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In this Issue

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SCMG Société canadienne des médecins gestionnaires

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Opinion:

What do physicians need to lead?

by Johny Van Aerde, MD

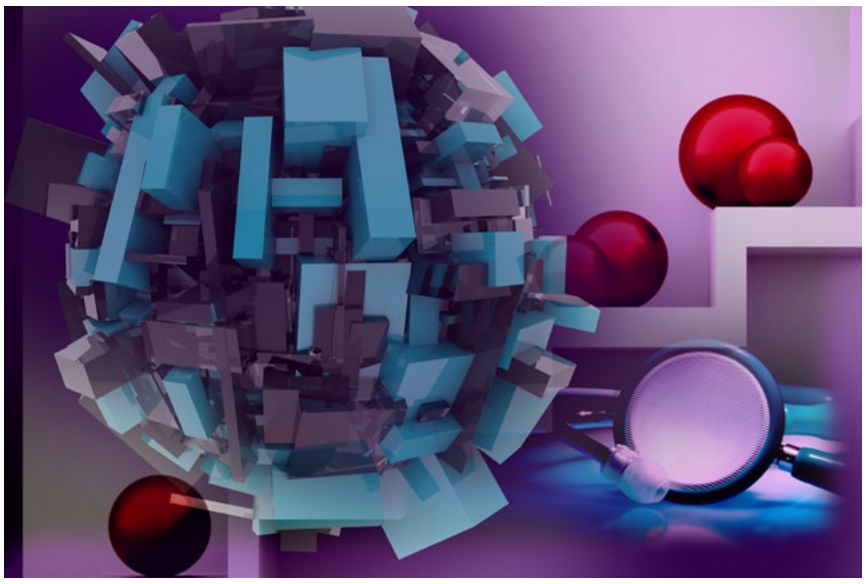
A recent study, "Understanding physician leadership in Canada," reveals that physicians are deterred from taking on leadership positions because of the negative attitude toward physician leaders throughout the medical component of the health care system and the lack of training for leadership available in that complex system.[1] Embedding training in leadership skills into the entire health care system, from medical school and residency to clinical practice, would change the perception of physician leaders and be one factor in promoting physician engagement in systemic and organizational leadership.[2,3]

The study, which was a collaborative effort of the Canadian Society of Physician Executives (CSPE), the Canadian Medical Association (CMA), and the Centre for Healthcare Innovation (CHI) in Manitoba, raises new and fundamental questions on how to prepare physicians for leadership in the best possible way. What leadership styles and skills are most appropriate in today's complex health care system? What evidence do we have that leadership development interventions make a difference? These questions are timely, not only in view of the study's findings, but also because of the release of the new CanMEDS 2015 framework, which includes competencies for the role of "Leader" without guidance on the tools needed to acquire those competencies.[4]

What leadership styles are appropriate?

From a review of the academic and grey literature on leadership and leadership development in health care,[5] a few points jump out. Of all leadership styles, transformational and authentic leadership are the two that most predict quality outcomes in health care settings. A small number of studies have identified authentic leadership as essential for building leader legitimacy through honest relationships with followers, valuing their contributions and behaving ethically and transparently. As this approach develops trust, it further enhances engagement and individual and team performance, resulting in better organizational performance.[6] Improved organizational performance, in turn, has been linked to a higher level of physician engagement in a reinforcing, positive feedback loop.[7]

A large number of research studies have shown that transformational leadership, as detailed below, is strongly linked to staff satisfaction and retention, team and unit performance, work–life integration and well-being, patient safety and satisfaction, and a better organizational climate.[8,9] Organizational climate is defined as "the shared meaning employees attach to the policies, practices and procedures they experience and the behaviours they observe that are



rewarded, supported and expected at work."[10] Academic tradition has focused on leadership in terms of entities, i.e. leaders, followers, and shared goals.[11] However, the changing nature of health care organizations and increased ambiguity and interconnectedness arising from the perspective of a whole system approach to patient care require a broader focus and view of leadership as a shared responsibility, guided by three leadership outcomes: direction based on agreement on goals, aims, and mission; alignment achieved by organizing and coordinating systemic knowledge; and commitment, as a willingness to subsume one's own interests and benefits within the collective benefits and interests.[12,13] In such terms, the practice of leadership involves leaders, followers, shared goals, direction, alignment, and commitment. Thus, leadership development should include all those elements and the processes linking them.

In such a model, it is understandable that the transformational style and skills of leadership have proven to be most effective.[5] It is the strong interconnection between all the elements of such a system, the collective nature of the whole system, and the complexity of the elements' interactions that lead to creativity, learning, adaptability, and change,[14] without necessarily a central authority. Yet, because of the characteristics of emergence and non-linear dynamics, physicians are often uncomfortable in such complex systems because of feelings of inertia, pressure and pushbacks, contradictory demands, conflict, and inefficiency.[13,15] Some of these feelings were also expressed in the recent CSPE/CMA/CHI study.[1]

A combination of transactional and transformational leadership is required for success. The transformational leader allows processes to develop at the frontline, which may lead to better outcomes. Although this may be seen as a subversive effort to counteract the beneficial policies and procedures developed by those at the top of the hierarchy, and as criticism of them, there is still a role for the bureaucratic or administrative leadership style in the health care system, when standard practices must be executed according to organizational processes.[14] In this instance, administrative or transactional leadership[16] minimizes variation from evidence-based practices and enhances patient outcomes.

Therefore, there is a tension that is both productive and challenging between the bureaucratic (transactional) and the entrepreneurial (transformational) leadership efforts that should lead to reflection on what response is best, rather than reaction in the familiar bureaucratic style of "the expert." While the health care system remains under the influence of the administrative

Table 1. Styles and skills of traditional and transformational leaders

Traditional leadership	Transformational Leadership
Leadership through hierarchy, providing direction	Creating adaptive space in which leadership can emerge through interaction and learning
Coordinated set of actions toward clear vision and goal	Vision includes diverse and multiple possibilities, which leads to innovation and creativity
Answers are predetermined expert solutions	Powerful questions asked, to develop solutions over time
Leaders ensure that efforts fit within existing organizational structures	Leaders remove barriers constraining entrepreneurial improvement efforts
Actions for "change" added to or substituted for existing processes	Time and space carved out for discovery and learning to develop new processes
Work is predictable, linear, amenable to project management	Work is unpredictable, non-linear; sense-making required to determine next steps

Source: Cohn 2015.[15]

approach to analyze and solve problems, with the introduction and reinforcement of policies by those in titled administrative leadership positions, these skills are insufficient to transform the health system: for example, to improve health outcomes of a particular underserved community.

In British Columbia, for example, Divisions of Family Practice empower family doctors to effect change at the local level. In Nanaimo, this has led to several demonstration projects: delivering care for 150 non-insured people with moderate depression and anxiety, transitioning frail elderly from hospital to nursing homes, and other projects that are prioritized collaboratively.[17]

Which leadership development interventions make a difference?

An extensive literature review on this topic[5] found that the widely used, multisource 360-degree feedback via questionnaire, on its own, had only a very weak positive effect on performance improvement in two-thirds of the studies reviewed; in a third of the studies, it had a negative effect.

This approach may be more useful when combined with specific training and interventions for the individual. Such a combination can be found in the developmental assessment centre process, which has a positive effect on subsequent leadership performance. This process is usually spread over three days and involves multi-source feedback, in-basket exercises, aptitude tests, interviews, group exercises, writing assignments, and intensive reflection processes.[18] One example is the New and Emerging Academic Leaders (NEAL) program at the University of Toronto.[19] However, these centres are costly and often preserved for the most senior executives.

There is also variable evidence that action learning is effective, but no evidence that job rotation increases leadership effectiveness. Mentoring, although useful, increases leadership effectiveness only to a limited degree. Some studies on executive coaching claim that this method is effective, but many are flawed and the practice is expensive.[20,21]

In short, the research literature seems to indicate that there is no best way to develop leaders and good development of leaders is context sensitive.[22] Leader development seems best when it's based on the needs of the individual, linked with the gap between the person's current capacity and the desired capacity to lead.[5]

In contrast to the focus on leader development, the development of the capacity for leadership of groups and organizations as a shared and collective process has been explored and researched much less. The available evidence highlights the importance of collective leadership[5,13,23] and advocates a balance between individual skill enhancement and organizational capacity-building.[24] Table 1 and the example from Nanaimo[17] indicate that entrepreneurial or transformational leadership flourishes within the frame of relational coordination, which includes the elements of shared goals, shared knowledge, mutual respect for each other's role, and accurate high-quality communication.[25]

When creating programs for leadership development, what moderating factors lead to improvement in performance of the health care team or organizational outcomes? The literature indicates that these factors are: the design of the program, the knowledge and skills of the facilitators, the motivation of the trainees, supports in the workplace, and processes to facilitate the transfer of training.[5] A successful program design is characterized by clear learning objectives and meaningful content appropriately sequenced, an appropriate mix of training methods and opportunities for active practice, relevant and timely feedback that promotes the trainee's self-confidence, and follow-up activities including specific tasks in the organization.[26] Processes to facilitate the transfer of training include embedding the practice and maintenance of the newly learned skills into the organizational culture.[27]

Two health-care-related leadership frameworks were developed in Canada: LEADS, for leadership development in a health systems context[28] and, specifically for physicians, the "Leader" role in CanMEDS 2015.[4] However, unlike standardized courses and exams to test clinical competencies, we have no universal Canadian framework against which to gauge the competencies and capabilities described in LEADS and CanMEDS 2015. We also have two national

organizations —the Canadian Society of Physician Executives and the CMA's Physician Leadership Institute — that can act as coordinating forces.

The preceding arguments bring a number of important questions to mind that need to be answered if we are to move forward on the leadership agenda. Nationally and systemically, we have to ask ourselves how the capabilities of the two frameworks can be rationalized and integrated. How can leaders be developed within a collective, relational context? How can such learning be maximized in the context of health reform and around innovative projects, some of which are sprouting up around the country?

There are also questions related to learning. How do we embed leadership learning into existing courses in medical schools, and should we do so without adding a course in leadership, disconnected from all other courses? How can preceptors acquire what is needed to be role models for residents, i.e., walk the talk, and how might they integrate leadership into clinical teaching? How will the creation and delivery of well-designed programs for practising physicians be paid for?

Some questions may be better answered locally. Will physicians and physician leaders be held accountable for leadership skills through credentialing and privileging, not dissimilar from their accountability for clinical skills? How will physicians' time be remunerated? How can the practice and maintenance of such leadership skills and behaviour be structurally and culturally embedded into a supportive and safe environment in each health care organization, each clinical practice, and throughout the system?

In summary, now that we know that there is a need for physician leadership development throughout the entire Canadian health care system,[1] and now that we have two models, LEADS[28] and CanMEDS 2015,[4] with defined competencies and capabilities, we have to determine how physicians can actually develop, practise, and maintain these skills, not differently from what we expect regarding the development, practice, and maintenance of their clinical skills. Only when we resolve this issue will our health care system have a better chance of being transformed sustainably.

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This article has been reviewed by a panel of physicians.

2015 CSPE Excellence in Medical Leadership Award

(Chris Carruthers Award)

Dr. Dorothy Shaw

Vice-President, Medical Affairs, BC Women's Hospital and Health Centre and Clinical Professor, Departments of Gynaecology & Medical Genetics, University of British Columbia

Dr. Shaw received her medical degree from the University of Edinburgh in 1972 and her Fellowship in Obstetrics and Gynecology in 1978. She joined the UBC Department of Obstetrics & Gynecology in 1979 after a fellowship in Perinatal Genetics with a cross appointment in Medical Genetics where she continues as clinical professor.

Dr. Shaw has held many positions in the UBC Faculty of Medicine including Associate Dean for Equity, Senior Associate Dean, Professional Affairs; Senior Associate Dean, Faculty Affairs; and the university's Acting Associate Vice President for Equity. She developed and coordinated a Leadership Development Series for senior and mid-level leaders in the Faculty of Medicine from 2002-2005 before joining the planning team as a facilitator for the Academic Leadership Development Program for UBC. She was active in establishing and participating in the Faculty Mentoring Program at UBC and worked on the Faculty of Medicine's processes related to the UBC Policy on Conflict of Interest and Conflict of Commitment. She is a Royal Roads Certified Executive Coach (2004).

At BC Women' Hospital and Health Centre she has been Vice-President Medical Affairs since 2011 and held several leadership roles prior to this.

