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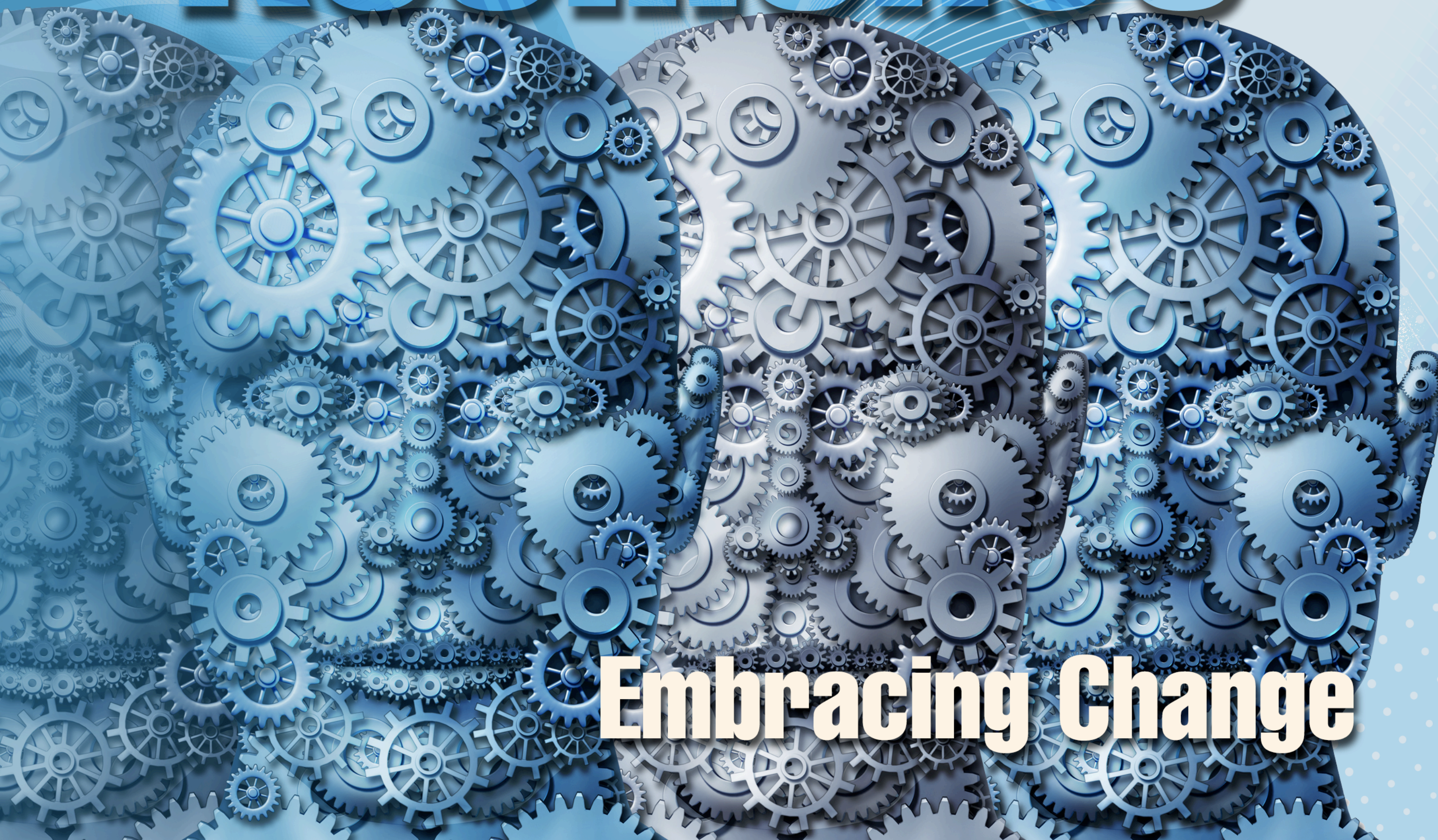


In this Issue

Relationship-centred care: toward *real* health system reform
Rethinking power in a hospital setting
The 5 Cs of physician resilience

CSPE Canadian Society of Physician Executives
SCMG Société canadienne des médecins gestionnaires

Contents

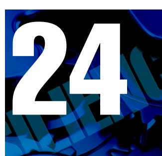
3 Opinion: Relationship-centred care: toward *real* health system reform Johny Van Aerde, MD

7 Rethinking power in a hospital setting Peter Dickens, PhD

12 Enhancing physician leadership resilience Greg McQueen, PhD, and Chris Bart, PhD

16 The facilitative leader: Designing engaging and productive meetings Monica Olsen, MHRD, and Mary Yates, MEd

20 Seeing differently: applying the Theory of Constraints in health care Alex Knight, MBA, CEng, and Ruth Vander Stelt, MD


24 The 5 Cs of physician resilience Mamta Gautam, MD

Service Fanatics: How to Build Superior Patient Experience the Cleveland Clinic Way 28

The Systems View of Life: A Unifying Vision 29

Opinion:
Relationship-centred care toward *real* health system reform

Johny Van Aerde,
MD, MA, PhD, FRCPC

The health care system and its professionals are criticized, at times even politicized and moralized, for the way they conduct their business.

Some discussions on reforming the system are about ideology, some are about effectiveness and efficiency, while others focus on private and public resources or the financial sustainability of provincial and federal health care systems. Because viewpoints are often driven by politics and self-interest, conversations evolve into debates rather than dialogue.

These debates about "health care reform" are often not really about that at all. If they were, they would include the socio-economic aspects of the Canadian health system.[1] If they were, they would focus more on the essence of care, on the way caregivers partner with patients and with each other to reduce human suffering. Many of these debates are also divorced from meaningful action.

Many of us are longing for a cultural transformation that returns some of the "caring" to the system; we also want to own that change, rather than have more structural changes imposed on us. The feeling of helplessness permeating the system is, in part, a result of the fact that we continue to apply old frameworks to what have become complex, adaptive systems. Clinical interaction, the basic element of any health care system, is a complex, adaptive process.

The traditional view of clinical interaction is based on a form of Cartesianism, where the body is a machine and medical professionals are technicians whose job it is to repair that machine. In this mechanistic model of doctor-centred care, medical decision-making is viewed as an exclusively professional prerogative where physicians have the greatest authority.[2,3] In the 1960s and 70s, authority and expert knowledge were challenged in all sectors of society, but it wasn't until the late 80s and early 90s that resentment arose against the unilateral authority of doctors and the tendency to depersonalize care. New integrative disciplines were encouraged to counteract the scientific fragmentation that encouraged physicians to divide their care into disease- and organ-oriented specialties.[2,3] The time had arrived to reintroduce "health" and "care" into the health care system. Patient-centred care was born.

Patient-centred care was to focus on the patient's goals and values, making him or her an active participant and sometimes the ultimate decision-maker. At times, the pendulum swung completely to the side of the patient when some practitioners endorsed unproven interventions or treatment to satisfy the patient.[4] As a result, when patient satisfaction was used to evaluate an organization's performance, subjective patient experiences confounded objective outcome measures. In reality, in a culture of patient-driven care, no correlation exists between patient satisfaction and clinical outcomes.[4-7]

One initiative to reduce patient-driven care, Choosing Wisely Canada,[8] helps to engage physicians and patients in conversations about unnecessary tests and treatments. However, this may not yield the intended results unless the conversations take place within the context of relationship-centred care (RCC), where neither the clinician nor the patient but the relationship as a whole is the focus.[9]

What is the genesis of RCC? The Pew-Fetzer Interprofessional Task Force saw clinical interaction as a complex adaptive system.[2,3,9] It recognized that, while the purpose of health care is to respond to the needs of the patient, the process

can be understood neither from a doctor- nor patient-centred perspective, but requires an explicit focus on the *relationship* between the partners.[9] The patient–clinician relationship is an entity different from either of its parts, and it has all the characteristics of a complex, adaptive system.[2] Twelve years after the Task Force's initial monograph, Beach and Inui[10] articulated four principles of RCC:

- relationships in health care ought to include the personhood of participants (the patient's and clinician's unique experiences, values, and perspectives)
- affect, empathy, and emotion are important components of these relationships
- all health care relationships occur in the context of reciprocal influence (although the patient's goals take priority, both clinician and patient influence each other and benefit from the relationship)
- RCC has a moral foundation, allowing clinicians to develop the interest and investment needed to serve others and to be morally renewed by those they serve

More than anything, RCC is about partnership at every level and the respect, mutual understanding, and shared decision-making of which each partnership is comprised.[3]

In his new book, *Service Fanatics*, James Merlino,[11] a keynote speaker at the 2014 Canadian Conference on Physician Leadership and chief experience officer at the Cleveland Clinic, describes the theory around RCC and evidence of how it can be practised successfully. The Cleveland Clinic has been a world leader in medical outcomes for decades, but it had lost some of its caring. In 2008, although ranked among the top

"Patients were coming to us for the clinical excellence, but they did not like us."

four for outcomes in all but one specialty, the Cleveland Clinic was mediocre in terms of overall patient experience: in the 16th and 14th percentile for nurses' and physicians' communication, respectively, and in the 4th percentile for room cleanliness.

As the CEO, Dr. Toby Cosgrove said, "Patients were coming to us for the clinical excellence, but they did not like us."[12] Because medical excellence could not be improved much and because most people form their opinion based on the perception of experiences rather than clinical outcomes alone, the Cleveland Clinic made patient experience an enterprise-wide priority and named it Patients First. The organization also faced a penalty: the federal government would soon start to withhold 2% of Medicare payments from facilities ranking low based on the Hospital Consumer Assessment of Healthcare Providers and Systems.[13] Within 5–6 years, the Cleveland Clinic became a frontrunner in the study of patient experience and soared from below average to high scores for patient experience.[11,12]

Because one cannot provide

what has not been defined, the Cleveland Clinic first had to come up with a definition of patient experience. If defined too narrowly as patient satisfaction, patient safety may be marginalized.[4-7] Therefore, the definition had to include outcomes and safety. Following the four principles of RCC,[10] a definition also had to include the patient's understanding of his or her experience, while also adjusting the caregiver's beliefs, assumptions, and presumed knowledge of what patient experience should be. Taking all this into consideration, the clinic's current aim is to provide safe care, of high quality, in an environment of exceptional patient satisfaction, in a values-conscious environment. All 43 000 members of the Cleveland Clinic enterprise were defined as caregivers, as each one could affect the patient experience, directly or indirectly.

