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Public Health SEEEPHI harmonization, employability, leadership and outreach

ASPHER The Association of Schools of Public Health in the European Region

Maastricht University

School of Public Health Faculty of health sciences Ben-Gurion University of the Negev Science | Policy | Leadership | Society

WP 5

Building Leadership Capacity in the Israeli Public Health System

Public Health Leadership Course Guide

BGU & MU

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Introduction

In the following chapters we offer a guide for developing a public health leadership course. The guide should serve as a platform to be adapted in the different schools of public health in Israel, according to specific contexts (e.g., addressing more relevant communities that are engaging with the school), existing curricula, priorities, and emphases. The guide is divided into three chapters: Leadership, Problem-Based Learning (PBL) and Simulations. The aim of the guide is to provide tools to develop a course that will introduce students to the foundations of leadership in public health through a combination of frontal lectures, case study analysis according to PBL method, and simulation training.

The guide is built on previous experiences developed by ASPHER, especially ASPHER/WHO Europe Road Map to Professionalizing the Public Health Workforce. It is part of a larger project titled: Sharing European Educational Experience in Public Health for Israel (SEEEPHI): Harmonization, employability, leadership and outreach, an EU ERASMUS+ funded project on Capacity Building in the Field of Higher Education. Based on previous work packages within SEEEPHI and course pilot conducted at Ben Gurion University Health Leadership Program during Spring 2022 the current guide is part of workpackage lead by Ben Gurion University of the Negev and Maastricht University on building leadership capacity via cutting edge training in the Israeli public health schools and programs, including peer-to-peer and train the trainers offerings.

We hope that by using this guide, all schools will have to the foundations to provide students with tools to develop leadership competencies, and to experience decision making processes in health while working in a multi-professional team. The next step would be leading to the development of Public Health Leadership Academy in Israel based both on Leaders for European Public Health (LEPHIE) methodology and the Israeli experience emerging from this specific work package and the broader SEEEPHI project.

Syllabus: Public Health Leadership Course

Name of the module: Public Health Leadership

Number of module: xxx

Course Description: In an era of dwindling public trust in health care systems, leadership training for public health professionals is more important than ever. This course will deal with the salient leadership skills required for developing and improving teamwork within the public health system. The first part of the course starts from drawing the distinction between leadership and management and proceeds to introduce the students to modern leadership theories. These theories are the basis from which modern problems in health leadership, such as non-adaptive and naive leadership can be tackled. The second part of the course will be based on PBL method and will present students with practical leadership tools and allow them to test them in a case study and in practical simulations.

Aims of the module: Introducing students to the foundations of leadership in public health through a combination of frontal lectures, a case study analysis according to PBL (Problem Based Learning) method, and simulation training.

Objectives of the module: providing students with tools to develop leadership competencies, and to experience decision making processes in health while working in a multi-professional team.

Learning outcomes of the module: On successful completion of the course, the student should be able to:

1. Define leadership and understand different approaches to modern leadership.
2. Analyze ethical aspects of dilemmas in the fields of leadership and decision making in health.
3. Analyze case studies in public health and health policy.
4. Be better prepared to utilize problem solving skills and leadership skills in situations that require it.
5. Be better prepared to chairing small groups and collaborate with others.

Attendance regulation: mandatory attendance.

Teaching arrangement and method of instruction: Frontal lectures, group projects and simulations.

Assessment:

1. Assessment task simulation 40%
2. Case study analysis and presentation 60%

Work and assignments:

1. Active participation in the simulation and a written summary report on the activity.

2. Active participation in class discussions as well as presentations according to the analysis tasks of the case study.

Time required for individual work: in addition to attendance in class, the students are expected to do their assignment and individual work in a scope of 10~ hours

Module Content\ schedule and outlines:

Lesson 1: Introduction- What is Leadership and how does it differ from management?

Required reading:

Algahtani1, A. (2014). Are leadership and management different? A review. Journal of Management Policies and Practices, 2(3), 71-82.

Kumar, R. D. (2013). Leadership in healthcare. Anaesthesia & Intensive Care Medicine, 14(1), 39-41.

Lessons 2-3: Leadership in health theories- Servant leadership, transformational leadership & ethical leadership.

Required reading:

Rowitz, (2013), Public Health Leadership: Putting Principles Into Practice, Chapter 2, Leadership Styles and Practices

Avolio, B.J., Walumbwa, F.O. and Weber, T.J., 2009. Leadership: Current theories, research, and future directions. Annual review of psychology, 60, pp.421-449

Jambawo, S. (2018). Transformational leadership and ethical leadership: their significance in the mental healthcare system. *British Journal of Nursing*, *27*(17), 998-1001.

Northouse, P.G. (2015), Chapter 9: Transformational Leadership

Additional reading:

Van Dierendonck, D. (2011). Servant leadership: A review and synthesis. *Journal of management*, *37*(4), 1228-1261.

Trastek, V. F., Hamilton, N. W., & Niles, E. E. (2014, March). Leadership models in health care—a case for servant leadership. In *Mayo Clinic Proceedings* (Vol. 89, No. 3, pp. 374-381). Elsevier.

Lesson 4: Conflict resolution in healthcare

Required reading:

Rowitz, (2013), Public Health Leadership: Putting Principles into Practice, Chapter 21: Leadership and decision making.

Additional reading:

Shortell, S.M., & Kaluzny, A.D. (2011). Health Care Management: Organization Design and Behavior, Chapter 5: Conflict Management and Negotiation

Shortell, S.M., & Kaluzny, A.D. (2011). Health Care Management: Organization Design and Behavior, Chapter 8: Coordination and communication

Lesson 5: Ethical decision making.

Kimberly S. Peer & Jonathon S. Rakich (1999) Ethical Decision Making in Healthcare Management, Hospital Topics, 77:4, 7-14, DOI: 10.1080/00185869909596532

Ignatowicz, A., Slowther, A. M., Bassford, C., Griffiths, F., Johnson, S., & Rees, K. (2022). Evaluating interventions to improve ethical decision making in clinical practice: a review of the literature and reflections on the challenges posed. Journal of medical ethics, medethics-2021-107966. Advance online publication. https://doi.org/10.1136/medethics-2021-107966

Lesson 6: What is PBL? Briefing for the following sessions

Wood, D. F. (2003). Problem based learning. *Bmj*, *326*(7384), 328-330.

Lesson 7: Case study: Vaccine hesitancy- presenting the case + supporting lecture

Lesson 8-9: Case study: group work on the project

Lesson 10: Case study 1: presentations of students' investigative process and recommendations.

Lesson 11-12: Leadership simulations.

Lesson 13: course summary

Chapter I: Leadership

Lesson 1: Leadership; Definitions and theoretical background

The question "what is leadership" has many answers. It can be answered through descriptions of who the leader is (i.e., traits and abilities), what the leader does or should do, who the leader is working with, what is the position from which a leader functions, etc. That being said, Leadership does have a common defining core that sets it apart from similar concepts like management. In this section, I will provide a brief overview of some of the main leadership theories that represent these different perspectives.

One of the earliest descriptions of leadership was one which stemmed from the traits of the leader. Originating in the 19th century, Thomas Carlyle's "Great man theory" was the first frequently mentioned conceptualization of leadership and was based on historical accounts of past famous leaders. This theory depicts the leader as a hero, one that is born, not made, a godsend who is noble, just, and knows what's best. Fittingly, it is the public's duty to identify and obey the "great man" (Spector, 2016). While this theory is considered archaic, its echo can be seen today in what is known as "the trait approach" or "trait theory". This approach is concerned with what traits differentiate effective from ineffective leaders (Northouse, 2019). An interdisciplinary example of this are studies which look at how leaders are positioned on "the big five" personality dimensions (e.g., Langford; Dougal & Parkes, 2017). Recent emphasis has also been given especially to visionary and charismatic leadership (Bass, 2008; Jacquart & Antonakis, 2015; Taylor, Cornelius & Colvin, 2014).

Another approach which deserves a brief mention is the "skills approach". It is similar to the traits approach, but shifts the focus from personality characteristics, which are usually viewed as innate and largely fixed, to skills and knowledge one can master (Northouse, 2019). A good representation of this approach can be seen in the early works of Katz (1955) on the three skills approach (dividing the leadership skills into technical, human and conceptual skills).

The Trait and skills approaches can help us understand who would make a good leader, but they do not address the question of what is it exactly that a leader does? This brings us to the behavioral approach to leadership. Researchers studying the behavioral approach determined that leadership is composed of two general kinds of behaviors: task behaviors and relationship behaviors. Task

behaviors facilitate goal accomplishment: They help group members to achieve their objectives. Relationship behaviors help followers feel comfortable with themselves, with each other, and with the situation in which they find themselves. The leader combines these behaviors to influence people to reach a goal (Northouse, 2019). It is within this framework that we may ask, how does leadership differ from management? Since both terms refer to the influence of one person (leader or manager) on others in order to reach certain goals. In that sense, every leader also manages, and every manager also leads.

Indeed, management and leadership are sometimes used synonymously in the literature. In a review article designed to elucidate the similarities and differences between the two terms, Algahtani (2014) summarizes the role of the leader as comprised of two components: "the process of influencing a group of individuals to obtain a common goal; and to develop a vision." The latter aspect being an important differentiating characteristic from management, which is focused more on **formal** directing and controlling of resources (e.g., human, budget, structures etc.) to reach **short term goals** (Kotter, 2001; Kotterman, 2006). In the words of Kotter (2001) "The aim of management is predictability—orderly results. Leadership's function is to produce change. Setting the direction of that change, therefore, is essential work." Leaders go about setting a direction for change through people-oriented inspiration, of both vision and trust (Bennis & Townsend, 1989; Barbuto, 2005; Northouse, 2019).

In summary, the answer to the question "what is leadership" depends on the aspect of leadership we're looking at. Leadership can be viewed through the image of the leaders themselves, their capabilities, some of which are considered more innate, like extraversion, while others can be learned, like analytical skills. Leadership can also be understood through the process that is to lead: Influencing other people to achieve a certain goal. And unlike management, doing so not only from a formal position of power to control for organizational chaos, but through inspiration, setting forth a vision and long-term strategies which give the organization its direction.

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Algahtani, A. (2014). Are leadership and management different? A review. *Journal of management policies and practices, 2*(3), 71-82.

Barbuto Jr, J. E. (2005). Motivation and transactional, charismatic, and transformational leadership: A test of antecedents. *Journal of Leadership & Organizational Studies*, *11*(4), 26-40.

Bass, B. M., & Press, R. M. S. F. (2008). The Bass Handbook of Leadership Theory Research and Managerial Applications Ebook.

Bennis, W. G., & Townsend, R. (1989). *On becoming a leader* (Vol. 36). Reading, MA: Addison-Wesley.

Jacquart, P., & Antonakis, J. (2015). When does charisma matter for top-level leaders? Effect of attributional ambiguity. *Academy of Management Journal*, *58*(4), 1051-1074.

Katz, R. (1955). Skills of an effective administrator. *Harvard BusinessReview*, Jan-Feb.

Kotter, J. P. (2001). What leaders really do. *Harvard business review*, *79*(11).

Kotterman, J. (2006). Leadership versus management: What's the difference. *The Journal for Quality and Participation*, *29*(2), 13-17.

Langford, P. H., Dougall, C. B., & Parkes, L. P. (2017). Measuring leader behaviour: evidence for a "big five" model of leadership. *Leadership & Organization Development Journal*.

Northouse, P. G. (2019). *Leadership: theory and practice.* Eighth Edition. Los Angeles: SAGE Publications.

Spector, B. A. (2016). Carlyle, Freud, and the great man theory more fully considered. *Leadership*, *12*(2), 250-260.

Taylor, C. M., Cornelius, C. J., & Colvin, K. (2014). Visionary leadership and its relationship to organizational effectiveness. *Leadership & Organization Development Journal*.

Offered presentation – Lesson 1

What Is Leadership?

How does it differ from management?

Great Man Theory

- depicts the leader as a hero, one that is born, not made.
- a godsend who is noble, just, and knows what's best
- it is the public's duty to identify and obey the "great man"
- "the history of the world was the biography of great men"

(Spector, 2016)

Trait Approach

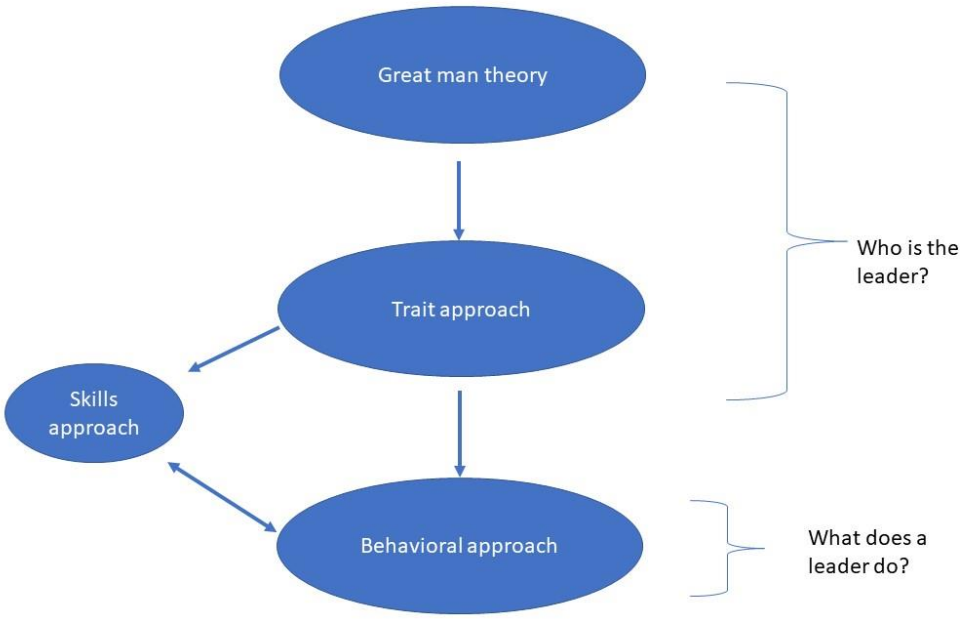
- A more recent evolution of the great man theory.
- Attempts to answer the question: "what traits differentiate effective from ineffective leaders?" (Northouse, 2019)
- Examples: Measuring leaders' traits on the Big Five Model of personality.
- Other Models identified many characteristics of emergent or effective leaders (e.g. Self-confidence, emotional stability, conscientiousness, creativity etc.)