In 2008 she was named one of "Canada's Most Powerful Women: Top 100" in the Trailblazers and Trendsetters category. She was the first woman president of the International Federation of Gynecology & Obstetrics, (FIGO), from 2006-2009. She is a past President of the Society of Obstetricians & Gynecologists of Canada, and was the youngest person ever to lead that organization in this role.

Dr. Shaw is internationally recognized for her publications and advocacy efforts to advance women's rights and improve the health of women, newborns, and children. Her past accomplishments include being named as Canada's spokesperson for the G8/G20 by the Partnership for Maternal, Newborn & Child Health in 2010. She was the Executive Producer for an award-winning documentary "The cutting tradition: Insights into FGM" in 2009. In 2010 she was invited to be the inaugural chair of the Canadian Network for Maternal Newborn Child Health.

She has received numerous awards and honorary fellowships and was the first recipient in 1999 of the Dr. Dorothy Shaw Award for "outstanding inspirational leadership" from the Planned Parenthood Association of BC. In 2012 she received the Christopher Tietze Humanitarian Award given by the National Abortion Federation as its highest distinction, honoring significant, lifetime contributions in the field of abortion service delivery or policy.

She has been active in the BCMA Section of Obstetrics and Gynecology and was a member of the executive from 1993-1995. She was a member of the Board of the BC Physician Health Program from 2006-2010. She has been a member of the Canadian Society of Physician Executives since 2000 and was recognized in its inaugural program as a Canadian Certified Physician Executive (2011). She has served on the Canadian Medical Association (CMA) Gender Issues committee 1992-1995 and the CMA Risk Management Institute Advisory Group 2000-2001. She received honorary member status of the CMA in 2014.

Dr. Shaw lives in Vancouver with her three daughters and her husband Marc. Their support underpins whatever she has achieved.

Natural justice and fair process: what physician leaders must know

by James Sproule, MD, and Tracy Murphy

Abstract

In this first of three articles on medico-legal issues, we advise physician leaders about their responsibilities in cases involving the investigation or discipline of a physician.

In Canadian Medical Protective Association (CMPA) cases that involve investigation and discipline of a physician by a hospital or health authority, issues concerning fair process feature prominently. These cases illustrate that physician leaders should be aware of their organization's bylaws, policies, and procedures for investigating and disciplining doctors.

Principles and rights

All physicians are entitled to procedural fairness when facing an administrative proceeding. The principles of natural justice and fair process require decision-makers to follow the appropriate procedures when investigating and adjudicating complaints or issues about a physician, as well as when conducting hearings into possible disciplinary actions.

By following appropriate processes and respecting established protections, physician leaders can more effectively manage the situation. Leaders will also be able to minimize the risk of legal actions due to unfair procedures.

Hospital bylaws

Hospital bylaws establish a framework under which doctors and other health care providers provide clinical care. Physician leaders should be familiar with and prepared to implement their organization's bylaws (including any proposed modifications) and procedures.

Privileges and contracts

In hospital and health authority investigations and proceedings, the rights of doctors are determined by their professional relationship with the institution.

Most physician leaders have experience with the traditional privileges-based model, which is a unique legal relationship between physicians and hospitals. This model gives physicians certain procedural and substantive rights, including rights concerning changes to their privileges. Under this model, the processes hospitals can use to suspend and terminate a physician's privileges are legally governed by the hospital or health authority's bylaws. These processes are not governed by traditional human resources or employment law principles.

Most bylaws guarantee physicians certain procedural rights if their privileges are suspended or terminated, such as a right to notice of the suspension/termination, the right to know the case against them, and potentially the right to a hearing with legal counsel present. Physician leaders should be acquainted with their province's or territory's legislation and regulations on renewing, restricting, and terminating privileges, as well as the associated procedures set out in hospital bylaws.

As physician–hospital relations evolve, doctors' privileges are being replaced, in some instances, by employment or contractual agreements. The procedural safeguards for privileges that were guaranteed in hospital bylaws might not necessarily extend to physicians in other practice arrangements. This may include when physicians work under contract with a hospital. Although there are Canadian examples of hospitals and health authorities entering into employment contracts with physicians, the majority of physicians now working in hospitals or health authorities

are independent contractors with privileges, not employees of the hospital or the health authority.

Complaints

Physician leaders should be familiar with their organization's protocols for receiving and handling complaints, as described in the bylaws of the institution or health authority.

Physician leaders should strive to ensure that the processes stipulated in hospital bylaws are followed and physicians' rights are respected, including:

- notice of a complaint and full disclosure of relevant documents
- the opportunity to obtain advice and representation from legal counsel
- the ability to respond to a complaint
- a hearing on the matter
- the ability to present evidence and examine and cross-examine witnesses
- an impartial adjudicator
- a decision within a reasonable period
- reasonable resolutions, including proportionate sanctions
- written reasons for any decision
- the right of appeal

As alluded to above, complaints about a physician from hospital staff may also be subject to employment legislation or could involve a union grievance in some cases.

A complaint against a doctor can lead to the hospital imposing sanctions, such as restricting, suspending, or terminating his or her privileges. When a patient complaint leads to disciplinary action or changes to a doctor's privileges, the hospital administration is generally responsible for communicating to the patient the investigation's findings and the actions taken.

Hospitals are increasingly relying on alternative dispute resolution (ADR) processes to address complaints. Physician leaders may recommend that the physician consider professional development programs in areas such as communication, dealing with conflict, and managing stress. Physician leaders should help ensure that information gathered and disclosed during an ADR is kept confidential, where appropriate or required.

Sharing information with colleges

In most Canadian jurisdictions, hospitals are required by legislation and regulations to advise the medical regulatory authority (college) when physicians are suspended or their authority to admit, attend, or treat patients has been terminated or altered because of incompetence, negligence, or misconduct. Colleges might also have to be notified when doctors resign during an investigation into alleged incompetence, negligence, or misconduct.

Documentation

Physician leaders should document their decisions and actions to comply with their institution's bylaws and processes. This includes decisions and actions in the areas of administration, coordination of professional services, quality assurance, complaints, and physician professional development.

Liability protection

The CMPA monitors changes in the law and in the medical practice environment, as well as evolving leadership models.

The CMPA generally does not assist physicians who are acting in an administrative capacity. Physician leaders should ensure that they have the appropriate liability protection for their specific role in their institution, including liability protection that may be provided by the hospital or regional health authority.

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This is the first of three articles written by the Canadian Medical Protective Association (CMPA) for physician leaders. The topics are: natural justice and fair process; professionalism and managing physicians who exhibit disruptive behaviour; and the physician leader's role in managing patient safety incidents. More information on all these topics can be found in the CMPA's Medico-legal handbook for physician leaders (2015), available online at cmpa-acpm.ca.

For the purposes of this document, procedural fairness refers to the legal concept that administrative proceedings should be conducted in a manner that is fair to the parties involved. Although the extent of fairness varies with the nature of the proceedings, at minimum, affected parties should be given a fair opportunity to participate in the proceedings. This includes providing parties with notice of the proceedings and the ability to respond to any prejudicial argument or evidence.

This article has been reviewed by a panel of physicians.

Dealing with anger: the four As

by Mamta Gautam, MD

Abstract

Whether you are dealing with an angry patient or a difficult colleague, strategies and advice are available to help you handle any situation with ease and success. Be aware of your own response to anger and be on the lookout for early signs of anger in others. Then apply the four As: Agree/Admit to the facts of the situation, Acknowledge its impact, Apologize for the situation, and Act to correct it.

Managing angry people is one of the biggest challenges leaders face. In medicine, we deal regularly with angry patients, family members, staff, and colleagues. Yet, many physicians are uncomfortable with angry feelings and prefer to maintain a positive environment, sometimes by trying to avoid or ignore the anger. Such a response is partial and temporarily effective at best, and it does not properly resolve the situation. It is important to recognize anger as a normal feeling and work to be more accepting and comfortable with it, so that it can be addressed more effectively.

Conflicts in any relationship are normal and inevitable. A useful way to understand the conflict is to focus on the solution, instead of the need. Acknowledge the needs of all sides, but then work together toward a mutually agreeable solution. As physicians, we are trained to have the answers, make decisions for others, and write orders. Thus, we often come up with the solution, even when we are not asked to do so or without including the other person in the process. Being right is not enough! To be a leader, we need people to choose to follow us — a decision more easily made by others when they feel engaged in the process.

As many as 15% of all patient encounters involve angry patients.[1] Patients become angry for many reasons. This is particularly common when we break bad news to them. Anger is also a normal part of the grief reaction; it is important to expect it, accept it, address it, and not take it personally. Although some difficult situations are a result of the patient's behaviours, there are times when the physician's attitude, language barriers, cross-cultural issues, or the need to break bad news is a contributing factor. Patients can also become angry when they are dealing with pain, are afraid and worried about their illness and future prognosis, feel threatened, feel unheard or uninvolved in their care, or are dealing with complex medical or psychiatric problems.[2]

We will all encounter angry co-workers in our careers. We work with colleagues who are dealing with complex patients, who have to do more with fewer resources, who feel underappreciated and overwhelmed, and who may be experiencing stress and burnout. Other causes of angry behaviours include substance abuse, psychiatric disorders, such as depression or bipolar illness, and personality disorders.[3]

Regardless of the root cause of the anger, there are strategies to help you handle any such situation with ease and success. Some excellent articles and guidelines offer advice and tips on managing difficult behaviour.[4-7] After working with physician colleagues and leaders for over 25 years, I know how busy we are, but I also recognize how important it is to address this behaviour. Taking time to do so

sooner can often prevent more time and energy required to deal with the issue later. With this is mind, I offer a streamlined approach.

Be aware of your own response to anger

Take time to think about your own experience with anger growing up and how you have handled it in the past. If your childhood was spent with adults with angry outbursts, you may have learned to react in a certain way — ignored the angry emotions, backed away, hid from them, became defensive, or joined in the angry behaviour. Chances are high that you continue to use this coping strategy, even though you are now an adult, have more power in this situation, and could respond differently. If you did not witness much anger as a child, you may feel uncomfortable during angry incidents now and not have confidence in your ability to cope with them as a leader.

Be on the lookout for early signs of anger in others

As stated earlier, conflicts are inevitable. Be aware that they can arise, and know how to spot them early. There are common signs that can indicate when people are no longer calm and may be losing their temper. They can exhibit changes in body language, such as a tightened jaw, tense posture, clenched fists, or fidgeting. They may start to raise their voice; or a talkative person may suddenly become quiet. It helps to recognize these signs early, before the angry person reaches a climax and loses control. Although it may be tempting to leave or rush the interaction, spending extra time with this person may actually be most beneficial. Remain respectful and courteous, calm, and professional. Listen carefully to the concerns being raised.

The four As

I have devised "four As" as a practical framework to manage a situation in which anger is being openly expressed. They are:

- ***Agree/admit*** to the facts of the situation.
- ***Acknowledge*** the impact of the situation on the angry person.
- ***Apologize*** to him or her and express regret that the situation occurred.
- ***Act*** to correct the situation and minimize the consequences.

Agree with the facts in the situation — When people are angry, first let them "vent" without interruption. Just feeling that they have been heard can often help to decompress the situation. You do not have to agree with everything they are saying, especially if they are being accusatory or judgemental. Try to listen carefully, and try to find some facts with which you can agree. This also allows you to retain a degree of detachment and objectivity in a difficult conversation. Maintain eye contact, and take time to absorb what they are saying and understand why they may be angry.

Acknowledge other people's right to be angry, and the impact of the situation on them. Putting this into words helps them feel that that you have actually listened to them and appreciate how this affects them. This expression of empathy and compassion is critical in a positive working relationship.

Apologize for the situation — Too often, we feel that to apologize is to accept responsibility and be accountable and, so, we hesitate to say we are sorry. In fact, we know that apology is perceived by patients and families affected by adverse events as essential and that an apology has a significant impact on minimizing risk of litigation.[8] Aside from the litigation issue, the apology is a powerful tool. It helps to heal, improve communication, and improve relationships. It is the right and compassionate thing to do.[9] Even if we are not referring to a specific event or have a role in the situation, we can still apologize and express regret that the situation occurred.

Act to correct the situation and minimize the consequences. Let people know what you plan to do next to help them. Define the next step, and let them know what it is and when you will be doing it. Conducting a root-cause analysis is a longer process that can help you isolate the factors that led to the problem and prevent it in the future. Inform the other person that you will do this, and follow up. A future clash can be much more challenging if someone believes that you promised follow up but did not deliver.