Although institutions talk a lot about the importance of empathy in delivering good care, there was actually little knowledge of what a patient experiences as he or she navigates the health care system.

Although institutions talk a lot about the importance of empathy in delivering good care, there was actually little knowledge of what a patient experiences as he or she navigates the health care system. For that reason, the Cleveland Clinic collected and continues to collect data from patients, using surveys and interviews. For example, patients said that they wanted the reassurance that the people taking care of them really understood what it was like to be a patient. Anything patients and families saw and heard was processed against what they believed was important according to their values and assumptions; this affected how they viewed their care and the organization.[11] The studies also revealed that patients often used proxies in their ratings: for example, they might see a dirty room as a sign that the hospital delivered poor care. Another striking finding was that satisfaction was higher if the caregivers had a happy demeanor: patients believed that unhappiness meant they were doing something that made the health care provider unhappy or that something was going on with the patient that the caregivers did not want to reveal.

As in any cultural change, both the brain (facts) and heart (empathy) of all caregivers and employees had to be engaged to align with the organization's vision of Patients First. To accomplish this, several points of action were needed: support from the top of the organization, a chief experience officer who reported directly to the CEO, resources to support the initiative, a sense of urgency created by the poor performance data and pending financial implications, and the development of tools for the change "by us, for us."[11]

Although everyone from physician to janitor co-owned the initiative, the development and delivery of the tools was adjusted for different groups. Everyone in the organization, without exception, participated in half-day exercises. After working interactively in groups of 10 with a facilitator, participants were offered follow-up mentoring to maintain the new skills. Despite physicians expressing fears that the new initiative would conflict with efforts to maintain high standards of quality, safety, and cost reduction, the clinic rose in rankings for quality and safety, and efficiency in delivery of care improved too. People were, and still are, involved — including patients on whom the institution relies heavily to identify problems and improve processes.[11]

Although involvement was not easy for any group of caregivers at the clinic, engaging physicians was most challenging. Without physician engagement, patient experience (or almost anything else) is difficult to improve. In "Turning doctors into leaders," Dr. Thomas Lee writes, "The problem with healthcare is people like me — the doctors."[14] Most physicians want to help, particularly for a noble cause, but they are often not asked or engaged in a meaningful way. An invitation from senior leaders is a start. At the Cleveland Clinic, other motivational tools included articulating a common purpose that reflected physicians' values, satisfying self-interest by rewarding the achievement of targets, and earning respect from the physicians to be engaged.[15] Making the invisible visible by sharing data and educating physicians about how they were going to be judged in a new values-based rather than volume-based world helped them

understand what the scores on patient experience meant and how those ratings could affect the organization's and their own finances.[11]

The data from the clinic's interviews and surveys helped the physicians understand patient experience scores and what needed to be changed. Initially, there was a significant disconnect between how physicians thought they communicated with patients and how patients rated their actual ability to communicate: 75% of the negative comments about physicians pertained to communication.[11,12]

Once the physicians were aware of the data and their meaning, the clinic had to figure out how to help doctors acquire, practise, and maintain the necessary skills to improve their communication. The delivery format and timing of courses and workshops were adjusted to accommodate physicians' learning style and schedules. Merlino[11] found that level of engagement was as difficult for salaried as for fee-for-service physicians. Learning in highly interactive small-group sessions, led by credible peers who had taken specific training, followed by peer-based coaching to maintain the learned skills proved to be the most successful way to address communication issues. The physician facilitator was often one of the physician leaders, who make up 10% of all doctors in this physician-led organization, and this too may have contributed to the successful implementation of Patients First. As a consequence, the patient experience score for physician communication rose to the 67th percentile in 2014 — up from 14th in 6 years.[11] All patient experience scores and outcomes are listed on the Internet.[16]

In Canada, do we know what the patient experience (not patient satisfaction) is in our organizations? How is each of us perceived by our patients? How can we make the invisible visible for RCC? How can physicians become more engaged in these types of organizational changes and system transformation? Although governments should be engaged in dealing with the socio-economic aspects of health, we, physicians, together with other caregivers and patients, have to lead transformational changes like relationship-centred care at the front line. The Cleveland Clinic provided the evidence that successful cultural changes around RCC affect all performance indicators and move us toward a sustainable health care system.

Investing in RCC is long overdue. It keeps empathy central in clinical interactions and it also serves self-interest. Someday, a loved one or you will be a patient. When that day comes, what do you want your patient experience to be?

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Author

Johny Van Aerde is president of the Canadian Society of Physician Executives. He is clinical professor of pediatrics at the University of British Columbia and the University of Alberta, he is an associate faculty member at the School for Leadership Studies at Royal Roads University in Victoria, and he is on the faculty of the CMA's PMI Physician Leadership Program.

Correspondence to: johny.vanaerde@gmail.com

This article has been reviewed by a panel of physician leaders.

Rethinking power in a hospital setting

by Peter Dickens, PhD

Abstract

Although hospitals are among the most complex human systems ever devised, they continue to deliver quality patient care. A brief examination of the literature related to power and hospitals reveals some interesting patterns that I then frame through a case study in a Toronto hospital that has demonstrated a commitment to interprofessional collaboration and distributed leadership. The case study involved a series of interviews with participants in a Process Improvement Program that dramatically reduced wait times in the emergency department. Rather than leaving the development of strategy with those who typically hold "power," the challenge was given to two teams of nurses, porters, physicians, and housekeepers: those closest to the problem and those with a personal stake in finding an effective resolution. The case study suggests that there are significant opportunities to improve care processes when power is redistributed.

The nature of power

The health care system in Canada is going through what Alvin Toffler[1] once referred to as a "power shift": a deep-level change in the very nature of power. It can be argued that this power dynamic was not merely accidental or a result of the mores of the time, but rather it had its origins in medical and nursing school training.

> While medical school training can be seen as a "toughening up" process preparing students for the rigours of a doctor's life, nursing training is an object lesson in submission. In nursing training *others* get tough. The nurse is taught to follow rules, to be deferential to doctors, and the importance of routine is emphasized.[2]

As Mintzberg[3] points out, traditional assumptions about power are deeply rooted in the dominant modernist metaphor of the organization as a machine: all the parts running smoothly, but with all the power vested in the hands of a few individuals.

When we hear the word "power," our minds often gravitate to the rampant abuses of power that litter the pages of history — and today's headlines. We can become obsessed and appalled by these excessive displays of brute force. Northouse[4] suggests that, "in discussions of leadership, it is not unusual for leaders to be described as wielders of power, as individuals who dominate others. In these instances, power is conceptualized as a tool that leaders use to achieve their own ends" (p. 9).

We get a little closer to a more engaging construct of power when we consider it simply as the capacity to get things done. Northouse would simply say that, "power is the capacity to influence. People have power when they have the ability to affect others' beliefs, attitudes and courses of action"[4] (p. 7).

Power in a health care setting

As early as 1962, Georgopoulos and Mann[5] noticed that, "the hospital is dependent very greatly upon motivations and voluntary, informal adjustments of its members." Despite its complexity and this need for such adjustments, descriptions of the construct of power in a health care setting are lacking.

That said, Fried[6] did explore the concept of power acquisition in a health care setting through the lens of strategic contingency theory, suggesting that, "power acquisition is a function of one's centrality to organizational functions, substitutability, and ability to cope with uncertainty." He notes the limitations of applying

organizational theories to health care organizations because of the unique nature of physician roles and attributes and demonstrates the distinction between doctors and nurses when it comes to the acquisition of power. Doctors achieve their power because they are perceived to be irreplaceable, while nurses "must be central and cope with organizational uncertainty in order to achieve power."

This distinction is exacerbated in Ontario where physicians are recruited by hospitals because they have a required skill in a medical subspecialty, but they are not employees of the hospital in the formal sense. They are given privileges, but have no formal accountability to the hospital and are not paid by the hospital. This gives them the potential for enormous power. Nurses, on the other hand, are hired and can be fired as normal employees. Thus, nurses have historically tended to focus career development on one of two distinct tracks: some pursue management roles while others move into the advanced practice roles that are beginning to fill the gap between physicians and nurses. This enhances their centrality and increases the difficulty of replacing them. Ironically, their perceived easy replaceability may be more myth than fact as Ontario, like many other jurisdictions, is facing a "pandemic" nursing shortage[7] brought on by an aging work force.

The power dynamics that exist between physicians and nurses can have a trickle-down effect on the power dynamics between nurses and patients. In this case, "power has been viewed as the right of professionals that they exercise to inform (informational power) clients on the basis of their knowledge (expert power), even to persuade them to change their behavior."[8] Health care providers also indicate their power by using jargon, dictating the topics, disregarding the patient's initiative, interrupting, questioning, and controlling the time.[8]

Fortunately, these power dynamics are beginning to change. Today, virtually every hospital has begun to think in terms of patient-centred care, which ensures that patients are viewed as central to, not excluded from, any discussion about their care. The following case study affirms the importance of taking a patient-centred perspective, even when trying to solve a complex, hospital-wide challenge.

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A case study: the Process Improvement Program initiative

The PIP initiative, in a Toronto hospital, brought together two teams of front-line staff who were to look for process improvements that would reduce wait times in the Emergency Department (ED) and improve the flow of admitted patients from the ED to the medicine floor. A key measure in the ED is the number of patients who have been admitted for observation and care, but for whom there is no available bed in a medical unit. They end up waiting, sometimes for several hours, in the ED on a gurney, thus limiting the capacity of the ED to care for new, incoming patients. Both departments were involved in the initiative, because it became clear that the challenges in the ED could not be resolved without a concurrent effort to improve bed capacity in medical units.

The province's Ministry of Health and Long Term Care provided two "coaches" who had experience in Lean process-improvement methods. The PIP initiative was limited to an 8-month time frame and the ministry set out clear guidelines: a maximum 4-hour time limit for treatment in the ED of patients not being admitted and 8 hours to an inpatient bed for those requiring admission.

