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PHYSICIAN LEADERSHIP AND THE IMPLEMENTATION OF EVIDENCE BASED PRACTICE: AN INTERACTIONAL JUSTICE PERSPECTIVE

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ABSTRACT

The objective of this study is to propose a relationship between physician leadership and the implementation of evidence based practice (EBP). This narrative review distinguishes physician leadership from top management and provides a unique approach to understand physician leadership's commitment to EBP implementation. This study suggests that the implementation of evidence based practices will be successful when the clinical staff's perceptions of physician leaders' interactional justice are high. Moreover, there are useful insights for future researchers to measure physician leaders' commitment.

Keywords: Physician leadership, interactional justice, implementation, evidence based practice

INTRODUCTION

Evidence based practice (EBP) refers to the integration of the best research evidence with clinical expertise and patient values[1].Since the last four decades, attitude toward the appropriate use of evidence into practice has evolved in many phases; from the era of optimism to the era of information technology and systems engineering[2, 3]. The current era of evidence based practice is mainly concerned with the redesigning of service delivery systems to address the facilitators and barriers for narrowing the gapbetween evidence and practice, and is mainly driven by the emphasis on describing the effective ways to change the behavior of healthcare organizations and service providers[3, 4]. When there comes the issue of provider's behavior, leadership can be viewed as an important organizational factor with the capacity to implement (or not) change and innovation[5].

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Unlike industrial organizations, the concept of leadership in healthcare organizations is not limited to the leadership from governing body, the chief executive officer, and other senior managers[6]. Owing to the presence of an organized body of clinical professionals, healthcare organizations have a diffuse leadership structure[7]. This diffuse structure manifests that the leadership in healthcare organizations may come from different sources[7, 8]. In most healthcare organizations we can find a group of leaders recognized as clinical or physician leaders[6, 7]. The presence of this group is because the physicians possess a unique body of knowledge that confers a certain measure of autonomy in clinical decision making.[7](p.494).

Senior management and physician leaders, although work together toward a common goal, both groups of leaders use different professional philosophies during a work process. The common professional philosophy used by senior management can be explained as the support for quality improvement and the availability of human and technical resources, while the professional philosophy of clinical leaders follows the concepts of presence, engagement, facilitation, and leading the change implementation[9].

An important distinction between senior management and the physician leaders is that clinical leaders have the standing to provide clinical supervision and oversight of its members' clinical care and performance[6](p.2). While performing supervisory role, they are well positioned to lead change. This supervisory role involves them in direct interactions with the clinical staff during the implementation process. Implementation of evidence based practice takes place majorly through the medical staff who works under the supervision of physician leaders.

This research focuses on physician leadership. The objective of this study is to propose a relationship between physician leadership and the implementation of evidence based practice (EBP). The next section provides argument in developing this relationship. The final section provides conclusion and implications of the study.

PHYSICIAN LEADERSHIP AND THE IMPLEMENTATION OF EVIDENCE BASED PRACTICE

The importance of physician leadership for implementing evidence based practices has been well documented in healthcare literature[10, 11]. Previous research developed taxonomy to identify the factors influencing the success of improvement efforts to increase the use of ?-blocker after acute myocardial infarction[4]. The results of the mentioned study indicate that physician leadership was perceived as a dominant success factor for enhancing ?-blocker use (p.2607). In another studyhighlighted that the specific process for reducing door to balloon time, along with other factors, requires clinical leadership for overcoming barriers to organizational change[12]. Recently, a qualitative research was conducted to identify the factors related to better performance in AMI (Acute Myocardial Infarction) care[13]. The results of their research show that in low performing hospitals there was not enough physician leadership for implementing change.

Thisresearch presents a perspective of leadership commitment developed in the professional responsibility model of medical leadership[14] and relates it to the interactional justice[15]. When it comes to the implementation of evidence based practice clinical leader's interactions with his/her staff become more relevant because a leadership culture of respect and fair treatment to the group members has been suggested for the implementation of clinical practice guidelines[16].

The professional responsibility model of medical leadership is based on Plato's concept of leadership as a life of service and the professional medical ethics of Drs John Gregory and Thomas Percival[14](p.1). Using insights from Plato's work, Republic (424–348 BCE) this model emphasizes that the leaders have the responsibility of protecting and promoting the subordinates' interests. The authors further highlight that doing so (i.e. to protect and promote subordinates' interest) is a commitment that provides direction and purpose to the leadership role[14](p.1).

Based on the Gregory's (1724-1773) and Percival's (1740-1804) medical ethics, this model presents four professional virtues that direct the physician leader's role, complementing managerial skills[14](p.3). These four virtues are; self-effacement (be unbiased and impartial), self-sacrifice (take risk for the organization's legitimate interest), compassion (be aware of and respond with appropriate support to the distress of colleagues and staff), and integrity (decide on the basis of intellectual and moral excellence).

Self-effacement and compassion are closelyrelated to the clinical leaders'interactions with their subordinates. As the successful implementation of evidence based practices cannot be achieved without the positive participation of medical staff[17], self-effacement and compassion are necessary to achieve their participation. These ideas are consistent with Percival who was aware that the clinical staff especially physicians will be able to achieve sustainable professionalism only in the context of a supportive organizational culture[14] (p.3). Physician leaders are responsible for creating a positive culture that is transparent and non-exploitative[14]. One important aspect of positive organizational culture is a fair and unbiased professional treatment of subordinates[14,16].

