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**CSPL** Canadian Society of Physician Leaders

**SCLM** Société canadienne des leaders médicaux

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# Has regionalization of the Canadian health system contributed to better health?

Johny Van Aerde, MD, PhD

## Abstract

When the concept of regionalization was introduced, there was at best only anecdotal evidence that it would bring improvement. Two decades later, evidence of its efficacy or efficiency is still very limited. This paper addresses the history and relevant background of health care regionalization in Canada, explores real and perceived evidence that it has made health better or worse, and ends with basic principles from leadership and systems theories necessary for transforming our health care systems.

It is difficult to find a consensus definition of regionalization.[1] In Canada, the meaning comes close to the integrated organization of health care resources and the delivery of risk-appropriate care to the total population within a geographically defined area to achieve the best outcomes in the most cost-efficient manner.

In 2004, one decade into regionalization, Lewis and Kouri[1] wrote, "The universal theme in Canadian regionalization may well be instability," and that statement still applies today.[2-5] Currently, politicians and the public are so dissatisfied with health care outcomes that several provinces, such as Nova Scotia, Prince Edward Island, and Quebec, are gambling on going even further with regionalization and centralization, despite the lack of evidence and the near chaos it caused in Alberta.[6] International experience indicates that lack of baseline measurements often result in "positive hindsight bias" to justify changes that were made before.[7]

Besides "politics" and the wish to curtail costs, there was no clear vision or direction behind regionalization when it was first implemented.[3,4,6,8] Over time, the purpose evolved: to create a better continuum of care through integration and better coordination of services, and to reallocate resources from acute to primary care, as well as to public health and prevention.

Little was done to include the non-medical and socioeconomic factors that determine health. Input into the regionalization process by the public and physicians, both important drivers of health care consumption and health outcomes, was also limited. Regionalization does not appear to have resulted in greater input or democratic accountability, as boards were abolished or became political extensions of governments.[9] Despite the variety of regionalization models and timeframes across Canada (Table 1), no comparative studies across regions or provinces exist.

## Evidence connecting regionalization and health outcomes

Three types of documents provide different lenses on the evidence: regular reports on health and financial indicators, opinion papers (of which there are many), and a recent qualitative report commissioned by the Canadian Foundation for Healthcare Improvement (CFHI).[9]

In 2013, the Health Council of Canada reported that hospital care rather than health continues to dominate the health care scene.[10] The same report indicates that none of the changes made during the last decade of regionalization has transformed the health system and

## Table 1. Snapshot of regionalization in Canada

Northwest Territories

Yukon

1997
8
8

Nunavut

Newfoundland and Labrador

British Columbia

Alberta

Saskatchewan

52
1997
5

17
1994
1

32
1992
13

1994
6
4

Manitoba

12
1997
5

Quebec

1989
18
18

Ontario

14
2005
14

Prince Edward Island

1993
6
1

Nova Scotia

New Brunswick

1996
4
1

1992
8
2

🔴 Year regionalization initiated

🟢 No. of regions in first year

🟣 No. of regions in 2015
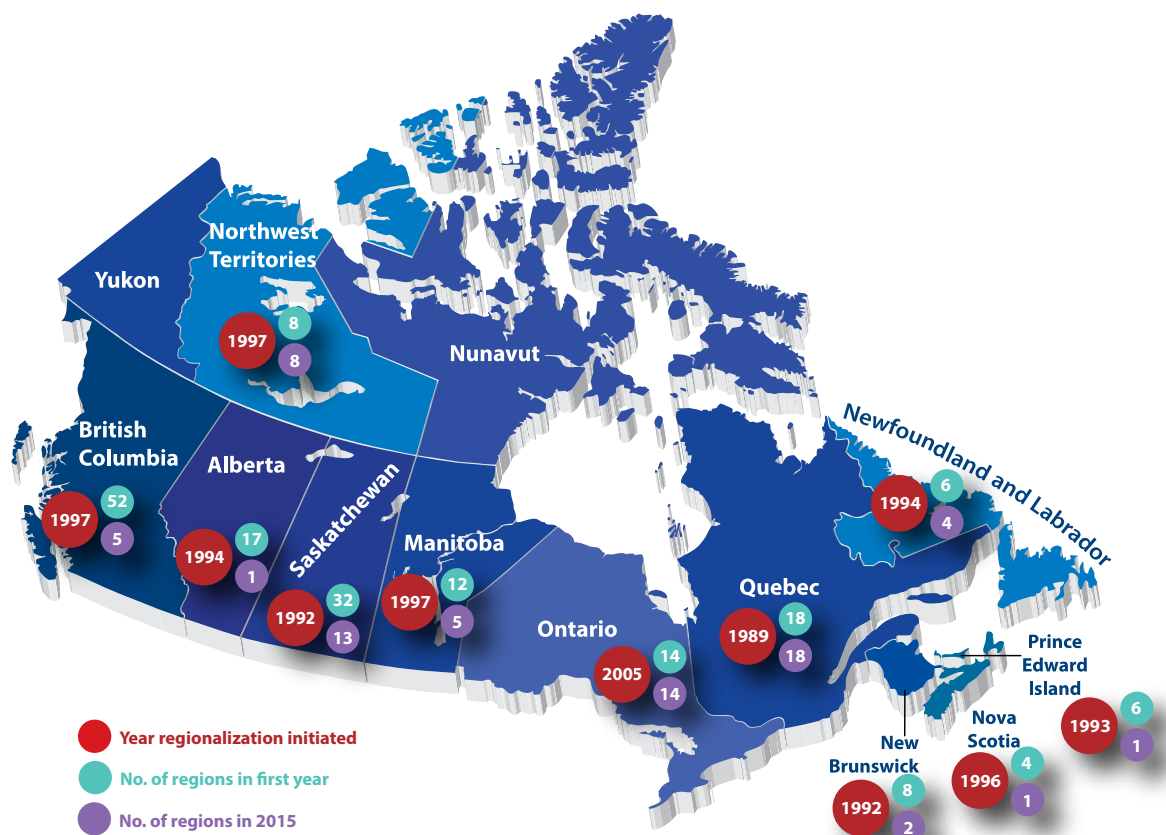
that the health of Canadians has improved only marginally.