The four As are easy to remember in the midst of a difficult situation and will help to defuse tension effectively, gain time for reflection, and build trust, setting the stage for you to function at your best in your leadership role.

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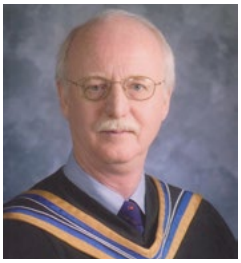

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The facilitative leader:

Keeping the discussion on track

Part 3 in a 5-part series on facilitation skills for physician leaders — an emerging necessity in a complex health system

by Monica Olsen, MHRD and Mary Yates, MEd

Abstract

In an earlier article in this series, we presented a model to help facilitative leaders hold engaging and productive meetings. Here we focus on processes and techniques to help keep meeting discussions on track for maximum engagement and productivity.

In our first article of this series,[1] we talked about basic facilitation skills — the skills that are useful for dealing with predetermined issues requiring an improvement in the status quo rather than the more advanced skills that involve systems thinking. Last issue, we focused on designing engaging and productive meetings.[2] We stressed the need for leaders to challenge their assumptions about how meetings should be run and pursue more effective approaches. We presented a three-part model for leading engaging and productive meetings: create context, do a check in, clarify and agree to the "GRIP" (goals, roles, interpersonal relationships, and processes).[3] In this article, we focus on processes and techniques to help keep meeting discussions on track for maximum engagement and productivity.

Most physician leaders express concern over the level of engagement of meeting participants. When asked what can be done to improve it, most will talk about the need to keep the discussion "on track." Time is valuable and when the discussion is allowed to wander, participants become disengaged or even outwardly angry.

Keeping discussions on track increases the level of engagement, as participants feel their time is valued. As a result, relevant information is shared in a respectful way, problems get solved, and decisions are made.

Task and maintenance functions

In our article on designing meetings,[2] we distinguished between content and process: what gets done and how it gets done. Effective meeting leaders pay attention to both to ensure maximum levels of engagement. When leaders and participants are paying attention to content, they are performing "task" functions. When they are paying attention to process, they are performing "maintenance" functions. Meeting leaders are advised to model, observe, and encourage both types of functions.

Task functions

This category of group behaviours promotes meeting effectiveness by focusing on getting the job done, i.e., accomplishing the objective or task that the group has before it. This includes all formal and informal methods for sharing information, solving problems, and making decisions (Table 1).

The following questions are helpful for understanding how team members contribute to the group's task functions.

1. Does anyone ask for or make suggestions on the best way to proceed or to tackle a problem?
2. Does anyone attempt to summarize what has been covered or what has been going on in the group?
3. Is anyone giving or asking for facts, ideas, opinions, feelings, and feedback or searching for alternatives?
4. Who keeps the group on topic? How do they do that?

Maintenance functions

This category of group behaviours promotes effectiveness by focusing on relationships and cohesiveness among meeting participants. Their purpose is to create and maintain collegial, respectful relations and to create a group atmosphere that enables participants to contribute to their full potential (Table 2).
The following questions are helpful for understanding how team

Table 1. Task functions

Function or behaviour	Description
Initiating	Suggest new ideas or alternative ways of looking at a group problem or goal, propose new activities to address issues
Information seeking	Go beyond surface comments by constructively asking for relevant facts or hidden information
Information giving	Share suggestions, ideas, facts, beliefs, opinions, solutions, and proposals
Clarifying	Probe for meaning, assumptions, and understanding; restate something the group is considering; clear up confusion
Elaborating	Build on a previous comment, enlarging on it and giving examples
Summarizing	Show or clarify the relations among various ideas, pull ideas or suggestions together, determine where the group is and what has been covered
Orienting	Define the progress of the discussion in terms of the group's goals, raise questions about the direction of the discussion
Testing	Check with the group to see if members are ready to make a decision or to take some action
Time keeping	Provide reminders of how much time is left to cover the agenda or a specific topic on the agenda

Table 2. Maintenance functions

Function or behaviour	Description
Listening actively	Look at the person who is speaking, nod, ask probing questions, and acknowledge what is said by paraphrasing point(s) made
Supporting	Encourage others to develop ideas and make suggestions; extend recognition of others' ideas
Gate-keeping	Ask quiet members for their opinion; make sure all have a chance to be heard; possibly suggest limited talking time for everyone
Harmonizing	Reconcile opposing points of view; link similar ideas; point out where ideas are the same
Managing conflict	Listen to the views of others; clarify issues and key points made by opponents; seek solutions

Table 3. Behaviours that interfere with keeping the meeting on track

Dysfunctional behaviour	Description
Hogging	One person dominates the "air time"
Flogging	Going over the same thing, again and again, without moving forward or getting closure
Bogging	Getting bogged down; the discussion is focused on an unnecessary level of detail
Fogging	Clouding the issue, not speaking directly to the issue
Frogging	Jumping all over the agenda, not getting closure on agenda items
Dead buffalo	"The elephant in the room" — an extreme version of fogging; avoiding the one thing that absolutely needs to be talked about to move forward (but no one wants to be the person who brings it up)

members contribute to the group's maintenance functions.

1. Who helps others contribute to the discussion?
2. Did you notice whether anyone was cut off? Any patterns? What happened afterward?
3. How well are participants getting their ideas across? Is anyone preoccupied and not listening? Were there any attempts to help others clarify their ideas?
4. What evidence of group support is there? Which participants seem to be particularly concerned about peoples' feelings and keeping the group together?

Dysfunctional meeting behaviours

Participants will sometimes leave a meeting with a vague (and sometimes not so vague) feeling that "things did not go well." Often, this feeling is a result of a third group of behaviours: dysfunctional behaviours that interfere with keeping the discussion on track (Table 3).

These labels for dysfunctional behaviours are easy to remember. They give meeting participants a "language" to describe their behaviours and motivate them to self-monitor. Because the language is humorous, meeting participants are more likely to provide feedback to one another, sharing ownership of the meeting's effectiveness, rather than leaving the responsibility for controlling dysfunctional behaviour to the meeting leader.

Keeping your (facilitative leader's) head up

Leaders' emotions — both positive and negative — are highly infectious. It is not only critical to be aware of your emotions; you also need to manage your feelings.

Ask yourself, "What kind of climate do I want to create in this meeting space?" A healthy purpose would be to design a meeting environment where people openly share relevant information, opinions, and questions and work together to solve problems, make decisions, and get things done. They will only do so in a psychologically safe atmosphere. As the leader, you will need to be vigilant of your own emotions first, and then help others do the same. Do what is right for the group.

Next, when facilitating meetings, you need to ensure that the content and process (task and maintenance) are helping the discussion move forward. Here is a list of key elements to monitor,[4] and, if necessary, intervene appropriately:

- ensure that everyone participates
- manage conflicts or differences of opinion
- keep the group on topic and park off-topic items (e.g., keep a "parking lot" sheet)
- set time guidelines for each discussion
- monitor time and maintain an appropriate pace

- help participants adhere to the ground rules
- intervene if there are problems
- maintain high energy and a positive tone
- help members articulate points, assumptions, or questions
- keep track of ideas by making clear and visible notes

How does a facilitative leader do this? Periodically make the following checks.

Check the purpose
Ask, "Is everyone still clear about what is being discussed?" [fogging]. "Are we still discussing our topic or have we shifted focus?" [frogging].

Paying attention to both task and maintenance functions can be challenging for any meeting leader. Delegating the time-keeping function is a simple and effective way to help keep the discussion on track.

Check the process
Ask if the approach being used is working. "We said we would work this issue through as a large group, rather than subgrouping. Is this approach working or should we try something else?" "It feels like we're immersed in a lot of detail right now. Is this helpful for moving ahead?" [bogging]. "I notice that we keep circling back to this point. What do we need to know to better understand the concern here?" or "Should this be taken off-line?" [flogging]. "I noticed that we haven't heard from everyone yet, and I'm concerned that we only have 10 minutes left for this item" [hogging]. Adjusting the process throughout ensures that things are working.

Check the time
Ask members how the pace feels to them. "Is this discussion dragging or are you feeling rushed?" "What can we do to improve the pace?"

Take the pulse of members
Constantly read faces, voice tone, and body language to determine how people are feeling. Ask, "Is anyone sensing they've dropped out? How can we get our energy levels up again?" Reading people lets you know when to stop for a break or bring disengaged members back into the conversation.

Tools and techniques to keep your discussions on track

7 plus or minus 2
One of the simplest techniques for keeping a discussion on track is to ensure that the group is the optimum size for problem-solving or decision-making, i.e., five to nine people, as it is much easier to balance participation (and reach agreement) in a small group. In cases where the group size exceeds nine, break it up into smaller groups of five or six to discuss a particular topic or answer a particular question. In an average one-hour meeting, these small-group discussions should not exceed 10 minutes and groups should be required to report back on their conversations. In a one-hour meeting, three small group discussions can be balanced with larger group discussions to improve productivity and engagement.

Using a flip chart
Recording the group discussion in point form on a flip chart enables all meeting participants to see what has been talked about and helps them avoid repeating ideas that have already surfaced. Be sure to remove and post flip chart pages as you go, so that all group members can see all the ideas (not just those recorded on the current page). If one member of the team tends to dominate the discussion, recording ideas on a flip chart is an excellent way to demonstrate that he or she has been heard and to allow the discussion to move along. Meeting leaders may choose to enlist the help of a volunteer recorder so that he or she can pay attention to other tasks and relationship functions.

Parking lot
Meetings often go off track for two reasons: great ideas that have nothing to do with the agenda come up and the group starts talking about them; group members have questions about the topic being discussed and no one in the meeting has an answer.

The meeting leader is advised to pay attention to these great ideas and questions and suggest that they are recorded on the flip chart so that the meeting can get back to the agenda. The bonus of the "parking lot" is that most, if not all, of these items become the agenda for the next or subsequent meetings.

Volunteer time-keeper
Paying attention to both task and maintenance functions can be challenging for any meeting leader. Delegating the time-keeping function is a simple and effective way to help keep the discussion

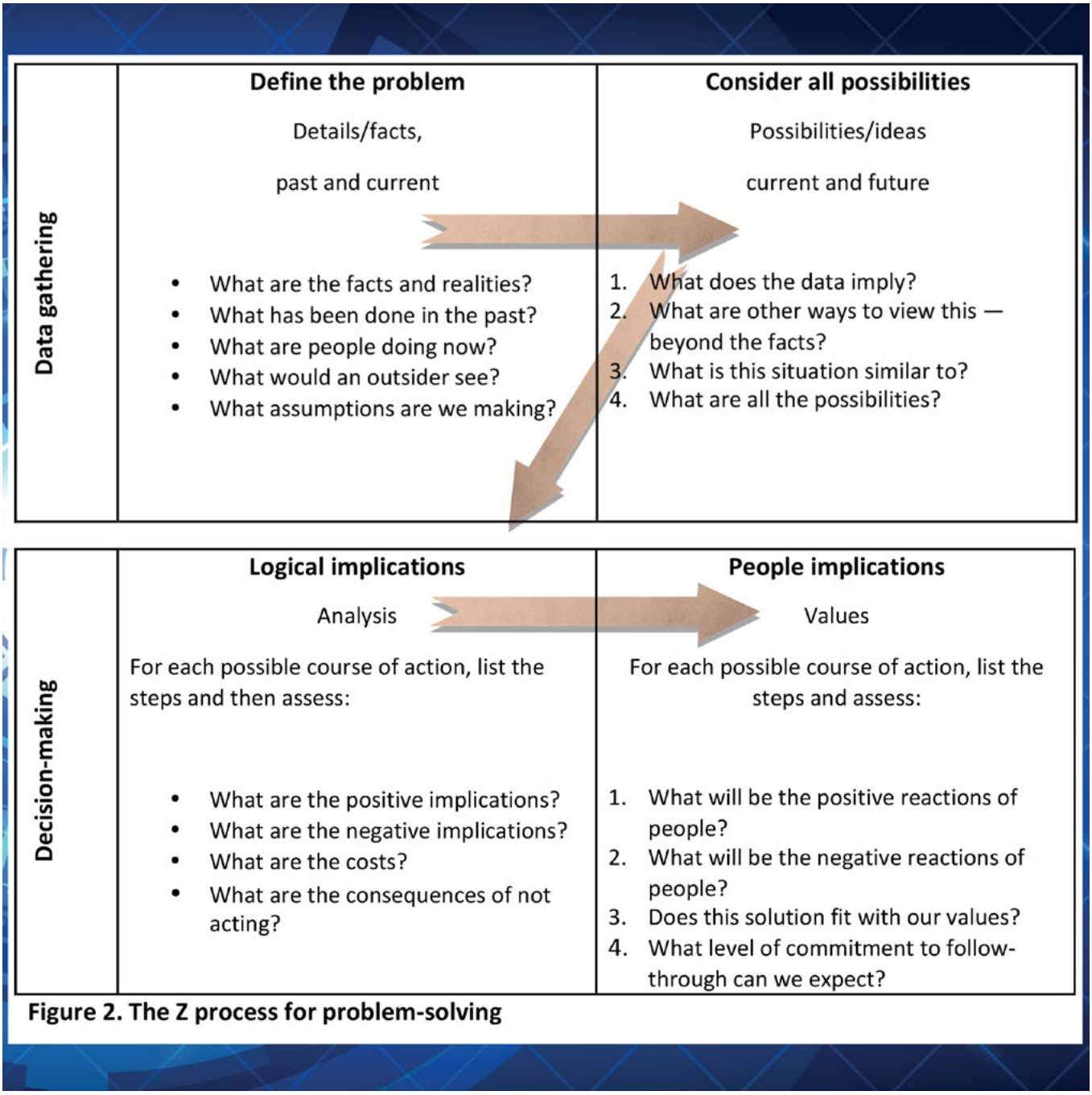

Figure 2. The Z process for problem-solving

on track. Ask for a volunteer to fulfill this role and ask him or her to indicate: half time; two minutes before the end of the meeting; and when time is up.

