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Leadership finds its Bearings

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In this Issue:

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Patient experience is much more than patient satisfaction

John Van Aerde,
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Abstract

Measuring patient satisfaction based on concepts borrowed from business and linking them incorrectly with outcomes can lead to problems. Terms such as quality and satisfaction depend on a number of variables, both objective and subjective. At the Cleveland Clinic, already renowned for technical excellence, system-wide emphasis on patient experience (the combination of objective and subjective elements) dramatically increased its ranking in terms of quality, safety, and efficiency in delivery of care.

During the Cold War, Soviet leaders didn't use capitalist measures of outcome, such as profits, and no one tracked customer satisfaction. Instead, for nail manufacturing as an example, they measured production in terms of weight. When ordered to increase production, nail factories responded by switching from the nails needed for construction to huge, heavier railroad spikes that were not needed. When Moscow saw this result, they changed the measure of production to number of units; the factories went on to produce billions of tiny, useless nails.

When people fail to create measures that produce the right kind of influence or change in (organizational) behaviour, they end up measuring incorrect variables

When people fail to create measures that produce the right kind of influence or change in (organizational) behaviour, they end up measuring incorrect variables (Grenny et al. 2013). If the very process of measuring outcomes could drive the wrong behaviour, as in the case of nail production, then we must also be sure to measure faithfully the actions or behaviours underpinning the results that need to be produced. In health care, when the wrong measuring tools are used to evaluate evidence-based outcomes, e.g., patient satisfaction surveys, the results drive the wrong behaviour and lead to worse outcomes (Fenton et al. 2012, Detsky and Shaul 2013), just as in the example of the Russian nails. A large amount of evidence indicates that patient satisfaction has no correlation with quality improvement or evidence-based medical outcomes (Rahmquist 2001, Lee et al. 2008, Fenton et al. 2012, Detsky and Shaul 2013). This is particularly bad news for jurisdictions with a legislated requirement for hospitals to perform yearly surveys of patient satisfaction to guide quality-improvement plans (Detsky and Shaul 2013).

Clear definitions needed

Some of the confusion around patient satisfaction and quality improvement may originate from the fact that definitions have not been clear. When we adopt customer-oriented concepts from the business world, we should examine them carefully before introducing them into the health care system.

According to Lowenthal (2001), customer satisfaction is related to the quality of the product or service delivered. What is quality? It has many definitions, depending on what lens is used to view it**.** *Transcendentally*, "Quality is neither mind nor matter…. even though quality cannot be defined, you know what it is [when you experience it]" (Pirsig 1974). It is a simple, unanalyzable property that we learn to recognize only through experience. It is mostly based on perception. The *product-based* approach defines quality as differences in the quantity of some ingredient or attribute of a product. It is a precise and measurable variable. The *manufacturing-based*

lens, which looks at engineering processes and cost reduction, has us believe that quality is the degree to which a specific product conforms to design specifications and how reliable it is (Garvin 1984). The user-based definition indicates that, "Quality is the degree to which a specific product satisfies the wants of a specific customer" (Garvin 1984).

In the business world, all these definitions converge to define quality as a mark set by a customer for a product or a service, and much of the quality of a product lies in the way it is perceived. The manufacturing-based and product-based lenses define the *objective* elements, the specifications, the reliability, and the resulting cost of the product or service. Translated for the health care industry, this means evidence-based outcomes, such as morbidities, mortalities, efficiencies, costs. However, the customer- or user-specific and transcendental definitions of quality in business are about perception by the customer of the product or services delivered, i.e., mostly the *subjective* elements of quality.

Pitfalls in measuring quality and patient satisfaction

In health care, that perception is measured with patient-satisfaction surveys. If one erroneously uses subjective measures, such as patient satisfaction, to evaluate objective evidence-based outcomes, it is understandable that people will manipulate the subjective perception of quality. This helps explain why subjective, perception-based patient-satisfaction surveys do not correlate with quality improvement. Consequently, reports indicate that high patient satisfaction is more closely associated with higher prescription drug costs, higher overall health care expenditures, and higher mortality than the lowest levels of satisfaction, even after adjusting for covariables (Fenton 2012, Detsky and Shaul 2013). Besides the fact that the definition of satisfaction itself has varied across studies, it is greatly influenced by age, income, pain management, anxiety, education, comorbidities, and the length of time between the encounter and the survey (Rahmquist 2001, Lee et al. 2008, Manary et al. 2013).

Some have speculated that the use of discretionary care, i.e., interventions or treatments for which there is no proven benefit, is increasing, in part to avoid patient dissatisfaction. When discretionary care is demanded by the patient, it may lead to iatrogenic harm, diagnosis of pseudo-diseases, and overtreatment, resulting in an ongoing rise in medical costs. The power and fear of defensive medicine also contributes to this type of care (Glauser 2013). Patient satisfaction may be further decreased by conversations related to prevention and lifestyle, conversations that, despite being part of good health care, are often perceived negatively by the patient. Using legislation or reimbursement schemes to force a link between subjective satisfaction surveys and objective elements of quality improvement may mean that the interpretation of patient autonomy may also change (Detsky and Shaul 2013). At what point does patient-centred care, which includes the patient's right to accept or reject proposed treatments, become patient-directed care, where patients demand specific tests or treatments, such as convenience cesarean sections or Internet-evidence-based interventions?

Patient experience: a complete model for quality care

Perhaps Merlino and Raman (2013) provide a complete model of quality care, in which they combine many organizational indicators of patient experience and health, including evidence-based objective outcomes and subjective measures of patient satisfaction. This successful new model takes patient-centred care to the next level.

Although institutions in general talk a lot about the importance of empathy in delivering good care, there is actually little knowledge of what patients experience as they navigate the health care system, except for their interactions with physicians and nurses.