Criticism of the trait approach

- Too simplistic (Conger & Kanungo, 1998).
- Situation dependent
- Hard to find a unifying model
- Assumes leadership cannot be learned.

Behavioral approach

- Leadership as a set of skills that can be learned, practiced and improved upon.
- Originated in the mid-20th century.
- Research shifted its focus from innate traits to the behaviours of effective leaders.
- Among its pioneers was Katz (1955) with the three skills approach: technical, human, and conceptual skills.



Behavioral approach- what does it mean to lead?

- "Leadership is a process whereby an individual influences a group of individuals to achieve a common goal." (Northouse, 2013)

- Two general types of behaviour:

1. Task Behaviors
2. Relationship Behaviours

This all sounds quite broad, how does it differ from management?

Leadership vs. Management

- Leadership: "the process of influencing a group of individuals to obtain a common goal; **and to develop a vision**."

- Management: focused more on **formal** directing and controlling of resources (e.g., human, budget, structures etc.) to reach **short term goals** (Kotter, 2001; Kotterman, 2006)

Leadership Vs. Management

Leader	Manager
Establishing directions	Planning and budgeting
Creating a vision	Establishing agendas
Clarifying the big picture	Setting timetables
Setting strategies	Allocating resources
Inspires trust	Relies on control

Lessons 2-3: Transformational, ethical, and servant leadership

In the last lesson, we've discussed an abridged evolution of leadership theories, and established some differentiating characteristics between leadership and management. Now we turn our attention to the characterization of specific leadership styles. namely transformational, ethical, and servant leadership. Following that, we'll take a look at the importance of these leadership styles in public health.

The term transformational leadership was introduced by Burns (1978), who recognized it and "transactional leadership" as two distinct styles of leadership, that should be complimentary. In short, the transactional leader engages others in the reciprocal activity of exchanging one thing for another. That is, the leader and the follower both act to serve their own self-interests. It may take different forms, for instance: the leader could clarify for the follower through direction what the follower needs to do to be rewarded for the effort. it could also take the form of monitoring the follower's performance and taking corrective action if the follower fails to meet standards (Bass, 1999).

In contrast to transactional relationship, Transformational leadership refers to the leader moving the follower beyond immediate self-interests. Burns (2003) stated "When I wrote my book Leadership in 1978 I described this process as one of 'leading by being led.' The leader's self-actualizing qualities are turned outward. He empathetically comprehends the wants of followers and responds to them as legitimate needs, articulating them as values…(his) ability to stay closely attuned to the evolving wants, needs, and expectations of followers — in short, to learn from and be led by followers. And it requires a commitment to a process in which leaders and followers together pursue self-actualization" (Burns, 2003, p. 143). This pursuit of self-actualization requires the transformational leader to be visionary, creative, and to promote radical change whenever necessary (Burns, 1978, 2003).

Expanding on the work of Burns, Bass and colleagues offered a four-dimensional model (also known as the four I's) to break down the characteristics of transformational leadership. These are: **idealized influence (charisma), inspirational motivation, intellectual stimulation, and individualized consideration** (Bass, 1998a, 1998b; Bass, Avolio, Jung, & Berson, 2003). Idealized influence refers to whether a leader is perceived as ethical, confident, trust worthy, idealistic and charismatic; (b) inspirational motivation refers to leadership behavior that motivates

followers by portraying optimism, inspires commitment to a shared vision, and communicates high expectations;(c) intellectual stimulation comprises of critical thinking about solution of problems, and stimulating creativity; and (d) individualized consideration is identified by providing supportive climate for individual development, growth and considering individual needs of follower (Avolio & Bass, 2004).

Despite being around two decades old, these four dimensions are strongly tied to the way leadership in general, and transformational leadership in particular, have been measured over the years, with the MQL (Multifactor Leadership Questionnaire; MLQ 5X; Bass & Avolio, 1996) Being the most commonly used (Angel & Leper, 2020; Batista-Foguet, Esteve & van Witteloostuijn, 2021).

While intrinsically connected to transformational leadership, notably missing from Bass and colleagues' four-dimensional model are the ethical and societal components of leadership. Misusing and manipulating the loyalty and obedience of others is of course something that should be avoided when practicing leadership, especially in healthcare where the overarching goal is to work for the greater good. This brings us to the concepts of servant and ethical leadership.

It was Greenleaf (1977) who formulated and explained the concept of servant leadership theory. This approach view leaders as servant to their followers, as Greenleaf asserts that the servant-leader is a servant first. a servant leader puts the needs, well-being and welfare of the followers first. Therefore, the main focus of servant leadership is to serve the interest of the followers first (Yasir & Mohamad, 2016).

The concept of ethical leadership is relatively new compared to the other two. Brown et al. (2005) defines ethical leadership as "the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision making" (p. 120). These leaders influence ethical conduct of their followers by encouraging ethical behavior (Treviño et al., 2003). Ethical leaders consider ethics in mind while making any decisions, and are likely to enforce policies, procedures and practices that serve to uphold ethical behavior (Mayer et al., 2010). Thus, ethical leaders seek to influence subordinates by managing their ethical behaviors and attitudes (Brown and Treviño, 2006).

All three of these leadership styles have significant overlaps, however there are some distinctions. Yukl (2010) identified the differences between servant leadership and ethical leadership. He asserts that the main concern of servant leaders is to develop, empower and protect followers. Whereas the main concern of ethical leaders is to act and make decisions ethically, including rewarding ethical conduct and punishing or criticizing unethical conduct (i.e., employing transactional leadership).

Transformational, Ethical and Servant leadership in the context of public health

Public health, by its nature, presents problems of large scale that cannot be solved by a single actor or organization. As such, they require collaborations between multiple sectors which don't always have formal ties, nor a built-in hierarchy (Sun & Anderson, 2012). Meaning, employing transactional leadership skills cannot suffice in order to achieve fruitful collaborations.

We can take two components of transformational leadership, "intellectual stimulation" and "individual considerations" as examples and review how they are uniquely helpful in the context of collaborative leadership:

Intellectual stimulation: When issues are shaped to resonate with the dominant logics of partner organizations, there is a greater willingness for partners to engage in new learning without being overly defensive. This forms the base for the integrative public leader to intellectually stimulate others to question time-worn assumptions and to be creative in their problem-solving approach (Ospina & Foldy, 2010).

Individual Consideration: This higher-order behavior helps partners in the multi-sector collaboration to deal with changing economic, social, and political forces that may affect them. Because transformational leaders are individually considerate, they are able to understand and thus give due consideration and respect to the opinions and feelings of the diverse stakeholders in the collaboration. They are able to intellectually craft compelling messages in different ways so as to resonate with the valued identities of individual organizations (Jansen, Vera, & Crossan, 2009).

Another important contribution of transformational and servant leadership is in times of crisis. transformational leadership has long been believed to be particularly effective during crises

(Zhang, Jia & Gu, 2012), and collaborative contexts frequently involve crises, such as major differences in views. This is also true on a macro level when we consider the COVID-19 pandemic. Indeed, research on the topic has shown that transformational leadership had a positive effect on work performance and innovation among health-center workers, and servant-leadership was connected to reduced burn-out among nurses during the crisis (Suprapti et al., 2020; Ma et al., 2021).

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Bass, B. M. (1998a). Transformational leadership: industry, military, and educational impact. Mahwah, NJ: Lawrence Erlbaum Associates.

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Greenleaf, R. K. (1977). Servant Leadership (PaulistPress, New York).

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Treviño, L. K., Brown, M., & Hartman, L. P. (2003). A qualitative investigation of perceived executive ethical leadership: Perceptions from inside and outside the executive suite. *Human relations*, *56*(1), 5-37.

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Offered presentation – Lessons 2-3

Leadership Styles in health

Transformational, servant, and ethical leadership

Leadership Challenges in Healthcare

Macro:

- Crisis response: requires collaborations between multiple sectors that don't have a formal hierarchy (e.g., dealing with vaccine hesitancy)
- Budget constraints, measures taken to avoid deficits.
- Inequalities in access to healthcare

Meso:

- Beurocratic and hierarchical culture hindering interdisciplinary collaborations and efficiency
- Emphasis on targets over care quality

Micro:

- Increasing dual clinician and manager and leadership roles
- Managers' roles aren't always clearly defined.
- High rates of burnout in healthcare workers, especially during COVID.

Addressing the issues: Transactional vs. Transformational Leadership

Transactional Leadership	Transformational Leaderships
• Leadership is responsive • Works within the organizational culture • Employees achieve objectives through rewards and punishments set by leader • Motivates followers by appealing to their own self interest • Management-by-exception: maintain the status quo; corrective actions to improve performance.	• Leadership is proactive • Works to change the organizational culture by implementing new ideas • Employees achieve objectives through higher ideals and moral values • Motivates followers by encouraging them to put group interests first • Individualized consideration: Each behaviour is directed to each individual to express consideration and support. • Intellectual stimulation: Promote creative and innovative ideas to solve problems.

The Four I's of transformational Leadership

- **Idealized influence**

Is the leader perceived as leader is perceived as ethical, confident, trustworthy, idealistic and charismatic?

- **Inspirational motivation**

leadership behavior that motivates followers by portraying optimism, inspires commitment to a shared vision, and communicates high expectations

- **Intellectual stimulation**

comprises of critical thinking about solution of problems, and stimulating creativity

- **Individualized consideration**

individualized consideration is identified by providing supportive climate for individual development, growth and considering individual needs of follower

Servant Leadership & Ethical Leadership

Servant Leadership:

Mainly deals with the way leaders conducts themselves with their followers:

- Put the needs and well-being of the followers first and clarifying that to followers (a goal in it of itself, not just to promote efficiency).
- see themselves as stewards of the organizations In which they work.
- Behaving Ethically: interacting honestly, openly and fairly with followers.

Servant Leadership & Ethical Leadership

- **Ethical Leadership:**

"the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision making" (Brown et al., 2005)

Relevance to aforementioned challenges

- Servant leadership and job satisfaction (Bennet & Hylton, 2020).
- Servant leadership and proactive behaviour in the public health sector (Mostafa & Motalib).
- Transformational Leadership and public health center workers' innovative behaviour during COVID (Suprapti et al., 2020).
- Transformational leadership and psychological well-being of healthcare workers (Irshad, Majeed & Khattak, 2021).
- Ethical Leadership in nursing effects on satisfaction among both nurses and patients (Barkhordarh-Sharifabad et al., 2018).

Lesson 4: Conflict Resolution in Healthcare

In previous lessons we've discussed the importance of articulating a vision and inspiring followers. Of course, any organization's vision and mission need to be tied to the real world. A vision without substance is pointless. In the journey for realizing a vision, conflicts between decision makers are highly likely to arise, and resolving these conflicts effectively is an essential skill for the aspiring leader. This chapter will briefly summarize (a) advantages and disadvantages of shared decision-making; (b) main sources of conflict and obstacles to conflict resolution; (c) leadership styles of dealing with conflict, and (d), a conflict resolution process as described by weeks (1992).

*This chapter is taken (edited) from Rowitz's book "Public health leadership: Putting principles into practice" chapter 21 (2014)

As you well know, the decision-making process does not occur in a vacuum and is usually a group process (e.g., teams, coalitions). This is especially true in public health collaborations, where power is shared. This is both a boon and a bane for the decision-making process. There are at least 3 advantages to shared decision-making: (a) each party brings to the table new information, a diversity of experience, different professional credentials, and a different perspective. Second, a group is likely to come up with more options than an individual. Third, a decision made in a group is likely to receive more acceptance and legitimacy- it is a decision with a ready-made consensus.

There are also at least 3 disadvantages to shared decision making: First, the process can consume a great amount of time where reaching a quick decision is often crucial. Second, a strong minority will sometimes try to dominate the process and will sometimes succeed (conformity). Third, shared decision making could also lead to distribution of responsibility: where no one feels responsible for negative outcomes related to the decisions made.

Due to the multicultural nature of our society and the wide spectrum of political positions held by policy makers, there will almost always be individuals who disagree with any position taken on an issue. A disagreement can be both over the solution and/or over its implementation.

Major sources of conflict and obstacles to conflict resolution include the following:

1. Leaders asserting their authority and engage in a power struggle (in parliament for example, this often leads to a gridlock).

2. Assignment of the wrong people to a team or task force can lead to conflict. It is unfortunately common to see an executive appointed to a major task force either not attend most of the meetings or send as a proxy someone without the power to make decisions.
3. Naturally arises in a meeting run by someone who lacks respect for the attendees, communicates poorly, or hides the reason for the meeting.

Prerequisites for conflict resolution:

(a) Conflict resolution by a group requires that it be given full authority to resolve the conflict. If the group doesn't have adequate authority, it will spend fruitless hours discussing issues that are beyond its power to do anything about.
(b) Effective interpersonal communication skills are crucial to conflict resolution (e.g., active listening, conversational etiquette).

A preliminary step in resolving conflict is to select an appropriate strategy or style. Which conflict resolution style is best depends on the nature of the conflict and the situation in which it occurs. Rahim (1983) has mapped 5 styles that a leader might use to deal with conflict. These are arranged by the degree of concern the leader shows for himself/herself and others.

1. **Integrating style:** involves collecting pertinent facts as part of the conflict resolution process. It is oriented towards finding an innovative solution that satisfies both parties. The leader who uses this style exhibits a concern for both self and others.
2. **Obliging style**: typical of a leader who showed great concern for others but little concern for self. The leader would tend to go along with whatever the other party to the conflict wanted, perhaps out of a worry that he or she lacked the expertise necessary to resolve the conflict in any other way.
3. **Dominating style**: diametrically opposed to no.2. the leader exhibits great concern for self but little for others. The leader acts in an authoritarian manner and basically lays down what the resolution is going to be.
4. **Avoiding style**: used by leaders who exhibit a low degree of concern for self and for others. The goal is to protect the status quo, and the conflict avoiding leader stays in the background and lets others deal with the conflict and its ramifications.
5. **Compromising style**: the middle of the road style. The compromising leader shows average concern for self and others. Compromise involves reciprocity, which means that

each party to the conflict gets something. Useful for resolving conflicts between partners, as they are treated the way they expect to be treated- with equal respect.