These guidelines can be used to monitor the time spent on each agenda item or the time spent on the entire agenda. Of course, when time is up, the meeting leader always has the option of asking the group if they would like to continue discussing the item.

1-2-4-all

Balancing participation (gate-keeping) is an important maintenance function. All those who wish to participate and contribute to the meeting discussion should be enabled to do so. However, some team members are less likely to contribute because of their temperament or personal style. Others may unintentionally dominate the discussion. All group members, regardless of personal style, can experience fear about expressing their personal perspective or uncomfortable "truths." 1-2-4-all[5] is a method that takes these dynamics into account

and allows for both balanced participation and gradual disclosure.

1. Participants are asked to reflect privately on a question or topic and record their response in writing (1)
2. Participants are invited to share with one other person (2)
3. Each pair is asked to share with another pair (4)
4. Participants are then invited to share with the whole group (all)

For smaller groups, 1-3-all may be an appropriate alternative.

Mind mapping

A mind map[6] is a powerful graphic technique — using words, images, numbers, logic, rhythm, colour, and spatial awareness — to unlock the potential of the brain (see Buzan[6] for instructions and examples) .

A mind map can be used to help groups make visible a broad pattern of concerns or trends. Everyone indicates where on the map they want their item and what words to use; this avoids interpreting, controlling or shaping peoples' thoughts. A mind map also enriches information, as people build on each other's ideas and connections.

We have used mind maps in retreats and meetings when we need stakeholders to identify all the trends affecting the future of a specific initiative, e.g., "the future of family medicine at XYZ." Before the meeting, we post a large piece of blank paper (2 metres by 4 metres) with the topic at the centre. We ask everyone to stand by the mind map as we review the ground rules, which remain posted next to the map. This engaging (and kinesthetic) activity provides colourful visual data for further dialogue and identification of the most compelling items requiring further action.

The four-step Z process for team problem-solving

The Z process[7] is a way of understanding the four vital steps in the problem-solving process. Before deciding on a specific course of action, help the group work through this process to keep from overlooking a critical step.

A table (Figure 2) can be provided ahead of time to allow meeting participants to think about a situation and make notes. Walking through the table in sequential

fashion, adjusting as necessary, can be done in conjunction with the 1-2-4-all technique.

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This article has been reviewed by a panel of physicians.

Developing criteria-based privileging in British Columbia

Jon Slater, MD, and
Emma Bloch-Hansen, MBA

Abstract

Despite a foundation of engagement, transparency, and accountability, BC's physician privileging project revealed some valuable lessons regarding communication, timing of implementation, and resistance to change. This four-and-a-half-year project provides an excellent case study in innovation and change management.

In 2010, the Interior Health Authority of British Columbia reviewed its privileging processes and considered the introduction of one based on criteria. In 2011, following concerns regarding diagnostic imaging, the province commissioned a report by Dr. Doug Cochrane,[1] which recommended, among other things, the introduction of a single system of criteria-based privileging across the province. We were asked to lead this change process. In this article we review privileging systems, the system chosen, the process of engagement, and the lessons learned.

Privileging systems

Although many use the terms privileging and credentialing interchangeably, they are separate processes. Credentialing examines the past to inform the future. It's a process that confirms an individual's identity, training, licensure, experience, reputation, and skill. Although credentials are updated, the process generally occurs on initial application for membership to a medical staff.

Privileging is the process used to request, review, and grant a practitioner permission to undertake defined activities in a specific facility. The process is informed by the practitioner's credentials, but also by the ability of the facility to support an activity.

In 2011, two systems of privileging were used in British Columbia. The most common was the permissive approach. Practitioners were granted privileges in their discipline and were expected to restrict their activities to the usual and customary activities of the discipline. This had the advantages of simplicity, flexibility, and ease of administration.

It also had disadvantages. What was considered usual and customary by some might be considered reckless by others. There was a tendency in some groups to grant privileges by clinical department. Members of the department of pathology for example, commonly had privileges in "pathology." This ignored the reality that a pathology department might include as many as six unique disciplines, with no obvious overlap in activity. Although the vast majority of practitioners limited their activities to those in which they were skilled, the few that did not created doubts in the system, especially among boards of governance and the health authority's insurer.

The second system involved checking off laundry lists of procedures. Although more precise than the permissive approach, it lacked guidance as to the appropriateness of applying for or granting a particular privilege. Some of these checklists comprised several pages and were overly detailed.

In contrast, criteria-based privileging sets criteria to be met before a practitioner can be considered for a privilege. The definitions in Table 1 may be helpful.

An effective privileging system ensures that patients are seen only by practitioners trained in the activities undertaken; reduces risk to the patient, the practitioner, and the organization; reduces unreasonable restrictions on a practitioner's scope of practice; reduces unreasonable expectations of practitioners; and promotes mobility between sites. We believe that criteria-based privileging meets

Table 1. Glossary of terms

Term	Definition
Core	Activities that a recently graduated member of the discipline can reasonably be expected to perform
Non-core	Activities that require further training or demonstration of skill
Current experience	The level of experience below which a focused discussion is triggered regarding support required
Context-specific privileges	Take into account what a facility can support
Grandparenting	A guarantee that privileges held before introduction of the new system will continue to be held

those objectives in a way that other systems do not.

Project framework and governance

The Provincial Privileging Project was part of a suite of projects[2] intended to improve the quality of medical staff care across the province. The other projects included:

- Core Dataset Project, which established the information required for credentialing
- Physician Performance Enhancement Framework
- Legislative Review
- Radiology Quality Improvement System
- Physician Leadership Project
- Credentialing and Privileging Project (software solution)

These projects were overseen by the Physician Quality Assurance Steering Committee (PQASC) composed of representatives from the College of Physicians and Surgeons of British Columbia, the medical association, the Ministry of Health, and the health authorities. The project had its own steering committee drawn from the provincial college, the health authorities, and the medical association. A charter defined the goals and objectives as well as what was and was not within the scope of the project.

The project team consisted of a full-time project/change manager and a part-time (0.5 full-time equivalents) executive medical director as project lead. In addition, 12 senior medical leaders participated with the project/change manager to act as co-chairs at meetings with the various panels. No funding was available for administrative support. Funding for participation on panels was provided through the medical association for medical practitioners and the Ministry of Health for non-medical participants.

The project determined the approach, schedule, support materials, and routines that could be replicated for consistency, capitalizing on efficiency and effectiveness. Regular updates were provided to the PQASC.

Process

The project was based on three foundations for success: engagement, transparency, and accountability. We employed change management methods to encourage active and visible executive sponsorship, develop and deploy communications and training, engage in coaching conversations, and address and manage resistance to the change.

Initially, we consulted with the chair of Interior Health's board, senior administrative and medical leaders, and chiefs of staff. As the project expanded to become provincial in scope, consultation included the College of Physicians and Surgeons of British Columbia, the medical association, the Ministry of Health, and the medical leadership of the other five health authorities, each of which had consulted with its stakeholders.

Early feedback revealed discomfort among chiefs of staff with a permissive privileging system that gave no guidance around how they should recommend certain privileges. There was also unease among operational administrators and directors of the board about the quality of the recommendations received.

The project defined a recruitment process for panel members and

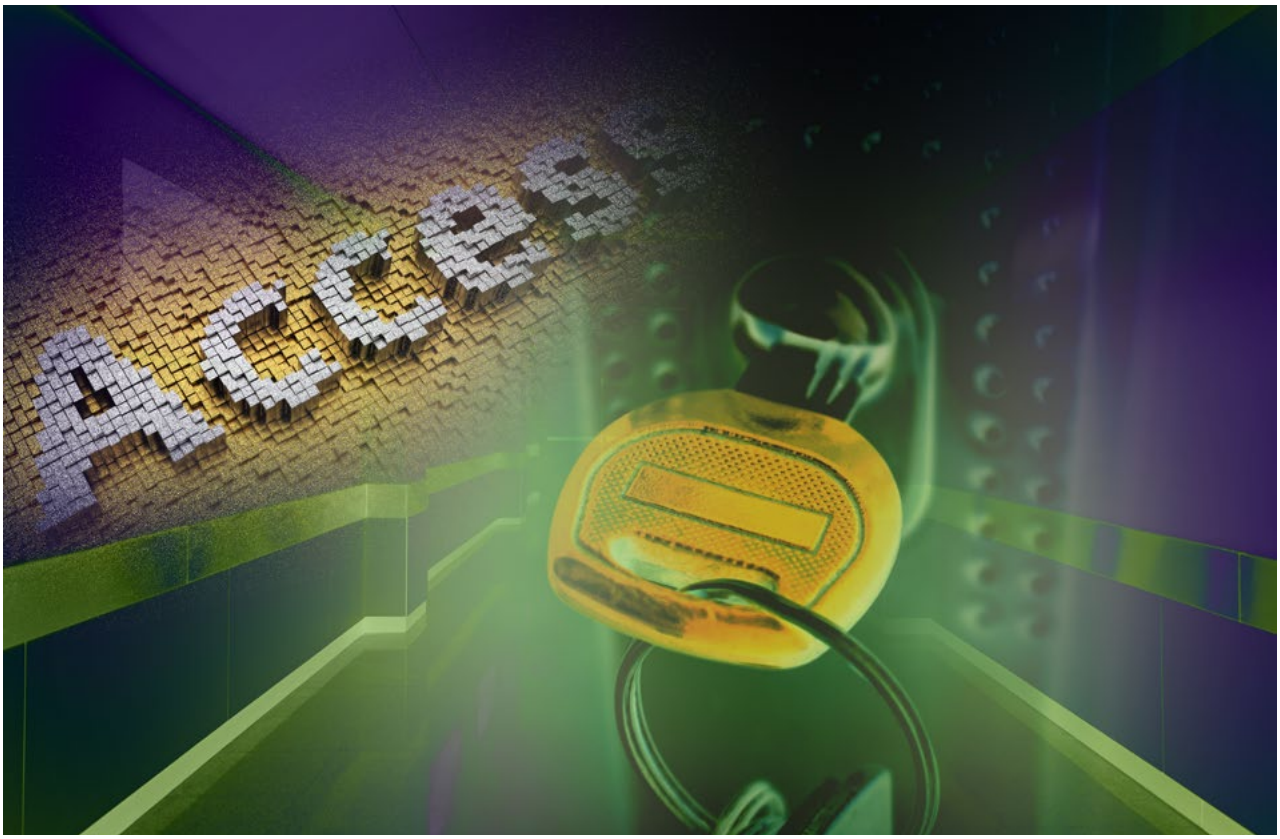
key information and expectations to share with the selected representatives. We contacted the leaders of each medical staff discipline, usually through the provincial medical association, but in the cases of dentists, midwives, and nurse practitioners through their regulatory colleges and professional associations. We briefed the board of the medical association and its two component societies representing family physicians and specialists.