Dr. James Merlino, a keynote speaker at this year's Canadian Conference on Physician Leadership (www.2014leadership.ca), is CEO at the Cleveland Clinic, where CEO stands for chief experience officer. He oversees the Office of Patient Experience with 112 employees. Like many prestigious hospitals with impressive medical advances (the Cleveland Clinic's heart program was ranked no. 1 for outcomes), the clinic had focused almost solely on medical outcomes in the past. Yet, in overall patient satisfaction, it ranked only at the 55th percentile. The clinic was good at performing procedures and treatments, but if they failed to explain those procedures fully in terms that patients could understand and did so in a room that was not clean (the clinic was in the 4th lowest percentile for room cleanliness), that would diminish the patient experience as reflected in the poor patient-satisfaction surveys. Patients came to Cleveland Clinic for clinical excellence, but they did not like the place!

As medical excellence could not be improved much more, and as many people perceive quality based on experience rather than on excellence in clinical outcomes, the Cleveland Clinic made patient experience an enterprise-wide priority. Merlino brought everyone at the clinic together, including the physicians who thought that only objective medical outcomes mattered. By impressing on everyone, from administrators to janitors, that patient satisfaction is a significant issue, the Cleveland Clinic demonstrated to its employees that all are caregivers who play a role in the patient experience (Merlino and Raman 2013). The patient is included, not only to develop an understanding of his or her needs, but also to establish realistic expectations. Patients are not always right and sometimes have desires whose fulfillment would not be in their best interests.

Although institutions in general talk a lot about the importance of empathy in delivering good care, there is actually little knowledge of what patients experience as they navigate the health care system, except for their interactions with physicians and nurses. For that reason, Merlino and his team undertook studies, the results of which indicated that patients want the reassurance that the people taking care of them really understand what it is like to be a patient. Patients want better communication and better coordination of their care. The studies also revealed that patients often use proxies in their ratings: for example, if a room is dirty, they might take that as a sign that the hospital delivers poor care. Another striking finding was the importance of a care provider's demeanor: patient satisfaction is lower when caregivers appear unhappy because patients believe that they (the patients) are responsible or that something is going on that the caregiver does not want to reveal.

After the study results were known, Merlino had 43,000 employees — everybody in the organization with no exceptions — participate in a half-day exercise in groups of 10 with a facilitator. Everyone learned basic good behaviour, such as smiling, telling patients and other staff members their name and role, explaining what to expect during an activity, actively listening or assisting, learning something personal about the patient or staff member, and saying thank you (Merlino and Raman 2013). The cost of the exercise was $11 million. Despite physicians expressing fears that the new initiative would conflict with efforts to maintain high standards in terms of quality, safety, and cost reduction, the Cleveland Clinic rose dramatically in rankings for quality and safety, and its efficiency in delivery of care improved too. Currently, the annual budget for the Office of Patient Experience totals almost $10 million and everyone

is involved, including patients on whom the clinic relies heavily to identify problems and improve processes.

Conclusions

To change culture, which is driven by behavioural patterns, the correct tools have to be chosen. Patient satisfaction (the subjective measure of patient experience) and evidence-based outcome (the objective measure of patient experience) are two different components of how patients experience the quality of care provided, and each component deserves different, independent evaluation tools. Changing culture and processes to improve patient experience within the context of evidence-based objective quality outcomes can lead to substantial improvements in safety, quality, costs, and patient satisfaction as demonstrated at the Cleveland Clinic, where health and care around patient experience isn't a new program, "It's a way of life" (Merlino and Raman 2013).

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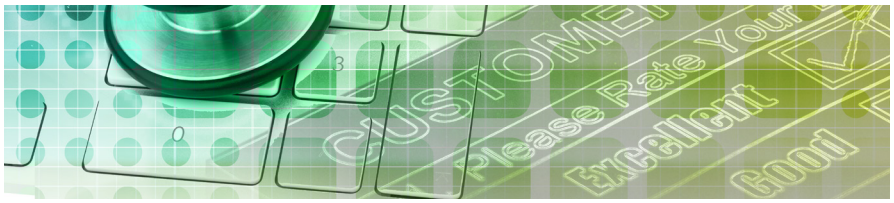

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Principled physician (and other health care) leadership: introducing a value-based approach

Abraham Rudnick, MD

Abstract

A value-based approach to leadership by physicians and other health care professionals has not been addressed systematically, although it seems to be important. This paper introduces such a principled approach, using a selective literature review and conceptual analysis, as well as illustrations from physician leadership experience. This approach prioritizes, in a context-sensitive non-formulaic way, three (sets of) values: being person-centred, being evidence-informed and being socially responsible. Research exploring and examining this approach would be helpful.

Successful health care requires effective leadership, including effective physician leadership (Taylor 2011). Various approaches to facilitate effective leadership in general and, more specifically, in health care have been described with some evidence to support them (Mintzberg 2009). However, there is a need for far more rigorous empirical research on leadership in health care, partly because counter-intuitive findings have emerged from such research. For example, senior leadership's consultative engagement with frontline workers was found to be somewhat disruptive (Hanna 2010). Yet, health care's prime rationale is to improve people's lives as an end in itself. This is so even in regimes such as that of the United States where there is no universal health care. Hence, values are fundamental in health care.

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Various approaches to health care values (and their ethical prioritization when they are in conflict) have been described and analyzed in relation to health care practice. Perhaps the most common approach in this regard is principlism (Beauchamp and Childress 2012), which upholds four general values: autonomy (respect for persons), beneficence (most benefit to persons), non-maleficence (least harm to persons) and justice (fairness to persons). A similar approach to health care leadership has not been addressed systematically, although it seems to be important. This paper introduces such an approach, using a selective literature review and a conceptual analysis, as well as illustrations from physician leadership experience.