Conflict resolution process

There are at least two sides to every conflict. Each party enters the conflict with agenda based on personal, organizational or community concerns and values and possibly goals and objectives. Emotions often get involved. Out of this mix, a consensus of some kind needs to be forged. The steps toward reaching that consensus are outlined by Weeks (1992) who devised a process for dealing with conflict. The steps are as follows:

1. **Create an effective atmosphere**. (e.g., make sure that the times and locations of the meetings are agreeable to everyone, a neutral place).
2. **Clarify perceptions**: the leader needs to determine whether the conflict is tied to personal, organizational, community or professional concerns. Is the conflict related to values or needs? Are goals and objectives driving the process? Finally, the leader must examine the components of the conflict and develop strategies based on the analysis.
3. **Focus on individual and shared needs**: each party to the conflict identifies their personal needs. The leader then helps the parties to identify needs that they share. The process of looking at their needs often helps the parties to discover needs, values and perceptions they unknowingly possess.
4. **Build shared positive power**. For power sharing to occur, the parties must come to share a clear mission and vision, be willing to settle for realistic goals and objectives, and view resolution of the conflict as in everyone's best interest.
5. **Lead to the future, then learn from the past**. Requires the leader to evaluate how past decisions influence the present conflict and prepare the way for a less conflictive future. The parties need to be careful not to let past experiences get in the way of building a better future.
6. **Generate options**. Parties identify and explore options for resolving the conflict. These options can help the parties to see the issues more clearly and be less governed by previous perspectvies. This requires the parties to be creative and analytic to examine the likely consequences of various options. Dialogue can be very useful here (i.e, allowing each party

to present their position and possible solutions to the conflict without interruption). Moving into the discussion, the agenda of each party will be on the table.

7. **Develop doables**. Small actions that are easy to complete and which will improve the relationship between the parties (building trust). Hopefully this will make them better able to agree on a final resolution to the conflict.
8. **Make mutually beneficial agreements**. Must be realistic and mutually beneficial.

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Offered presentation – Lesson 4

Conflict Resolution In healthcare

Shared Decision Making: a Boon and a Bane

- Decision making, especially in public health, does not occur in a vacuum.

Advantages of shared decision making include:

- More diversity of information, experience, credentials and perspectives.
- More solutions to choose from.
- Decisions have a “ready-made consensus”

Shared Decision Making: a Boon and a Bane

Disadvantages of shared decision making:

- Time consuming where sometimes reaching a quick decision is crucial.
- A minority might dominate the process (conformity)
- Distribution of responsibility

Common Sources of Conflict

- Leaders asserting their authority and engage in a power struggle (Think of a gridlock in parliament)
- Assignment of the wrong people to a team or task force can lead to conflict
- Naturally arises in a meeting run by someone who lacks respect for the attendees, communicates poorly, or hides the reason for the meeting.
- differences in ideologies and organizational objectives

Prerequisites for conflict resolution

(a) Conflict resolution by a group requires that it be given **full authority to resolve the conflict**. If the group doesn't have adequate authority, it will spend fruitless hours discussing issues that are beyond its power to do anything about.

(b) **Effective interpersonal communication skills** are crucial to conflict resolution (e.g., active listening, conversational etiquette).

Dealing With Conflict

Rahim (1983) defined five styles a leader might use to handle conflict:

1. **Integrating style:** involves collecting pertinent facts as part of the conflict resolution process. It is oriented towards finding an innovative solution that satisfies both parties. The leader who uses this style exhibits a concern for both self and others.

2. Obliging style: typical of a leader who showed great concern for others but little concern for self. The leader would tend to go along with whatever the other party to the conflict wanted.

Dealing With Conflict

- **Dominating style**: diametrically opposed the obliging style. the leader exhibits great concern for self but little for others. The leader acts in an authoritarian manner and basically lays down what the resolution is going to be.
- **Avoiding style**: used by leaders who exhibit a low degree of concern for self and for others. The goal is to protect the status quo, and the conflict avoiding leader stays in the background and lets others deal with the conflict and its ramifications.
- **Compromising style**: the middle of the road style. average concern for self and others. Compromise means that each party to the conflict gets something. Useful for resolving conflicts between partners, as they are treated the way they expect to be treated- with equal respect.

Conflict Resolution Process

1. **Create an effective atmosphere**. (e.g., make sure that the times and locations of the meetings are agreeable to everyone, a neutral place).
2. **Clarify perceptions**: the leader needs to determine whether the conflict is tied to personal, organizational, community or professional concerns. Is the conflict related to values or needs? Are goals and objectives driving the process?
3. **Focus on individual and shared needs**: each party to the conflict identifies their personal needs. The leader then helps the parties to identify needs that they share.

Conflict Resolution Process

4. Build shared positive power. the parties must come to share a clear mission and vision, be willing to settle for realistic goals and objectives, and view resolution of the conflict as in everyone's best interest.

5. Lead to the future, then learn from the past. Requires the leader to evaluate how past decisions influence the present conflict and prepare the way for a less conflictive future.

Conflict Resolution Process

6. Generate options. Parties identify and explore options for resolving the conflict. Requires creativity and analytical skills to examine the likely consequences of various options. Dialogue can be very useful here

7. Develop doables. Small actions that are easy to complete and which will improve the relationship between the parties (building trust).

8. Make mutually beneficial agreements. Must be realistic and mutually beneficial.

Exercise

- "Purpose: to recognize the causes of conflict and how to resolve the conflicts.
- Procedures: the class should break into groups of 8-10 members. First, each group member offers one word in reaction to the term "conflict". The words are put on a large sheet of paper and discussed by the group. The group then divides into two subgroups, one of which assumes the role of a team from the local health department, the second of which assumes the role of a management team from a local health maintenance organization (HMO). The HMO wants to build a major new medical center on land owned by the city, but the public health department wants the land for a new substance abuse clinic. Each team explains its position, and together they try to resolve the conflict between them."- Rowitz, 2014, p.547

Lesson 5: Ethical Decision-making in health

The weight and impacts of decisions made by healthcare organizations often carry with them moral implications that should be considered. This makes ethics, sometimes referred to as the science of morality, central to their decision-making processes (Peer & Rakich, 1999). The goal of this chapter is to introduce students to the ethical aspects of decision-making in healthcare organizations, from both a bioethical and a public health perspective.

In the field of philosophy, ethics is a branch that deals with understanding and justifying different approaches to morality. Ethics provides a compass to human behaviour at both the personal and the professional level. Fittingly, Brown defined ethics as "a process of deciding what should be done" (Brown, 1990). Of course, since ethics is rooted in personal beliefs and values, establishing ethical principles often leads to disagreements regarding their importance and how they should be applied.

That being said, ethics can and should be applied to both management and leadership in healthcare. Applied ethics involves the integration of normative ethical principles. It provides a strategy for fostering professional responsibility by focusing on the stimulation of moral imagination, recognition of ethical issues, development of analytical skills, promotion of a sense of moral responsibility, and the tolerance and resolution of disagreement (Peer & Rakich, 1999).

Leaders in healthcare should be familiar with the field of bioethics, and with its subfield of public health ethics, as the two offer different points of focus in their application. Bioethics is the study of ethical issues emerging from advances in medicine, biology and technology. It was first conceptualized as a bridge between two cultures: sciences and the humanities, and it posits that "ethical values cannot be separated from biological facts" (Potter, 1971). Its application is usually focused on decisions regarding the individual in healthcare, such as informed consent, decisions affecting resource allocation, experimentation, death and dying, abortions etc. (Peer & Rakich, 1999; Lee, 2017).

Public health ethics is a newer field, coming into its own in the early 2000s. Initially the field borrowed heavily from the principle-based approach of clinical ethics, but added a clear focus on justice—social justice and distributive justice—and on public beneficence— doing good for the community (Lee, 2017). Applied ethics in public health are often manifested as dillemas between principles of individual autonomy and the common good (Davidovitch, Levin & Rashfon, 2009).

One prominent example of such a dilemma can be seen in the different restrictions and vaccination strategies for combatting COVID-19. A challenge facing public health leaders is how to promote community health with minimal breaches of bodily autonomy and privacy, that is by increasing compliance rather than relying on coercion.

Furthermore, public health interventions sometimes unintentionally generate social inequalities on a socio-economic basis. Such interventions are often media campaigns or workplace smoking bans that are of greater benefit to advantaged groups compared to disadvantaged groups (Lorenc et al., 2013). These unintentional consequences highlight the importance of developing interventions with these ethical considerations in mind, and working to mitigate inequalities (Bast et al., 2021).

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Offered presentation – Lesson 5

Ethical Decision-Making

What is ethics?

- The philosophical discipline that seeks to understand different approaches to morality.
- Studies the nature and justification of moral principles, decisions, and problems.
- Provides guidance to human behaviour at both the personal and the professional levels.

Bioethics

- the study of ethical issues emerging from advances in medicine, biology and technology (e.g., ethical implications of CRISPR, euthansia, etc.)
- Attempts to bridge between the sciences and the humanities: “ethical values cannot be separated from biological facts" (Potter, 1971)
- Its application focuses more on curative clinical practice in the context of individuals. For example decisions affecting resource allocation, death and dying, experimentation ethics, etc.

Public Health Ethics

- Focuses on the public, the good of the community (e.g., addressing inequalities)
- How to implement a national or local vaccination strategy?
- Sometimes public health interventions have unintended consequences: such as generating inequalities (as in reduced smoking rates mostly in advantaged groups.

Ethical dilemmas

- Ethical dilemmas are faced at the macro, meso and micro levels.

The conditions to ethical dilemmas according to Hiller (1986):

(a) "A real choice must exist between possible courses of action "

(b) "each possible action or its consequences must hold a significantly different value and the manager must be able to distinguish between ethics and values and to acknowledge that personal values often affect decisions"

Ethical Dilemmas

- The real dilemma occurs when a resolution has conflicting effects on the various constituencies; it is then that the manager must rely most on the ethical foundations for decision making and the organizational philosophy (Price 1992).

An evaluation questionnaire (Transformational leadership).

Recommended to hand out at the beginning and at the end of the course.

Clark, D. R. (2011). Transformational Leadership Survey

1. I go out of the way to make others feel good to be around me.
2. I help others with their self-development.
3. I help others to understand my visions using tools, such as images, stories, and models. 4. I ensure others get recognition and/or rewards when they achieve difficult or complex goals.
5. I let others work in the manner that they want.
6. I get things done.
7. I have an ever-expanding network of people who trust and rely upon me.
8. I provide challenges for my team members to help them grow.
9. I use simple words, images, and symbols to convey to others what we should or could be doing.
10. I manage others by setting standards that we agree on.
11. I rarely give direction or guidance to others if I sense they can achieve their goal.
12. I consistently provide coaching and feedback so that my team members know how they are doing. 13. People listen to my ideas and concerns not out of fear, but because of my skills, knowledge, and personality.
14. I provide an empathic shoulder when others need help.
15. I help others with new ways of looking at new and complex ideas or concepts.
16. I ensure poor performance gets corrected.
17. As long as things are going smoothly, I am satisfied.
18. I monitor all projects that I am in charge of to ensure the team meets it goal.

- Charisma (questions 1, 7, 13)
- Social (questions 2, 8, 14)
- Transactional (questions 4, 10, 16)
- Delegation (questions 5, 11, 17)
- Execution (questions 6, 12, 18)

Chapter II: PBL

Problem-Based Learning (PBL) as an instructional approach

A part of this course is designed for a different style of teaching than the lecture based, teacher-centered approach most of us are used to in academia. This short chapter aims to answer 3 questions: 1. What is PBL? 2. Why should we use PBL in a leadership in health course? And 3. What strategies should the teacher (facilitator) employ to promote effective learning?

Beginning with the first question, PBL is a type of experiential learning approach. It is an instructional (and curricular) learner-centered approach that encourages learners to conduct research, integrate theory and practice, and apply knowledge and skills to develop a viable solution to a defined problem. An integral part of the approach is the selection of ill-structured problems (often interdisciplinary) and a facilitator who guides the learning process and conducts a thorough debriefing at the conclusion of the learning experience (Savery, 2015). It is set apart from other similar experiential learning methods (like the Inquiry-based approach) by the role of the facilitator. That is, in a PBL approach, the tutor supports the process and asks questions, but they do not provide information related to the problem- that is the responsibility of the learners.

PBL has been described as organized around the investigation and resolution of messy, real-world problems, that don't have a single correct answer (Hmelo-Silver, 2004). The key learning principles behind the PBL process are that it is (1) **constructive**, in that it emphasizes learning as an active process where students are stimulated towards activation of prior knowledge and elaborations on the topic, thus effectively constructing or reconstructing their knowledge networks; (2) **self-directed,** in that learners play an active role in planning, monitoring (including both cognitive and motivational self-regulation) and evaluating the learning process; (3) **collaborative,** In that learners should be stimulated to interact with each other because these interactions may positively influence learning; and (4) **Contextual,** in that learners are exposed to the problem in a professionally relevant context and from multiple perspectives, as this stimulates transfer of knowledge (Dolmans et al., 2005).

In line with those principles, students are to work in collaborative groups to identify what they need to learn in order to solve a problem, engage in self-directed learning, apply their new knowledge to the problem, and reflect on what they learned, and the effectiveness of the strategies

employed. Literature reviews of PBL tend to converge around the following learning outcomes: (a) an extensive yet flexible base of knowledge, (b) problem-solving skills, (c) self-directed learning (SDL) skills, (d) intrinsic motivation to learn, and (e) collaboration skills (Hmelo-Silver, 2004; Loyens et al., 2012; Loyens, Magda, & Rikers, 2008).

Now that we understand what the PBL approach is, we can move on to the second point: its effectiveness in leadership development. Among the key leadership development trends recently identified for Human resources development practitioners is the use of experience-based programs (Ardichvili et al., 2016). Experiential leadership development initiatives are cited as an essential part of leadership development (Allio, 2005; Amagoh, 2009; Dalakoura, 2010), and they seem to be particularly well suited for developing the complex skills required of leaders (Hezlett, 2016). That is, dealing with ill-structured problems that have multiple solutions better emulates the challenges that managers and leaders in healthcare face. Furthermore, overuse of conventional didactic methods such as lecturing and teacher-centered instruction consistently tops critics' lists of reasons why institutions have failed to develop the teamwork, leadership, and problem-solving skills necessary for managers to be successful in the 21st century (Scott, 2017).