Although some health indicators show improvements since the introduction of regionalization, others have not. For example, improvements include a decrease in the prevalence of smoking (from 24.5% to 17.5% between 1995 and 2009) and cardiovascular disease (from 938 to 792 per 100 000 between 1995 and 2004).[11] However, during the same period, there was no reduction in lung and airways cancers or chronic respiratory diseases,[11] the prevalence of hypertension increased from 12.5% to 19.4%,[12] and obesity steadily increased in all provinces, affecting one in five Canadians.[11] In terms of prevention,

measles vaccination rates have decreased from 96% to 89% and those for diphtheria/tetanus/pertussis from 87% to 77% since regionalization.[11,13]

In short, keeping in mind that health indicators are influenced by many factors, some have improved and some have deteriorated since regionalization.[14] Although some people argue that health has improved and others submit that it is worse, the truth is that we don't know whether regionalization has made any difference to the health of Canadians.

Using wait time for medically necessary treatment as an indicator of efficacy and efficiency does not support the value of regionalization

either. The wait from referral by a primary care physician to treatment has doubled since the introduction of regionalization: from a mean of 9.3 weeks in 1993 to 18.3 weeks in 2015.[15]

If regionalization and super-centralization can improve wait times, then how does one reconcile the fact that Alberta, with the most experience in restructuring, has wait times 40% higher than the national average, while Ontario, which was the last province to introduce regionalization, is below the national average?[15,16] Saskatchewan's success in reducing wait times for surgery provides evidence that systemic change can be achieved when all stakeholders participate (providers, patients,

and government officials),[14] an approach more inclusive than many regionalization processes. Similarly, Ontario's numbers might be explained by the way the local health integration networks and interorganizational networks engaged more stakeholders to decrease wait times and improve health outcomes.[13,14,17,18] Although evidence does not exist, one could argue that without regionalization, wait times might have been worse because the pressure on health services has also increased over the last 20 years.

Perhaps the most complete document on the value of regionalization is the report by the CFHI,[9] which is based on interviews with 30 senior Canadian leaders in health care and backed by a review of the international literature. This mainly qualitative study confirms that there were no clearly defined objectives for the regionalization process, except for cost savings and consolidation of fragmented services across a continuum of care. Health outcomes were expected to improve as the focus of the system shifted upstream, mainly to primary care.

The report[9] also confirms the lack of literature on the association between regionalization and better health, which was a major impetus for the study. Study participants agreed that regionalization had impacts beyond the original goals. They described the increased focus on public health, which, however, did not necessarily lead to better outcomes.[9] The authors argue that regionalization boosted evidence-based decision-making with resulting improvements in quality of

care, but that too is not confirmed by evidence.