Values

There are different types of values. Most famously, there are moral values, such as the importance of treating others as one would treat oneself (the golden rule). There are also epistemic values, such as the importance of truth and, as a key part of that, the importance of evidence (Haddock et al. 2009). Using these two key types of values, I am introducing a value-based approach to health care leadership — including physician leadership. Note that what I refer to below as being means intending to act (in a certain way), as the ethics of acting unrelated to intention (utilitarianism and more) and as the ethics of intending unrelated to action (deontology and more) may each be inadequate.

The first value of this approach is the importance of being person-centred. This is similar to the first three values of principlism (autonomy, beneficence and non-maleficence), but can be interpreted more broadly. It can be viewed as consisting of the importance of being person-driven, which refers to the person as the decision-maker about his or her care; person-focused, which refers to the person as the intended beneficiary of care; person-sensitive, which refers to care as addressing particular needs of the person; and person-contextualized, which refers to care as considering the person's history and current circumstances (Rudnick and Roe 2011). This multidimensional value is demonstrated in relation to health care leadership in systems planning that is based on patient inputs, on individual needs as well as population needs and on consideration of specific — hence varying — circumstances.

The second value is the importance of being evidence-informed. This epistemic value is not captured in principlism, which addresses only moral values. It is addressed by other approaches, such as standard hierarchies of evidence-based health care, which state that systematic reviews and randomized controlled trials (RCTs) result in the most sound health care evidence, while less well controlled studies result in less sound evidence and case reports and other anecdotal reports, such as individual or group statements that are based on opinions rather than studied facts, constitute the least sound health care evidence (Guyatt et al. 2000). It has been recognized recently that such hierarchies are problematic, because, for example, they give little or no weight to evidence from the "grey literature" and first-person accounts of patients and others involved, even though these sources of information are useful too, e.g., to evaluate feasibility and appropriateness (Evans 2003). This multilayered value is demonstrated in health care leadership in program evaluation that is informed by patient views and uncontrolled evaluations, such as plan-do-study-act (PDSA) cycles (Langley et al. 2009), in addition to RCTs when the latter are feasible.

The third value is the importance of being socially responsible. This is similar to the fourth value of principlism (justice), but can be interpreted more broadly. It can be viewed as consisting of the importance of being fair to all stakeholders, fiscally prudent, legally accountable and otherwise socially responsible. This multidimensional value is demonstrated in relation to health care leadership in policymaking that addresses all these dimensions as relevant.

Prioritizing values

When acceptable values conflict, decision-making must prioritize them to be ethically sound (Rudnick and Wada 2011). Principlism suggests a primarily context-sensitive, non-formulaic prioritizing of its four values. What could the principled approach to health care leadership suggest in relation to prioritizing its three values? Arguably, principlism's suggestion would be relevant here too, as there may not be a universal way to rank being person-centred, evidence-informed and socially responsible. Indeed, the values of being person-centred and socially responsible are similar enough to the four principles of principlism that it may be self-evident that principlism's suggestion applies to them too.

In terms of prioritizing, some situations are typically clearer than others; e.g., where many people may be harmed by one person, being socially responsible usually trumps being person-centred (hence utilitarianism's common use in public health situations). In regard to ranking being evidence-informed

...there may not be a universal way to rank being person-centred, evidence-informed and socially responsible.

against the other two values, principlism is not informative, as it does not address epistemic values. Arguably, evidence is a necessary but insufficient means to an end — delivering effective care, as evidence clarifies whether care is effective or not. Hence, the need for evidence regarding the effectiveness of health care should not be ignored, although the type of evidence needed is debatable, as argued above, and may be context-sensitive and not determinable by a formula. Thus, prioritizing the three values of this principled approach to health care leadership in a context-sensitive, non-formulaic way may be appropriate. How would such an approach manifest in a concrete situation?

Illustration

Let's imagine a (not uncommon) situation in which a health care intervention is deemed valuable by service users and staff, but there is no robust evidence that it is effective or even safe. This is the case for many, if not most, group counseling interventions in mental health care, such as for depression (Huntley et al. 2012). What should physician and other health care leaders do in such a situation, using the value-based approach introduced above?

I would argue that all relevant evidence should first be reviewed thoroughly. If the available evidence is promising, e.g., there are no published RCTs in this area, but less-rigorous research mainly shows positive findings, the leadership may be expected to support further empirical evaluation of — and possibly full-fledged research on — this intervention. On the other hand, if the available evidence is not promising, e.g., RCTs and one or more related systematic reviews in this area mainly show negative findings, the leadership may be expected to communicate their lack of support for this intervention and to lead a culture shift so that service users and staff endorse the need to conduct other, more effective and possibly safer interventions. This example highlights the prioritization of person-centredness when relevant evidence is not clear and the prioritization of social responsibility when relevant evidence is clear (and shows that being person-centred would not be effective, other than perhaps for service satisfaction).

Conclusion

The value-based approach to physician (and other health care) leadership introduced here prioritizes, in a context-sensitive, non-formulaic way, three values: being person-centred, being evidence-informed and being socially responsible. Theoretical and empirical research is required to further explore and examine this approach, including its advantages and challenges, as well as its practical implications and its evidence base.

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The myths of multitasking: taking a mindful approach to enhance leadership focus

Paul Mohapel, PhD

Abstract

Increasingly physicians are experiencing greater demands and pressures in their roles as both clinicians and leaders. As demands increase, we are seeing many physicians moving more to multitasking strategies to cope. This paper outlines some of the myths and misconceptions around the benefits of multitasking and offers mindfulness-based approaches to minimize the impairments associated with distraction and bring greater focus to self-awareness, interpersonal relationships and innovative thinking.

The myths

Multitasking increases efficiency and effectiveness — Although this is one of the most prevalent and enduring myths about multitasking, research data do not support such claims. For example, researchers Cao and Liu (2013) present evidence that multitasking physicians demonstrate measurable delays in completing complex clinical decisions, such as making diagnoses.