Applied to leadership development, PBL has been described as a powerful approach to simultaneously teach transferable critical thinking skills and domain-specific content, allowing learners to achieve both the cognitive and behavioral development necessary to solve complex problems (Scott, 2017). Furthermore, it may be an effective technique for developing tacit knowledge, or knowledge that is difficult to explain to others, derived from experience, and associated with higher levels of job performance (Armstrong & Mahmud, 2008).

Asking the students to **define the problem, generate hypotheses, identify knowledge gaps and, research them and seeks solutions is the formal structure of PBL**. However, if the facilitator shouldn't provide information regarding the problem, what exactly is it that they should do? To answer this question, we'll draw upon Hmelo-Silver & Barrows (2006) analysis of the goals and strategies of the PBL facilitator. In general, the facilitator is always looking for moments in which he or she can use any of a variety of strategies to (1) keep the process going with all students involved, moving in productive directions, (2) help make students' understanding and thinking transparent, and (3) guide them towards the curriculum's educational goals. These strategies are not scripted in advance but are rooted in the students' discussions while keeping the overall goals

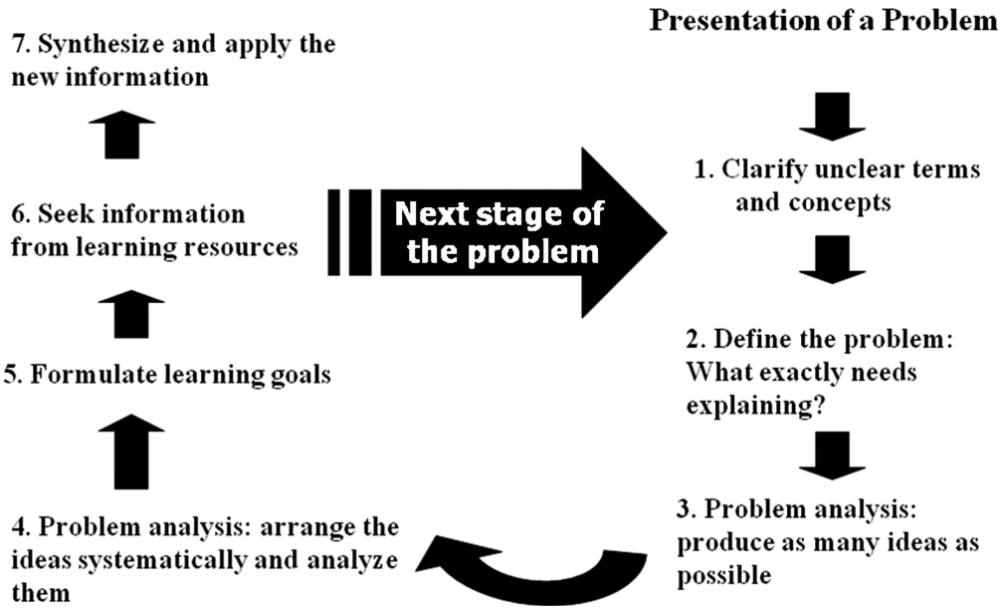
in mind. Below is a list of some of the strategies Barrows used in a PBL program for medical education, with brief explanations. It is important to note that this summary is by no means an exhaustive review of these strategies, and the reader is encouraged to read the full text.

1. Pushing for explanations: when a student raises an idea in the group, the facilitator should strive to make their thinking process apparent by asking them to explain their idea, or to define the terms that they used when expressing that idea. Ideas and answers, even when flawed, can evoke thinking in the rest of the group as well as provide a window for the facilitator into the current understanding of the student, so as to help him/her with guiding questions. More importantly, asking the student to clearly define the building blocks of their idea helps them realize the limits of their own understanding.

2. Revoicing: essentially restating what the students have said. This is a useful tool when hypotheses or ideas come fragmented or vaguely phrased (e.g. different students contributing to the same idea). It can also be useful in navigating the discussion and giving attention to some ideas over others (can keep important ideas in the discussion and legitimize the voices of low-status learners in the group).

3. Generating hypotheses: encouraging students to generate hypotheses can help students focus their inquiry and become aware of the limitations of their knowledge. This is important for promoting self-directed learning as well as keeping the process moving along. It can help prevent students from engaging in unfocused data collection.

As for a protocol for the PBL process itself, we'll draw on a case study by (Stankunas et al., 2016) where a PBL healthcare management training course was implemented. The learning process is outlined in figure 1 (taken from Stankunas et al., 2016)



In their study, the following schedule was repeated each day. In our course they will be performed over 3 lessons. An outline of the schedule is presented below:

1. Supporting lecture on the topic.
2. Pre-discussion session: analyzing the PBL case (first 5 steps- ends with identification of 2-3 goals).
3. Self-study/group work time (no strict instructions).
4. Post discussion to sum up learning results and previous discussions.

* Each pre- and post-discussion session had a chair and note-taker selected from among the group of students. All steps are supervised by the facilitator.

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Case study: Vaccine hesitancy

Vaccines are an essential tool in disease prevention, as they have been responsible the for the eradication or drastically reduced mortality rate of various infectious deadly diseases (e.g., smallpox, measles, and polio; Greenwood, 2014). However, In some regions where vaccinations are readily available and accessible, certain groups are slow to accept or outright refuse vaccination due to various concerns. This has resulted in difficulty controlling new diseases (such as COVID-19) and in reversing decades of progress towards elimination of diseases like measles in many countries (Gardner et al., 2020). This phenomenon, known as Vaccine hesitancy, is therefore one of the greatest challenges facing public health leaders today (MacDonald, 2015).

In the distant past, one way of dealing with vaccine hesitancy was to make them mandatory, as was the case in the UK's 1871 Vaccination Act (Allen & Fitzpatrick, 2007). Since coercive methods like these are both morally controversial and may propel vaccine-hesitancy sentiments, a more sensitive method that promotes cooperation is required. In order to come up with specific solutions, we must start by exploring the known determinants of vaccine hesitancy.

First, it's important to note that vaccine hesitancy is vaccine and context specific. That is, the degree of vaccine hesitancy in a community depends on various factors (e.g., the vaccine itself, community characteristics, perception of policy-makers motivations etc.; MacDonald, 2015). According to the 3 C's model, developed by the WHO, the three components determining an individual's vaccine hesitancy are Confidence, Complacency, and Convenience (MacDonald, 2015; Gerretsen et al, 2021).

Confidence refers to the perceived safety and effectiveness of the vaccine and the system recommending and providing it. **Complacency** exists when perceived risks of the vaccine-preventable disease are low, vaccination isn't believed to be necessary, and when possible, consequences are believed to outweigh the benefits. Immunization programme success may, paradoxically, result in complacency, as individuals weigh risks of vaccination with a particular vaccine against risks of the disease the vaccine prevents, which is no longer common. **Convenience** refers to the the quality of service (real or perceived) and the degree to which vaccination services are delivered at a time and place and in a cultural context that is convenient, comfortable, and affordable (MacDonald, 2015).

These 3 individual components are of course influenced by a variety of larger factors, such as: communication of vaccine-related policies by authorities, media environment and misinformation, historical influences, religion, mode of administration, education, vaccination schedule and others (Macdonald, 2015; Truong et al., 2022).

Exercise:

Each group, consisting of 5-6 students chooses a vaccine to investigate (e.g., COVID, MMR, Polio, Influenza etc.)

The final product should be a 20-30 minutes long presentation that includes:

1. Presenting the subject (each group and their vaccine).
2. Policy abroad
3. The issue of vaccine hesitancy in the context of the specific vaccine, what are the vaccine characteristics that result in hesitancy.
4. Israeli and worldwide vaccine coverage.
5. Characteristics of vaccine-hesitant group (what communities are they from)
6. Offer at least 3 ideas for combatting the issue. For each idea the group should analyze advantages, disadvantages, and applicability.

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Chapter III: Simulation

What is a simulation?

A simulation is a tool which allows participants to experience reality-like situations in a controlled, safe environment, in order to improve professional and personal skills through practice, reflection and feedback (Eizenhammer, 2014). It combines theoretical knowledge and practical experience in a variety of fields, such as: health sciences, educations, management, leadership, flight etc. In health sciences the simulation facilitates the practice of a variety of skills like clinical skills, therapeutic procedures, time management, teamwork and decision making under pressure (Lane, Slavin & Ziv, 2001). Additionally, healthcare workers operate in a professionally and culturally diverse environment, and thus must have high social awareness. For this purpose, simulation of cultural pluralism practices can strengthen egalitarian and inclusive behavior. Moreover, it allows to simulate conflictual situations and thus hone communication skills and effective ways of managing conflict.

The simulation is based on The Experimental Learning Cycle, according to which learners should be faced with a direct experiential encounter with a meaningful phenomenon, the interrogation of which requires reflective observation stemming from related knowledge and experience (Kolb, 1984). The simulation-based experiential learning process includes four different steps that repeat themselves in a circular motion: concrete experience in which the individual performs a task and handles a challenge, observation of the experience and reflection, construction of new perceptions and ideas, application through the acquired insights and experiencing a new scenario. That is, learners must link the theoretical knowledge they acquired and the practice they experienced, while employing reflective processes. The reflection, which is done as part of the debriefing, helps in raising awareness of the existence of varying courses of action through group reflective observation in the simulation workshop.

Facilitation

A successful simulation begins with proper facilitation. A simulation is an engineered situation, therefore the scenario's flow and the extent to which the simulation objectives are achieved hinge largely on the facilitator's skill (Franklin et al., 2013). The facilitation is comprised of three aspects: pre-scenario, within-scenario and post-scenario. In the pre-scenario phase, the facilitator must know the primary and secondary objectives of the scenario and create a scenario that is as

realistic as possible. Therefore, it is crucial to phrase the scenario and participants' roles clearly. The scenario should then be allowed to proceed uninterrupted, and the facilitator should observe the group dynamics carefully. After the scenario the facilitator should perform the debriefing.

Debriefing

The debriefing is an integral and crucial part of the simulation (Kolbe et al., 2015). It is one of the most important components that contribute to simulation-based learning (McGaghie et al., 2010), and is usually based on reflective watching of the experience as it was recorded on video. It is a learning mechanism which allows for (a) venting emotions that arose from the experience; (b) exposure to challenges and successes and discussing them as part of the professionalization process, and (c) analyzing the situation and performing a personal and group reflection (Levett-Jones & Lapkin, 2014). The debriefing deals with the process rather than the result and is designed to identify strong and weak points of the participants' conduct while addressing both overt and covert aspects of their behavior. The overarching goal of the debriefing is to help participants understand, learn and apply insights from the simulation experience (rather than focusing on mistakes), in order to change their future behaviors according to the learning objectives. Upon completion of the debriefing, the facilitator summarizes the lessons learned, to imbue the learners with the feeling of achieving practical and useful information. The facilitator should ensure that the debriefing is conducted in an enabling, respectful, non-judgmental way, and that he provides feedback to the learners. There are many models for preforming a debriefing. The two leading models are the Structured and supported Debriefing Model, and the Debriefing with Good Judgment Model (Bowe et al., 2017). Below is a brief overview of the models:

<u>The Structured and Supported Debriefing Model (O'Donnell et al., 2009):</u>

The acronym of the structured section are GAS (Gather, Analyze, Summarize). *Gather*- The purpose of this stage is to gather information which will be used for the later stages. At the beginning of this stage, participants are invited to share their thoughts and concerns regarding the simulation. The facilitator should use open ended questions such as: "what are your thoughts?" or "how did that make you feel?" to create an open dialogue and investigate the most relevant topics for the participants. Additionally, the facilitator can begin to identify perception gaps in performance. Perception gaps refer to the dissonance between participants' perceptions of their own performance compared to the facilitator's perception of it. The Gathering stage should take

around 25% of the total debriefing time. *Analyze*- in most cases, 2 or 3 learning objectives provide the focal point for topics to be discussed during the analysis stage. The purpose of the analysis stage is to encourage reflection among the participants and promote self-discovery. The analysis stage draws from the information gathered in the previous stage and guides the participants to reflect and progress through their skill set. The analysis stage should take around 50% of the total debriefing time. *Summarize*- the purpose of this stage is to guarantee a clear understanding of the most important points. It is recommended that the facilitator makes the transition to this stage clear. For instance, "I think we had a fantastic discussion, let's talk about the main points we can take away from this simulation". In this model the summary stage is organized around Plus-Delta technique. Plus-Delta is a model which focuses on effective actions or behaviors (+) and behaviors and actions where there is room for improvement (Δ). During the summary stage, the participants will be asked to provide 2 positive aspects of performance and 2 aspects that they will change the next time they encounter a similar scenario. The summary stage should take the remaining 25% of the total debriefing time.

Debriefing with Good Judgment Model (Rudolph et al., 2006)

This model is characterized by 4 key principles: (1) defining clear learning goals prior to the simulation, (2) defining clear expectations for the session, (3) approaching the learners with genuine curiosity and feedback while resisting the urge to "correct" them, and (4)- dividing the debriefing session into 3 stages: responses, analysis and summary. *Responses*- this stage is an opportunity to clear the air following an emotionally loaded and stressful experience. The stage begins with questions like "how did it feel?" so as to hear preliminary reactions, corroborate emotional responses and note potential goals created by the learner for the debriefing session. The responses stage is comprised of feelings and facts. *Analysis*- the analysis stage allows the facilitator and learners to work together in order to observe the gaps between the desired performance and actual performance, to provide feedback on these gaps and work towards closing them through discussion and didactics. The performance gaps won't be uniform among a group of learners and won't be perceived equally by each learner. The analysis stage provides an opportunity to reach cohesion in content and in the extent of the gaps, so they can be efficiently solved for each learner. Questions like "I noticed that…" or "I'm happy/concerned about…" may be used, followed by concrete examples of what the facilitator had watched. Afterwards, an open-ended question

(inquiry) to understand the perspective or frame of reference of the learner, like "what were you thinking about at the time?" or "how did you see it?" *Summary*- the summary stage is the facilitator's opportunity to encourage learners to share insights to take away from the session. That is, the main lessons they intend to use. It allows learners to process and fully review what they plan on taking away from this experience, with the hope that they will also apply it in practice.