Over the course of 2 days, I interviewed 11 people in connection with the initiative: physician leads, nurses, porters, and members of the executive team.

A new perspective

This initiative was an intentional attempt to look at the process from the patient's perspective, not the provider's. Although this may seem obvious to outsiders, hospitals can be so complex that it is common for providers to feel that they are the only ones who fully understand what is going on. This change in perspective created a powerful common point of focus.

A second novelty was that the people who were most directly involved in the processes related to patient flow were identified as the ones to drive the initiative. This was part of the framework provided by the ministry, to which the hospital had to adhere. A third key element that became clear from the interviews was that any proposed changes must be driven by careful analysis of available data. Hospitals, like many other institutions, build up layers of myths and assumptions that then guide decisions. Given the "bottom-up" nature of this initiative, it was critical to combat these myths with unassailable data. The end result was that the metrics established at the beginning were met or exceeded — and expectations continue to be exceeded 2½ years later!

Power dynamics

One of the central questions that I was curious about was how participants perceived power in a general sense and what power dynamics were in evidence in the initiative.

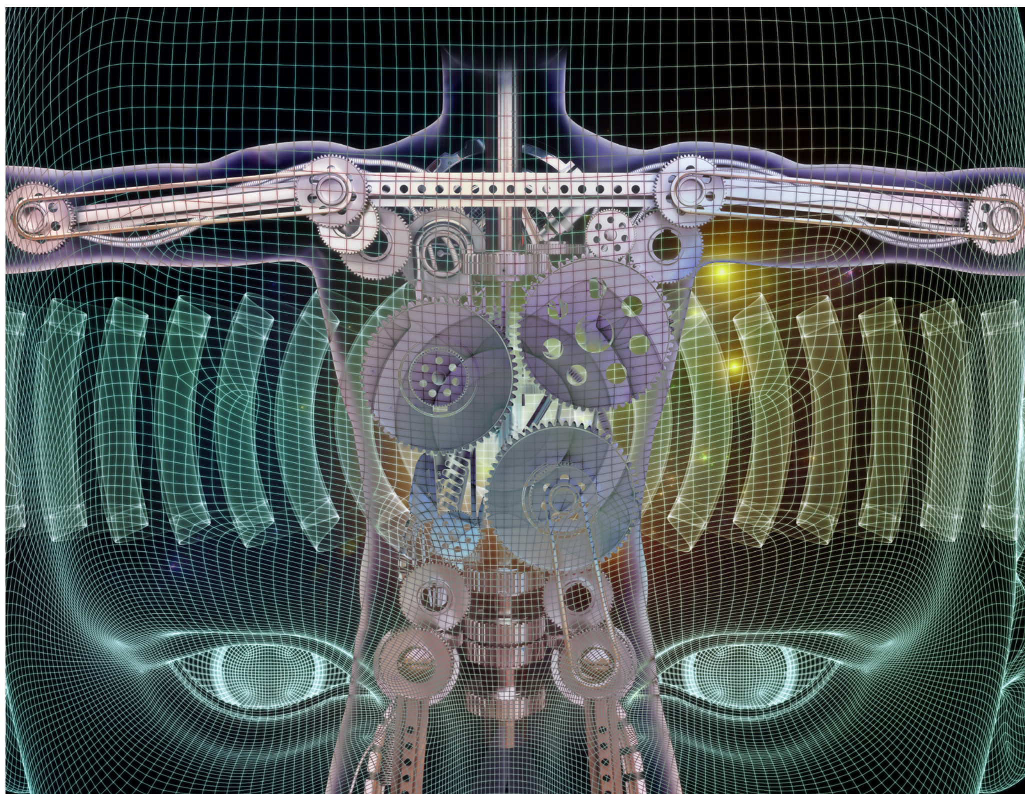
As one participant noted, "Traditional, positional power in which the physician assumes he is in charge and that he has all the right answers was not going to solve this problem. The Lean process put the power in the data. Clear, accurate data dissolve power relations and politics. Lean ensures that we bring data, structure and the appropriate tools to deliver validated improvements. That's where the power is. Interestingly, it allowed us to be comfortable giving people who might resist change a legitimate voice because we always had the data to challenge them."

The power of data was contrasted with the potentially destructive power of myths and assumptions. One person noted that, "For years, hospitals have lived on the basis of urban myths, assumptions and distorted mental models. Key decisions were made based on someone's 'gut feeling' or well-worn assumptions that were taken as truth. The data challenged and changed all that."

Another participant described this as creating a level playing field, which was seen as important in a setting where clinical expertise is generally held in very high regard. In the same way, physicians and others were willing to engage in process change when the data were clear and when they had

a clear indication of what one interviewee called "off ramps." They needed to know what data were required to indicate that a change was not working as anticipated and people would be willing to rethink the approach.

This initiative challenged the hospital executives to think about their power in a very different way. The CEO told me that, in the past, if he saw negative data related to patient flow, he would immediately assume the lead, convene a meeting, and try to solve the problem. "This process has really affirmed that that approach not only doesn't work but it is completely counter to any rhetoric about empowering people. I had to learn a whole new level of patience."



I received some interesting feedback on the nature of physician power. As one doctor commented, "A physician's power comes from their 'separateness' from the hospital [in terms of their employment relationship]. Doctors can appear to others to be behaving irrationally or using their power inappropriately, but it is because they have a very different agenda. They have different incentives and not all of them are savory."

Key lessons

I ended most of the interviews by asking participants to reflect on the key lessons learned from the PIP initiative in terms of power. Four themes immediately emerged.

The first was clearly the power of data. The director of the ED commented, "Today, data and the transparency of that data drive power. The CEO is very much driven by real time data, especially when it comes to the ED. I know that, good or bad, I will get a call between 7:15 a.m. and 7:30 a.m. every day, so I need to be prepared to explain the data and think about who the people are that need to be engaged in driving any change."

The second theme was the importance of clarity of focus and roles. One executive suggested, "You need every one to be very clear about what it is you want to achieve. We [the executives] needed to be clear and consistent in defining *what* needed to be done, *why* it needed to be done now, and *who* needed to be involved. What we didn't do — and can't do — is define *how* something was to get done."

In a new setting, being clear about the various roles can be challenging. As one executive put it, "When you're new to something, it's easy for people to trip over each other. You need to have patience and discipline to let people get on with it and not feel like you have to interfere."

Another executive suggested, "Distributed power is great, but it does require very clear parameters. I believe that the majority of changes are distributable, but only if you provide clarity."

The third theme was that Lean methodology works. As one interviewee commented, "While it was first developed for the automotive industry, the same approach to looking at simplifying

processes can work in a health care setting." However, it requires a fundamental change in the culture of an organization. This begins with getting people to work together in a highly collaborative way across departments.

As one team member put it, "Lean demands a blame-free environment in which people feel safe to try new approaches. However, the media immediately want to attach blame if anything goes wrong. Freedom of information is an important concept, but it leads to headlines and knee-jerk responses. It's vital that we find the right balance."

The final theme related to the power of collaborative learning. It started right at the beginning with a significant investment in the time required to train the two PIP teams so that they were confident and comfortable with the tools and processes. This initial learning was clearly well supported by the external coaches. Then, as the initiative unfolded and began to achieve some successes, the teams became more and more comfortable sharing their learning, experimenting, and developing novel solutions.

As one interviewee said, "New knowledge was being created at the front end of the process, with the PIP teams. Learning by doing can exclude some in the hierarchy and they may not have the knowledge that front-line staff are developing, but then the question is, do they need it or is this an example of wanting knowledge for the power it may provide? When you invert the knowledge pyramid, really interesting things happen. There can be comfort in the bubble, thinking that you know what is going on and that things are getting done your way, but the inversion process forces formal leaders to go out and see what's actually happening."

"We have learned the collective power of working and learning across systems," commented one interviewee. "We have taken huge steps forward in the relationship between ED and medicine. We have a better understanding of each other's challenges, people are much more respectful, and people have clear accountabilities for their piece of the process. The results tell the tale."

"I think that one of the things we have all learned about power," said an interviewee, "is that any one person has actually very little power — even the CEO. What you need is for a couple of things to converge and then recognize the power that you have to take advantage of the convergence. The wins at the end of the day were not based on one thing, but on a whole bunch of smaller changes converging to produce a transformational change. That has been significant learning for all of us: don't look for the one magic bullet."

Conclusion: creating the structural conditions for empowerment

The case study demonstrates the efficacy of intentionally designing the structural conditions through which people have the opportunity to empower themselves, thus allowing sustained change. What is particularly significant is that, in the 4 years since the PIP initiative, new structures have evolved into disciplined strategies. The organization continues to review data and performance. They bring content experts together to create "tests of change." Together, they set targets for improvement based on current evidence; they have developed lead and lag measures that are monitored over time and then re-evaluated to set new goals. As a result, cycles of improvement continue.

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Author

Peter Dickens, PhD, is a principal in the Iris Group, providing leadership and organizational change consulting to hospitals. He is also a member of the faculty of the Canadian Medical Association/Ontario Medical Association Physician Leadership Development Program, offered through the Schulich Executive Education Centre.

Correspondence to: peter@irisgroup.ca

This article has been reviewed by a panel of physician leaders.

Enhancing physician leadership resilience

by Greg McQueen, PhD, and Chris Bart, PhD

Abstract

Resilience — the capacity to cope with stress and bounce back — is a critical attribute for physician leaders. Two methods for cultivating resilience have received only scant attention, and these are the focus of our article: viewing stressful and painful situations as opportunities to learn and grow rather than wither and die; and engaging in non-arbitrary social cooperation and consensus-building.

Although there are many definitions of the term resilience, we think that *Mosby's Medical Dictionary*[1] provides one that resonates with most physicians:

> A concept that proposes a recurrent human need to weather periods of stress and change successfully throughout life. The ability to weather each period of disruption and reintegration leaves the person better able to deal with the next change.

Resilience, therefore, is the positive capacity to cope with stress and adversity resulting in an individual bouncing back and learning from the experience. Like all other assets that humans work with, resilience is a valuable but expendable resource that can be increased or depleted; and, like all other human resources or skills, it can be nurtured and developed through learning and practice.