This is not so surprising, if you consider that mentally switching tasks decreases cognitive processing efficiency by as much as 50% compared with tasks completed separately in sequence (Rubinstein et al. 2001). Dr. Gloria Mark and associates (2008) found that an average employee takes about 25 minutes to return to the same level of concentration with each interruption, and the average worker switches attention every three minutes (most of these interruptions are self-initiated). Each time you abandon a mental task to attend to an interruption, your emotional and cognitive engagement with the task immediately begins to decay. According to Basex, a business research company based in New York City, workplace interruptions lead to a productivity loss of about 28% for the average worker (Spira 2011).

Performance improves with greater multitasking proficiency — Clifford Nass, a prominent psychologist from Stanford University, led a study that assessed and compared light with heavy multitaskers on a battery of cognitive tasks (Ophir et al. 2009). Heavy multitaskers were less efficient at multitasking than light multitaskers. In particular, heavy multitaskers were worse at filtering irrelevant information and performed significantly worse at switching between tasks. They were also more distracted by irrelevant environmental stimuli, stored less content in their working memory and were unable to sustain concentration as long.

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Technology saves time — Technology that is heralded as making our lives easier — email, the Internet, RSS feeds, short message service (SMS), instant messengers, Twitter — is, in fact, encouraging more multitasking behaviour and creating more distractions. For example, the average person now glances at his or her email 30–40 times an hour (Renaud et al. 2006). Recent studies with physicians have found that the use of personal devices, such as smart phones, also seems to be contributing to further distraction and, potentially, medical errors (Wallace et al. 2012). Professor Glenn Wilson, a psychologist from King's College, London University, discovered that

handling email can cause a 10-point drop in one's IQ score, which is the equivalent of the cognitive impairment seen after the loss of a night of sleep (Wainright 2005).

The dangers

More critically, chronic multitasking may be taking a serious biologic and psychologic toll on physicians and leaders. According to Dr. Edward Hallowell (2005), a psychiatrist specializing in attention deficit disorder, high multitasking environments are contributing to a clinical syndrome that he has termed attention deficit trait, or ADT. The core symptoms include distractibility, inability to sustain focus and impatience, and they lead to constant feelings of panic, irritation and guilt. People with ADT have difficulty staying organized, setting priorities and managing time. Moreover, Dr. Hallowell has frequently observed these symptoms in executives and leaders, who are more likely to multitask.

Over the past few years, evidence that multitasking is impairing our ability to sustain required attention and to learn has been mounting. Using magnetic resonance imaging (MRI) scans, Small and colleagues (2009) demonstrated that multitasking "overstimulates" the prefrontal cortex (the region of the brain responsible for directing attention) and, thereby, inhibits the processing of information in the hippocampus (the area of the brain responsible for the creation of memories), which impedes the learning of new items and the retrieval of memories. In particular, it appears that working memory, which is critical for focused attention and moving information into long-term memory, is compromised with multitasking.

Linda Stone (2009), a respected speaker, suggests that constantly switching between tasks has led to a pathologic state that she calls continuous partial attention. In this state, our minds habitually attend only partly to any given task, as other parts of the brain are busy scanning the environment for new stimulation. This constant need for stimulation contributes to heightened states of stress and anxiety by activating the more primitive limbic brain structures that are in part responsible for constantly scanning the environment for potential threats. These stress responses activate an adrenaline rush and other damaging stress hormones that, when prolonged, can damage cells in the hippocampus that contribute to the formation of new memories (Wetherell and Carter 2013). Prolonged stress states have been shown to contribute to and exacerbate various psychologic conditions, including depression, anxiety disorder and obsessive-compulsive disorder (Lucassen et al. 2013).

A recent study found that physicians self-reported greater psychophysical strain when multitasking (Weigl et al. 2013). Moreover, multitasking may be contributing to alarming rates of professional and personal distress, with up to 60% of practising physicians reporting at least one aspect of burnout syndrome: excessive emotional exhaustion, depersonalization or a low sense of accomplishment (Shanafelt et al. 2012).

A mindfulness approach to enhance focus

Given that multitasking contributes to increased distraction and stress and may culminate in burnout for physicians (Dunn et al. 2007), what strategies should physician leaders adopt to counter these effects? The obvious answer is simply to minimize multitasking. At face value, that makes sense, at least from the perspective of

"containing" the problem (i.e., a "survival" strategy), but it may be incomplete given the pragmatic demands of leadership in the hectic, modern world of medicine. Given that demands and pressures will only continue to escalate for the physician leader, I suggest a more holistic strategy that is based on "thriving" — that approach is mindfulness.

Mindfulness, in a sense, is the polar opposite of multitasking in terms of behaviour and impact on one's psychology and brain. Mindfulness refers to a quality of focus that includes the ability to sustain attention in a way that is intentional, in the present moment and nonjudgemental. It includes the ability to notice, observe and experience bodily sensations, feelings and thoughts as they arise. It reflects the capacity to adopt a particular orientation toward one's experiences in the present moment (as opposed to ruminating about the past or fretting about the future) that is characterized by curiosity, openness and acceptance. It is about overcoming the natural tendency to be on "autopilot" and distracted, overcoming emotional reactivity to challenging experiences and suspending the need to label or judge them (Kabat-Zinn 2013).

Mindfulness is gaining credibility and wider acceptance in the medical and leadership communities (Ludwig and Kabat-Zinn 2008); for example, the University of Toronto Residency Wellness Program teaches mindfulness skills to medical residents. As a means of improving well-being and clinical performance, mindfulness has shown great potential in research trials with health care professionals. For example, primary care physicians who participated in a program on mindful communication demonstrated improvements in various measures of well-being and enhanced personal characteristics associated with leadership, including emotional stability, empathy and conscientiousness (Krasner et al. 2009). More recently, Dr. Luke Fortney and colleagues (2013) looked at the effects of a short mindfulness course and found decreased levels of burnout, anxiety, depression and distress among doctors that lasted nearly a year later, even without any further mindfulness training sessions. Moreover, an investigation of internists found that their "ability to be present" correlated more strongly with finding meaning and a sense of control in their role as a physician than either diagnostic or therapeutic successes (Horowitz et al. 1995).