Reaction to the project was positive among the non-medical disciplines and mixed among the medical ones. Those disciplines that had previously been under public scrutiny, notably diagnostic imaging and hematopathology, were more enthusiastic than others. Trust between practitioners and regulatory bodies influenced reaction to change and, in some cases, was a barrier that needed to be addressed. Working through the marinade of emotions and perspectives required patience, curiosity, and energy to allow us to maintain a conversation with all groups. Key to our strategy was the inclusion of medical staff advocates, such as the societies representing each discipline, and the medical association.

Steering committee members presented the project to medical advisory committees across the province. A blog,[3] posting the results of the work done and inviting comments, had as many as 1200 visits a month, 85% coming from British Columbia, 9% from other parts of Canada, and 6% from other countries. Despite requests for comments, very few were received through this mechanism.

We asked the individual generalist and specialist societies to keep their members informed about our progress and published an article about the project in the *BC Medical Journal*.[4]

Following the process defined by the project, we asked each discipline's society to nominate an expert panel with members from each subspecialty and each health authority. The health authorities also had input into the panels. Typically, panels met for 4 hours face-to-face on three occasions. Meetings were scheduled to allow panel members to obtain feedback between meetings. The "dictionary" defining a discipline's scope of practice was finalized in a 2-hour teleconference.



The first meeting was devoted to orienting panel members to the reasons for change and the

terminology involved, defining in broad terms the scope of practice for the discipline, and addressing questions and reactions to the work. The panel was introduced to the HCPro[5] dictionary template and asked to establish credentialing criteria for members seeking privileges in the discipline.

Resistance management demanded fast, personalized responses to contain damage in an environment where trust is fragile.

During the second meeting, panels reviewed feedback from colleagues, addressed additional questions and concerns, defined activities core to the discipline, and started to consider non-core activities. Usually, in this meeting, the recommended current experience for core privileges was established.

At the third meeting, panels also reviewed feedback and revised the core and non-core activities accordingly through additional thoughtful debate. By the end of the third meeting, the dictionary was usually complete. It was then distributed through the Ministry of Health to the health authorities for discussion with staff.

At the final meeting, a teleconference, panels approved final changes before the dictionary was submitted for entry into electronic privileging software.

For the most part, members of the various panels worked well together, had thoughtful and respectful debates, and felt a sense of accomplishment in completing the development of their dictionary. As one panel member said, "Now I can tell my mum what it is I actually do!"

Panel members had variable success in sharing the work with colleagues. Organization structure, supports (visible and active executive sponsorship, established communication channels, time), along with a sense of accountability and comfort/confidence in discussing the work with colleagues outside the panel, all affected the level of success in sharing the work and its intention with the broader community.

This process evolved during a pilot project with diagnostic imaging. The project plan scheduled writing of the remaining dictionaries for December 2012 through to December 2014. The credentialing and privileging project, which depended on our output, drove this aggressive schedule.

Change and resistance management

It is difficult to create enthusiasm among medical staff for any change initiative, and cultural change is particularly challenging. It's not just that medical staff organizations are conservative; most members don't have the time to consider anything not immediately affecting their practice. The privileging project extended over four and a half years; it was easy to ignore until just before implementation.

Resistance management demanded fast, personalized responses to contain damage in an environment where trust is fragile. Our difficulties in getting the message out to the medical staff allowed rumours to flourish. The ones we heard were dire and difficult to manage despite attempts at communicating facts.

The most prevalent rumour was that current experience would be used as a surrogate for competency and that physicians whose experience fell below the recommended level would be disqualified. This was not the intent of the project or of senior medical administrators, but the rumour persisted. For one panel in particular, this resulted in the need to double the number of scheduled meetings.

Writing 62 dictionaries over two years led to challenges. One unfortunate misstep was the circulation of a draft dictionary as a final document. This damaged trust between the panel and the project team and between the members of the panel and their professional colleagues; this damage had to be repaired.

The other major difficulty was the presence of gaps in planning between development and implementation, as these were separate projects. These gaps included the need for a consistent approach to reappointment, a process for issues management, a process for renewal of dictionaries, and a process to catalogue requests for a privilege not in the dictionary.

Lessons learned

As we approach the end of the project, it's time to reflect on lessons learned. We intended

to develop dictionaries for each discipline represented on the medical staffs and we succeeded. We appreciated the fact that the dictionaries are a first effort and will require an iterative improvement process, but we could not let perfect be the enemy of good. We also intended to do this in a manner acceptable to the major stakeholders. Results can be described as mixed. Bujak[6] argues that the only power the medical staff has is in saying no. That's rather extreme, but physician autonomy and conservative attitudes make change a difficult process.

The entire privileging project was planned and executed over four and a half years. It achieved its assigned goal of developing privileging dictionaries for each discipline of medical staff.

The first lesson we would like to emphasise is the importance of active and visible executive leadership and the need for ongoing communication. Setting and communicating clear expectations and supporting staffs through the transition are key. Engaging in two-way communication, explaining the whys and emphasizing benefits, and inviting and encouraging tough questions and comments make a significant difference. There is a difference between having change done to you and feeling part of it.

Lesson two: there is no such thing as too much communication. Our communication plan relied heavily on panel members doing much of the one-on-one messaging, but this idea was crippled by the lack of appropriate communication channels and funding for that function. We know that face-to-face communication is most effective and email is least effective and most problematic. We learned that email, even from representatives elected by the medical staff, is rarely read.

The third lesson is that no project should be undertaken without considering implementation. Plans are underway to deal with the gaps we identified, but at the cost of considerable anxiety among the medical staff.

Fourth, fear is a powerful emotion to contend with when introducing change. Thoughtful and timely responses are required. Naysayers need to be confronted by appropriate stakeholders, and resistance needs to be dissected, accountabilities defined, and resolutions implemented. Transition can be a relatively easy response or a challenging reaction. Many factors and influential individuals can shape the path individuals will take.

Finally, savings in administrative support are illusory. The physician lead and project manager found themselves doing administrative work at a higher cost and with less effectiveness than would have been the case with appropriate administrative assistants. Focusing on administrative tasks also took away from higher-value work and additional efforts that could have been directed toward tackling identified gaps or opportunities.

Summary

The entire privileging project was planned and executed over four and a half years. It achieved its assigned goal of developing privileging dictionaries for each discipline of medical staff. The proof of the value of criteria-based privileging will be the degree to which the medical staff accept the dictionaries and the degree to which they support the other initiatives of the PQASC.

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

Skills for leaders in health care — “SERVANTS” and “MASTERS”

Owen Heisler, MD

Abstract

A review of the business and philosophy of leadership development leads to a framework for developing the entire basket of skills needed to lead in today’s health care environment. To improve our current state, health care requires an invigorated leadership paradigm, rather than yet another organizational redesign, one that better reflects basic business and philosophy principles. Leadership development must focus less on standardization and more on skill development, judgement, and cultural appreciation, given the variability of inputs and the desired customization of outputs underpinning health care environments. Effective operational leaders maximize sense-making, innovation, relationship building, visioning, and interpersonal communication, attributes represented by the mnemonic and spirit of SERVANTS leadership. Effective change leaders add the softer skills — motivation, teams, and communication — that can be captured in the mnemonic MASTERS. Although the latter implies mastery, it is at one’s peril to forget that, to be a master, one must first, and always, be a servant.

“Science is organized knowledge. Wisdom is organized life.” — Immanuel Kant

Health care delivery is fragmented and chaotic. Systems continue to reorganize — looking for better answers, pushing for more science, promoting best business practices, searching for the next big breakthrough — all under the flag of promoting evidence-based medicine.[1] In spite of valiant efforts, it is estimated that only 55% of care in the United States currently meets generally accepted standards.[2]

Interminable organizational redesign cannot continue to be touted as the answer. Instead, it is time to redesign health care leaders. What is needed are leaders who measure performance by patient outcome, apply both financial and behavioural incentives, optimize processes, and re-engineer current dysfunctional cultures — leaders who organize care delivery around the needs of patients rather than providers.[3]

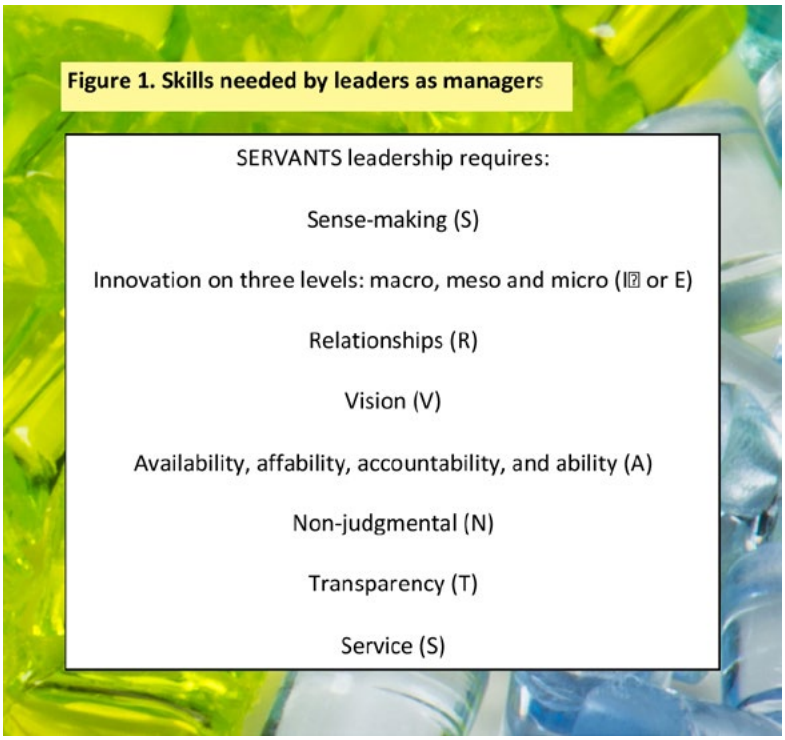
The current leadership paradigm places heavy emphasis on standardized business management principles, such as process redesign and elimination of waste. However, the business literature suggests that, when inputs are variable (as each patient is variable) and when customers value variation in outputs (individualized medicine), leadership must be less about standardization and more about investing in employee skill development, judgement, and cultural appreciation.[4] Input/output variability is the reality of health care environments; unfortunately, such leadership investments are not.

Leadership skill development must consider both “leader as manager” and “leader as leader.”[5] Managers are the operational stalwarts who deal with the status quo and promote stability; leaders manage and promote change. Managers remove ambiguity; leaders not only tolerate but also at times relish and create ambiguity. Current leadership development is skewed toward development of the skills required to be an excellent manager. To promote a new paradigm, we need skill development focused on change management, judgement, and cultural appreciation

The following is an agenda for developing change leaders. I outline a framework for developing skills needed to be a change leader based on the business and philosophy literature (including suggested resources) and paying special attention to my perspective on top leadership articles from the last 15 years from the pre-eminent business magazine, Harvard Business Review.

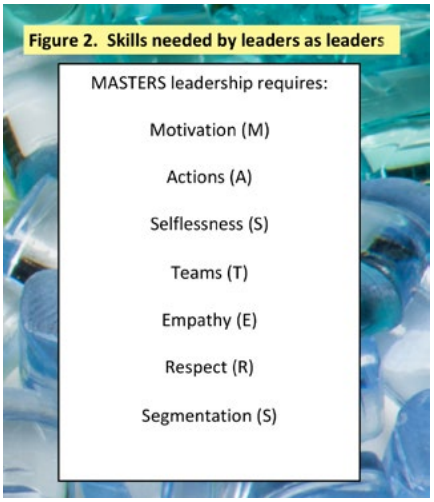
Skills for leaders as managers — SERVANTS

For operational managers, key skills are focusing, business plans, tactical plans, and process improvement methodologies such as LEAN or Six Sigma. Managers use skills flowing from the Drucker tradition.[6] They rely on acquisition and management of content knowledge within extensive networks. They develop and promote habits (repeatable ways of doing things) through practice, in keeping with the dictum that if one does the same thing the same way 10 000 times it will become a habit. The four most important skills of a leader as manager are sense-making, innovation, relationship building, and vision, in that order.[7] Attention must also be directed toward interpersonal communication. These include the "surgeon creed" taught to me by a mentor during residency: the skills required of a good surgeon are availability, affability, accountability, and ability (in that order). There is also great value in transparently considering all perspectives by suspending judgement until one can truly understand the issues and perspectives. This leads to the SERVANTS mnemonic (Figure 1). It also represents servant leadership as advanced by Robert Greenleaf.[8] We are ultimately all in service to each other. Although servant leadership has a significant presence in the spiritual world, it has not had significant traction in secular health care environments, even though it applies equally well to the caring professions that make up the health care system.