Simulation based learning- developing leadership in health

In order to build leadership skills, simulations that allow for experiential learning and immediate feedback are required. Simulations that develop leadership skills are applied around the world in all health professions and through all career stages and have been proven effective in developing leadership and management skills (e.g., Adams et al., 2010; Cooper et al., 2011; Fernandez et al., 2020; Labrague, 2021). The underlying assumption at the heart of developing the current simulation in the setting of a public health leadership course is that collective involvement of the participants in a reality-like situation which contains a leadership dilemma, will illustrate basic concepts of teamwork and decision-making, and act as a steppingstone to the learners for examining their leadership and management skills (Johnson, Huang & Shepherd, 2021).

Goals of the simulation experience in the present course

- Promoting skills in a complex environment and creating collaborations with organizations outside the health system.
- Improving cultural competence.
- Improving conflict management skills.
- Strengthening teamwork and mobilizing a multi-professional team while leading by example.
- Developing an ethical decision-making ability, through persuasion and reaching consensus.
- Developing skills of conveying messages in a convincing fashion, including to the press.

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Scenario 1- Leadership in a complex environment

All following scenarios open with a general overview and definition of the learning objectives. Next, there are detailed descriptions of the case, participants, and each participant's role. After which there are reference points in the debriefing based on the different stages of the scenario, and finally an evaluation questionnaire to be filled by the participants on the simulation. It is important to note that all scenarios and roles are designed for all genders, and he/his pronouns were used for clarity and convenience purposes only.

Figure 1: a general overview of the simulation "leadership in a complex environment"

Simulation title	Leadership in a complex environment
Simulation developer	Dr. Keren Dopelt
Estimated time:	20 min
Estimated debriefing time	40 min (20 without watching the video footage)
Target group:	Students in the leadership in health course

Core: developing leadership skills

1. Leading a coalition of parties outside the health system to promote change
2. Creating a vision and a plan for action
3. Creating a plan for removing barriers identified by the team

Learning outcomes: students who complete the scenario will demonstrate an ability to use leadership skills to form a coalition and mobilize stakeholders from different fields to action.

Specific learning objectives:

1. To advance processes in a complex environment
2. To create collaborations with parties outside of the health system
3. To develop a vision and relay it to stakeholders
4. To define barriers
5. Planning how to overcome barriers. Thinking outside the box
6. Managing a team
7. Managing conflicts.

Prior to the simulation:
Each participant will read the scenario carefully and realize their specific role.
Each participant will sign an informed consent form for recording the session for learning purposes.

Figure 2: Scenario, participants, and roles descriptions

a) Case abstract		
In the city of Be'er Sheva the vaccination rate of children ages 5-12 against COVID-19 is around 24%, whereas the national goal was set to 75%. One of the main components of the lack of adherence to children's vaccination against COVID is distrust in the health system and parental concern over side effects. The largest HMO in the city did not designate enough facilities, flexible hours and manpower for the vaccination operation. The HMO turned to the municipality in a request to vaccinate in the community centers spread across the city, and the municipality is taking its time with responding. COVID incidence among children is rising, and the mission to increase vaccination rates is of great national importance.		
b) Main context		
The minister of health is expressing his concern to the COVID project manager given the high incidence rates and low vaccination rate in the city. The project manager convenes a multidisciplinary team for a discussion on what he views as a national responsibility, as well as on the barriers that prevent parents from vaccinating their children.		
c) the team participating in the scenario		
Negev regional HMO manager	Head of the city's parental committee.	COVID tsar (COVID national coordinator)
	Director of education	The mayor
d) The environment		
Mayor's office		
e) Required equipment		
A quite room	Cameras	Microphones
	A table circled by chairs	A recording program
f) description of the participating characters		
<u>COVID national coordinator-</u> a doctor with a rich history in administrative roles, including hospital administration. Has been in office for about a year and is determined to prove himself so he could get to a more senior position within the ministry of health. He is Assertive and extreme in his positions regarding children's vaccination. In his opinion, parents should be forced to vaccinate their kids. He is under tremendous pressure in the wake of a new wave of COVID which he is trying to prevent through encouraging vaccinations. The prime minister and minister of health are urging him to increase vaccination rates and lower incidence rates without imposing further restrictions on the population. The project manager is the one who initiated the meeting and is leading the discussion. His goal is to plan an intervention program that will incorporate all parties in order to increase vaccination rates.		
<u>The mayor-</u> In his 40's, father of 2 vaccinated children. He takes the side of the project manager on the issue of raising the vaccination rates, not through coercion, but rather through soft interventions, advocacy, and persuasion. He refuses to allocate community		

centers as vaccination centers for the HMO. From his perspective it is a hang-out place for children, and he doesn't wish to see it turned into a medical facility. He is angry at the district manager who pressures him to authorize this. He wants to raise vaccination rates in the city, but also to look after citizens' welfare and to appease them, meaning not turning urban recreational facilities into vaccination facilities. He thinks the HMO can put in more effort and allocate its own facilities for this purpose. He also wishes to issue a press release on the planned intervention program after the meeting.
Head of the city's parental committee- approaching age 40, an energetic high-tech man, highly intelligent and difficult to persuade. Father of 3 three children ages 6, 9 and 12. All of whom study in the education system. He and his wife were vaccinated, but they are hesitant to vaccinate their children. He is dealing with many inquiries of parents regarding the vaccines. He is angry at the project manager for his intent to force parents to vaccinate their kids and asks pediatric doctors to explain the side effects to the parents, so as to alleviate their concerns.
Director of education- 55 years old. He has a PhD in education. Father of adults. Seeks to create a climate of transparency, involvement, and partnership with all parties for the good of the children. Interested in open dialogue with the students, parents, and pedagogical staff. He believes it is important to act with sensitivity and to develop a feeling of solidarity among the parents who are concerned about vaccinating their kids. He is also interested in coming up with solutions for immune suppressant students and staff. He is against pedagogical staff giving information on the vaccines and insists that this is job is the health system's only. Isn't interested in vaccination knowledge translation to parents or kids on school grounds.
Negev regional HMO manager- a medical doctor, has been in office for 4 years. Has experience in a variety of managerial positions in the southern district of the HMO. He is under a huge workload and is going around the different cities to try and convince people to get vaccinated. Due to the shortage of HMO facilities and the difficulty to allocate rooms for the vaccines he turned to the mayor in a request to allocate designated rooms in local community centers. The mayor refused which created tension between the two. He is angry at the mayor and is trying to convince the rest of the team members to help him get an authorization to vaccinate in community centers.

Debriefing:

The debriefing will be done immediately upon completing the simulation (with no intermission). It is vital to conduct the debriefing in a reflective manner, while addressing the skills that the simulation attempted to develop. For instance, "As COVID project manager you said that… what was the purpose of this statement? Did it promote the discussion in your opinion? Did it

lead to cooperation, or did it lead to the opposite goal? What could have been done differently to further the mutual goal?" etc.

Figure 3: points of reference in the debriefing based on the different stages

Points of reference	stage
Mutual listening, patience, ability to analyze the barriers. The facilitator should pay attention: did everyone express their opinion in the discussion? Were participants interrupting each other? Were barriers addressed?	The project manager convenes the meeting in the mayor's office to discuss barriers to vaccination in the city.
Ability to lead/participate in a discussion, thinking outside the box, getting the team to cooperate. The facilitator should pay attention: did the team members listen to each other? Has there been cooperation between team members or did each of them only represent their own side without open mindedness and flexibility? Did the team members try to find creative solutions to barriers?	Overcoming the barriers and developing strategies to increase vaccination rates
Leadership, teamwork, ability to manage and solve conflicts, reaching consensus. The facilitator should pay attention: what were the main barriers that created conflicts? How long did it take to reach consensus? What caused a change and reaching consensus? And finally: take an idea of one of the participants, was it a compromise or a new idea?	Developing an intervention program that includes all parties
Scenario end:	
Ability to convey messages, ability to draft a press release. The facilitator should pay attention: was the message agreed upon? Was the team able to convey the message they wanted and draft a short press release?	Drafting a press release on the planned program for the city

Evaluation

It is recommended to give the participants an evaluation questionnaire so that we could learn which objectives were achieved and where there is room for improvement.

Figure 4: scenario evaluation questionnaire for the participants

Demographic questions
1. What is your position at work? 2. What was your role in the simulation? 3. How old are you? 4. Have you participated in simulations before? If so, please state when, where, and what the goal of the simulation was.
Open-ended questions
1. How did the experience feel to you? 2. Did you have the knowledge and abilities to achieve the scenario's learning objectives? 3. What gaps did you identify in your set of knowledge and/or the preparation for the simulation? 4. What relevant information was missing in the scenario that affected your performance? 5. How did you overcome the knowledge gap? Did it happen in a short period of time? 6. What did you take away from the simulation experience? 7. What strengths or weaknesses of yours were you able to identify? 8. What did you enjoy the most in the simulation? 9. What did you enjoy the least in the simulation? 10. Will the participation in the simulation help you when encountering similar situations in the future?
Closed questions (Likert Scale, 1-5 from not at all to very much)
1. How satisfied were you from the conditions under which the simulation was performed? (room, equipment etc.) 2. How confident did you feel having the discussion? 3. How confident did you feel in your ability to identify issues that require leadership and in your own leadership ability? 4. To what extent did you feel that the discussion was run in a respectful manner? 5. To what extent did you feel that you are furthering the team's dynamics? 6. To what extent did you feel able to influence the others? 7. To what extent did you feel that you could have been a role model in your professional behavior? 8. To what extent did you feel able to defend the decision and draft a press release? 9. How satisfied were you from the results and the conveyed message?

Scenario II- Decision making and dealing with ethical dilemmas

Figure 5: a general overview of the simulation "decision making and dealing with ethical dilemmas

Simulation Title	Decision making and dealing with ethical dilemmas
Simulation developer	Dr. Keren Dopelt
Estimated time:	20 min
Estimated debriefing time:	40 min (20 if not watching the video footage)
Target group:	Students in the leadership in health course

Core: developing leadership skills

1. Decision making under pressure
2. Dealing with ethical dilemmas
3. Dealing with objections

Learning outcomes: students who complete the scenario will demonstrate the ability to use leadership skills to make decisions under pressure, deal with ethical dilemmas and objections.

Concrete learning objectives:

1. Ability to make decisions (sometimes "unpopular") under pressure
2. Dealing with objections from within and from outside of the health system
3. Having a discussion about ethical dilemmas, advantages, disadvantages and alternatives.
4. Managing conflicts while defending the decision and conveying it outwards through the press.

Prior to the simulation:
Each participant will read the scenario carefully and realize their specific role.
Each participant will sign an informed consent form for recording the session for learning purposes.

Figure 6: Scenario, participants, and roles descriptions

a) Case abstract
The state of Israel, like the rest of the countries in the world, is combating the corona virus. At the beginning of the month a new variant has been discovered in Africa, a deadly and contagious one. The variant has leaked to the country of Israel through Israelis who stayed in Africa, contracted the variant and brought it into the country. More Israelis, some vaccinated and some unvaccinated, were found to be carriers of the new variant. In light of the experience with the delta variant, which is also very contagious and caused the outbreak of a fourth wave

(after there have been nearly no new cases in the country), there is a concern that the new variant will cause a fifth wave outbreak of corona incidence.		
b) Main context		
In light of previous experience and the concerns over a fifth wave outbreak, and due to the fact that the new variant is deadly and contagious, and it is unclear whether it is resistant to the vaccine, the minister of health has convened different parties to discuss ways of preventing further spread of the variant.		
c) the team participating in the scenario		
Corona National coordinator	Head of public health services	Minister of health
	Minister of defense	Minister of finance
d) The environment		
Minister of health's office		
e) Required equipment		
Microphones	Cameras	A quite room
	A table circled by chairs	A recording program
f) description of the participating characters		
Minister of health- in his 50's. has been appointed to be minister of health about half a year ago as part of the forming of a new government. He stands at the head of a radical left-wing party that advocates for guarding individual rights. It is important to him to raise vaccination rates. He encourages communication and actively advocates for the importance of the vaccines, and like any public figure he is very concerned with public relations around the issue. Thus, he is trying to produce an image of persuasion and advocacy rather than coercion. He realizes that the African variant may be lethal and highly contagious. Therefore he is supporting the stance of the head of public health services, according to which the spread of the variant must be contained so that we can try and avoid a fifth wave, which may lead to further strain on the health system and its already burned out staff. However, since he stands at the head of a party that advocates for individual rights, he is uncomfortable with the idea of cellphone tracking of the variant's carriers by the GSS (General security service, Israel's equivalent of the FBI). The minister of health is the one who initiated the meeting and is leading the discussion. He must decide on this issue, that is between individual rights on the one hand, and guarding the public's health and keeping the health system from collapse on the other. Meanwhile it is well-known that he adamantly opposed cell-phone tracking for the same purpose when the previous government was using it.		
COVID national coordinator- a doctor with a rich history in administrative roles, including hospital administration. Has been in office for about a year and is determined to prove himself so he could get to a more senior position within the ministry of health. He is Assertive and extreme in his positions regarding children's vaccination. In his opinion, parents should be forced to vaccinate their kids. He is under tremendous pressure in the wake of a new wave of COVID, especially upon the appearance of the African variant in the country. He is an		

enthusiastic supporter of cell-phone tracking by the GSS in order to eradicate the plague, and from his point of view, the ends justify the means.
Head of public health services- a doctor, in his 40's, entered office two years ago during the pandemic and is fighting to end it. He is assertive and interviews a lot for the media. He is dealing with harsh criticism from the public on his conduct, with slander and even threats to his life by anti vaxxers and Covid deniers. He is less extreme in his position than the national coordinator and is not convinced that a tool which violates individual rights should be used for the relatively few cases discovered in the country. He trusts the epidemiological investigations conducted by the healthcare system.
Minister of finance- in his 60's. an assertive and tough type. Has been in office for 6 months. Has filled many meaningful roles during his rich political career. Has emigrated to Israel from the former Soviet Union, so government intervention in citizens' lives is nothing new to him. He is interested in avoiding sanction on the population for as long as possible, so as not to harm the economy, and therefore supports GSS cellphone tracking of carriers of the African variant. From his perspective, the good of the country is above all else, even if invasion to privacy is required by security services. He does not trust the healthcare system to perform the best investigation to identify infections.
Minister of defense- in his 60's. In the past he assumed senior commanding positions in the military. He has been in office for 2 years as minister of defense. Not an assertive type. As part of his role, he is responsible for the secret security services, and was therefore invited to the meeting. He is not sure that the extreme measure of cellphone tracking should be taken, but he is not intending to oppose whatever is decided.