Why physician leaders in particular should take time to enhance their resilience is obvious. The complicated and complex nature of the health care system, with its internal forces and external factors pushing up against each other, creates enormous occupational stress. Moreover, advances in medicine and health care, along with the changing roles of health professionals and changing health care delivery systems, call for a high capacity to bounce back on the part of all those in leadership roles.

As much as physicians may like to delegate, that is not really an option when it comes to resilience. In Robert Smith's book, *Breakfast with Socrates*,[2] Socrates suggests there are two things that cannot be delegated: going to the doctor and going to the gym. In "Resilience: a responsibility that can't be delegated," Kent Helwig[3] suggests that this is also true for resilience. If resilience cannot be delegated, what does the physician executive have to consider exploring to build resilience?

When 60 physician executives were surveyed during the 2014 Canadian Conference on Physician Leadership in Toronto, April 2014,[4] 100% answered yes to the question, "Do you need to have a high degree of resilience to be a good/great leader?" In the same survey, only 55% indicated that current physician leaders have such resilience. Incredibly, 55% of participants rated themselves as either "In a borderline survival state" or "Burnt out."

The urgent need to enhance resilience among physician leaders thus appears to be extraordinarily clear. Fortunately, there is an abundance of literature on the topic of resilience and how one can increase it. Some of the more popular methods are intentional focus and minimizing distractions, a positive predisposition and sense of happiness, narrative medicine, and increased emotional intelligence. However, there are two other methods that have received only scant attention, and these are the focus of our article: viewing stressful and painful situations as opportunities to learn and grow rather than wither and die; and engaging in non-arbitrary social cooperation and consensus-building.

Viewing stressful and painful situations as opportunities to learn and grow

Let us look at a colourful example of the stress one physician leader experienced. A biomedical ethicist

in a medical school would often be called to do morning rounds with an infectious disease specialist who also held leadership positions at both the hospital and medical school. Generally, a biomedical ethicist is never called to do rounds if everything is going well; however, this particular physician wanted the ethicist's opinion regarding some of his most difficult cases.

What the bioethicist saw during those consults was a physician with an extraordinary bedside manner. He was sensitive, empathetic, had a broad perspective, and was open to ideas from other team members. He strived to understand what

the patient was thinking, helped the patient understand complex medical information, and engaged the patient in shared problem-solving. Yet, at staff meetings (after morning rounds), that same physician became a different person. In meetings, he would be impatient, demeaning of others' ideas, fixated on his solution to the problem, and not interested in others' perspectives. Afterward, the bioethicist would have a vigorous discussion regarding the physician's "non-constructive behaviour."

The urgent need to enhance resilience among physician leaders thus appears to be extraordinarily clear. Fortunately, there is an abundance of literature on the topic of resilience and how one can increase it.

After several months, the physician came to visit the bioethicist. He had been bothered about the post-staff-meeting discussions and said that he had finally asked himself: why is this stress happening to me and what might I do about it? In other words, he started running toward his pain rather than away from it.[5] In so doing, he was eventually able to conclude why the staff meetings were so upsetting and stressful for him.

He explained that, when he was with patients, he knew his role, i.e., the conduct and behaviour expected by his patients as their physician. He knew the patients' role, and patients knew their role as well as that of the physician. He went on to explain that, in staff meetings, he was often unsure what role was expected of him and what others' roles were and, thus, as he described it, he "flailed around and was less than constructive while feeling very agitated."

The good news was that once he understood this about himself, he clarified his role and that of others in the meetings and applied the skills he used when working with patients. He became a highly contributing participant in staff meetings and experienced a lot less anxiety and agitation. He used his

problem-solving and learning skills as part of his resilience strategy to "bounce back," especially when dealing with highly contentious or controversial medical issues in some intense meetings.

The most complex level of moral reasoning, "post-conventional morality," does not rely solely on what one thinks is right ("pre-conventional morality"), nor does it rely predominately on the rules in play ("conventional morality").

We believe that understanding one's role(s) — and what one is required to do in them — as a leader (as well as becoming more proficient in these roles) is one of the best methods physician leaders can use to avoid unnecessary stress and anxiety and, thereby, avoid having to deploy their resilience skills in the first place. As Bart[6] has noted in his 10-year best seller *A Tale of Two Employees and the Person Who Wanted to Lead Them*, the number 1 reason why anyone does not do what is expected and needed of them (a highly stressful state!) is because they do not know clearly, specifically, precisely, and unambiguously what it is that they are supposed to do. Once such clarity is brought to roles, stress and anxiety are reduced immediately for both the role giver and the role receiver.

Moreover, McQueen's work in the Niagara Institute's Leadership Development Program[7] has highlighted the critical importance of leaders' need to enhance their ability to engage effectively in difficult conversations and to do so through their ability to engage in non-arbitrary social cooperation and consensus-building.

Engaging in non-arbitrary social cooperation and consensus-building

Change is always stressful. Accordingly, dealing with change well and helping others deal with change is not only important in being an effective leader but it is also an indispensable key to personal resilience and developing resilience in the team one leads. Facilitating or leading change, however, always involves making decisions that will inevitably affect others in varying degrees, typically presenting the necessity for them to change as well.

Kohlberg[9] and Rest and colleagues[10] have pointed out that decisions that affect others — or that have a social impact — involve moral reasoning (i.e., trying to find the right or fair solution) and are ethical decisions involving the application of a particular system of values and principles of conduct, either held by a person or group of persons (society).

In our research with the Directors College of Canada since 2004,[11] we have asked over 600 board directors what percentage of the decisions they make on their boards have social implications. Approximately 85% of all their decisions have social implications for individuals or groups and, therefore, require moral reasoning. We suggest that this is also the case, if not more so, for physician leaders given the complexity of the world they work in and the social implications of their decisions. We have also discovered that the secret to successfully working with others in decision-making is the leader's ability to engage in non-arbitrary social cooperation and consensus-building with those who are party to and potentially affected by the decision.

According to Rest et al.,[10] there are three levels of complexity in moral reasoning. The first hinges on the concept of "personal interest," in which the decision-maker says, "I know what the right decision is because it is what I want [which usually involves his/her seeking pleasure and avoiding pain/punishment with little if any concern for others], and I expect others to support me on my choice. Or else." This, of course, is the world of the omniscient, bully physician leader.

The second level of complexity is based on the concept of "rules" where pre-existing norms or laws tell the decision-maker what he or she must do to fit in and to belong to a group, profession, or society. Under this form of moral reasoning, the world is black and white, and one knows the decision is right because one is following the rules. In the world of medicine and health care, many physicians find comfort — and sometimes legal protection — in the form of guidelines or unwritten rules of the profession or the health care unit of which they are a member.

The most complex level of moral reasoning, "post-conventional

morality," does not rely solely on what one thinks is right ("pre-conventional morality"), nor does it rely predominately on the rules in play ("conventional morality"). Instead, it depends on a more sophisticated and advanced level of decision-making using a process of social cooperation and consensus-building in which meaningful interaction and input from others (who are party to and/or affected by the decision) are both solicited and valued. The opinions of others are thoughtfully considered; a sincere attempt is made to accommodate their concerns; and, at the end, they feel as if they are being treated fairly.

We suggest that physician leaders with the capacity and tendency to use this highest level of moral reasoning will be more resilient than others in dealing with, and recovering from, debilitating and enervating decision conflicts and will be a role model for their colleagues regarding being more resilient.

The second level of complexity is based on the concept of "rules" where pre-existing norms or laws tell the decision-maker what he or she must do to fit in and to belong to a group, profession, or society.

Our research[12] and that of others[9,10] shows that leaders using the most complex level of moral reasoning tend to understand and appreciate the reasoning used by all others. They also tend to exhibit the following characteristics that make them more resilient and, thus, able to help others be more resilient. Complex moral reasoners:

- Have a broader perspective on issues
- See more alternatives and potential solutions
- See themselves in a larger social context
- Are able to step into the shoes of others and see things from another's point of view
- Are more inquisitive
- Understand more complex dimensions of justice and fairness

With these characteristics, leaders are more effective in interacting with others and, therefore, engaging in higher-quality decision-making. They are more comfortable dealing with change and helping others work their way through change.[9] These characteristics also tend to create more trust between the physician leader and those they lead and work with.[13] As a result, physician leaders are more comfortable engaging in difficult conversations. Finally, these physician leaders will be especially more adept at viewing stressful and painful situations as opportunities to learn and grow rather than wither and die.

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Authors

Greg McQueen, PhD, is senior associate dean and professor of medical humanities, ethics, and health care leadership at the A.T. Still University of Health Sciences, Arizona. He also holds a faculty appointment with the Niagara Institute, an international leadership development centre.

Chris Bart, PhD, FCPA, is the world's leading authority on organizational mission and vision statements. He is currently CEO of Corporate Missions Inc., Hamilton, Ontario, an international consulting firm dedicated to helping organizations excel in executing their strategies.

Correspondence to: gmcqueen@atsu.edu

This article has been reviewed by a panel of physician leaders.

The facilitative leader

Designing engaging and productive meetings

Part 2 in a 5-part series on Facilitation skills for physician leaders — an emerging necessity in a complex health system

by Mary Yates, MEd and
Monica Olsen, MHRD

Abstract

In part 1 of this series, we described how a facilitative approach is replacing the directive or autocratic style among physician leaders. In this article, we focus on a key skill that facilitative leaders need: the ability to hold effective meetings. We encourage leaders to let go of past assumptions and, instead, create context; do a check-in; and clarify goals, roles, relationships, and processes.

In an introductory article,[1] we differentiated between the approaches used by traditional and facilitative leaders and stressed the necessity for leaders to acquire facilitation skills. In this and three future articles, we focus on "basic facilitation skills" — those skills that are useful for dealing with predetermined issues requiring an improvement in the status quo. The practice of basic facilitation focuses the leader's attention on guiding the group through the following three processes:

- Sharing relevant information
- Problem-solving
- Decision-making that builds long-term commitment

Developing these basic facilitation skills is prudent before a leader embarks on acquiring the advanced facilitation skills essential for more complex situations focused on transforming the health care system. At the conclusion of this 5-part series, we will shift the focus to those advanced facilitation skills required for systems thinking.

