting team input
  - Participatory decision making
  - Building a shared vision
- Dialogue to align quality and safety agendas
- Co-designing performance measures:
  - Provides autonomy
  - Meaning
  - Enables local improvement
- Budgetary participation improves commitment, performance and self-efficacy



**OPEN ACCESS**

# Effective physician leaders: an appreciative inquiry into their qualities, capabilities and learning approaches

Mairi Savage,<sup>1</sup> Marie Höjriis Storkholm,<sup>1,2</sup> Pamela Mazzocato,<sup>1</sup> Carl Savage<sup>1</sup>

Savage M, et al. *BMJ Leader* 2018;**2**:95–102. doi:10.1136/leader-2017-000050

**Table 2** Qualities of senior and emerging leaders

Themes	Senior leaders	Emerging leaders
<b>I. Clarity of purpose: improve care.</b>		
I show such a passion for the patient. This is patient first, not just words. I can always connect all my actions to why this is good for the patient. (PS18)*	Trigger to take a leadership role arises from a perceived dissonance between the purpose of healthcare and the status quo.	Trigger to take a leadership role arises from their ambition to implement new ideas to improve care.
<b>II. Endurance.</b>		
You need to be willing to stick to it [a good goal], and keep going back to it, even when it's not easy, even when it's tough – you just keep going. And, in the end, you'll get there. (PS10)	Follow-up, keep people accountable, remind them about goals and purpose, take initiative even in tough situations, remain true to one's own principles and ethics.	Stand tall, persist despite resistance, maintain drive and ambition.
<b>III. Positive outlook.</b>		
People need energy and something I've learned is that everyone wants to be seen. That holds true for anyone at any level. And people feel more seen if [...] you give them opportunities to actually present and discuss and you do that by being open, so I think enthusiasm and openness go hand in hand. (PE05)*	Look forward, see possibilities, demonstrate enthusiasm and energy.	Focus on opportunities instead of problems, receive positive reinforcement and feedback, demonstrate enthusiasm and energy.
<b>IV. Authenticity.</b>		
I had to be sincere, honest, and really try to get the discussions down to facts and also try to, as often as I could, demonstrate how we had come to the decision. (PS14)	Humility, openness, listen, be trustworthy, passion.	Humility, openness, ambitious, curious, professional, demonstrate commitment.

\*PS: senior leaders. PE: emerging leaders.

### Ground management in medicine

Participants integrated their knowledge of medicine with that of economics, quality improvement and organisational development to help others see the rationale for change. Their in-depth medical knowledge and understanding of care processes granted them credibility among staff, and it helped them understand and address the medical consequences of change initiatives.

### Engage others: 'Working with the system' versus 'working the system'

When engaging others, participants empathised with staff, maintained motivation and developed resonant relationships. However, there was a distinction in how they related to their context. Senior leaders 'worked with the system.' They mediated conflicting interests by focusing on a shared purpose and brought together strategic allies. They engaged and empowered staff by creating space and challenging them to take the lead in problem identification and solution development by being present and visible in the organisation. They did not rush to solve problems for others, but through delegation and sharing their decision-making powers, got others to identify problems and develop solutions themselves. Senior leaders listened first to truly understand and empathise with what matters to people.

Emerging leaders, on the other hand, 'worked the system.' Without a formal position of authority, they built support by negotiating terms and teamed with people whose competencies compensated for their own shortcomings. They engaged others in change initiatives by asking questions that tested their own hypotheses about the situation. They too listened to people, but it was in order to understand how to tailor their communication and demonstrate good social skills.

### Catalyse systems by acting on interdependencies

Participants recognised patterns and led by example; using themselves as learning tools. They connected ideas (senior) and acted on the interdependencies in the system through goal setting and providing structure (emerging).

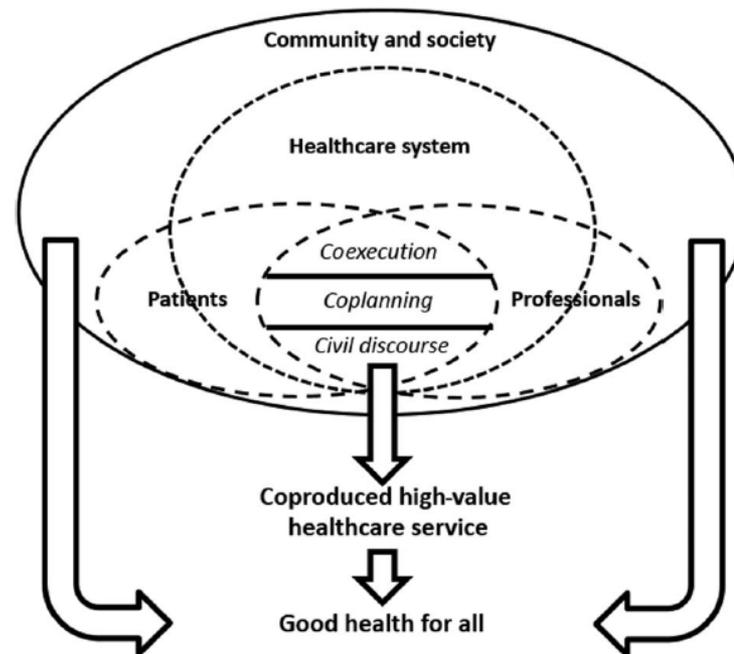
They saw themselves as part of everything that was going on in the system. Senior leaders reflected on the importance of improving self-awareness through testing ideas on themselves. Emerging leaders 'walked the talk' as a strategy to illustrate the validity of their ideas.

### Employ a scientific approach to understand problems and measure progress

Participants used a scientific approach to analyse problems, develop hypotheses and measure progress. Senior leaders described this as being curious, asking questions and listening carefully to be able to understand problems before jumping into solutions. Emerging leaders talked about maintaining a healthy scepticism and the importance of critical thinking, in particular to check and analyse the data used to inform decisions.

# Increasing the relevance and impact of healthcare

- Patient co-production (Batalden et al 2015)



**Figure 3** Conceptual model of healthcare service coproduction.

# Patient co-production

- MMC Research programmes
    - *Co-care*: patient-professional collaboration in rheumatology, neurology and cancer care (2014-2020)
    - *Patient in the driver's seat*: five patient innovations (2018-2024)
  - Digital tools enabling communication and collaboration
  - The importance of social networks
  - Demonstrated benefits in terms of clinical outcomes and patient QoL
-

# The Coming Third Health Care Revolution: ← 2003! Personal Empowerment

*Duncan Neuhauser*

## **Personal Empowerment: Revolution #3**

The third and most revolutionary stage is the empowerment of enrolled individuals and families to care for themselves. **Self-help, self-care**, and hospice are movements in this direction. Here nursing and other health professions may come to play the leading role with their focus on education, reduction of stress and anxiety, social support, wellness, and viewing the person in a wholistic way. Self-care, if it reduces costs to the HMO, is the logical consequence of capitation. Another driver for this change is the **Internet**, which provides an ocean of information, some of it excellent, some awful, for anyone to peruse. This means that the patient will, in most cases, know more about his or her condition than the provider will. One early example of this has been many patients with AIDS who become highly knowledgeable about their condition, so as to challenge even AIDS specialists. That the provider is no long the font of knowledge is a **fundamental change** in health care (Table 3).

# Paying tribute to Duncan

---







(Staffan Lindblad)

# THE DUNCAN ROOM

- A VENUE FOR CREATIVE AND COURAGEOUS THINKING

Named in honour of

Professor Duncan E. Neuhauser

Long-term friend and supporter of the Medical Management Centre

June 8, 2011