Mindfulness, in a sense, is the polar opposite of multitasking in terms of behaviour and impact on one's psychology and brain.

With respect to enhancing leadership capacity, the literature has identified several benefits of mindfulness training: expanded self-awareness, insight, receptivity, balance and clarity for oneself and others (Santorelli 2000, Kabat-Zinn 2013), greater leadership presence and authenticity (Santorelli 2000), improved interpersonal workplace relationships (Hunter and McCormick 2009) and increased creativity (Langer 2006). Boyatzis and McKee (2005) view mindfulness as an essential element of leadership and define it as the capacity to be fully aware of what is happening inside and around us.

Similarly, Daniel Goleman (2013), a popular author on emotional intelligence, identifies three crucial areas that leaders must heed to enhance their focus, what he calls the "triad of awareness": awareness of one's internal experience; awareness of one's relationships with others; and awareness of the wider context that promotes innovation and creativity. Although he does not explicitly make the link, all of these attributes are central to mindfulness and leadership. These three attributes of focused awareness are further discussed below.

Recently, in a survey, 75 members of the Stanford Graduate School of Business Advisory Council rated self-awareness as the most important capability for leaders to develop (Toegel and Barsoux 2012). Self-awareness is about obtaining insight into why, how and when one thinks, feels and behaves in certain ways. It includes the ability to examine one's emotional triggers, thinking patterns, assumptions, values, principles, strengths and limitations. As noted above, mindfulness training will enhance self-awareness. Further support comes from brain imaging studies conducted by Sara Lazar and her group at Massachusetts General Hospital. They compared experienced mindfulness practitioners with those with no meditation experience

and found that parts of the cerebral cortex involved in self-reflection (right anterior insula) and empathy (Brodmann area 9/10) were significantly thicker in the meditators than in controls (Lazar et al. 2005).

Greater empathy and compassion are other benefits associated with mindfulness training in leaders. Goleman (2013) refers to three kinds of empathy: cognitive empathy — the ability to understand rationally another person's perspective; emotional empathy — the ability to feel what someone else feels; and empathic concern — the ability to sense what another person needs from you. All three types of empathy can be developed through mindfulness training, as demonstrated by research conducted with physicians at Boston's Massachusetts General Hospital (Riess et al. 2012). In this study, researchers trained physicians to monitor themselves by using deep, diaphragmatic breathing and to cultivate focus, rather than being lost in their own thoughts and feelings. They found this kind of training improved ability to decode facial expressions of emotion and achieve better patient outcomes.

Finally, another benefit of mindfulness practice for leaders is enhanced innovative and creative thinking. Carson and Langer (2006) describe mindfulness as a process of noticing and drawing novel distinctions that can lead to number of outcomes, including: enhanced sensitivity to one's environment, greater openness to new information, the creation of new categories for interpreting events and enhanced awareness of multiple perspectives when problem-solving. Their research shows that when we are mindful, we are perceived as charismatic, genuine and authentic by those around us.

Greater empathy and compassion are other benefits associated with mindfulness training in leaders.

To conclude, physician leaders who cultivate mindfulness will not only counter the negative impact of their highly distracting and stressful multitasking environment, but they will also strengthen their ability to focus attention on their own internal state, more likely listen deeply to others and be better able to consciously respond rather than react. At the same time, mindfulness practice can support a more disciplined and directed approach to the steady stream of thoughts that prevent us from being in the present moment, where true innovation and foresight emerge.

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More women leaders needed in medicine

Mamta Gautam, MD

Abstract

Despite increasing numbers of women in medicine, they continue to be underrepresented in executive and academic leadership positions. Women bring many attributes and strengths to leadership roles, and research shows there is advantage to gender diversity in leadership. Attempts are being made to understand why there is such a lack of women leaders in medicine, and steps are being taken to support and increase female leadership. Harnessing the potential of all medical leaders will help to ensure successful health care transformation and optimal patient care.

Women are changing the face of our medical profession. There are more women in medical school and more women clinicians than ever before. However, despite these increasing numbers, women continue to be underrepresented in executive and academic leadership positions in medicine in Canada. Although women make up 50–60% of medical school graduates, only 13% of medical department heads across the country are women. It was not until after 175 years of medical history that Canada's first female dean of medicine was appointed in 1999.

Contribution of women leaders

Women bring many attributes and strengths to leadership roles. They have been identified as offering a higher level of emotional intelligence, better communication skills, greater collaborative interaction, more team initiatives and a healthier work–life balance in the workplace. Research on women in leadership positions reveals that there is advantage in gender diversity in leadership (Troiano 2013).

In *Unlocking the Full Potential of Women at Work*, Joanna Barsh and Lareina Yee (2012) demonstrate how gender diversity creates open, accepting, inspiring cultures; generates stronger business results, and fuels creativity and innovation. According to Daniel Goleman (1998), business leaders are no longer being defined by their IQ or even their technical skills. It is their emotional intelligence skills that make the difference; in top leadership positions, over 80% of the difference in performance can be attributed to emotional competence.

Women bring many attributes and strengths to leadership roles. They have been identified as offering a higher level of emotional intelligence, better communication skills, greater collaborative interaction, more team initiatives and a healthier work–life balance in the workplace.

Several studies have shown that companies with few or no women in leadership positions rob themselves of a competitive edge. In a study of 279 companies, Desvaux et al. (2010) found that those in the top quartile in terms of women in top management positions exceed companies with no women in top management by 41% for average return on investment and by 56% for operating results. Catalyst reported a study demonstrating a 53% higher return on equity among Fortune 500 companies with a higher proportion of female board directors (Carter and Wagner 2007).

Why the lack of women leaders in medicine?