Assumptions about meetings

The first element for consideration is determining what model or framework you follow for creating engaging and productive meetings. In most instances, physician leaders simply default to past meeting practices, even though they have found them ineffective. After facilitating numerous physician leadership courses on Managing People Effectively, where good meeting practices are both discussed and modeled, we have discovered many assumptions that physician leaders have about meetings. It is critical to reveal and examine these assumptions, which often operate at a subconscious level, as they keep leaders thinking and acting in ways that may no longer serve a useful purpose (e.g., reacting vs. acting) and, thus, hold them back from exploring new ways of doing things. Here is a sample of some commonly held assumptions about meetings.

- Must be 1 hour in length
- Must include everyone in the department/group
- Everyone is seated
- It is acceptable for some people to monopolize the meeting
- Agenda items must be discussed by everyone all together at the same time
- It is the chair's fault if the meeting is ineffective
- The chair is solely responsible for time-keeping, gate-keeping (ensuring everyone has a chance to speak), and the meeting environment
- Endless status reports are the norm
- Recycling agenda items is considered acceptable, if not preferred, over accepting a change to the status quo
- Majority vote is the best decision-making process as it is transparent and efficient

A model for better meetings

The following three steps will contribute to more engaging and productive meetings: create context; do a check-in; clarify and agree to the goals, roles, interpersonal relationships, and processes (GRIP).[2]

Create context

Engagement, in part, depends on creating context. Leaders must be clear about what is compelling for the group to come together, *before*

calling the meeting. Many meeting participants report confusion about why they are meeting. It is not at all unusual for each participant to come to the meeting with a completely different understanding of why the meeting is being held, and these misunderstandings can create unnecessary conflict. Understanding the "backdrop" for the meeting conversations is essential for engagement.

Leaders should think about the following questions before organizing the meeting:

- What issues compel us to meet now?
- What is going on in the internal and external environment that requires our attention?
- How will the compelling issues affect our conversations and decisions?

The ideal way to create context is for the leader to begin the meeting by describing it. Doing so requires answering the questions, "Why are we here?" and "Why are we here now?" Depending on the topic of the meeting and how long ago participants last met, asking the meeting participants to answer the question, "What's happened since we last met that may influence our conversations and decisions today?" is an ideal way to ensure that the context is fully clarified and to increase engagement of the group members. If the group has never met before, this question can be modified to, "What has happened in the last 2 weeks (insert any relevant time period here) that may influence our conversations and decisions today?"

Another essential element in creating context is clarifying the boundaries of the problem-solving space: those features of the system that would be considered constraints (such as budget and time) and decisions that have already been made. Meeting leaders often find themselves attempting to manage conflict among participants when constraints and previously made decisions are not communicated clearly at the beginning of the meeting. Before going into a meeting, leaders should ask themselves: "What are the known constraints affecting our decision-making?" and "What decisions have already been made?" And make sure they communicate the answers to the participants before moving forward with the meeting.

The ideal way to create context is for the leader to begin the meeting by describing it. Doing so requires answering the questions, "Why are we here?" and "Why are we here now?"

What happens if the meeting leader does not know the boundaries of the problem-solving space? It could be argued that, in this case, the meeting should not take place until this information is clarified. Alternatively, the meeting leader may know some of the boundaries or constraints but not all. In this case, it is perfectly acceptable to ask the participants to identify additional constraints. In fact, asking participants to identify boundaries or constraints could serve as a meeting "check-in."

Do a check-in

A check-in is a best practice for creating engagement. It serves three important functions. First, it orients participants to the business of the meeting by serving as a transfer in or bridging function: from where participants have been, to where they need to be now. Participants come to meetings with many things on their minds, most of which have nothing to do with the meeting. A check-in provides participants with an opportunity to "take a breath" and focus their attention on the business of the meeting.

Second, the check-in is an important tool for building relationships among members of the team. People who know one another as people, rather than as boxes on an organizational chart, tend to have more productive and respectful conversations, which, in turn, lead to more informed problem-solving and better decision-making. The check-in provides an opportunity to get to know one another.

Finally, the check-in can help both the meeting leader and participants more clearly understand their needs with respect to the meeting agenda and use this information to ensure that the meeting conversation reflects those needs. The check-in can also be used to create an agenda in cases where the meeting is scheduled at the last minute.

Although check-ins need not take a lot of time (5–10 minutes depending on the length of the meeting and how frequently the group members meet), the time they do take is valuable in terms of helping to

create the psychological safety necessary for group members to share information effectively, solve problems, and make decisions.

A check-in that achieves all three of the purposes mentioned above could consist of asking participants to state: one thing on their mind that has *nothing* to do with the meeting today and one thing on their mind that has *something* to do with the meeting today.

Clarify and agree to the GRIP

The meeting leader is responsible for ensuring clarity and agreement regarding:

- Goals — what we are trying to accomplish
- Roles — who will do what to accomplish our goals
- Interpersonal relationships — explicit agreements about how participants will engage in the meeting conversation
- Processes — how we will accomplish our goals

Goals: The overarching goals for the initiative or project should be stated at the beginning of the first meeting. The goals for subsequent meetings should be stated at the beginning of each meeting and included in the agenda. Meeting goals should focus on the results the group is trying to achieve.

A word of caution: all too often, both meeting leaders and meeting participants are overly ambitious in terms of what might be accomplished in any given meeting. Many meetings are scheduled for only 1 hour. If leaders want to create an environment of psychological safety, which is critical for healthy dialogue, and ensure that all participants have an opportunity to contribute their perspective, then they must build adequate time into the design. Participants often feel discouraged when agreements for moving forward (a.k.a. “decisions”) never seem to get made. Engagement is more likely to occur when participants feel that meaningful progress is being made. When setting meeting goals, less is almost always better than more.

Roles: Meeting leaders often assume that they need to do everything themselves. However, when meeting participants assume some responsibility for meeting effectiveness, the level of engagement tends to increase and the role of the leader is less onerous. Meeting roles can include: time keeper; recorder; someone to alert the group when the conversation is going off track; someone who keeps track of decisions that the team has made; someone who keeps track of questions for which the team members do not have answers; someone who drafts the agenda for the next meeting (the agenda should include “great ideas” that came up during the meeting but were not explored and questions for which no one at the meeting had an answer).

Processes: The meeting leader should clearly state how the group will do its work. Some examples include:

- How many meetings the participants will be required to attend
- How long the meetings will last
- How decisions will be made
- How the team will keep the discussion moving along
- What will need to happen to encourage participants to “tell the truth” about what is important to them

As a facilitative leader, the meeting leader must strike a balance between telling meeting participants about meeting processes (i.e., how many meetings and how long the meetings will last) and asking

participants for input (i.e., "How will we keep the discussion moving along?").

The agenda should reflect which of the three meeting processes (sharing information, solving problems, and making decisions) will be the focus of the meeting. In the early stages, not all meetings have to result in decisions. It is perfectly acceptable, for instance, to focus on sharing information with no attempt to solve the problem or make a decision about moving forward.

Interpersonal relationships: Engagement is directly affected by how the meeting leader and meeting participants interact. Facilitative leaders focus on creating an environment of psychological safety and they are responsible (along with the team members) for maintaining it.

Meeting guidelines (also known as ground rules and team charters) must be explicit. Options for creating meeting guidelines are determined by the type, frequency, and goals of the meeting.
If a meeting has been called to deal with an emergency or crisis or if the meeting is a one-time occurrence to deal with an unusual circumstance, there will probably not be enough time to engage the group in agreeing to meeting guidelines. In this case, the leader should state the meeting guidelines at the beginning of the meeting; for example, "tell the truth, listen hard, and be decent."[3] It should be noted that just because a meeting is called to respond to a crisis or a special set of circumstances, it does not negate the responsibility of the meeting leader to state the meeting guidelines.

Typically, however, the group will be meeting over time. In this case, the participants should be included in creating the meeting guidelines, as this will contribute to their sense of engagement. One way to do so is to ask meeting participants:

- What can the meeting leader do to help us have productive and engaging meetings?
- What can the meeting leader do to hinder having productive and engaging meetings?
- What can the meeting participants do to help us have productive and engaging meetings?
- What can the meeting participants do to hinder having productive and engaging meetings?

The responses to these questions should be compiled to create a set of five to seven meeting guidelines that are reviewed at the beginning of each meeting and included in the meeting agenda.

Meeting guidelines enable the meeting leader and meeting participants to "intervene" respectfully when the behaviour of participants interferes with sharing information, solving problems, and making decisions. Although the development of meeting guidelines is considered an essential practice of the facilitative leader, the extent to which meeting participants interact respectfully with one another during meetings is also determined by the extent to which meeting goals, roles, and processes are clarified and agreed to.

A resource for further reading

A wonderful resource for designing engaging meetings is Liberating Structures: Including and Unleashing Everyone.[4] It provides a menu of 33 free, easy-to-learn "liberating structures" or microstructures that enhance relationships and trust. Instructions and video demonstrations are provided for each approach to replace or complement conventional practices.

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Authors

Monica Olsen, MHRD, is an independent organization development consultant (Olsen and Associates Consulting Inc., Richmond Hill, Ontario). Her current focus is on leadership development in the health care sector through customized education programs, facilitation, and coaching. She is a long-standing faculty member of the PMI Physician Leadership Program.

Mary Yates, MEd, is principal of Align Associates, offering expertise in the areas of leadership development, team effectiveness, performance management, meeting and retreat facilitation, human resources management, curriculum design, and quality improvement. She has been on the faculty of the PMI Physician Leadership Program for the last 16 years.

Correspondence to:
olsenandassociatesconsulting@rogers.com
or marytyates@rogers.com

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Seeing differently: applying the Theory of Constraints in health care

by Alex Knight, MBA, CEng, and Ruth Vander Stelt, MD

Abstract

With increasing health care costs and growing demands, most countries are facing the challenge of providing high-quality, timely care that remains affordable. To improve productivity, a shift in perspective is required: from seeing complex systems as best managed by breaking them down into parts to seeing them as a chain of activities where system performance is determined by a few underlying constraints. This approach, based on the Theory of Constraints, focuses on ongoing improvement achieved through a rapid process of identifying and strengthening the weakest link in the chain.