Debriefing

The debriefing will be done immediately upon completing the simulation (with no intermission). It is vital to conduct the debriefing in a reflective manner, while addressing the skills that the simulation attempted to impart. For instance, "As the minister of health you decided to… what was behind this decision? Could you have decided differently given the positions expressed by X?" etc.

Figure 7: Reference points in the debriefing based on the different stages

Points of reference	stage
Mutual listening, patience, ability to analyze each participant's stance. The facilitator should pay attention: did everyone express their opinion in the discussion? Were participants interrupting each other? Were stances regarding the tracking issues addressed?	The minister of health convenes the meeting in his office to discuss the possibility of GSS cell-phone tracking in light of

	the newly discovered variant in the country.
Ability to lead/participate in an ethical discussion around clashes of values. The facilitator should pay attention: was there a discussion around the clash of values with the fifth wave of infections looming in the background? did the team members listen to each other? Did they try to convince each other?	Discussing the ethical considerations regarding the issue of GSS tracking and whether they are necessary at this stage
Leadership, decision making under pressure. The facilitator should pay attention: how was the decision reached? Was the team able to reach consensus? How long did it take to decide? What were the decisive considerations?	Reaching a decision of whether to track cell phones.
Scenario end:	
Ability to convey messages to the press The facilitator should pay attention: were they able to convey the message as well as the different considerations that led to the decision?	Drafting a press release of the decision

Evaluation

It is recommended to give the participants an evaluation questionnaire so that we could learn which objectives were achieved and where there is room for improvement.

Figure 8: scenario evaluation questionnaire for the participants

Demographic questions
5. What is your position at work? 6. What was your role in the simulation? 7. How old are you? 8. Have you participated in simulations before? If so, please state when, where, and what the goal of the simulation was.
Open-ended questions

11. How did the experience feel to you? 12. Did you have the knowledge and abilities to achieve the scenario's learning objectives? 13. What gaps did you identify in your set of knowledge and/or the preparation for the simulation? 14. What relevant information was missing in the scenario that affected your performance? 15. How did you overcome the knowledge gap? Did it happen in a short period of time? 16. What did you take away from the simulation experience? 17. What strengths or weaknesses of yours were you able to identify? 18. What did you enjoy the most in the simulation? 19. What did you enjoy the least in the simulation? 20. Will the participation in the simulation help you when encountering similar situations in the future?
Closed questions (Likert Scale, 1-5 from not at all to very much)
10. How satisfied were you from the conditions under which the simulation was performed? (room, equipment etc.) 11. How confident did you feel having the discussion? 12. How confident did you feel in your ability to identify issues that require leadership and in your own leadership ability? 13. To what extent did you feel that the discussion was run in a respectful manner? 14. To what extent did you feel that you are furthering the team's dynamics? 15. To what extent did you feel able to influence the others? 16. To what extent did you feel that you could have been a role model in your professional behavior? 17. To what extent did you feel able to defend the decision and draft a press release? 18. How satisfied were you from the results and the conveyed message?

Simulation chapter translated into Hebrew

מהי סימולציה?

הסימולציה היא כלי המאפשר להתנסות במצבים מדמי מציאות בסביבה בטוחה ומבוקרת, כדי לשפר מיומנויות מקצועיות ואישיות באמצעות תרגול, רפלקציה ומשוב (איזנהמר, 2014). היא משלבת בין ידע תאורטי והתנסות מעשית בתחומים מגוונים, כמו: מדעי הבריאות, חינוך, ניהול, מנהיגות, טייס ועוד. במדעי הבריאות מאפשרת הסימולציה לתרגל מיומנויות שונות, כגון: כישורים קליניים, הליכים טיפוליים, ניהול זמן, עבודת צוות וקבלת החלטות תחת לחץ (Lane, Slavin & Ziv, 2001). בנוסף, אנשי מקצועות הבריאות מתנהלים בסביבה מגוונת מבחינה פרופסיונלית ותרבותית, ועליהם להיות בעלי מודעות חברתית גבוהה. לשם כך ההתנסות בסימולציה בפרקטיקות של פלורליזם תרבותי יכולה לחזק התנהגות שוויונית ומכילה. זאת ועוד, הסימולציה מאפשרת לדמות מצבי קונפליקט ולחדד מיומנויות תקשורת ודרכים אפקטיביות לניהול מצבים קונפליקטואליים.

הסימולציה מתבססת על מעגל הלמידה ההתנסותית (The Experimental Learning Cycle), לפיו יש לזַמן ללומדים מפגש ישיר וחווייתי עם תופעה משמעותית, אשר חקירתה מחייבת התבוננות רפלקטיבית הנשענת על הידע והניסיון הקשורים לתופעה (Kolb, 1984). תהליך הלמידה ההתנסותית בסימולציה כולל ארבעה שלבים שונים החוזרים על עצמם באופן מעגלי: התנסות קונקרטית בה הפרט מבצע משימה ומתמודד עם אתגר, תצפית בהתנסות ורפלקציה, הבניית תפיסות ורעיונות חדשים, יישום בעזרת התובנות שנרכשו והתנסות בסיטואציה חדשה. כלומר, המתנסים חייבים לקשר בין הידע התיאורטי שרכשו לבין הפרקטיקה שבה התנסו, תוך שימוש בתהליכים רפלקטיביים. הרפלקציה נעשית במסגרת התחקיר והיא מסייעת לחזק את המודעות לקיומן של דרכי פעולה שונות באמצעות התבוננות פנימית וקבוצתית בסדנת הסימולציה.

הנחיה (Facilitation)

סימולציה מוצלחת מתחילה בהנחיה מתאימה. סימולציה היא מצב מהונדס, לכן זרימת התרחיש ומידת השגת יעדי הסימולציה הן במידה רבה תוצאה של מיומנות המנחה (Franklin et al., 2013). ההנחיה כוללת 3 היבטים: קדם-תרחיש, תוך-תרחיש ואחר-תרחיש.

בקדם התרחיש על המנחה לדעת את המטרות הראשוניות והמשניות של התרחיש, וליצור סימולציה מציאותית ככל האפשר. על כן יש לנסח בצורה ברורה את הסיטואציה ואת התפקידים של המשתתפים. בתוך התרחיש יש לאפשר לתרחיש להתקדם ללא הפרעה וללא התערבות ולהתבונן היטב בדינמיקה בין המשתתפים. לאחר התרחיש על המנחה לבצע את התחקיר.

תחקיר (Debriefing)

התחקיר הוא חלק אינטגרלי וקריטי בסימולציה (Kolbe et al., 2015). זהו אחד המרכיבים החשובים ביותר התורמים לאפקטיביות של למידה מבוססת סימולציה (McGaghie et al., 2010), והוא בדר״כ נשען על צפייה רפלקטיבית בהתנסות המצולמת בווידאו. זהו מנגנון למידה, המאפשר לאוורר רגשות שעלו מתוך ההתנסות, להיחשף לאתגרים ולהצלחות ולדון בהם כחלק מתהליך של התמקצעות, לנתח את המצב ולבצע רפלקציה אישית וקבוצתית (Levett-Jones & Lapkin, 2014). התחקיר עוסק בתהליך ולא בתוצאה והוא מתוכנן מראש כדי לזהות נקודות חוזק וחולשה תוך התייחסות לרבדים הגלויים והסמויים בהתנהלות המשתתפים. המטרה

הכללית של התחקיר היא לעזור למשתתפים להבין, ללמוד וליישם תובנות מחוויית הסימולציה (ולא להתמקד בטעויות) כדי לשנות את ההתנהגויות העתידיות שלהם בהתאם ליעדי הלמידה. בסיום התחקיר המנחה מסכם את הלקחים שהופקו, כדי ליצור בקרב הלומדים תחושה שהם רכשו מידע חיוני ופרקטי. על מנחה התחקיר להקפיד שהתחקיר מתנהל באופן מאפשר, מכבד ולא שיפוטי, ונותן משוב למתנסים.

ישנם מודלים רבים לביצוע התחקיר. שני דגמי התחקיר המובילים כוללים את מודל התחקיר המובנה והנתמך (Structured and Supported Debriefing Model) ואת מודל התחקיר עם שיקול דעת טוב (Debriefing with Good Judgment Model) (Bowe et al., 2017). להלן הצגת המודלים בקצרה:

<u>מודל התחקיר המובנה והנתמך</u> (O'Donnell et al., 2009)

ראשי התיבות של החלק המובנה הם GAS (Gather, Analyze, Summarize). *לאסוף* (Gather)- מטרתו של שלב זה היא לאסוף מידע שישמש בשלבים המאוחרים. בתחילת השלב, המשתתפים מוזמנים לחלוק את מחשבותיהם ותחושותיהם לגבי הסימולציה. על המנחה להשתמש בשאלות פתוחות, כגון "מהן המחשבות שלך?" או "איך זה גרם לך להרגיש?" כדי לייצר דיאלוג פתוח ולחשוף את ה נושאים הרלוונטיים ביותר למשתתפים. בנוסף, המנחה יכול להתחיל לזהות פערי תפיסה מול ביצועים. פערי תפיסה מתייחסים לדיסוננס בין תפיסת המשתתפים את הביצועים שלהם לעומת תפיסת המנחה. שלב האיסוף צריך לקחת כ-25% מזמן התחקיר הכולל. *לנתח* (Analyze)- ברוב המקרים, 2 או 3 יעדי למידה מספקים את המוקד לנושאים שבהם יש לדון במהלך שלב הניתוח. מטרתו של שלב הניתוח היא לעודד רפלקציה בקרב המשתתפים ולקדם גילוי עצמי. שלב הניתוח שואב מהמידע שהתקבל בשלב האיסוף ומנחה את המשתתפים לשקף ולהתקדם לאורך רצף היכולות שלהם. שלב הניתוח צריך לקחת כ-50% מזמן התחקיר הכולל. *לסכם* (Summarize)- המטרה של שלב הסיכום היא להבטיח הבנה ברורה של הנקודות החשובות ביותר. מומלץ שיהיה מעבר ברור שנעשה על ידי המנחה לשלב זה. לדוגמה, "אני חושב שהיה לנו דיון נהדר, בואו נדבר על הנקודות העיקריות שאנו ניקח מהסימולציה הזו." במודל זה שלב הסיכום מאורגן סביב טכניקת פלוס-דלתא. הפלוס-דלתא הוא מודל המתמקד בפעולות או התנהגויות יעילות (+) ופעולות או התנהגויות שיכולות לעבור שיפור (Δ). במהלך שלב הסיכום, המשתתפים יתבקשו לספק 2 היבטים חיוביים של הביצועים ו-2 תחומים שהם ישנו בפעם הבאה שהם ייתקלו בתרחיש דומה. שלב הסיכום אמור לקחת את 25% הנותרים מזמן התחקיר הכולל.

<u>מודל התחקיר עם שיקול דעת טוב</u> (Rudolph et al., 2006)

מודל זה מאופיין בארבעה עקרונות מפתח: (1) הגדרת מטרות למידה ברורות לפני הסימולציה, (2) הגדרת ציפיות ברורה למפגש, (3) פניה ללומדים בסקרנות ובמשוב אמיתיים תוך הימנעות מהדחף "לתקן" אותם , ו-(4) ארגון פגישת התחקיר ל-3 שלבים: תגובות, ניתוח וסיכום. *תגובות*- שלב התגובות הוא ההזדמנות לנקות את האווירה, לאחר חוויה חינוכית טעונה רגשית ומלחיצה. שלב זה מתחיל בשאלות כגון "איך זה הרגיש?" כדי לשמוע תגובות ראשוניות, לאמת תגובות רגשיות ולציין יעדים פוטנציאליים שנוצרו על ידי הלומד לפגישת התחקיר. שלב התגובות מורכב מרגשות ועובדות. *ניתוח*- שלב הניתוח מאפשר למנחה וללומדים לעבוד יחד על מנת לצפות בפערים בין הביצועים הרצויים לביצועים בפועל, ולספק משוב על הפערים הללו ולפעול לקראת סגירת פערים אלו באמצעות דיון ודידקטיקה לפי הצורך. פערי הביצוע לא יהיו אחידים בקרב קבוצת לומדים ולא ייתפסו באופן שווה על ידי כל לומד. שלב הניתוח מאפשר הזדמנות להגיע לאחדות בתוכן ובהיקף הפערים, כך שניתן יהיה לטפל בהם ביעילות עבור כל לומד. ניתן להשתמש בשאלות כמו: "הבחנתי ב..." או "אני מודאג/שמח ש..." ואחריהן דוגמאות קונקרטיות למה שהמנחה צפה בו. לאחר מכן, שאלה פתוחה (חקירה) כדי

להבין את נקודת המבט או מסגרת ההתייחסות של הלומד, כגון "מה עלה בדעתך באותו זמן?" או "איך ראית את זה?" *סיכום*- שלב הסיכום הוא ההזדמנות של המנחה לאפשר ללומדים לחלוק תובנות "לקחת הביתה", כלומר, את הנקודות העיקריות שבהן הם מקווים להשתמש. זה מאפשר ללומדים לעבד ולסכם באופן מלא את מה שהם מתכננים לשמור מהניסיון הזה, ובאופן אידיאלי ליישם במציאות.