Why, then, are there disproportionately fewer women

leaders in medicine? Several contributing factors have been identified as obstacles to advancement of women in academic medicine (Buckley et al. 2000, Richman et al. 2001, Yedidia and Bickel 2001, Bickel et al. 2002):

- Male-oriented institutional culture or practices favouring traditional gender roles

- Gender difference whereby women may undervalue leadership roles or have lower ambitions, expectations and self-confidence than their male colleagues
- Lack of mentorship of junior physicians
- Lack of leadership training
- Voluntary career interruptions

These are all also applicable to non-academic areas of medicine, although specific data for these fields is lacking.

Dr. Virginia Roth (2011), director of physician leadership development and physician engagement at the Ottawa Hospital, undertook to study the reasons behind the dearth of women leaders as part of her master of business administration thesis work. Her key finding was that many women physicians exclude themselves from leadership positions because they perceive the cost as too high compared with the potential benefits. The women physicians she interviewed placed a premium on their time, family contribution, satisfaction outside work and a collaborative (rather than competitive) working environment. They viewed these priorities as incompatible with leadership roles as they are currently structured.

The Federation of Medical Women of Canada (FMWC) has long been an organization committed to the development of women physicians and the well-being of all women.

Steps to increase female physician leadership

Although the Ottawa Hospital has many of the ideal characteristics for success — strong senior management support for and nurturing of female physician leaders and female physicians who are willing to drive change — Dr. Roth identified and is taking further steps to increase female physician leadership. These include articulating guiding principles and an inspiring definition of leadership; identifying potential leaders; mentoring and training leaders, and recognizing and supporting leaders. The Canadian Medical Association is addressing the training of women leaders through its Physician Management Institute (PMI). The highly popular PMI course, *Leadership for Medical Women: Strengthening Your Leadership Capacity*, is geared toward helping women in medicine

- Identify what influences leadership and recognize both internal and external factors affecting the career progression of medical women today
- Explore the leadership direction that resonates most strongly with them
- Leverage their natural strengths

to engage others more effectively and address factors that may be limiting success
- Identify opportunities to drive and support female physician leadership in our complex health care system

The Federation of Medical Women of Canada (FMWC) has long been an organization committed to the development of women physicians and the well-being of all women. Associated with the Medical Women International Association, it supports the development of women leaders in medicine by offering educational opportunities; creating networking opportunities at the local, national and international levels; providing a leadership mentoring program, and ensuring a recognized voice for women in medicine.

In fact, the theme of the next Annual General Meeting of the FMWC (Sept. 19-21, 2014, Vancouver) is *Women as Medical Leaders: Empowered, Engaged, Extraordinary*. It will feature key women leaders in medicine in Canada sharing the lessons they have learned through plenary presentations, thought-provoking panel discussions and workshops to hone leadership skills, in addition to its usual medical practice updates. As one member stated, "The FMWC has become a stepping stone in leadership development for women."

It is encouraging to see such efforts being made to increase the number of women leaders in medicine. Working together with our male colleagues, we can harness the potential of all medical leaders to lead health care transformation in this country and achieve optimal and sustainable health care for our patients.

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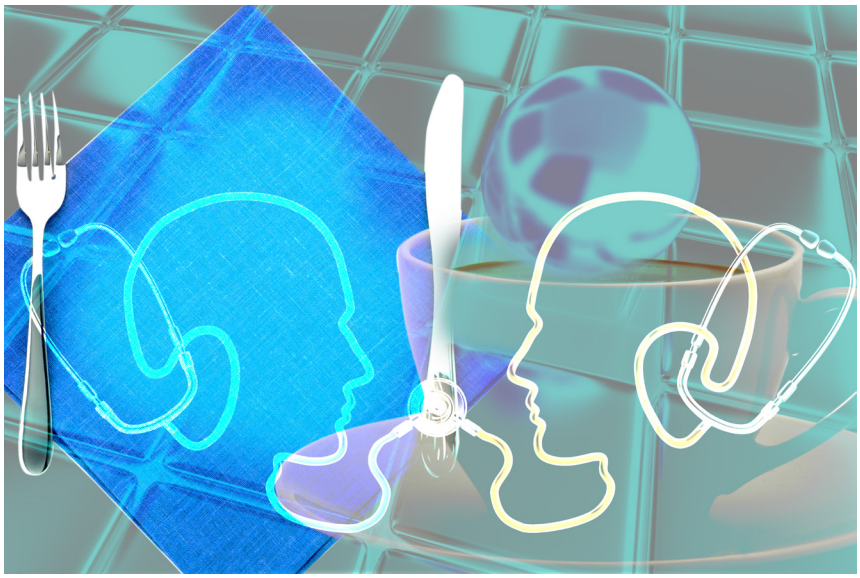
Physician breakfast club: more than tea and toast — building physician leadership capacity in health system improvement

By Leane Bettin, MD

I had been in practice only three years when I stepped into the medical director role at the Saskatoon Community Clinic. Although it was one of those cases where "no one else wanted the job," I had great aspirations for physician engagement and quality improvement.



However, less than two weeks after I assumed this new leadership position, my predecessor and mentor suddenly became seriously ill. I was left to fend for myself and quickly felt the isolation that a leadership role can bring. The Saskatoon Physician Breakfast Club began that same year and has been instrumental in overcoming my "lonely at the top" feeling and facilitating personal leadership development.

The Saskatoon Physician Breakfast Club is a journal club with a focus on building physician leadership capacity in health system improvement. The idea was spearheaded by Dr. Susan Shaw, division head of critical care, and Dr. Kishore Visvanathan, then division head of urology. Since its inception, the club has not only served to build greater physician leadership capability among its members, but it has also brought a diverse community of providers together, who routinely share ideas, solve problems and learn from each other's experiences.

A broadly balanced representation of physicians involved in quality improvement and in leadership roles was recruited to the club. A group of eight with a range of ages, leadership experience and medical specialties emerged, promising a variety of perspectives to enrich discussions.