Health care is a fundamental necessity in every society, but one that comes at a cost. Total expenditure on health care is rising year after year, and Canada has one of the highest levels of per capita spending (Figure 1). This growth means that health care often constitutes a significant and increasing percentage of a nation's gross domestic product (GDP; Figure 2). The cause of this growth cannot simply be ascribed to the actions of the people running the system. However, the need for rapid and sustainable breakthroughs in productivity is becoming urgent in many territories, and the pressure to reduce costs is formidable, even in the most prosperous countries.

"Quality of care suffers and catastrophic incidents increase when front-line staff experience growing pressure."

Front-line clinical workers' salaries account for the largest category of expenditures in most health care budgets. Furthermore, the common experience of health professionals is that quality of care suffers and catastrophic incidents increase when front-line staff experience growing pressure.[3]

Unfortunately, many nations are between a rock and a hard place. Any successful health care system must simultaneously provide high-quality and timely care for patients and, at the same time, be affordable (Figure 3). As concerns about quality of care and waiting lists grow worldwide, the temptation to increase front-line resources or invest even more in productivity and innovation initiatives is understandable. However, there is equal pressure to reduce front-line resources in the drive for affordability and to question the speed and return on investment of many improvement efforts.

It is not enough to choose one side of the conflict over the other. Reducing front-line resources may improve financial stability in the short term, but this may damage quality of care or, worse still, cause a catastrophic failure.

On the other hand, adding more resources when budgets are tight attracts scrutiny and challenge. Trying to save a little bit here and there under the banner of "balancing capacity with demand" can lead to unintended negative outcomes, such as the creation of wandering bottlenecks across the system, which become a nightmare to manage and which jeopardize the quality, timeliness, and affordability of care. What is required is not balancing capacity but balancing flow.

The Theory of Constraints

The Theory of Constraints (TOC) was developed by physicist Dr. Eliyahu M. Goldratt in 1984.[4] At its core, the TOC approach aims to identify those few areas that affect the performance of an entire system, what Goldratt calls constraints.

Our common reaction to the apparent complexity of the challenge involves breaking

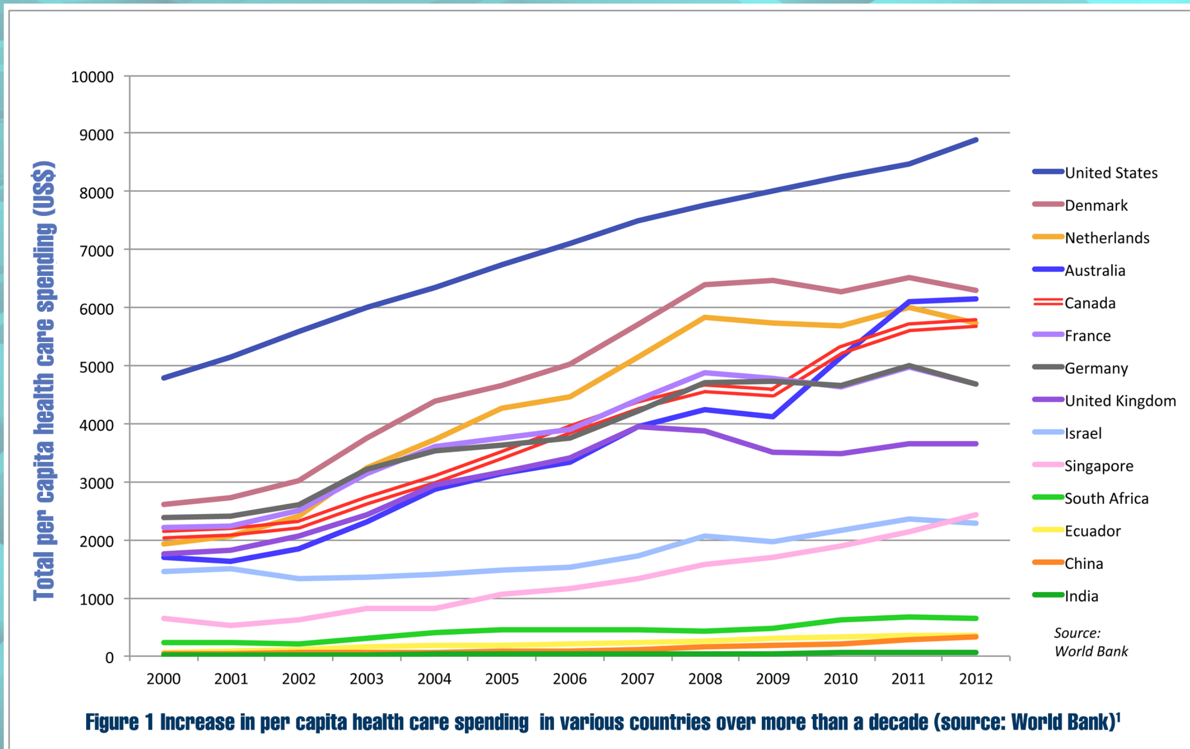

Figure 1 Increase in per capita health care spending in various countries over more than a decade (source: World Bank)[1]

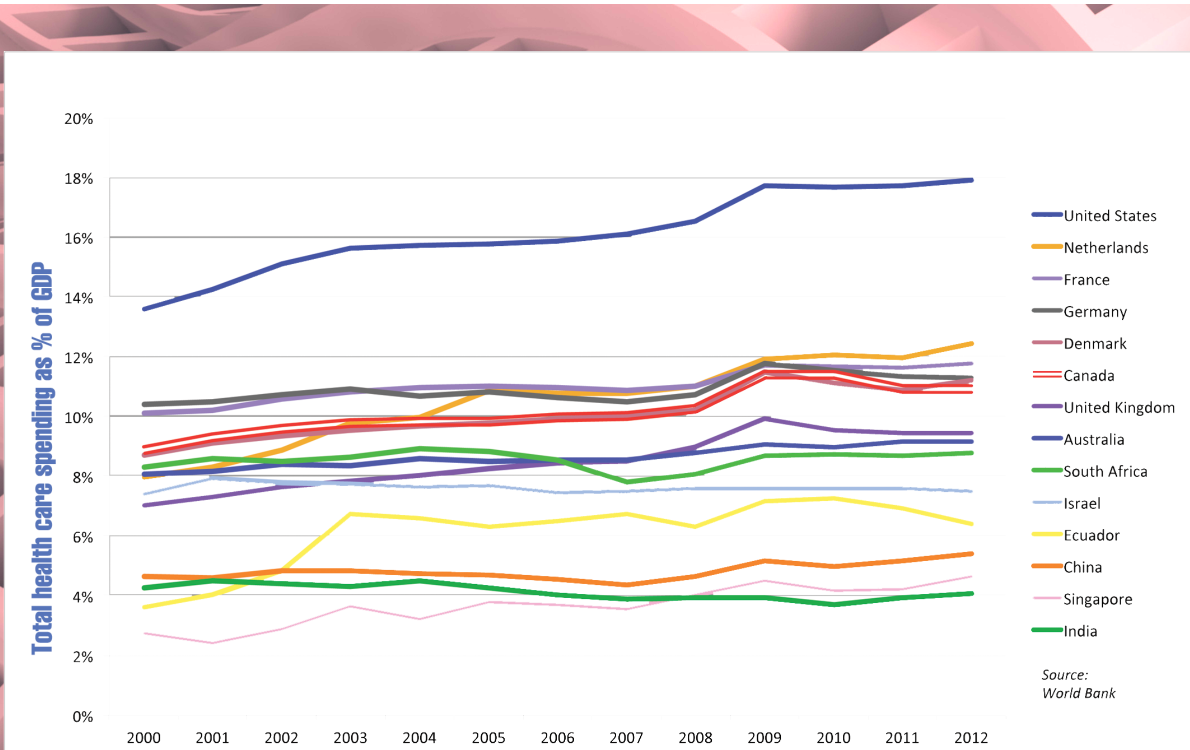

Figure 2 Increase in health care spending as a percentage of GDP in both developed and developing nations (source: World Bank)[2]

the system down into parts and attempting to maximize the performance of each part to improve the whole; but this does not work. Achieving local optima almost never leads to an overall optimum because local measurements do not take account of the importance of the constraints and their connections to the rest of the system.

Instead, to strengthen a chain, we need only identify and strengthen its weakest link. To achieve a breakthrough in performance, we must focus all our efforts on identifying and eradicating the underlying cause of a poorly performing situation, rather than spreading ourselves thinly across the multitude of its effects.

This shift in thinking — from seeing systems as complex and best managed by breaking them down into manageable parts to seeing them as a chain of activities where performance of the system is determined by a few underlying constraints — has profound implications for any improvement effort. Rather than embarking on a large-scale, organization-wide improvement of every part of the system, the TOC mindset focuses on ongoing improvement achieved through rapid cycles of identifying and strengthening the weakest link in the chain.

"Breaking the system down into parts... does not work."

Aiming high

TOC has been applied in the health care environment and is explained in the business novel, *Pride and Joy*.[5] It has delivered substantial results in terms of meeting three criteria:

- Rapidly improving the quality and timeliness of care across the health care system
- Improving the system's financial performance
- Not exhausting staff or taking imprudent risks

For successful implementation of TOC in health care, the primary objective is to improve patient flow. Clinicians and staff need a robust mechanism to synchronize resources and provide an answer to the question: of all the patients I could treat next, which one should I treat first in order to improve the flow of all patients through the system? (that is, after urgent clinical care needs are attended to). Synchronization of resources

dramatically improves the flow of patients through the system and patients receive their care more quickly.

Second, a focused process of ongoing improvement to balance flow is vital. Ask yourself: of all the areas I could try to improve, which will have the greatest impact on the performance of the whole system? This process is essential for identifying and removing the underlying causes of delay in the system, improving patient flow, and releasing clinical staff from the stress of managing disruption to their patients' care. The release of this capacity opens the door to new strategic choices for the health care system.

Third, the removal of local performance measures will eradicate less-productive behaviour. "Tell me how you'll measure me, and I'll tell you how I'll behave." If you continue to measure someone only in relation to their part of the system, then do not be surprised when relations between the links of the chain erode. Replacing some performance measures with a few well-defined objectives based on patient flow enables management to understand and improve the performance of the system as a whole.