Skills for leaders as leaders — MASTERS

Growth into strategic leadership involves not only acquisition of SERVANTS skills, but also the softer skills of motivation, teamwork, and communication that can be captured in the mnemonic MASTERS (Figure 2). These skills are different and focus on change management, judgement, and cultural appreciation; they are not merely continued enhancement of manager skills.



Motivation

•*Macro* — Kaplan and Porter[9-11] propose that the cost crisis in health care arises from providers' almost complete lack of understanding of how much it costs to deliver patient care. They suggest that the remedy is neither further medical science breakthroughs nor more governmental regulations, but rather a new way to measure costs and outcomes. Look and understand associations before

quickly assuming a cause-and-effect relationship. Some decisions are simple (categorize), some complicated (determinable and repeatable), some complex (deciding changes the landscape), and some chaotic (where to start?). Understand and act accordingly.[12]
Resources: Kahneman,[13] Hume,[14] other 17th- and 18th-century philosophers

•*Micro* — Understand yourself, your preferences, and your decision style. Different leaders lead differently, but can transform.[15-17] One can't purposely change what one does not understand; the only change possible without understanding is destabilization.
Resources: Robbins,[18] a Meyers-Briggs, colour profile or similar

•*Meso* — Consider all four drivers of human behaviour: acquisition, bonding, comprehension, and defence.[19] The acquire driver, especially financial, often receives preeminence, to the exclusion of others. Consider other acquire drivers, such as prestige and sense of worth. The drive to be part of a high-functioning team (bonding) and the drive to learn and understand (comprehension) are very powerful, often ignored, drivers in health care. The defensive driver of command and control provides short-term success but seldom demonstrates lasting effects. Recent research from social scientists and evolutionary biologists suggests that people behave far less selfishly than most assume, perhaps related to a genetic predisposition to cooperate.
Resources: Social science courses/ readings in psychology, behavioural economics, or sociology

Action

•*Words you say* — Stories are more powerful than statistics in health care. However, for stories to move and captivate, they must be true to you, your audience, the moment, and the mission.[21] Harness the science of persuasion.[22]
Resources: Patterson et al.,[23] courses in communication

•*Things you do* — Not everyone will like you; that is a reality outside your control. However, whether people respect you is within your control as it will depend on how you treat those around you more than what you say. As only one in three change programs succeed, how you treat failure will be more noticed than how you respond to success.[24] Treat others as you would like to be treated. Relativism is significant, especially for physicians; it is not just what an individual receives but just as important what other "like" individuals receive.
Resources: Conduct a 360-degree review, through something like the Pulse 360 Program[25]

Selflessness

Consider becoming the "quiet moral leader" who follows four rules in meeting ethical challenges and making decisions: put things off until tomorrow; pick your battles; bend but do not break the rules; and find a compromise.[26] All perspectives should be heard, transparently considered, and balanced. Principles will invariably collide as the urge to "do good" (beneficence: the Golden Rule), not "do bad" (non-maleficence: the Silver Rule), be just, and respect autonomy cannot all be maximized for every situation. Promote justice as fairness to encourage long-term buy in. Walk a mile in someone else's shoes. Consider that a virtue is the golden mean between two

vices (one of excess and one of deficiency) to better understand that some people are just working to get to virtue with a bit more experimentation than you might be comfortable with today; there will be a tomorrow. Very few people wake up in the morning intending to "do bad," but sometimes it takes a bit of work to discover the intended good.
Resources: Beauchamp and Childress,[27] Rawls,[28] Aristotle and Sachs,[29] any book by Daniels[30]

Teams
Surowicki[31] promotes the wisdom of crowds, where in a respectful, non-hierarchical environment, an informed group will outperform the best experts in the group (known in math as Condorcet's jury theorem). High-functioning teams can be nurtured by carefully managing information signals and reputational pressures.[32-34] Such teams commit to and become mutually responsible for a common purpose and performance goals.[35] When they make decisions, greater emphasis is placed on the dynamics and motivation of the team while they amass sufficient, rather than maximal, content knowledge.[36] Skills include seeing the bigger picture, working within a scope, asking good questions, and treating each other with respect. Physicians and others, who are classically trained as experts rather than team players, struggle at times in such environments.[3,37-39]
Resources: Surowicki,[31] books/articles on generative governance

Empathy
Everyone — our patients and our providers — has and lives a life narrative. Respect and try to understand others' narratives. Try different lenses when looking at problems. Be curious. Ask why five times. Think in metaphors on occasion. Think outside the box. Read around rather than about. Medicine is about human beings and the human condition; don't devote all your time to learning about the science. Forsake the art at your peril!
Resources: Homer,[40] Augustine,[41] take a language course

Respect
The best way to care for patients is to care for and listen to providers. We need to respect and support those who provide front-line care with more than just a pay cheque. Rather than imposing top-down change programs, try "positive deviance," which is bottom-up and inside-out and encourages change from within by identifying and leveraging innovators.[42] Develop emotionally and physically safe, respectful environments for optimal patient outcomes and provider performance.
Resources: Lee,[43] religious/spiritual books of choice and one more that you have not read before (the Bible, the Quran, the Book of Mormon, etc.), check out the Greenleaf Foundation website[8]

Segmentation
When thinking about organizational structures and forming groups, remember that groups of over 150–200 people tend to split into smaller groups. Plan group sizes to accommodate the realities of social networks and social contacts. Individuals will be in multiple groups at the same time. Identify and respect the informal leader of a group; the formal leader will not always be your best ally. Segmentation is a robust tool for understanding and reflecting on how different people require different incentives. Generations — Gen X, Gen Y, or Baby Boomers — are among the most powerful forces in history; although they seem unique, even they follow a pattern.[44] Learn about the four Ps and three Cs of marketing. Marketers do this consciously every day. Learn these skills, not to exploit those we manage, but rather to provide contextually appropriate support for those providing and receiving care; we succeed when they succeed.
Resources: Fisher and Ury,[45] Lax and Sebenius,[46] Logan et al.,[47] any of the original writers on social contract (Hobbes,[48] Locke,[49] Rousseau[50]), take a course in marketing or advertising

Conclusion

Operational managers are essential to any organization. However, they are not change leaders. The skills required for leaders of change — the few who move to the top and provide direction to an organization — are not continued development and enhancement of manager skills. Their skills are different. Change leaders, described by Collins[51] as level 5 leaders, have genuine personal humility blended with intense professional will.

Growth of such leaders requires a different kind of training. It involves broadening rather than focusing; respect; valuing and seeking out diversity; pattern recognition; bringing something unique to the table; doing 10 000 *different* things — not to create habits, but

rather to identify and break habits and paradigms blocking needed change.

SERVANTS and MASTERS leadership are complementary. Metaphorically they remind us that one must first be and continue to be a servant if one is to take on mastery and leadership. Both reflect the value of strong teams built around respectful diversity channeling all talents for the common good.

Centuries ago, Aristotle maintained that it was not only possible but essential to train leaders to do the right thing, focusing on the cardinal virtues of prudence, justice, temperance, and courage. When talking about the level 5 leader, Collins[51] promotes the same qualities, suggesting while some may have the "seed within," leaders need development based on life experiences. This is virtue ethics.[29,52,53] This is servant leadership.[8] This is the way forward out of our current paradigm to a better system through better prepared leaders — adventurous, creative, and courageous.

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

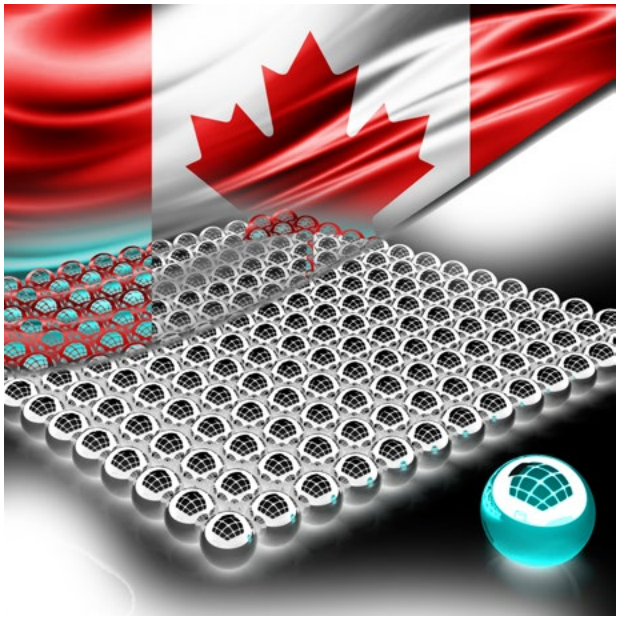
Understanding physician leadership in Canada: overview of a CSPE/CMA/CHI study

by Johny Van Aerde, MD

Abstract

Physician leadership is necessary for the transformation of the Canadian health care system because physicians have a unique knowledge of that system. However, many physicians are not compensated for their leadership roles, receive little support in terms of training or resources, and may be viewed with suspicion by colleagues.

The rapidly changing environment of the health system requires physicians to become engaged as leaders.[1,2] Physician leaders can play a significant role in innovation and transformation within the health care system.[3-5] Physicians can truly influence the value equation: value equals quality divided by cost.[6] However, to optimize participation of physicians as leaders in the health care system, one needs to understand the factors that may help support those who wish to take a more active role in health care reform.[7] Given that their training focuses on clinical preparation, many physicians lack effective leadership skills; however, they must not only know what is needed to work in the system, they must also learn what is required to work on the system.[8]



To determine the demographics of Canadian physician leaders and to better understand the needs of physicians who take on leadership roles, the Canadian Society of Physician Executives (CSPE), in partnership with the Canadian Medical Association (CMA) and the Centre for Healthcare Innovation (CHI) at the University of Manitoba, conducted a study on physician leadership with the following objectives:

- To develop a baseline of demographic data on formal and informal leadership roles of physicians in Canada
- To understand the factors that enable and deter physicians from taking on leadership roles
- To gauge the current level of satisfaction and dissatisfaction of physicians with their leadership positions
- To determine ways for organizations to increase physician engagement in leadership

Data were gathered using a large electronic survey (689 responses for a 17% response rate) and semi-structured interviews (15). Some highlights of the results follow.

Profile of the physician leader

Physician leaders tend to work well beyond what is strictly required in their formal roles. In more than 50% of cases, they work in a wide variety of settings by taking on several formal and informal leadership roles simultaneously. Among survey respondents, 1 in 14 of those in formal leadership roles are not paid and 18% receive a stipend only. In general, rural physicians work more unpaid hours in leadership roles than urban physicians.

On average, respondents spend 38–81 hours a month on voluntary activities, for which half receive no support while the other half receive recognition, support for education, or office/administrative support. It was noted that two

thirds of all leadership learning is acquired through the CMA's Physician Leadership Institute (PMI) courses and the annual Canadian Conference on Physician Leadership cohosted by the CSPE and CMA. Most of the remaining third is acquired from courses offered by their organization or from advanced courses and degrees pursued by individual physicians on their own initiative.

Perspectives on physicians' current leadership roles

Physician leadership is thought to be necessary for the transformation of the Canadian health care system because physicians have a unique knowledge of that system. Physician leaders find it satisfying to make a difference and to influence change by enabling others and working as a team. This aligns with the hallmarks identified for effective physician leaders, including the courage to maintain strong values, such as servant-leadership, integrity, walking the talk even in the face of adversity, and working collaboratively with others toward a shared vision.

Although respondents reported that leading other physicians is both satisfying and dissatisfying depending on the circumstances, overall, they described it as "herding cats." Dissatisfaction with their current role comes from dealing with bureaucracy, which is often perceived as ineffective and impeding change. Work was portrayed as increasingly complex: long and sometimes unpaid hours without recognition, and a struggle to maintain work–life balance.

Challenges and opportunities to engage physicians as leaders in health organizations

The biggest challenges for physicians taking on medical leadership roles are the demands on personal time and the impact on their financial welfare. Structural issues include the ongoing and peripatetic regionalization of local and regional health care organizations and irregular and inconsistent characterizations of the formal physician leadership role.

Culturally, there is still a negative attitude emanating from practising physicians, who often view physicians who take on leadership roles as having "gone to the dark side." According to survey respondents, the negative attitude toward medical leaders is present throughout the entire medical system — from medical school through residency to clinical practice — and it is a limiting factor for physicians who want to develop leadership skills and take on leadership roles.

