An attention-based view of leadership

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Abstract:

Background: Healthcare leaders' attention is stretched in healthcare organisations due to the large number of issues that they must respond to. Effectively attending to legitimate attentional demands, which involves deprioritising less important demands, is a defining feature of competent leadership.

Method: This piece summarises key findings from research in the attention-based view, integrating its key findings with insights from conversations with healthcare leaders in executive education settings.

Findings: The attention-based view develops three premises that explain how organisations structure and channel attention in ways that shape what organisations do: (1) Given the scarcity of attention, where leaders focus their attention shapes what they do, (2) People's attention in situated (e.g. in the work they do, the meetings they attend), and (3) organisations structure roles and communication channels in ways that shape who pays attention to what. Five lessons drawn from these premises are that leaders should: create an architecture that will address critical issues; be mindful of attentional networks; cultivate opportunities for voice; create attentional capacity; and embrace creating attentional coherence as perhaps the core task of leadership.

Conclusion: Given the diverse issues, people, and demands that characterise contemporary healthcare organisations, effectively focusing attention on what matters is essential if organisations are to function well. A critical task for leaders is to prioritise for themselves and for everyone in their organisation the key issues that should be fundamental to, and hence merit attention from, everyone.

Leadership attention is stretched in contemporary healthcare organisations. Healthcare professionals in diverse leadership roles must contend with and pay attention to a multiplicity of goals, such as clinical & service quality, patient experience, operational efficiency, financial performance, and minimising waiting times. Healthcare leaders' attention is also stretched by a complex regulatory environment in which a variety of national- and non-national actors—e.g. professional bodies, accreditation organisations—place demands on both the organisation and the leaders that act on its behalf [1-3]. Internally, healthcare leaders must pay attention to the needs and demands placed on them by diverse people whose efforts they must coordinate – front line clinicians, support staff, and leadership peers in other professional roles – in order to deliver truly high performing care systems. Effectively attending to legitimate attentional demands, which involves also challenging other demands that may generate attentional overload, may be a defining feature of competent leadership.

Navigating these intense attentional demands, and the potential for attentional overload, is a critical leadership challenge. A basic premise of the attention-based view of the firm, a growing area of research in management and strategy, is that attention is scarce – i.e. people have limited attentional bandwidth. This means that focusing attention on one issue or initiative necessarily means *not* focusing attention on something else[4-7]. Following from this premise is the insight that what leaders focus attention on drives what organisations do. A key challenge for leaders, then, is to find a way to focus attention on those issues and initiatives that are central to building high performing healthcare systems, and, equally critically, to *not* focus attention on things that are less critical to achieving this end.

This translation piece, then, aims to communicate key principles and insights from the attention-based view of the firm with the aim of guiding leaders and organisations in their efforts to focus attention, and hence action, on issues and initiatives that are most critical to meeting the healthcare systems' (short/long term, transformational, and recovery) plans, aims and priority areas concerning service delivery. This can include care that balances patient priorities with population health needs, or the potentially competing demands of staff well-being, clinical quality, and financial sustainability. How these diverse goals are met, or not, is manifested through the ways that leaders focus their own attention, as well as the ways that healthcare organisations and systems structure and allocate leaders' attention. This translation piece summarises key findings and insights from research in the attention-based view. In addition, it presents guidance for leaders that draws on conversations about the attention-based view with diverse health care leaders that took place within executive education settings in both the United States and United Kingdom.

A Primer on the Attention-Based View

The attention-based view of the firm is rooted in the Carnegie school of management research developed in the 1950s and 1960s. This school of research focused on leaders' and organisations' bounded rationality, challenging models of perfect rationality that form the baseline assumption in economics. This work looks at the broad range of factors that might cause leaders and organisations to deviate from perfect rationality [4 8]. This could mean, for example, that limits to a medical director's cognitive abilities, access to information, time, or ability to see past historical precedent in their organisation might prevent them from taking the optimal set of actions that might maximise patient safety. As a result, efforts to advance patient safety would be bounded by these diverse constraints. The distinctive contribution of the attention-based view is to highlight the importance of attention specifically, rather than the full set of factors that might lead an organisation to deviate

from perfectly rational models of organisations. In addition, the attention-based view is distinctive in focusing on the social structuring of people's attention—i.e. examining the role of organisational structures and communication channels in shaping leaders' attention. The attention-based view posits that this structuring of attention is a key mechanism that shapes what organisations do [4 5]. The attention-based view develops an integrated view of the diverse factors that define or structure leaders' attention – including individual & social cognition, organisational structures, and environmental influences. In doing so, it explains how the attention of leaders or decision-makers within organisations is a "socially structured pattern" shaped by a wide range of cultural, social, and cognitive mechanisms.