Guiding principles for achieving integrated health care

- **Improving patient flow as the primary objective**
- **A focused process of ongoing improvement to balance flow**
- **Removing local performance measures to improve the chain of activities**

Implementing TOC: patient centred and doctor led

Any breakthrough in a health care system can be judged successful if it meets the criteria of presenting a patient-centred, clinically led approach, focused on improving both quality and timeliness of patient care. For each patient, a clinically based expectation of their recovery time is established — not based on national average or best practice, but on the expected clinical recovery time of that individual patient. This date can be used to synchronize the activities of all resources and eliminate local optimization. Any delays to a patient's care are analyzed to reveal the task/resource combination most often causing the most delay for the most patients. It is this focus that ensures that substantial actions produce immediate and substantial benefits.

Leadership from our clinicians is vital in ensuring that the approach remains patient-centred and sustainable. The front-line clinicians deliver the care and, so, ensuring their role in leading the improvement is just common sense.

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Authors

Alex Knight is an experienced management consultant, strategist, lecturer, and public speaker and is recognized as a leading authority on the Theory of Constraints. He is the author of *Pride and Joy*, a business novel based on 20 years of research into health and social care systems.

Ruth Vander Stelt is a full-practice rural family physician and the past-president of the Quebec Medical Association. She is currently enrolled in the international master's program in health leadership at McGill University and is applying constraints theory in her practice environment in western Quebec.

Correspondence to: ruthvanderstelt@storm.ca

This article has been reviewed by a panel of physician leaders.

The 5 Cs of physician resilience

by Mamta Gautam, MD

Abstract

Several years ago, I began to look at physician health in terms of understanding why some physicians appear to cope better than others in the same situation — why some are more resilient. I reviewed my practice population to identify dimensions of this quality that could be taught. My review produced "5 Cs of resilience": confidence/control, connections, commitment, calmness, and care for self.

As a psychiatrist, I have worked with physicians in distress for 25 years. For most of that time, I focused interventions primarily on pathology: recognizing, responding to, and solving problems. Several years ago, I began to look at physician health from a different perspective to understand why some physicians appear to cope better than others in the same situation, that is, why some are more resilient.

It sparked a process to gain better understanding of what resilience is, the qualities of a resilient physician. Is it something different that they did or thought? Could it be taught? This new focus on resilience is proactive, positive, and offers primary prevention. It helps to recognize strengths and skills and offers an opportunity to develop strategies for success that build on existing capabilities.

Post-9/11, the American Psychological Association defined resilience as "the ability to adapt well in the face of adversity, trauma, tragedy, threats, and from sources of stress such as work pressures, health, family, or relationship problems."[1] Resilience is the ability to deal with difficult events, be flexible, bounce back, and grow as a result. It is a dynamic concept, an ongoing process that can vary over time.

As physicians, we have many stressors that we manage on a daily basis — in our professional and personal lives. Resilience is the ultimate life skill.

According to Coutu,[2] "More than education, more than experience, more than training, a person's level of resilience will determine who succeeds and who fails."

I believe that resilience can be taught, so we can better succeed. Although universal agreement with this is lacking, some authors share this belief.[3] Although some non-modifiable factors, such as our genetics, parents, upbringing, and childhood experiences, play a role in our current ability to cope through difficult situations, there are also many modifiable factors.

I reviewed my practice population to identify several dimensions of resilience that can lead to specific tools for cultivating resilience. My 5 Cs of resilience are confidence/control, connections, commitment, calmness, and care for self; they are described below.

A resilient doctor is a confident doctor

Confident people are those who have a positive view of themselves, their strengths, and their abilities, and are known to cope better during stressful situations. Developing such confidence and nurturing a positive view of oneself is possible and helps build resilience and a greater sense of personal control. Confident physicians have a healthy and positive self-image, and can balance the sense of inadequacy and self-doubts felt by many physicians[4] with greater self-esteem and self-efficacy.

Self-esteem is the sense that we have strengths and can cope with what is going on in our life. Self-efficacy is our competence, our ability to learn knowledge and master skills, so that we can accept challenges, persist, and succeed. With the right combination of attitude and knowledge, in a time of stress or crisis, the confident person is optimistic and has the sense and belief that they can do it. As a colleague recently told me during an exceptionally stressful

time, "While I don't want to be going through this, I don't question that I can."

A resilient doctor is a connected doctor

Donald Winnicott[5] first conceptualized the "holding environment," which is the nurturing emotional environment that a "good-enough mother" provides to her child. The loving mother holds her baby, both physically and emotionally, is attuned and attentive to the baby's needs, and nurtures it to form the basis for the child to learn to trust and grow. Expanding this concept, I realize that we need nourishing holding environments throughout our life, so we can continue to feel safe and grow. As we get older, these holding environments build resiliency and can be found within the context of our school, sports teams, friendships, relationships, and in our workplace. The key aspect of the holding environment is the presence of people who make us feel held.

The single most powerful predictor of resilience is the presence of caring connections with others. We need to create these relationships, both at work and in our personal lives, and then reach out to them regularly for help, support, guidance, and encouragement.

Kjeldstadli et al.[6] looked at life satisfaction and resilience in Norwegian medical schools and concluded that the schools should encourage students to maintain their outside interests, friends, and personal lives. Jensen et al.[7] explored the dimensions of family physician resilience and highlighted the value of supportive relations, which include positive personal relationships, professional relationships, and good communication. Lemaire and Wallace[8] showed that support from spouse and co-workers as well as positive patient interactions are key factors in reducing stress and increasing well-being.

In our professional life, we must look for opportunities to build positive relationships —with our colleagues, medical team, staff, and patients. In our personal life, we all require a personal support system of partner, family, friends, and social and spiritual community. Such environments must be constantly nurtured. We need to allocate meaningful time for this, ensure regular communication, and be actively present.

A resilient doctor is a committed doctor

We choose to enter the medical profession because we want to make a difference. We took the Hippocratic Oath, promising to uphold professional ethical standards as we treat patients with spirit, diligence, and dedication. Having a continued sense of commitment to this cause allows us to face each day and persevere, especially at times when it is not easy to do so. This commitment to what we value and respect is key to our ability to be resilient. As long as we can feel that we are living fully and working toward meaningful goals, we are able to manage whatever is thrown our way.

In medicine, we must ask ourselves and constantly remember, "What drew us to this?" As we start working, it is easy to become too busy and lose sight of what was initially meaningful to us. Journaling is a way of telling and recalling our story. In her book, *Kitchen Table Wisdom: Stories that Heal*, Rachel Naomi Remen[9] invites us to "listen from the soul." Try it yourself! Sit with a blank piece of paper, and reflect. Ask yourself what made you decide to become a doctor? What now gives you meaning as a doctor? What story stands out in your memory as the best thing you have ever done as a doctor?

Although a vital commitment to our work is essential, this is even better extended to all aspects of our life. Ideally, we commit to life, to living fully and aiming for meaningful personal and professional goals. Victor Frankl[10] describes his experiences in the concentration camps and explains how his sense of commitment to values and goals enabled him to survive such an experience. Once the things we do in our life make sense, we can more easily cope with the challenges along the way and sustain the sense of wisdom, wonder, and richness of life.

A resilient doctor is a calm doctor

We all know them — the doctors who manage to stay calm in the midst of turbulence and chaos. We wonder how they do it, as we become increasingly frustrated and reactive. For physicians working in highly complex situations, challenges seem to occur daily, and it is normal to have resultant thoughts, feelings, and emotions.

Yet, the behaviour that can arise from such negative emotions is unhealthy for us, and often unacceptable to others.

Being calm includes two key factors: learning how to recognize triggers and times when things start to build up, and developing successful strategies for managing the associated emotions. None of us does this perfectly. During a quiet moment, take time to reflect what the triggers are, both at home and at work. It helps to have a range of tools to rely on as needed. There are many techniques we can learn to help ourselves remain calm, including deep breathing, cognitive strategies, such as reframing, positive thinking, relaxation exercises, journaling, and mindful meditation.[11]

Any of the above techniques can be effective in assisting us to feel a sense of calm at home and at work, but we have to practise. It is a process of learning and teaching our body what a calm state feels like and how to attain it. The more we do it, the easier it becomes. When practised regularly, these activities will lead to a reduction in daily stress levels and an increase in sense of joy and calmness. They serve as protective armour in the face of life's challenges and give us the strength and energy to remain resilient.

A resilient doctor is a caring doctor

Caring for others is inherent in being a physician. This is what we do best. It is intuitive for us, we are trained to do this, and it is our role and goal. It provides a sense of meaning to our work, which helps to ground us during times of stress and crisis. Yet, caring for others is not enough; to be sustainable, it must be balanced with caring for ourselves.

Caring for ourselves is often less intuitive and definitely not part of our training. It is not our role; we are caregivers, not care-receivers. Thus, it is no surprise that this is not easy for us to do consistently. We put our own needs last, and, often, they are lost.[4]

A large aspect of self-care is taking care of our physical health. We are the only ones who can ensure that we eat properly, sleep long enough and restoratively, exercise regularly, keep our brains active, and have a family doctor and see him/her regularly. We can also monitor our emotional health, knowing and watching out for the signs of burnout.

Once you find activities that you

enjoy, that make you feel relaxed and replenished, use the Tarzan rule to keep them going.[12] Just as Tarzan swings through the jungle and does not let go of one vine until he has the other one in hand, do not stop and let go of a positive activity until you have one more booked! That way, you know it is going to happen again.

All of this requires that we give ourselves permission to care for ourselves. As a group of professionals, we are very conscientious and responsible, and often feel guilty when we are not working. We see time for ourselves as a luxury, as being selfish and focusing on ourselves when there is so much else to do. In fact, this is an investment; if we take a small amount of time and energy for ourselves, we are much more likely to be available to those who count on us.

Remember the airline safety demonstration: in case of an emergency, you are advised to put on your own oxygen mask first before you assist someone else. You are no good to anyone else if you pass out! This is an excellent reminder for our work in medicine; we have to stop and do the metaphorical equivalent of "putting our own masks on first," especially in times of stress or crisis.