The lack of training in leadership skills was identified as a strong barrier to physician leadership. Respondents recommended the introduction of such learning at all stages of a physician's career and throughout the entire health system. Organizations were encouraged to optimize the chance to engage physicians in leadership roles by implementing succession planning and talent management and by providing financial remuneration or other rewards and recognition.

In addition to appropriate leadership training, respondents suggested

that physicians would also benefit from coaching and from promotion based on performance improvement and related accountability. Standardized evaluation and accreditation, such as the Canadian Certified Physician Executive (CCPE) credential, was noted as a method to improve the credibility of physician leaders among their peers and among administrators. Although maintaining a clinical practice appears to be important for credibility among peers, it seems less important for physician leaders with longer clinical experience or for those who need to spend more time on increasingly demanding senior leadership activities.

Conclusions

The findings of this study imply that health system transformation toward improved patient care requires physicians to engage in life-long leadership development, for which the system will have to find resources. The identified need for learning and for attitudinal changes toward physicians who want to engage in leadership activities constitute a large void that can be filled by the combined efforts of the CSPE and CMA's Physician Leadership Institute. The question is whether the health care system and the organizations within it are willing to make the structural and cultural changes required to make this happen and to free up the necessary time and finances.

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The Understanding Physician Leadership in Canada research study was conducted by Anita Snell, PhD, and directed by Graham Dickson, PhD, senior research advisor to the CSPE. The coordinating committee comprised:

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- Emily Gruenwoldt-Carkner, Canadian Medical Association
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This paper has been reviewed by a panel of physicians.

Book review

Bending the cost curve in health care: Canada's provinces in international perspective

Gregory P. Marchildon and Livio Di Matteo
University of Toronto Press, 2015

Reviewed by Johny Van Aerde, MD

With a title like that and authors who are experts in economics, most physicians would not even look at this book's table of contents, let alone its 480 pages. However, if you are interested in health care systems and their links with politics, economics, and some of the non-medical determinants of health, the book will hold your interest from beginning to end. More than two dozen Canadian and international authors address the past, present, and future of health care based on demographic, financial, and political evidence, adding reasonable projections where possible.

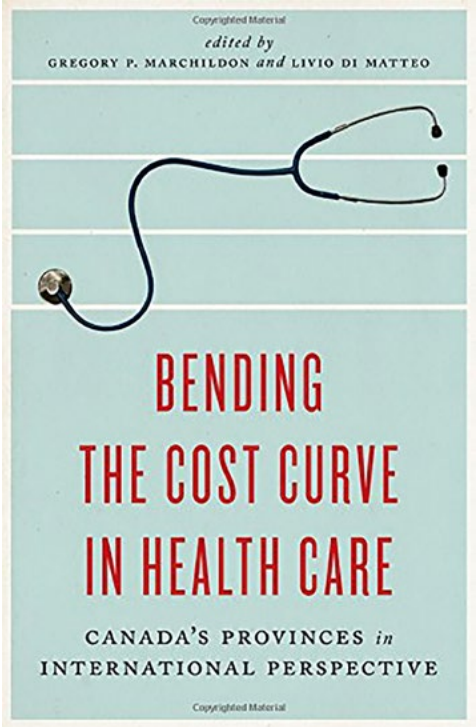
The sustainability of public health care spending is central to any policy debate in Canada. Unfortunately, this debate usually generates more heat than light, and there seems to be no general agreement on what sustainability in health care actually means. *Bending the Cost Curve* uses many different lenses to approximate that definition.

Part I deals with general considerations on how to "bend the cost curve" (i.e., reduce the rate of

increase in spending in a very broad political and economic context. Uwe Reinhardt's "alternative methods of controlling the use of real health care" gives a broad view of the determinants of health and the influences on the use of health care. Chapter 2, on financial incentives, provides evidence for the effect of payment method on quality of care and costs and why pay-for-performance often does not affect cost or quality significantly. The last chapter in part I addresses the fact that our aging population has a larger effect on reducing tax revenues than on increasing health care costs. In addition, many Canadians, opposed to "privatization" do not realize that 30% of health care is already paid for by private funds, leaving 70% for the public purse.

Part II describes the common drivers of cost in Canada and some of the political implications or forces behind them. Technological expansion (including pharmaceuticals), growing rates of utilization, population growth and/or aging, and inflation in health human resource costs all increase the expenditures faced by governments in various ratios. Technology and wage inflation are the most important cost drivers common to the entire country.

The last chapter in this section examines the impact of the federal stewardship role on provincial governments. Although the provinces are the main agents on the supply side of health care, the federal government remains a major determinant on the demand side, despite its recent insistence on a more limited role. The federal government will always be responsible for surveillance and control of epidemics, immigration, taxation and income redistribution, health and safety regulations, and, to some extent, drug use and the price of patented pharmaceuticals. Its refusal to take a lead role in influencing some of the cost components that it could affect contributes to the Canadian health care system being among the most expensive in the world.



Part III explores reasons for interprovincial differences in costs and sustainability, mainly differences in population growth, aging, health-care-specific inflation (including the cost of health human resources), technology (including pharmaceuticals), and politics. The six chapters give some interesting and sometimes unexpected insights and frank, evidence-based answers. Why does Alberta spend so much more per capita than other provinces without better outcomes, despite its youngest population? Why did Quebec's financial numbers for the same year look different when reported by different agencies? What is the real burden threatening the sustainability of the Atlantic provinces? What worked and still works in British Columbia, Saskatchewan, and Manitoba? Why does Ontario spend relatively more on physicians and relatively less on institutional care?

Part IV turns to international health care systems and evidence of success and failure in countries like the United States, Australia, England, the Nordic countries, and Taiwan. Each of these international systems has strengths and shortcomings, and the authors make comparisons with the Canadian health care system, suggesting what may and may not work for Canada.

However, well-informed and appropriate adoption of some of these international components would require evaluation of the changes. Unfortunately, governments in the United Kingdom and in provinces like Alberta and Nova Scotia have reorganized the governance and administrative systems multiple times without allowing for sufficient evaluation. Observations from the UK also indicate that, although clinical practices are crucial to bending the cost curve, the importance of physicians and their teams for efficient resource allocation has mostly been ignored during all the changes.

In the Nordic countries, the health care system is stable because these countries are fiscally sound.

At one end of the spectrum is Iceland, which was bankrupt a decade ago; at the other end is Norway, which has no problem with health care expenditures as it has managed its oil revenues better than any other country or province in the world. The use of voluntary supplementary private health care insurance is growing in most Nordic countries, with no limits on access to the public system.

What can we conclude from this book?

- Bending the health care cost curve is a long-term process, not a quick cost-cutting exercise or another structural "re-disorganization." Every Canadian is guilty because we are impatient for change and, as a result, those who are elected feel pressured to demonstrate significant changes within the short term of one election cycle.
- Attempts at cost control have focused on volume of services and number of providers; prices have not been addressed. Doing so will meet resistance, as one person's health spending is another person's income. Health care is not all costs; as part of the economy, it also generates jobs and government revenue in the form of income taxes.
- The focus has been on spending without attention to revenue from tax increases. There is an inconsistency in the attitude of the public, who want more and better health services with fewer and lower taxes.
- Improving the quality and quantity of evidence-based decision-making is a huge challenge in terms of systematically devising policies for bending the cost curve. Whereas physicians increasingly practise medicine based on evidence, policymakers and politicians often seem to make decisions based on beliefs.
- One cannot cherry-pick reforms from jurisdictions with different cultural contexts and force them on the Canadian system. As we have witnessed over and over again, grafting quick fixes onto one health care system based on experience in another without contextual adjustments can generate new problems to replace those they were intended to fix.

Reinhardt, a health economist from Princeton University who was studying at the University of Saskatchewan during the physician strike in 1962 and who witnessed the introduction of universal medicare, makes some disconcerting statements. For example, many of us believe that investment in the socioeconomic determinants of health will improve health and, ultimately, reduce the cost of health care.

Reinhardt states, "Focusing on the non-medical-care determinants of health is bound to increase both life-years and the quality of life lived, but it is unlikely to reduce health expenditures, other things being equal. People will live longer and healthier lives, but eventually their bodies will deteriorate and trigger expensive pressure on the health care system."

He adds, "Society faces a huge income-seeking medical-industrial complex that is just as powerful and persuasive as the military-industrial complex; the politically powerful medical-industrial complex will fight hard to protect its claim on the nation's GDP, and even to grow it."

Bending the cost curve in health care is not just about economics. The book offers us, as a society, many topics to reflect on and discuss. Based mostly on facts and little on ideological interpretation, the book digs deep into the historical, cultural, political, and financial aspects of our health system. Depending on what chapter you are reading, your emotions about the future of health care in Canada will fluctuate. One thing comes out clearly: there is no long-term plan for the Canadian health care system and, as long as health care and politics remain intertwined too closely, there is unlikely to be one.

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Canadian health care leaders' perceptions of physician–hospital relations

Part 2 of a report on the Canadian National Study of Interprofessional Relationships between Physicians and Hospital Administrators

by Atefeh Samadi-niya, MD, DHA

Abstract

This second article on the Canadian National Study of Interprofessional Relationships between Physicians and Hospital Administrators (CANSIRPH) focuses on health care leaders' responses to the CANSIRPH questionnaire. Health care leaders at senior levels of management perceive physician–hospital relations to be more collaborative compared with leaders at mid-levels of management. Non-physician leaders also perceive these relations to be more collaborative than physician leaders. Such differences could be the foundation of future planning to increase the satisfaction level of health care leaders toward the quality of physician–hospital relations, improve the quality of patient care, and manage budgets more efficiently.

An overview of physician–hospital relations from 1800 to 2014 in many OECD countries reveals skepticism, optimism, pessimism, and some harsh realism concerning the nature of relations between physicians and hospital administrators and its effects on the quality of patient care, health care costs, decision-making processes, and patients' satisfaction.[1-6] In the 1980s and 90s, the financial instability of health care systems led to increased interest in physician–hospital relations.[7] Recently, researchers have suggested moving from skepticism to engagement as a solution to this problem.[8-12] Lively interprofessional relations between physicians and hospital administrators have many benefits,[13,14] and their importance was the topic of an earlier article.[15] These discussions have shown that a gap exists in Canada's literature concerning the quality of physician–hospital relations, although these relations are crucial to the quality of patient care.[4,5,15,16]

The Canadian National Study of Interprofessional Relationships between Physicians and Hospital Administrators (CANSIRPH) is a quantitative multivariate correlational research study. The term interprofessional relations encompasses physician–hospital relations, physician–health care relations, physician–executive relations, physician–administrator relations, doctor–manager relations, and, recently, physician engagement in leadership. Thus, the term interprofessional relationships between physicians and hospital administrators (IRPH) in this article is used to emphasize the need for relations between physicians and hospital administrators to be interprofessional and interrelated rather than interdisciplinary and separate.[17-19] The acronym CANSIRPH (pronounced can surf) implies that the information gained from this research will help physician leaders and hospital administrators or managers successfully surf the waves of changing health care demands in Canada and beyond. According to the leaders who participated in CANSIRPH, interprofessionality is critical and crucial for physicians and managers as the key to the success of the Canadian health care system.[1]

Purpose of CANSIRPH

The main purpose of CANSIRPH was to determine the perceptions of health care leaders about the quality of IRPH across Canada. A second aim was to discover the factors that influence the professional opinions of health care leaders about IRPH in Canadian hospitals. The third goal was to determine whether and to what degree those factors are correlated with leaders' level of satisfaction with IRPH. Several open-ended questions were also included in the questionnaire to explore suggestions of health care leaders related to various aspects of

IRPH; however, this article focuses on the main purpose of the study: to understand how Canadian health care leaders perceive IRPH in their organizations.

CANSIRPH design

CANSIRPH was similar to studies designed by Shortell,[20] Rundall et al.,[5] and Davies et al.[21] in the United States and United Kingdom. A detailed description of methods and statistical analysis is available elsewhere.[1]

The main business of health care leaders is to provide quality care to patients; thus, some decisions they make might be different from those made by leaders in other industries. Four frameworks that are currently accepted as pertaining to physicians and hospital administrators shaped the design of CANSIRPH: LEADS in a Caring Environment Leadership Framework[22]; CanMEDS[23]; Interprofessional Care Framework[19]; Participative Leadership.[24]

These frameworks guide leadership expectations for health care managers/physician leaders (LEADs), practice/leadership expectations for physicians (CanMEDs), and the expectation that health care leaders will work interprofessionally and collaboratively (Interprofessional Care and Participative Leadership).