לוח 1 : השוואה בין שני המודלים השכיחים לביצוע התחקיר

מודל התחקיר המובנה והנתמך		מודל התחקיר עם שיקול דעת טוב	
שלב	שאלות מנחות	שלב	שאלות מנחות
לאסוף	"מה אתה חושב?" "מה מחשבותיך?" "איך זה גרם לך להרגיש?"	תגובות	רגשות - "איך זה הרגיש?" - "מהן המחשבות הראשוניות שלך?" - "מהן התגובות המיידיות שלך?"
לנתח	"לפני שנתחיל, אני רוצה לעבור על השלבים המתאימים לניהול התרחיש הזה." "שמתי לב שאתה... ספר לי עוד על זה." "איך הרגשת כש...?" "על מה חשבת כש...?"	ניתוח	עובדות - "ברצוני להקדיש כמה דקות כדי להציג את עובדות המקרה." - "לפני שנמשיך, ברצוני לסקור את המקרה כך שכולם יהיו מתואמים." סנגור/חקר - "ראיתי שחיכית עד ש... העיכוב גרם ל... אני תוהה מה חשבת באותו זמן?"
לסכם	"תודה לכולכם על ההערות. אני חושב שהיה לנו דיון מצוין. בואו נסכם כמה נקודות שחשוב לקחת הלאה" "סיקרנו מספר נושאים, אני רוצה שכולם יחשבו מה הם רוצים לקחת מהחוויה הזו"	סיכום	"תודה על השתתפותכם. התחקיר מסתיים. אני רוצה להזמין כל אחד מכם לחלוק את מחשבותיו על מה שהלך טוב, כמו גם על מה שאולי כדאי לשנות או לשפר בעתיד."

למידה מבוססת סימולציה - פיתוח מנהיגות בבריאות

במטרה לבנות יכולות של מנהיגות יש צורך בשימוש בסימולציות, המאפשרות התנסות חווייתית, למידה וקבלת משוב מידי. סימולציות בפיתוח כישורי מנהיגות מיושמות בעולם בכל מקצועות הבריאות ובכל שלבי הקריירה, והוכחו כיעילות בפיתוח כישורי ניהול ומנהיגות (לדוגמה, Adams et al., 2010; Cooper et al., 2011; Fernandez et al., 2020; Labrague, 2021). ההנחה העומדת בבסיס פיתוח הסימולציה הנוכחית במסגרת קורס מנהיגות בבריאות הציבור היא שמעורבות קולקטיבית של המתנסים בחוויה מציאותית-מדומה אשר כרוכה בדילמה מנהיגותית, תמחיש ללומדים מושגים בסיסיים של עבודת צוות וקבלת החלטות ותשמש עבורם קרש קפיצה לבחון את כישורי הניהול והמנהיגות שלהם (Johnson, Huang & Shepherd, 2021).

מטרות ההתנסות בסימולציות בקורס הנוכחי

- לקדם יכולת להניע תהליכים בסביבה מורכבת ולייצר שיתופי פעולה עם גורמים מחוץ למערכת הבריאות
- לשפר כשירות תרבותית
- לשפר את היכולת לנהל קונפליקטים
- לחזק עבודת צוות ולהניע צוות רב מקצועי תוך מתן דוגמה אישית
- לבסס יכולת קבלת החלטות אתית, תוך שכנוע והגעה לקונצנזוס
- לבנות מיומנות להעברת מסרים בצורה משכנעת, כולל בתקשורת

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תרחיש I - מנהיגות בסביבה מורכבת

כל התרחישים המתוארים להלן פותחים בסקירה כללית והגדרת יעדי הלמידה, בהמשך ישנם תיאורים מפורטים של המקרה, המשתתפים והתפקיד של כל משתתף, לאחר מכן נקודות להתייחסות בתחקיר ע"פ השלבים השונים של התרחיש, ולבסוף שאלון הערכת התרחיש על ידי המתנסים. יש לציין כי תיאורי התרחישים והתפקידים מתייחס לשני המינים כאחד ללא משוא פנים, ומטעמי נוחות בלבד מנוסחים בלשון זכר.

לוח 2: סקירה כללית של הסימולציה "מנהיגות בסביבה מורכבת"

כותרת הסימולציה	מנהיגות בסביבה מורכבת
מפתחת הסימולציה	ד"ר קרן דופלט
זמן מוערך:	20 דק'
זמן תחקיר מוערך:	40 דק' (אם לא צופים בצילום הווידאו, 20 דק')
קבוצת יעד:	סטודנטים בקורס מנהיגות בבריאות

ליבה: פיתוח כישורי מנהיגות

4. הנחיית קואליציה של גורמים מחוץ למערכת הבריאות להנעת שינוי
5. יצירת חזון ותוכנית פעולה
6. יצירת תוכנית להסרת חסמים שזוהו על ידי הצוות

תוצרי למידה: סטודנטים שישלימו את התרחיש יפגינו יכולת להשתמש במיומנויות מנהיגות כדי לייצר קואליציה ולהניע לפעולה בעלי עניין מתחומים שונים.

יעדי למידה ספציפיים:

8. להניע תהליכים בסביבה מורכבת
9. לייצר שיתופי פעולה עם גורמים מחוץ למערכת הבריאות
10. לפתח חזון ולתקשר אותו לבעלי עניין
11. להגדיר חסמים
12. לתכנן כיצד להתגבר על חסמים. לחשוב מחוץ לקופסה
13. לנהל צוות
14. לנהל קונפליקטים

לפני הסימולציה:

כל מתנסה יקרא היטב את התרחיש ויבין את התפקיד הספציפי שלו.

כל מתנסה יחתום על טופס הסכמה מדעת לצילום התרחיש לצורכי למידה.

לוח 3 : תיאור התרחיש, המשתתפים והתפקידים

א) תמצית המקרה		
בעיר באר שבע אחוז ההתחסנות של ילדים בגילאי 5-12 נגד קורונה הינו כ- 24%, כאשר היעד הלאומי שהוגדר הינו 75%. אחד המרכיבים המרכזיים בחוסר ההיענות לחיסוני ילדים נגד קורונה הוא חוסר אמון במערכת הבריאות וחשש של ההורים מתופעות לוואי. קופת החולים הגדולה בעיר לא הקצתה מספיק מתקנים, שעות גמישות וכ״א לצורך מבצע החיסונים. הקופה פנתה לעירייה בבקשה לחסן במתנ״סים המפוזרים בשכונות והעירייה מתמהמהת עם מתן התשובה. תחלואת הילדים בעיר עולה, והמשימה להעלאת שיעור ההיענות לחיסון הינה משימה לאומית בעלת חשיבות עליונה.		
ב) ההקשר המרכזי		
שר הבריאות מביע את דאגתו בפני פרויקטור הקורונה בשל נתוני התחלואה הגבוהים ושיעור ההתחסנות הנמוך בעיר באר שבע. הפרויקטור מכנס לדיון יזום צוות רב תחומי כדי לדון במה שהוא רואה כאחריות לאומית, כמו גם על החסמים המונעים מהורים לקחת את ילדיהם להתחסן.		
ג) הצוות שישתתף בתרחיש		
פרויקטור הקורונה	יו״ר ועד הורים עירוני	מנהל מרחב נגב של קופ״ח
ראש העיר	ראש מנהל החינוך	
ד) הסביבה		
לשכת ראש העיר		
ה) ציוד נדרש		
חדר שקט	מצלמות	מיקרופונים
תוכנת הקלטה	שולחן וכסאות מסביב	
ו) תיאור הדמויות המשתתפות בסימולציה		
<u>פרויקטור הקורונה</u>- רופא בעל עבר עשיר בתפקידי ניהול, כולל ניהול בית חולים. נמצא בתפקיד הפרויקטור כשנה ומאוד רוצה להוכיח את עצמו כדי להתקדם לתפקיד בכיר יותר במשרד הבריאות. אסרטיבי, קיצוני בעמדותיו לגבי חיסוני הילדים ולדעתו יש לכפות על ההורים לחסן את ילדיהם. הוא נמצא תחת עומס אדיר בפתחו של גל תחלואה נוסף אותו הוא מנסה למנוע באמצעות עידוד חיסונים. ראש הממשלה ושר הבריאות דוחקים בו להעלות את שיעורי ההתחסנות ולהוריד את התחלואה מבלי להטיל מגבלות נוספות על האוכלוסייה. הפרויקטור הוא זה שיזם את הפגישה והוא מנחה את הדיון. מטרתו הינה לתכנן תוכנית התערבות שתשלב את כל הגורמים לצורך העלאת שיעור ההתחסנות.		
<u>ראש העיר</u>- בשנות ה- 40 לחייו, אב לשני ילדים שהתחסנו. הוא מצדד בעמדת הפרויקטור שיש להעלות את שיעורי ההתחסנות, אך לא באמצעות כפייה, אלא באמצעות התערבות רכה, הסברה ושכנוע. הוא מסרב להקצות את המתנ״סים כדי להופכם למתקני חיסונים לטובת קופת החולים. מבחינתו זהו מקום בילוי והנאה לילדים ואיננו רוצה שיהפוך למתקן רפואי. הוא כועס על מנהל המחוז שלוחץ עליו לאשר זאת. חשוב לו להעלות את שיעורי ההתחסנות בעיר, אך גם לדאוג לרווחת התושבים ולרצות אותם, ולא להפוך מתקני פנאי		

עירוניים לעמדות חיסונים. הוא סובר כי קופת החולים יכולה לעשות יותר מאמץ ולהקצות את המתקנים שלה. מעוניין להוציא הודעה לתקשורת על תוכנית ההתערבות המתוכננת בעיר בסופו של הדיון.
יו"ר ועד הורים עירוני- מתקרב לגיל 40, איש הייטק נמרץ, מאוד אינטליגנט וקשה לשכנוע. אב לשלושה ילדים בגילאי 6, 9 ו- 12. כולם לומדים במערכת החינוך. הוא ואשתו התחסנו, אך הם חוששים לחסן את הילדים. מתמודד עם פניות רבות של הורים באשר לחיסונים. כועס על כוונת הפרויקטור לכפות על הורים לחסן את ילדיהם ומבקש שרופאי הילדים יסבירו להורים על החיסון ועל תופעות הלוואי, ויפיגו את חששותיהם. מתעקש לראות ממצאי מחקרים שיניחו את דעתו שהחיסון בטוח. מעוניין להפיג את חששותיו ואת חששות שאר ההורים.
ראש מנהל החינוך- בן 55. בעל תואר שלישי בחינוך. אב לילדים בוגרים. שואף ליצור אקלים של שקיפות, מעורבות ושותפות עם כלל הגורמים לטובת הילדים. מעוניין בדיאלוג והכלה עם התלמידים, ההורים והצוותים החינוכיים. מאמין שיש לפעול ברגישות ולפתח תחושת סולידריות בקרב ההורים שחוששים מהחיסונים. מעוניין גם במתן פתרונות עבור תלמידים וצוותי חינוך מדוכאי חיסונים. מתנגד שצוותי החינוך יעשו הסברה להורים ומתעקש שזהו התפקיד של מערכת החינוך בלבד. אינו מעוניין שהסברה להורים או חיסונים יקרו בין כותלי ביה"ס.
מנהל מרחב נגב של קופ"ח- רופא, נמצא בתפקיד 4 שנים. כיהן בשלל תפקידי ניהול במחוז דרום של הקופה. נמצא תחת עומס עבודה רב, ועובר בין הערים השונות כדי לנסות לשכנע אנשים להתחסן. בשל מצוקת מתקנים של הקופה וקושי להקצות חדרים לצורך החיסונים פנה לראש העיר בבקשה שיוקצו לכך חדרים ייעודיים במתנ"סים השכונתיים. ראש העיר מסרב ונוצר ביניהם חיכוך. הוא כועס על ראש העיר ומנסה לשכנע את שאר חברי הצוות שיסייעו לו לקבל אישור לחסן במתנ"סים.

תחקיר

התחקיר יתבצע מיד בסיום הסימולציה (ללא הפסקה בין לבין). חשוב לנהל את התחקיר בצורה רפלקטיבית, תוך התייחסות למיומנויות שהסימולציה ניסתה להקנות. לדוגמה, "בתור פרויקטור הקורונה אמרת... מה עמד מאחורי אמירה זו? האם לדעתך זה קידם את הדיון? האם זה הוביל לשת"פ או השיג את המטרה ההפוכה? מה אפשר היה לעשות אחרת כדי לקדם את המטרה המשותפת?" וכיו"ב.

לוח 4: נקודות להתייחסות בתחקיר ע"פ השלבים השונים

שלב	נקודות להתייחסות בתחקיר
הפרויקטור יוזם את הדיון בלשכת ראש העיר כדי לדון בחסמים להתחסנות בעיר	הקשבה הדדית אחד לשני, סבלנות, יכולת ניתוח של החסמים. על המנחה לשים לב: האם כל אחד הביע את דעתו בדיון? האם התפרצו אחד לדברי השני? האם התייחסו לחסמים?
התגברות על החסמים ופיתוח אסטרטגיות להעלאת שיעור ההתחסנות	יכולת ניהול דיון, חשיבה מחוץ לקופסה, גיוס הצוות לשתף פעולה. על המנחה לשים לב: האם הייתה הקשבה בין חברי הצוות? האם התקיים שת"פ בין חברי הצוות או שכל אחד ייצג רק את עצמו ולא היה פתוח וגמיש? האם התאמצו למצוא פתרונות יצירתיים לחסמים?

תכנון תכנית התערבות שמשלבת את כל הגורמים	מנהיגות, עבודת צוות, יכולת ניהול ופתרון קונפליקטים, הגעה לקונצנזוס. על המנחה לשים לב: מה היו החסמים העיקריים שיצרו קונפליקטים? כמה זמן לקח להגיע לקונצנזוס? מה גרם לשינוי ולהגעה להסכמה לבסוף: רעיון של אחד המשתתפים, פשרה או רעיון חדש?
סיום התרחיש:	
ניסוח הודעה לתקשורת על התוכנית המתוכננת בעיר	יכולת להעביר מסרים, יכולת לנסח הודעה לתקשורת. על המנחה לשים לב: האם הסכימו על המסר? האם הצליחו להעביר את המסר שרצו ולנסח הודעה קצרה לתקשורת?

הערכה

מומלץ לחלק למתנסים שאלון הערכה כדי ללמוד אלו יעדים הצלחנו להשיג ומה טעון שיפור.