Resilient physicians deserve resilient medical systems

There will always be stress in the practice of medicine. Much of it is positive, healthy, and motivating. The desirable goal in assisting physicians to become more resilient is to have them build skills and energy reserves so they can continue to cope well in times of stress. Young's modulus, from engineering's solid mechanics, refers to the measure of the stiffness of an isotropic elastic material.[13] It refers to the ratio of stress, with units of pressure, to strain. In medicine, although we are hoping to reduce the strain, we have no real "units of pressure" to measure the stress. As well, the stress comes from multiple sources, and varies depending on the physician, his or her specialty, and demographics; thus it requires multiple resources to manage.

Addressing the five components of resilience in an individual physician is like laminating a piece of paper. It gives it an extra coat, makes it hardier and more flexible. It will allow the physician to feel more empowered and confident to handle unforeseen and unpredictable events and, thus, can enhance the system. Yet, it is not enough.

As the situation in health care continues to progress with fewer resources and more stressors, we cannot merely respond by helping doctors just cope better and do more with less, or the system will not improve. As medical leaders, we must strive for a balance, one in which physicians feel more empowered to cope in difficult situations, and also have a voice and sense of control to identify and resolve problems constructively.

Enhancing physician resilience cannot occur in isolation. The relation between physician resilience and systemic resilience is complex and bidirectional. While we assist individual physicians to manage proactively in a healthier manner, we need system-level interventions too. Resilient physicians require and deserve a more resilient medical system in which to work.

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Mamta Gautam, MD, MBA, FRCPC, CPDC, CCPE — a psychiatrist with 25 years of experience treating physicians and physician leaders — is also a coach, author, and president of Peak MD, Ottawa, Ontario.

Correspondence to: mgautam@rogers.com

This article has been reviewed by a panel of physician leaders.

Book review

Service Fanatics: How to Build Superior Patient Experience the Cleveland Clinic Way

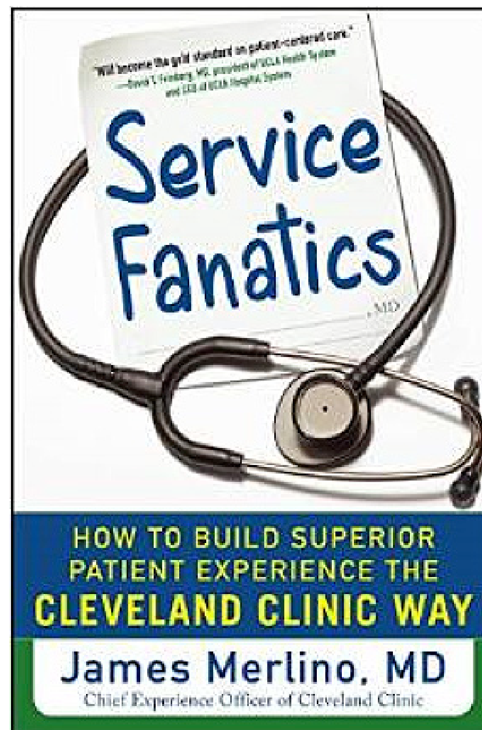
James Merlino
McGraw-Hill, 2015.

Dr. James Merlino, who was a keynote speaker at the 2014 Canadian Conference of Physician Leaders, is the Cleveland Clinic's chief experience officer. In *Service Fanatics*, he describes how the Cleveland Clinic, an organization with an excellent clinical reputation and some of the best clinical outcomes in the world, evolved from an organization with low scores for patient experience to one that is among the highest ranked in the business.

The book shares how the Cleveland Clinic came to lead the research arena on the topic of patient experience. Some of the research findings were quite unexpected. After collecting and analyzing data for the last 5–6 years, the Cleveland Clinic has a lot of evidence that can help others improve their organization and move toward a sustainable health care system.

The book reveals the theory and the practice, as well as the strategy and the tactics Cleveland Clinic applied to become a world leader in patient experience. It shares how principles can be translated into methods to help not only others in the health care system, but also other businesses with customer experience.

Some chapters cover how patient experience was defined and then how the Patients First platform was developed to improve that



experience. Other chapters describe lessons learned about organizational culture and how to change it, about training and recruitment, about measurement and improvement, and how to engage both salaried and fee-for-service physicians. As a result, patients and each of the 43 000 caregivers at the Cleveland Clinic are in a partnership, where the relationship itself affects outcomes of all measured parameters, simply because that relationship is the fundamental building block of the complex, adaptive system we call health care.

Merlino shares many examples of successes, failures, and his personal experiences, and he interweaves those with his feelings and thoughts as the process evolved. This sharing of personal experiences makes the book enjoyable to read, and it often feels like a narrative rather than a textbook. But be not mistaken, if you want to learn something about leading organizational cultural changes, about physician engagement, about successfully returning some of the caring into the health care system, you will find the theory and practice you need in this book.

In short, *Service Fanatics* deserves a spot on your shelf of leadership books.

Johny Van Aerde, MD

Note: CSPE members receive a 40% discount on McGraw-Hill leadership books. See the members only section of the CSPE website.

Book review

The Systems View of Life: A Unifying Vision

Fritjof Capra and Pier Luigi Luisi
Cambridge University Press, 2014

Capra's latest book, co-authored with Luisi, is a masterpiece and an accumulation of his work published over the last three decades. While building on some of Capra's previous publications, including *The Turning Point*, *The Web of Life*, and *The Hidden Connections*, this book adds an unbelievable amount of historical and new information in a nicely integrated manner. *The Systems View of Life* may well be the most comprehensive book on systems thinking, and it's written as much for the newly interested as for the well-informed reader.

The 500-page publication is divided into four large sections. The first deals with the mechanistic worldview, that part of systems thinking that originated in the 17th century and still permeates the views of many today. The history and philosophy behind the world-as-machine is insightful: the authors describe not only the evolution of the scientific method, but also the shifting of social paradigms and the changing understanding of biology.

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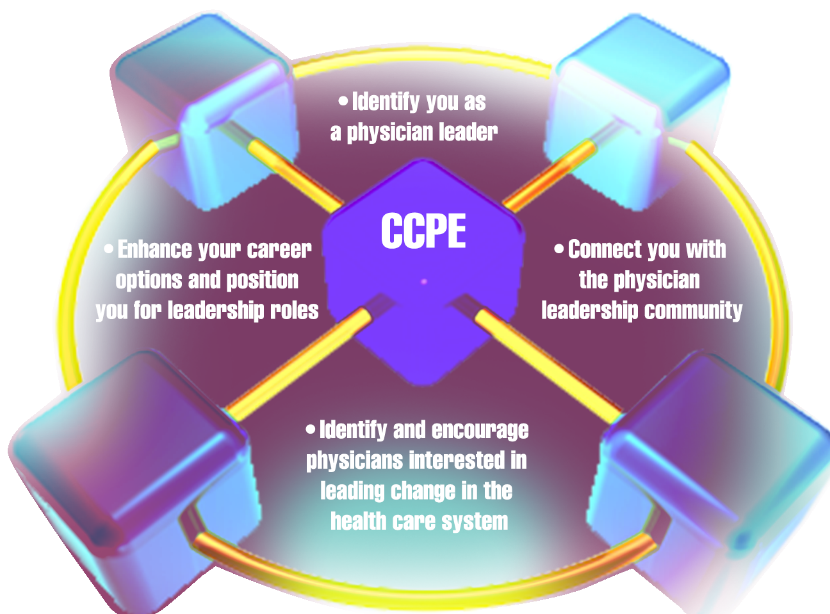

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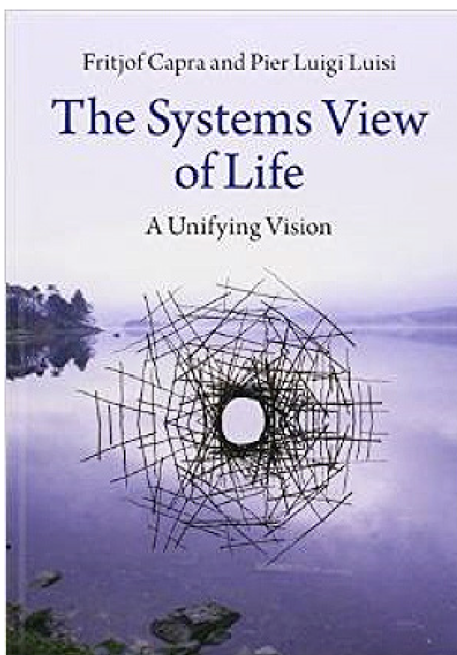
The second section starts with the emergence of systems thinking, the role of the new physics, and the concept of the observer as participant rather than as disconnected spectator in a system. In an organized and logical manner, Capra and Luisi take the reader through all the traditional aspects of systems theory, including cybernetics and its application to social systems and the self-organizing brain, non-linear mathematics, and non-linear



dynamics, including the concepts of strange attractors and fractals.

Although the first two sections are of interest to those who want to apply complex systems theory to the human body or to the health system, the third and fourth sections are equally fascinating for philosopher, biologist, ecologist, physician, and everyone else interested in life. In these two sections, the authors look at life and its evolution with the lenses of biology, consciousness, spirituality, science, and eco-sustainability.

In the third section, "a new conception of life," the authors start with the definition of life. Part of the answer is found in autopoiesis, one of the fundamental characteristics of molecular, living, and social complex systems. After an explanation of molecular self-organization of phospholipids and proteins, many examples from biology and sociology help with the understanding of the emergent properties of dynamic systems. Using complex systems thinking, the authors treat the reader to great writing on mind versus consciousness and science versus spirituality. Chapter 13 is a pure gem on this topic and includes systemic reflections on the origin of the conflict between science and religion.

After applying systems thinking to life, mind, and society, the authors progress to a systems view of health, integrating it into today's crises in the health care system, into global system problems, and into the eco-sustainability of our web of life. Ecology and the interconnectedness of world networks and problems, global capitalism and limits to growth, and some solutions for the global society toward a design for sustainability of life and ecosystems are the content of the fourth and last section.

In short, this book is a must read for the physician leader who is interested in complex systems thinking, health, health (care) systems, and global eco-sustainability.

Johny Van Aerde, MD

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Contact Information:
Canadian Society of Physician Executives
1559 Alta Vista Drive,
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