Study population

According to the Canadian Healthcare Association, 6000–7000 physicians and non-physicians work as senior and mid-level managers at hospitals across Canada. The study population consisted of Canadian physicians and hospital administrators whose email address appears in Scott's directories[25,26] (2800 mid-to-senior-level health care leaders in 566 hospitals across Canada). In addition, the Canadian College of Health Leaders and the Canadian Society of Physician Executives sent their members a link to the questionnaire with an invitation to participate and to pass the link along to their colleagues. After accounting for duplication and bounced-back messages, in all about 4000 physician leaders and hospital administrators received an email message that included an introductory letter and links to an online consent form and the CANSIRPH questionnaire.

Results

Demographics of questionnaire respondents

To generalize the study results to the total population of health care leaders at mid- to senior levels at acute care hospitals across Canada, a sample of at least 209 respondents was needed; the actual number of respondents was 215.

Half of the CANSIRPH respondents were physician leaders (107) and half were hospital administrators (108). About half were in senior leadership roles (113); the remainder were in mid-level management (102). Physician leaders were from a range of specialties including surgical specialties. There were respondents from all the personal, professional, geographic, organizational, and generational categories included in the CANSIRPH demographic questions.

Less than half of the participants were women (40%). Of the women leaders who responded to CANSIRPH, 66% were at the senior level of management, whereas male leaders were mostly at the mid-level of management (60%). No significant difference was reported for the opinion of leaders toward IRPH based only on their gender. As expected, most participants were 40–70 years old; half were 50–60 years old and only 5% were under 40 years old.

About 40% of the participants were senior-level hospital administrators, 10% were mid-level administrators (managers), 10% were senior-level physician leaders, and 40% were mid-level physician leaders. These differences imply that senior hospital administrators and mid-level physician leaders may be those most interested in physician–hospital relations.

The participants represented all types of acute care hospitals and health care centres across Canada, although most were at teaching and community hospitals; about 50% of the hospitals were teaching hospitals and 30% were community hospitals. The participants worked in mixed, private, and religious hospitals. About 54% of participants were from large urban areas, 30% from small urban areas, 8% from rural towns, and 4% from suburban areas. Remote and isolated hospitals were also represented.

Analysis of the data

The following is a brief summary of the results (Table 1). Please see Samadi-niya (2013)[1] for a full analysis and details.

Table 1. Summary of research questions regarding health care leaders' perceptions of interprofessional relations between physicians and hospital administrators (IRPH)[1]

*** How do *physician leaders and hospital administrators* across Canada perceive IRPH?**
More physician leaders and hospital administrators across Canada perceive IRPH as excellent or very good than those who considered them to be below average or poor.

*** How do *physician leaders* across Canada perceive IRPH?**
Significantly more physician leaders perceived IRPH to be below average or poor compared with those who thought them excellent or very good.

*** How do *hospital administrators* across Canada perceive IRPH?**
Significantly more hospital administrators perceived IRPH as excellent or very good than those who considered them to be below average or poor.

*** How do the opinions of *physician leaders differ from those of hospital administrators* about IRPH?**
Physician leaders are less optimistic than hospital administrators about IRPH across Canadian hospitals.

*** How do the opinions of *mid-level management* differ from the senior-level management about IRPH?**
Mid-level managers are less optimistic than senior-level managers about IRPH across Canadian hospitals.

*** How do the opinions of mid-level physician leaders, mid-level hospital administrators, senior-level physician leaders, and senior-level hospital administrators differ about IRPH?**
There are meaningful differences in the opinions of leaders toward quality of IRPH. Opinions toward IRPH across Canada, from most optimistic to least optimistic: senior administrators, mid-level administrators, senior-level physician administrators,mid-level physician leaders (Figure 1).

Table 2 shows the overall level of satisfaction of nine categories of leaders whose results were included in more advanced statistical analyses.[1] Overall, a higher proportion of all participants considered IRPH to be excellent or very good compared with those who believed them to be below average or poor. This was also the case for hospital administrators. The reverse was true for physician leaders; indeed, more considered IRPH to be non-collaborative as compared to those who felt the relationship to be excellent or above average.

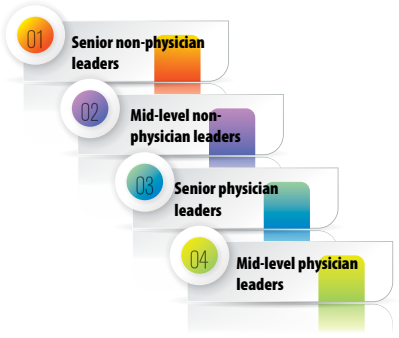
More senior-level leaders believed IRPH to be collaborative than their colleagues in mid-level management and the perception of non-physician leaders about the quality of IRPH was more optimistic than that of physician leaders.

Looking at all four groups — mid- and senior-level physician leaders and non-physician leaders — the data show that the group most optimistic about IRPH was senior-level hospital administrators followed by mid-level administrators and senior-level physician leaders. Mid-level physician leaders were least satisfied with the quality of IRPH (Table 2 and Figure 1).

Table 2. Interprofessional relations between physicians and hospital administrators as perceived by physician and non-physician leaders at senior and mid-levels of management in Canadian hospitals

Respondent group	Level of satisfaction with interprofessional relations, no. (%)					
	Excellent	Very good	Average	Below average	Poor	*n**
All participants	21 (10)	73 (34)	76 (36)	28 (13)	16 (7)	214
Physician leaders	5 (5)	26 (24)	41 (38)	26 (24)	9 (9)	107
Hospital administrators	14 (13)	48 (45)	36 (34)	8 (7)	1 (1)	107
Mid-level managers	1 (1)	34 (33)	39 (38)	22 (22)	6 (6)	102
Senior-level managers	17 (15)	45 (40)	35 (31)	11 (10)	4 (4)	112
Senior-level physicians	4 (15)	7 (27)	8 (31)	4 (15)	3 (12)	26
Mid-level physicians	1 (1)	19 (23)	33 (41)	22 (27)	6 (7)	81
Senior-level administrators	13 (15)	37 (44)	27 (32)	7 (8)	1 (1)	86
Mid-level administrators	0 (0)	15 (71)	6 (29)	0 (0)	0 (0)	21

Figure 1. Differences in perception of the quality of interprofessional relations between physicians and hospital administrators and their level of leadership based on CANSIRPH results. Numbers indicate gradient from most (1) to least (4) satisfied.



Discussion

Canada and other members of the OECD have witnessed a rise in the scientific–bureaucratic model of health care delivery, in which evidence-based medicine or evidence-based decision-making have replaced the traditional practice of medicine. In the scientific–bureaucratic model of health care delivery, the processes used by management may interfere with physicians' motivation and personal judgement.[27] Physicians must follow management dictates in caring for patients, despite the fact that they view themselves as independent, trustworthy, and knowledgeable professionals.

Administrators usually believe that medical and other staff members are highly satisfied with hospitals.[1,21] Although hospital administrators are aware of the importance of the role physicians play in allocation of their hospital resources,[4] they may sometimes forget to include physicians in the decision-making process and create a more collaborative environment

in which physicians feel sufficiently considered in decisions that affect their workplace.[28] Physicians usually want more input regarding "strategic decision-making and hospital operation."[29] The literature reveals discontent among physicians, which could be due, in part, to lack of satisfaction with physician–administrator relations.[30] Managers' interference with the professional autonomy of physicians and a lack of trust in the decision-making of managers has been causing professional unhappiness among both physicians and managers.[31] Reviewing historical events that led to the current situation helps us understand the challenges that physicians and administrators perceive in the 21st century health care system.[7,32] Hospitals faced with deficits often hire a new president or CEO to balance their budget, but they may not realize that IRPH are crucial to hospital performance.[33] Hospitals with better and more organized physician–hospital relations have less or no budget deficit.[34] Pairing medicine and management is necessary, not only for high-quality patient care, but also for managing the budget of the health care system, including hospitals.

The role of physician leaders has become difficult as they attempt to cut services and shorten lengths of stay for patients who need adequate resources for their medical care.[35] Researchers have acknowledged the difficult role of physician leaders, whose colleagues may view them as betrayers and collaborators with hospital administrators.[36] Periods of silence among physicians are alarming rather than reassuring, because indifference is a potent action.[36] More important, physician leaders may not receive payment for their managerial activities or their involvement in hospital administration.

Deciding on goals, measuring progress toward them, and sharing information regarding the results with other health care disciplines are key factors in a shared quality agenda.[37] As the biggest players in quality of care, physicians often receive the credit, control most of the costs in health care, and do not share any financial risks with hospitals.[38] Success in quality of care is equal to success in IRPH.[16,39-41] Thus, the success of a quality system depends on physicians' active and continuous involvement.[42]

At the Healthcare Financial Management Association Executive Roundtable in October 2010, executives and industry experts shared their ideas and specified that the only group of professionals who could define quality, control costs, and reduce redundancy is physicians.[43] Their findings indicated that physicians prefer simple straightforward reports, and they want to see the raw data on which reports are based. In addition, involving physicians in the process from the beginning and providing updates increases the likelihood of their acceptance of an initiative.

Remaining indifferent or not deciding to improve IRPH is an action. Indifference can negatively affect patient care.[16,44] A survey of members of the American College of Physician Executives found that lack of trust is one of the main issues affecting the development of collaborative IRPH.[45] Physicians involved in hospital management and leadership roles need special skill sets and managerial knowledge.[46,47] Engagement of clinical directors in hospital management is an opportunity to engage physicians in the decisions that affect their daily work. Use of CANSIRPH results could enable hospital administrators and physicians to establish national guidelines to improve IRPH and, as a result, increase the quality of patient care and patient safety in all Canadian provinces.

Some stereotypical images held by physician and hospital administrators affect IRPH.[48] Both groups consider the other to be more powerful and to have different goals.[48] Health care leaders ought to refute incorrect stereotypes and replace them with appropriate views of the other group.[49,50] After all, in a governance plan for Canada's health care system, collaboration among medical staff, senior leadership teams, and board members seemed necessary.[39] Many hospitals and health care centres claim that using teams made up of a physician leader and a non-physician leader has helped their organizations.[1,51-55]

Conclusion

Participants in CANSIRPH emphasized that IRPH are the key to the success of Canada's health care system. Improving IRPH means quality improvement or, in fact, "quality investment." IRPH and quality improvement mean patient satisfaction, patient care improvement, error reduction, employee and physician satisfaction, better interprofessional relations (not only with managers but also with other health care professionals), budget management, debt reduction for hospitals, and a sense of institutional pride.

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A new name

Canadian Society of Physician Leaders

During the Annual General Meeting of the Canadian Society of Physician Executives, members unanimously endorsed the board's proposal to change the organization's name to Canadian Society of Physician Leaders (CSPL). The name change is justified because the scope of the society has broadened since its inception, from supporting physician executives specifically to serving physician leaders overall. The Canadian Certified Physician Executive (CCPE) designation remains unchanged, as do the requirements to qualify for this credential.

The name change is intended to signal that the society is open not only to physician executives, but also to any physician who has an interest in leadership, who is planning to take on a leadership position, or who is fulfilling a leadership role. Organizations, such as Kaiser Permanente and the Mayo Clinic, state that every physician is a leader; the CSPL is the go-to organization for every physician in Canada who is looking for information and resources on physician leadership.

Benefits of membership in the CSPL include: the CCPE program, the Canadian Journal of Physician Leadership, an e-newsletter, our job opportunities listserv, the organizational website representing the voice of the Canadian physician leader, access to Leadership Bytes (CHLNet), and reduced registration rates or discounts for the annual Canadian Conference on Physician Leadership, pre-conference Physician Leadership Institute courses, Crucial Conversations and Crucial Accountability courses, courses and publications of the American Association of Physician Leadership, McGraw-Hill leadership books, and more.

Although the name of the society is changing, our values and mission remain unchanged:

Tagline: Inspiring physician leadership
Vision: To be the go-to organization for physician leaders
Mission: To develop and support physician leaders to be successful in health care leadership and management roles
Objective: To support physicians in their roles as physician leaders by providing:

- fora for education and networking
- leadership development and recognition
- tools to help our members grow and succeed

CSPL
Canadian Society of Physician Leaders

SCLM
Société canadienne des leaders médicaux