לוח 5: שאלון הערכת התרחיש על ידי המתנסים

שאלות דמוגרפיות
1. מהו תפקידך בעבודה?
2. מה היה תפקידך בסימולציה?
3. מהו גילך?
4. האם השתתפת בסימולציות בעבר? אם כן, פרט מתי, היכן ומה הייתה מטרת הסימולציה.
שאלות פתוחות
1. איך הרגישה עבורך החוויה?
2. האם היו לך הידע והכישורים לעמוד ביעדי הלמידה של התרחיש?
3. אילו פערים זיהית במאגר הידע שלך ו/או ההכנה לסימולציה?
4. איזה מידע רלוונטי היה חסר בתרחיש שהשפיע על הביצועים שלך?
5. איך התגברת על הפער בידע? האם זה קרה בזמן קצר?
6. מה לקחת מהחוויה של הסימולציה?
7. אלו חוזקות או חולשות שלך הצלחת לזהות?
8. ממה הכי נהנית בסימולציה?
9. ממה הכי פחות נהנית בסימולציה?
10. האם ההשתתפות בסימולציה תסייע לך בהתמודדות בסיטואציות דומות בעתיד?
שאלות סגורות (סולם ליקרט 1-5 מכלל לא ועד במידה רבה מאוד)
1. עד כמה היית שבע רצון מהתנאים בהם נערכה הסימולציה? (חדר, ציוד וכו')
2. עד כמה הרגשת בטוח בניהול הדיון?
3. עד כמה הרגשת בטוח בזיהוי נושאים הדורשים מנהיגות וביכולת המנהיגות שלך?
4. עד כמה הרגשת שהדיון התנהל בצורה מכבדת?
5. עד כמה הרגשת שאתה מקדם את הדינמיקה של הצוות?
6. עד כמה הרגשת שאתה מצליח להשפיע על האחרים?

7. עד כמה הרגשת שיכולת לשמש מודל חיקוי בהתנהגותך המקצועית?
8. עד כמה הרגשת מסוגל לסנגר על ההחלטה ולנסח הודעה לתקשורת?
9. עד כמה הרגשת שבע רצון מהתוצאה ומהמסר שהועבר?

תרחיש II - קבלת החלטות והתמודדות עם דילמות אתיות

לוח 6: סקירה כללית של הסימולציה "קבלת החלטות והתמודדות עם דילמות אתיות"

כותרת הסימולציה	קבלת החלטות והתמודדות עם דילמות אתיות
מפתחת הסימולציה	ד"ר קרן דופלט
זמן מוערך:	20 דק'
זמן תחקיר מוערך:	40 דק' (אם לא צופים בצילום הווידאו, 20 דק')
קבוצת יעד:	סטודנטים בקורס מנהיגות בבריאות
ליבה: פיתוח כישורי מנהיגות 1. קבלת החלטות תחת לחץ 2. התמודדות עם דילמות אתיות 3. התמודדות עם התנגדויות	
תוצרי למידה: סטודנטים שישלימו את התרחיש יפגינו יכולת להשתמש במיומנויות מנהיגות כדי לקבל החלטות תחת לחץ, להתמודד עם דילמות אתיות ועם התנגדויות.	
יעדי למידה ספציפיים: 1. יכולת לקבל החלטות (לעיתים לא "פופולאריות") תחת לחץ 2. להתמודד עם התנגדויות בתוך ומחוץ למערכת הבריאות 3. לנהל דיון אודות דילמות אתיות, יתרונות, חסרונות וחלופות 4. לנהל קונפליקטים תוך סנגור על ההחלטה ולתקשר אותה החוצה באמצעי התקשורת	
לפני הסימולציה: כל מתנסה יקרא היטב את התרחיש ויבין את התפקיד הספציפי שלו. כל מתנסה יחתום על טופס הסכמה מדעת לצילום התרחיש לצורכי למידה.	

לוח 7: תיאור התרחיש, המשתתפים והתפקידים

א) תמצית המקרה
מדינת ישראל, כמו שאר מדינות העולם, נאבקת בנגיף הקורונה. בתחילת החודש התגלה באפריקה וריאנט חדש של הנגיף, וריאנט קטלני ומדבק. הווריאנט זלג למדינת ישראל באמצעות ישראלים ששהו באפריקה, נדבקו והביאו את הווריאנט לארץ. ישראלים נוספים, חלקם מחוסנים וחלקם אינם מחוסנים, התגלו כנשאים של הווריאנט החדש.

לאור ההתנסות עם וריאנט הדלתא, שהיה גם הוא מאוד מדבק, וגרם להתפרצות של גל רביעי (לאחר שכמעט ולא היו מקרים חדשים בארץ), ישנו חשש שהוריאנט האפריקאי יגרום להתפרצות גל חמישי של תחלואה.
ב) ההקשר המרכזי
לאור הניסיון הקודם והחששות מהתפרצות גל חמישי, ולאור העובדה שהוריאנט החדש קטלני ומדבק, ולא ברור אם הוא עמיד בפני החיסון או לא, זימן שר הבריאות גורמים שונים לדון בדרכים למנוע את התפשטות הוריאנט.
ג) הצוות שישתתף בתרחיש

שר הבריאות	ראש שירותי בריאות הציבור	פרויקטור הקורונה
שר האוצר	שר הביטחון	

ד) הסביבה
לשכת שר הבריאות
ה) ציוד נדרש

חדר שקט	מצלמות	מיקרופונים
תוכנת הקלטה	שולחן וכסאות מסביב	

ו) תיאור הדמויות המשתתפות בסימולציה
<u>שר הבריאות</u>- בשנות ה- 50 לחייו. התמנה לשר הבריאות לפני כחצי שנה במסגרת הקמתה של ממשלה חדש. עומד בראש מפלגת שמאל קיצונית שמייצגת עמדות הדוגלות בשמירה על זכויות הפרט. חשוב לו להעלות את שיעורי ההתחסנות. הוא דוגל ומעודד בעצמו הסברה באשר לחשיבות החיסונים, וככל איש ציבור דואג מאוד ליחסי ציבור סביב העניין ומנסה לייצר מצג של שכנוע והסברה ולא כפייה. הוא מבין שהוריאנט האפריקאי עלול להיות קטלני ומאוד מדבק, והוא מצדד בעמדת ראש שירותי בריאות הציבור שיש למנוע את התפשטותו ולהימנע ככל האפשר מהתפרצות גל תחלואה חמישי, שעלול להביא לעומס נוסף על מערכת הבריאות ולשחיקה נוספת של הצוותים השחוקים ממילא. עם זאת, מכיוון שהוא עומד בראש מפלגה הדוגלת בשמירה על זכויות הפרט, איננו מרגיש בנוח עם הרעיון של איכוני טלפונים ניידים של נשאי הוריאנט על ידי השב"כ. שר הבריאות הוא זה שיזם את הפגישה והוא מנחה את הדיון. עליו להכריע בסוגייה זו, ובעצם בין שמירה על בריאות הציבור וחשש מקריסה של מערכת הציבור לבין פגיעה בזכות לפרטיות, כאשר ברקע ידוע כי הביע את התנגדותו הנחרצת לכך כאשר נעזרה המשלה הקודמת באיכוני שב"כ לצורך מיגור המגפה.
<u>פרויקטור הקורונה</u>- רופא בעל עבר עשיר בתפקידי ניהול, כולל ניהול בית חולים. נמצא בתפקיד הפרויקטור כשנה ומאוד רוצה להוכיח את עצמו כדי להתקדם לתפקיד בכיר יותר במשרד הבריאות. אסרטיבי, קיצוני בעמדותיו לגבי חיסוני הילדים ולדעתו יש לכפות על הורים לחסן את ילדיהם. הוא נמצא תחת עומס אדיר בפתחו של גל תחלואה נוסף, במיוחד עם היכנסו של הוריאנט האפריקאי לארץ. הוא תומך נלהב באיכוני השב"כ לצורך מיגור המגפה ומבחינתו המטרה מקדשת את האמצעים.
<u>ראש שירותי בריאות הציבור</u> – רופא, בשנות ה- 40 לחייו, נכנס לתפקיד לפני כשנתיים במהלך המגפה ונאבק למיגורה. אסרטיבי, מרבה להתראיין בתקשורת ומתמודד עם ביקורת קשה מצד הציבור על התנהלותו, עם השמצות ואף איומים על חייו מצד מתנגדי חיסונים ומכחישי קורונה. פחות קיצוני בעמדותיו מהפרויקטור

ואינו בטוח שיש להשתמש בכלי המפר את זכויות הפרט בשל המקרים המעטים יחסית של הווריאנט האפריקאי שנמצאו בארץ. סומך על החקירות האפידמיולוגיות שמתבצעות בלשכות הבריאות.
שר האוצר- בשנות ה- 60 לחייו. טיפוס אסרטיבי וקשוח. מכהן כחצי שנה בתפקיד. מילא בעבר תפקידים מאוד משמעותיים לאורך הקריירה הפוליטית העשירה שלו. עלה לארץ מאחת ממדינות ברית המועצות לשעבר, כך שהתערבות של שירותי הביון הממשלתיים בחיי האזרחים איננה זרה לו. מעוניין להימנע מהטלת סנקציות על האוכלוסייה עד כמה שניתן, כדי שלא לפגוע בכלכלה, ולכן מצדד באיכוני השב״כ כלפי נשאי הווריאנט האפריקאי. מבחינתו טובת המדינה היא מעל לכול, גם אם נדרשת פלישה לפרטיות על ידי שירותי הביון. איננו סומך על שירותי הבריאות שיעשו את החקירה המיטבית לאיתור המגעים.
שר הבטחון- בשנות ה- 60 לחייו. כיהן בעבר בתפקידי פיקוד בכירים בצבא. מכהן בתפקיד שר הבטחון כשנתיים. לא טיפוס אסרטיבי. אחראי מתוקף תפקידו על שירותי הביטחון החשאיים, ולכן הוזמן לדיון. הוא איננו בטוח שיש לפעול בצעד קיצוני של הפעלת איכון שב״כ כלפי נשאי הווריאנט האפריקאי, אך מאידך אין בכוונתו להביע התנגדות למה שיוחלט.

תחקיר

התחקיר יתבצע עם סיום הסימולציה (ללא הפסקה) בצורה רפלקטיבית, תוך התייחסות ליעדי הלמידה שהסימולציה ניסתה להקנות. לדוגמה, ״בתור שר הבריאות החלטת... מה עמד מאחורי החלטה זו? האם אפשר היה להחליט אחרת לאור העמדות שהביע X?״ וכיו״ב.

לוח 8: נקודות להתייחסות בתחקיר ע״פ השלבים השונים

שלב	נקודות להתייחסות בתחקיר
שר הבריאות יוזם את הדיון בלשכתו כדי לדון באפשרות לאיכוני שב״כ לאור הווריאנט החדש שהתגלה בארץ	הקשבה הדדית אחד לשני, סבלנות, יכולת ניתוח של העמדות של כל משתתף. על המנחה לשים לב: האם כל אחד הביע את דעתו בדיון? האם התפרצו אחד לדברי השני? האם התייחסו לעמדות כלפי סוגיית האיכונים?
דיון בסוגיות האתיות סביב סוגיית איכוני השב״כ והאם הכרחיים במצב זה	יכולת לנהל דיון אתי בסוגייה של התנגשות הערכים. על המנחה לשים לב: האם התקיים דיון בהתנגשות הערכים כשברקע מאיים גל חמישי של תחלואה? האם הייתה הקשבה בין חברי הצוות? האם התאמצו לשכנע אחד את השני?
הגעה להחלטה האם לאכן או לא	מנהיגות, קבלת החלטות בתנאי לחץ. על המנחה לשים לב: איך התקבלה ההחלטה? האם הגיעו לקונצנזוס? כמה זמן לקח להגיע להחלטה? מה היו השיקולים שהכריעו?
סיום התרחיש:	
ניסוח הודעה לתקשורת בדבר ההחלטה	יכולת להעביר מסרים לתקשורת. על המנחה לשים לב: האם הצליחו להעביר את המסר ואת השיקולים השונים שהובילו להחלטה?

<u>הערכה</u>

מומלץ לחלק למתנסים שאלון הערכה כדי ללמוד אלו יעדים הצלחנו להשיג ומה טעון שיפור.

לוח 9 : שאלון הערכת התרחיש על ידי המתנסים

שאלות דמוגרפיות
1. מהו תפקידך בעבודה?
2. מה היה תפקידך בסימולציה?
3. מהו גילך?
4. האם השתתפת בסימולציות בעבר? אם כן, פרט מתי, היכן ומה הייתה מטרת הסימולציה.
שאלות פתוחות
1. איך הרגישה עבורך החוויה?
2. האם היו לך הידע והכישורים לעמוד ביעדי הלמידה של התרחיש?
3. אילו פערים זיהית במאגר הידע שלך ו/או ההכנה לסימולציה?
4. איזה מידע רלוונטי היה חסר בתרחיש שהשפיע על הביצועים שלך?
5. איך התגברת על הפער בידע? האם זה קרה בזמן קצר?
6. מה לקחת מהחוויה של הסימולציה?
7. אלו חוזקות או חולשות שלך הצלחת לזהות?
8. ממה הכי נהנית בסימולציה?
9. ממה הכי פחות נהנית בסימולציה?
10. האם ההשתתפות בסימולציה תסייע לך בהתמודדות בסיטואציות דומות בעתיד?
שאלות סגורות (סולם ליקרט 1-5 מכלל לא ועד במידה רבה מאוד)
1. עד כמה היית שבע רצון מהתנאים בהם נערכה הסימולציה? (חדר, ציוד וכו')
2. עד כמה הרגשת בטוח בניהול הקונפליקט?
3. עד כמה הרגשת בטוח בזיהוי נושאים הדורשים מנהיגות וביכולת המנהיגות שלך?
4. עד כמה הרגשת שהדיון התנהל בצורה מכבדת?
5. עד כמה הרגשת שאתה מקדם את הדינמיקה של הצוות?
6. עד כמה הרגשת שאתה מצליח להשפיע על האחרים?
7. עד כמה הרגשת שיכולת לשמש מודל חיקוי בהתנהגותך המקצועית?
8. עד כמה הרגשת מסוגל לסנגר על ההחלטה ולנסח הודעה לתקשורת?
9. עד כמה הרגשת שבע רצון מהתוצאה ומהמסר שהועבר?