The idea of fair professional treatment of subordinates

originates in Immanuel Kant's (1724-1804) moral philosophy of respect. The professional responsibility model posits that a fair treatment of staff shows leader's commitment to patient care. A fair treatment of the staff develops those behaviors that are necessary for successful implementation of evidence based practice[16, 18].

The concept of physician leader's commitment built on the historical figures is relevant to modern medical leadership[14]and coincides with today's social psychology approach to organizational change such as organizational justice[19-21]. The origins of organizational justice root back to Aristotle's (384-322 BCE) canonical formulation of justice which posits that each individual receives what is due to him or her by treating like cases alike[14](p.3).

Organizational Justice Theory looks at workers' perceptions of fairness of work-related issues[22, 23]. Organizational justice—whether in terms of distribution, interactions or procedures—has emerged as a notion of fairness in social science literature and provides important insights to understand the process of successful organizational change[24-26].

Initial research on organizational justice was focused on distributive justice that is mainly concerned with the outcome of decisions[19, 24, 27]. Later research put focus on procedural justice—organizational justices related to the processes that lead to the outcomes[24]. Bies and Moag[15] presented the concept of interactional justice which is mainly concerned with the fairness of interactions during a work process.

Interactional justice is mainly related to the interpersonal treatment people receive during the enactment of procedures[15]. In other words, interactional justice refers to perceptions concerning the way authorities treat their subordinates[28](p.322). Interactional justice is promoted in an environment where the leaders treat people with respect and sensitivity, and rationalize their decisions[24]. These ideas coincide with the philosophical explanation of physician leaders' commitment developed in professional responsibility model of medical leadership[14].

We argue that clinical staff's perception of physician leaders' interactional justice will reflect the physician leaders' commitment to the implementation of evidence based practices. Effective implementation of evidence based practices requires the leaders to create a climate of fairness as it has been considered an important precondition for successful organizational change[25]. A climate of fairness is important for the leaders to legitimate their orders in subordinates' eyes[29]. In this sense fair treatment follows that a subordinate ought to accept leader's authority[30, 31]. If clinical leaders act fairly, the clinical staff perceives that the orders to implement practices are legitimate. So, a fair and unbiased treatment of subordinates is important in explaining the clinical staff's behavior toward EBP implementation.

An important aspect of the relationship between leadership's interactional justice and the implementation of evidence based practices is that fairness in treatment leads to positive behaviors[32] which have been considered important for successful implementation[33, 34]. In contrast, unfair treatment results in retaliatory behaviors[35] which are harmful to implementation process because they give birth to non-cooperative behaviors. Thus, considering interactional justice for encouraging positive behaviors and discouraging negative behaviors will benefit the implementation process[25].

Moreover, the literature on the implementation of evidence based practices has recognized the issue of resistance among individuals to implement the recommended changes in clinical process[17]. Resistance refers to clinicians' little interest in implementing change or simply suppressing any change effort[36]. Healthcare organizations require an active process to engage individuals in order to accomplish implementation[11](p.3). In order to overcome resistance and promote clinical staff's engagement in implementation process, the role of leaders has been well recognized. An effective way how physician leaders can reduce staff's resistance has been suggested in leader's role in improving staff's perceptions of fairness[29, 37, 38].

The above discussion suggests that the conditions under which the clinical staff's perceptions of interactional justice are high will reflect a higher physician leaders' commitment. Under these conditions the implementation of evidence based practices will be successful. Formally, it can be proposed that the greater the clinical staff's perceptions of physician leaders' interactional justice, the successful will be the implementation of EBPs.

CONCLUSION

The complexity of EBP implementation poses a real challenge on healthcare organizations to motivating clinical staff.Physician leaders are well positioned to handle this challenge as they directly interact with clinical staff. The interactional justice perspective proposed in this research guides physician leaders to face the challenge of EBP implementation. This research proposes that the higher clinical staff's perceptions of physician leaders' interactional justice will lead to a facilitative organizational environment for EBP implementation. The underlying assumption is that the physician leaders' failure to provide fair treatment to their subordinates will undermine the implementation process.

This research provides two important professional and future research implications. First, it warns physician leaders that

the successful implementation of EBP cannot take place in the presence of unfair treatment to clinical staff, and informs top management to monitor the state of interpersonal relationship between physician leaders and clinical staff. Second, the interactional justice perspective of physician leaders' commitment provides future researchers with insights of using the established measurement instruments[21]. The use of these instruments will facilitate empirical research on the issue of physician leadership.

CONFLICT OF INTEREST

There is no conflict of interest among authors, neither with any other person or organization.

ETHICAL ISSUES

It has been written on ethical issues related to medical/ clinical leadership.

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AUTHORS CONTRIBUTION

*All the authors made substantial contributions to conception and design of the study;
**All the authors participated in drafting the article or revising it critically for important intellectual content; and
***All the authors gave final approval of the version to be submitted