Dr. Jason Hosain, academic family medicine, Westwinds Health Centre, welcomed the chance to meet with individuals from different disciplines of medicine and break down the silos that plague our health care system.

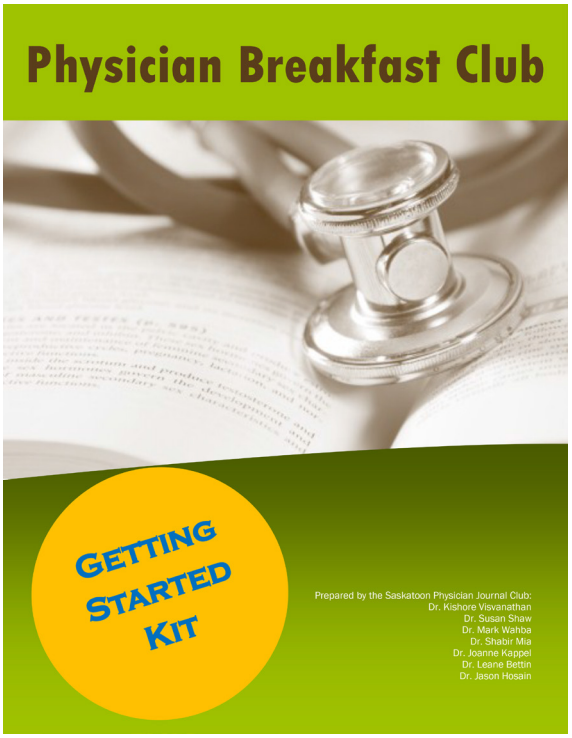
A broadly balanced representation of physicians involved in quality improvement and in leadership roles was recruited to the club.

Dr. Joanne Kappel, division head of nephrology, continues to be drawn by the supportive and collaborative nature of the group. Getting to know and trust others facing similar leadership challenges enables her to continue in her leadership role despite the trials. She particularly enjoys group discussions of real-life case studies.

Dr. Mark Wahba, emergency medicine, recognizes the irony that the people trying to make improvements are often viewed as "the enemy." He was surprised by the fact that many people felt isolated from their colleagues by their quality improvement work. Sometimes feeling like Sisyphus pushing a boulder up the hill, he appreciated the support of

colleagues in the group, "helping him push."

The group meets regularly, every second month, over breakfast at a centrally located hotel from 6:30 to 7:45 am, before the rush and interruptions of a typical day begin. Dr. Visvanathan notes how physicians' busy clinical work tends to restrict them to their own practice circles (i.e., surgeons in the operating room, general practitioners at their clinics). The group provides opportunities to interact with people from other



circles and to provide mutual support for medical leaders. Sharing conversation over a meal also contributes to the relaxed and cordial environment.

Dr. Shabir Mia, otolaryngology, appreciates the fact that leadership responsibility at the breakfast club rotates. The lead is responsible for selecting an article, posing reflective questions to the group, sharing a personal leadership challenge, facilitating the conversation and picking up the breakfast tab. One or two articles serve as a platform for discussing local and vexing leadership issues of the day, which is conducive to collective troubleshooting and problem-solving. The journal articles selected are relevant to physician leadership and health system quality improvement.

Every meeting "wrap up" includes a discussion of what went well and what to improve for the next meeting. Ongoing methods of evaluation include tracking attendance and periodically surveying members. Debra-Jane Wright, Provincial Kaizen Promotion Office director, a critical non-physician member of the club, provides unique quality improvement experience and administrative support to the group. Debra-Jane's efforts to coordinate meetings, disseminate journal articles and summarize key discussion points have been essential to the maintenance and sustainability of the club.

Remaining true to its original goals, the Saskatoon Physician Breakfast Club continues to:

- Create opportunities to collaborate and troubleshoot real issues or challenges that current members face
- Build knowledge of current leadership thinking and best practices by reviewing and discussing relevant journal articles
- Establish meaningful relationships to support members throughout their leadership journey

For a Physician Breakfast Club "Getting Started Kit," contact Debra-Jane Wright at dwright@hqc.sk.ca or download a copy from the CSPE web site - http://www.cspexecs.com/resources/BreakfastClub-StarterKit.pdf.

For additional information, feel free to contact any of the club's current members:
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This article has been reviewed by a panel of physician leaders.

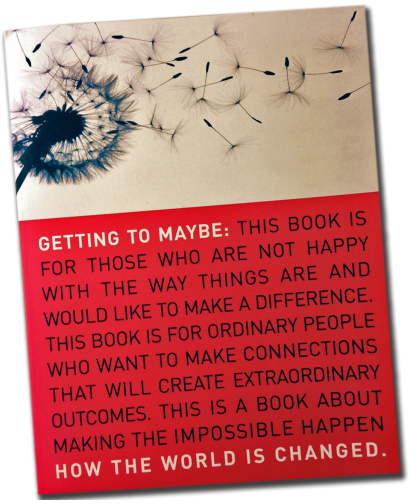
Book review

Getting to Maybe: How the World is Changed

Frances Westley, Brenda Zimmerman and Michael Quinn Patton
Vintage Canada, 2007

By Alykhan Abdulla, MD

As I have attended many Physician Management Institute workshops over the years and am a current participant in the Canadian Medical



Association/Ontario Medical Association Physician Leadership Development Program, I have had cause to read many books that deal with becoming a change agent in a complex health care system. Among these books, which range from The Tipping Point (Gladwell 2000) to Getting to Yes (Fisher et al. 2011) to Hidden Order (Holland 1995), none is as compeling and self-affirming as Getting to Maybe: How the World is Changed.

The eight chapters of this braided book weave an artistry of poetry and prose containing evocative stories of leadership and social change with iterative directives and questions from complexity science. The first chapter, "The first light of evening," guides our journey. As we understand the difference between simple, complicated, and complex problems, we are given ground rules. Be open to questions. Accept tensions and ambiguities. Let your mindset tolerate new lenses.