The attention-based view of the firm develops three premises that, taken together, explain how organisations act [4]. The first premise is that what leaders do will depend on the "issues and answers" they focus attention on. This principle is rooted in the scarcity of attention–nobody can focus attention on everything that may be relevant to their job. In practice, this means that one medical director with a broad goal of improving clinical quality might focus attention on the issue of hospital readmissions, and devote time and attention to the answer of coordinating with care homes. Given this focus they might develop processes for discharging patients into care home settings in ways that ensure that their health needs can be met appropriately, which would reduce the likelihood of readmission. Her peer in a similar organisation, also with a broad goal of improving clinical quality, might instead focus attention on the issue of the coordination of inpatient care, and the answer of developing processes to enhance coordination between diverse medical specialties, nursing, and allied health in ways that can help more holistically care for patients in the hospital setting.

The second premise is that this limited attention is situated—meaning it depends on the work that a person does, the meetings that they regularly attend (as well as those that they don't attend), the people that they routinely interact with, a particular career history that may shape how they see the world, or even the specific moment of time they are in, with its unique set of issues and events that may demand a leader's attention. A surgeon, for example, would be likely to pay a lot of attention to the booking—or over-booking—of operating rooms, which can potentially force the cancellation of surgery. They may be less attentive to crowding in a post-surgical recovery room, which they don't visit routinely, even if challenges in the recovery room may hamper the flow of patients through the OR [9]. Similarly, a general practitioner's attention is situated on their day-to-day work. Many general practitioners focus the bulk of their attention in two main ways: (1) managing the daily schedule of patient lists, and (2) attending to incoming (time-sensitive) new tasks (e.g. review and approval prescriptions, and making decisions to slot in and see patients running late to appointments). However, if one of their patients is admitted to hospital, they are less likely to focus attention on how their unique medical history (which hospital consultants may be unaware of) might require specific types of specialty care or whether they receive this care once admitted.

The third premise is the structural distribution of attention—organisations structure formal roles and communication channels, which in turn influence who is likely to focus attention on what. For example, a hospital-based clinical lead in a publicly funded NHS trust may, as part of their role, focus attention largely on clinical and professional issues, and interact largely with their own medical colleagues and their nursing and allied health partners. A department chair, a roughly equivalent role, in an American non-profit or for-profit hospital may be more directly in charge of both clinical and financial performance, and may more closely work with a business manager in addition to colleagues and peers from other clinical professions. Triad leadership in primary care in the UK may involve more intense coordination between a GP partner, lead pharmacist, and manager. This shared responsibility over the performance of the practice, as well as their distinctive roles in the

triad, would shape the breadth of issues that each member of the triad attends to. Across healthcare contexts, organisations can vary in the extent to which there is attentional coherence (i.e. a common focus of attention on at least a few key issues) between different clinical service areas, or between clinical service areas and the senior management team. The early stages of the COVID-19 pandemic offered numerous examples where the normal structuring of attention was suspended, leading to new communication channels, and as a result, different ways of structuring attention to allow diverse people to focus attention on issues and answers needed to coordinate an effective COVID-19 response.

Recent work has elaborated on the initial insights of the attention-based view in a few ways. One thread of work focuses on organisational architecture or design [6 10]. This work highlights that organisations adapt better when governance channels are both cross-level (e.g. including both the C-suite and major clinical areas) and specialised (e.g. focused on a specific issue such as either patient safety or tackling patient waiting lists, rather than a broad set of issues). This suggests that organisations can respond effectively to emergent issues in a complex and changing environment by creating dedicated channels that focus on new issues when they emerge. A second thread of work focuses on leaders themselves, and their attentional engagement—intentional efforts to allocate their own attention. This work examines the practices that leaders can engage in to manage their own attention in a way that allows them to perform their roles[11]. A key insight in this work is that leaders have agency, and can draw on a range of specific practices to cope with the problems of too much information and stretched attention.

Leadership Practices for Managing Attention

Drawing in particular on recent work, the remainder of this piece will flesh out five lessons from the literature on attention that leaders can draw on to manage attention effectively in their organisations, and for themselves. These five lessons are: creating an architecture that will address critical issues; being mindful of attentional networks; cultivating opportunities for voice; creating attentional capacity; and creating attentional coherence. The lessons map onto the three premises of the attention-based view of the firm as outlined above.

First, senior leaders, more than most organisation members, can create an architecture or organisational design that will structure attention and interactions in ways that will allow their organisations to adapt quickly to important issues relating to how their organisations deliver healthcare [4 6 10]. The research suggests that this involves identifying key issues, and creating meetings and reporting channels that get the right people interacting around these issues in dedicated spaces. If the issue is patient safety, it would mean creating dedicated meetings, roles, and reporting channels focused on patient safety, and making sure these issue specific meetings and reporting channels effectively aligned attention and perspectives across key professional groups, and between the senior leadership team and leaders and diverse professionals in key clinical areas. These dedicated channels might have to be appropriately resourced, both with people and their dedicated time, as well as with budget in some circumstances. In thinking about an appropriate organisational design, key questions to ask yourself are: (1) What are the critical set of issues that merit dedicated attentional channels? (2) How can we define the scope and mandate of these dedicated channels to appropriately balance breadth (capturing a range of related issues), and focus (not capturing so much to make the attention channel general)? (3) Who do we need to involve to ensure cross-unit. -profession, and -level membership, while avoiding involving so many people that it makes the channel meaningless? (4) How can we ensure that needed dedicated channels are resourced appropriately?