In "Getting to maybe," we open our mind to possibilities by supporting vision and improving our networks, interactions and information exchange. If we speak passionately about things that matter to us and find the attractors for others, we may become a generative model for others.

In "Stand still," we need to see what happens around us and its context. This is the paradox of reflective action.

In "The powerful strangers," we are serendipitously connected to those who share their awareness, connections, and resources because of aligning interests.

In "Let it find you," we find ourselves in the stream learning from others and teaching others.

"Cold heaven" teaches us how to deal with failures or obstacles.

In "When hope and history rhyme," our intentions and successes align, but we happen to be at the right place at the right time.

And finally, in "The door opens," we realize that we don't have any more doors than others. As social innovators, we see doors as opportunities. Future opportunities and change are there, if only we see them.

I have deliberately left the quizzical title to the end. Why would "getting to maybe" be a goal for anyone? The authors explain that our goal should not be to convert people to our mission or purpose, as dealing with social innovation is not a "cookie-cutter," "one-size-fits-all" or "leaders-spouting-directives" management style. Rather, intention and unpredictability hold possibilities (may) in cooperation and competition with the way things are (be).

This book will teach you how to parse the known and unknown, how to be risky and safe, and how to reflect and react as you lead. Getting to Maybe truly epitomizes the complexity of changing people's hearts, minds and souls. This book highlights how ordinary people can create extraordinary outcomes because they hope for what could be rather than accepting what is.

Author

Alykhan Abdulla, BSc, MD, LMCC, CCFP, DipSportMed CASEM, FCFP, CTH (ISTM), CCPE (2014) is currently a candidate for a master's certificate in physician leadership.

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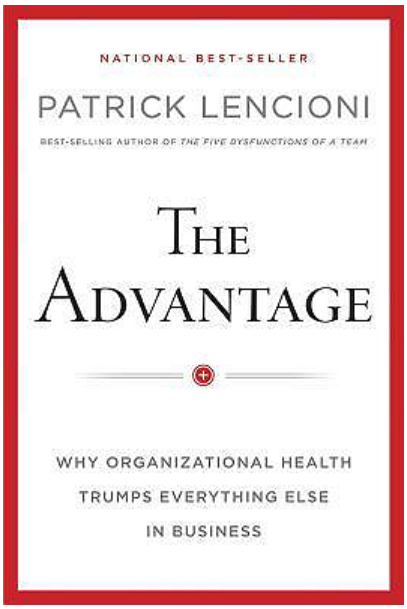
Book review

The Advantage: Why Organizational Health Trumps Everything Else in Business

Patrick Lencioni
Jossey-Bass, 2012

By John Van Aerde, MD

Patrick Lencioni's previous bestsellers Death by Meeting and The Five Dysfunctions of a Team gave us tools to improve our meetings and to make our teams more successful during and after those meetings. His most recent book, The Advantage builds on those previous books by making a healthy executive team the basis of a healthy organization or department.



He begins with a review of his previous work, which he further expands into the larger context of organizational culture and changes. He defines an organization as healthy when it has integrity — not in an ethical or moral way, as defined so often today — but when the organization is whole, consistent and complete, when its management, operations, strategy and culture fit together and make sense.

According to Lencioni, any organization that really wants to maximize its success must concentrate on embodying two basic qualities: it must be smart and it must be healthy. Smart means that the decision sciences, like strategy, marketing, finance and technology, have been covered well. Although only half of the equation, being smart occupies almost all the energy, time and attention of many executives.

The other half, being healthy, is often neglected and many organizations underinvest in that second half. Signs of a healthy organization include minimal politics and confusion, high degrees of morale and productivity and very low turnover among good employees. Because people in healthy organizations, including leaders, learn from one another, identify critical issues and recover quickly from mistakes, healthy organizations inevitably become smarter over time.

The book has four main sections, one for each of the four disciplines an organization requires to become healthy. The first explores how to build a cohesive leadership team. In this section, Lencioni re-dissects the content of his most successful book, Overcoming the Five Dysfunctions of a Team, by addressing the five behaviours of highly successful teams:

- Building trusting relations
- Resolving conflicts productively
- Achieving commitment to decisions and plans of action
- Holding one another accountable for these commitments
- Focusing on the achievement of collective results

This section is rich in tools and examples to facilitate success in each of these five functions.

The second discipline focuses on achieving clarity by asking six critical questions: why do we exist? (core purpose), how do we behave? (core values), what do we do? (business definition), how will we succeed? (strategy), what is most important right now? (top priorities), who must do what? (clear division of labour irrespective of role descriptions).

The third discipline, overcommunicate clarity, deals with how the answers to the six critical questions are communicated consistently to the rest of the organization — again and again. In this section, Lencioni also provides some tools and examples, but fewer than for the first two disciplines.

Finally, the fourth discipline of a healthy organization deals with reinforcing the clarity by embedding the answers to the six critical questions in the fabric of the organization. In this section, Lencioni explains how hiring, training, managing, compensating, rewarding, firing and evaluating performance of organizational members should reflect the answers to the six questions. For example, recruitment interviews often evolve around the "smart" skills, knowledge and expertise; they should also

include organizational values and leadership skills.

For those of us who have read little in the domain of team development and organizational culture, this is a book to include in our library, as it is a compilation of many basic principles all combined in one volume. If you have read books on this topic before, you are perhaps better off investing in books that cover newer insights into team development and organizational culture. I score this book a seven out of ten.

Author

John Van Aerde, MD, MA, PhD, FRCPC is currently president of the Canadian Society of Physician Executives. He is senior consultant for neonatology at Fraser Health, BC, clinical professor of pediatrics at the University of British Columbia, an associate faculty member at the School for Leadership Studies as Royal Roads University in Victoria, and on the faculty of the Physician Management Institute.

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