Second, all leaders should be mindful of their attentional networks. We pay attention to things, to a significant extent, through the people we interact with[11]. Their professional roles will shape what they pay attention to, which may be different from us. Moreover, communication channels are uneven – different people may hear things that you don't, and have unique insights into what merits your attention as a leader. The challenge for you as a leader, then, is to think about who you interact with and how that might shape your attention. Do you really interact with and hear from the diverse range of people whose perspective might give them unique insights into what is important and might merit your attention? Are their blind spots in your attentional network that might lead you to miss key issues before they become serious problems? Blind spots can vary by issue. Networks that don't cut across professional groups might lead to blind spots for issues relating to clinical quality, while networks that don't cut across gender, age, and race might lead to blind spots for issues relating to equality, diversity, or health disparities.

Third, and related to the second, is the importance of cultivating opportunities for voice. This is particularly important if you are a member of a traditionally higher status profession, or if you manage others in a hierarchy[12]. It is of course consistent with the rich body of literature highlighting the importance of psychological safety[13]. However, what an attention-based perspective will add is that you need to create specific space (i.e. time). For example, if you are a consultant and clinical lead and you are concerned about making improvements to patient safety, then you should set aside dedicated time to specifically hear from diverse people about potential patient safety issues – including consultants, doctors in training, nurses, allied health professionals, and other groups (e.g. porters, staff who handle the processing and sterilization of surgical instruments, nursing aides) who might have relevant insight. For issues that are strategically important to your role, what opportunities for voice are there, and who avails of it? Who doesn't, and why? Who are the set of people who might have a unique perspective?

Fourth, for leaders to make sure that important issues get the focus that they need, one tactic is for them to create attentional capacity – by assigning someone else to take a lead on dealing with an issue in cases where your own attention is stretched across too many issues[11]. For example, when someone steps into a role as a medical director for a health system or trust, they might reasonably appoint a few associate medical directors (e.g. an associate medical director for medical education) to make sure that a few key areas get the focused attention that they merit, even in periods when their own attention might be diverted, for example, to responding to ad hoc crises or issues. While work in the attention-based view suggests that creating attentional capacity is one practice that senior leaders can draw on to manage attention, it is not always possible. In order to create capacity, there has to be some degree of slack (i.e. available resource to take on leadership over an issue). For a new medical director to have an effective associate medical director for medical education, there have to be at least some clinicians with capacity to take on the role, and some administrative and financial resource to support them in the role[14]. In a health system where consultants are fully scheduled with clinical work, and with stretched administrative resources, this may not be feasible. In addition, to create attentional capacity, you may first have to create a mandate for the person who will lead on an issue[15]. For an associate medical director for medical education, this could mean speaking first to the key players who play a role in medical education, explaining the new role and its importance, and making sure that there is enough agreement and political support for the person to truly and effectively take leadership over the issue. Hence, key questions are: Around what issues do you need to create attentional capacity? Who are appropriate people to potentially lead on an issue? What resources, mandate, or support do they need, from you or from others, to effectively lead?

Finally, and consistent with the overarching message of the attention-based view, is the insight that a key work of leadership is creating attentional coherence[4 11 16]. Attentional coherence happens when there is a degree of alignment of attention around a few key issues throughout an organisation. Our professions, our work roles, or our position in the hierarchy may lead each of us to focus attention on a slightly different set of things. This is inevitable. However, for an organisation to not just function, but to thrive, there has to be some commonality of purpose, which requires some degree of alignment around what issues merit attention from everyone. The importance of attentional coherence is implicit in much work that has wide currency in healthcare. For example, the ideas of patient safety culture and patient-centred care suggest that patient safety and a patient perspective are both key issues that merit attention from everyone throughout a healthcare system, whatever their role in the care process. An emerging dialogue on kindness and human connection in healthcare suggests that the issue of kindness might also merit attention from everyone in health and care systems[17]. These issues can get lost, however, among the sea of other issues that compete for attention from leaders, and from the wide range of professionals who organise and deliver care. Moreover, leadership turnover in health care, both among clinical leaders and more generally, may make achieving attentional coherence particularly challenging, as new leaders might prioritise slightly different issues and answers [18]. The key question here is how, as leaders, can we cut through the sea of issues that inevitably compete for attention to effectively highlight, through our actions and communications, the limited set of fundamentally important issues? For people new to leadership roles, how might our efforts build on prior efforts to focus on key issues that remain important to the organisation? For all leaders, how can we ensure that central issues remain central even after we leave? This underscores, then, that a key work for leaders is to create attentional coherence, which means identifying and prioritising for themselves and for everyone in their unit or their organisation the key issues that should be core and fundamental to, and hence merit attention from, everyone.

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