The study does show that regionalization reduced fragmentation and duplication and increased partnerships.[9,19] It also increased the ability of the system to respond strategically and quickly during a crisis.[1,19] Regionalization facilitated the development of clinical networks.[19]

Although system fragmentation persists despite regionalization,[20,21] there are positive examples of collaborative integration and innovation, such as the Strategic Clinical Networks in Alberta and the regional Division of Family Practice in British Columbia.[9] In some provinces, intersectorial action for health was probably also facilitated by regionalization, resulting in partnerships among police, the education sector, and community services.[9]

Although fiscal control was an original purpose and has remained the main goal of regionalization, few examples of clear causality between decreased costs and the creation of regional structures exist.[9] There are isolated reports of cost savings in the areas of management and administration and for negotiated cost of drugs for institutional use.[22] Some regions have reported savings by shifting from fee-for-service to other modes of physician remuneration in primary care. However, participants in the CFHI study[9] believed that overall cost savings could not be attributed to regionalization. For example, Alberta, the province with the largest number of regionalization events and one

provincial system since 2008, still has the second highest provincial health care cost per citizen — and no proof of better outcomes.[3,4,23]

One reason why regionalization may not be achieving its desired goals is that at least two stakeholders remain missing from the process: citizens and physicians.[1,9] Regionalization has led to the loss of citizen engagement in governance and in local ownership of the health care system, despite the fact that the literature supports such engagement in health reform. The medical profession was also ignored in the regionalization process and, often, in subsequent attempts to bring about changes commensurate with the goals of regionalization. Both a literature review and the CFHI study show that integration of physicians or physician budgets was never an objective of regionalization. This has led the medical profession to disengage from regionalized structures, further limiting the accomplishments of regionalization.[1,9,20]

## What can we learn from leadership and systems theories?

Because health regions often behave as complex adaptive systems, the fundamental principles of leadership and systems theories should be applied to make regionalization work. The LEADS framework was developed with that perspective in mind. It has been accepted by many provincial and national health agencies, such as the Canadian Medical Association

and the Canadian Society of Physician Leaders, as the framework for leadership in a caring environment,[24,25] and it has been cited as the potential foundation for leadership development needs within the Canadian health system.[24]

For example, how could the four capabilities in the "Achieve results" domain have been used in regionalization? Those four capabilities are: set direction; strategically align decisions with vision, values and evidence; take action to implement decisions; and assess and evaluate.[25]

Realignment of the health care system requires a strategic and integrative vision, and goal setting is critical to align activities across the system.[26] The direction for regionalization was set, and is still being set, by the provincial governments, while the regional health authorities have a separate responsibility for the execution. The Jönköping experience indicates that, together, government bodies, organizations, and clinical teams can set consistent and clear directions and achieve high performance.[27] In Canada, not only has the vision and the direction of regionalization been skewed toward acute care and finances,[26] but the background landscapes have also changed too frequently to see any effect of those changes. As a result, the first capability has not been adhered to.

Because the direction is unclear or changed, the second capability, "align decisions with vision" cannot be accomplished; this shows why fragmentation of the system has

been perpetuated. The vision for Canada's health system, and the link to regionalization, may well have to be redefined from the bottom up, as the 50 year old definition of medicare appears to be outdated, and a new one has never been developed. As André Picard asked, in reference to Canadians' expectations of their health care system, "What are we trying to achieve?"[28]

As governments struggle with budget deficits again, the direction is changing once more. A decision to go with further centralization may or may not be consistent with that vision: it certainly is not consistent with the evidence to this point.[6] Without that evidence, and without knowing the other goals of our collective investment in health care, it is difficult to see how monetary responsibility aligns with our "patient-centred" vision of health and with our Canadian values as they relate to our health system.

"Take action to implement decisions," the third capability, can only reflect the skewed input of undefined or poorly defined direction and strategic plans as indicated in several recent reports.[9,25,26]

Finally, and perhaps most important, learning cannot take place without measurement. Even if goals are not clearly defined, baseline measures must be recorded and compared over time.[29] Canada missed a unique opportunity to make intra- and interprovincial comparisons of the various models and timeframes of regionalization (Table 1). In short, if the principles of the domain

"Achieve results" had been adhered to, we might have created a better chance to evaluate whether regionalization of the Canadian health system has resulted in better or worse outcomes.

Elsewhere, organizations that adhered to these principles rigorously provide examples of some of the best outcomes in the world.[26,30] These and other organizations also adhered to the "Systems transformation" part of the LEADS framework.[25] Systems thinking starts with including all stakeholders and elements of the system in the vision, planning, and execution of the change.[25,27,30,31] As regionalization is imposed on a complex adaptive system, some very basic questions underlying the principles of systems thinking need to be asked, beginning with defining the characteristics of the system: What stakeholders and elements need to be in the room and how do they have to be arranged?[32,33]

At least three groups of stakeholders were missing and remain missing in the attempt to make regionalization work: health care professionals in general and physicians specifically, citizens in general and patients specifically, and researchers and policymakers. First, it is well known that physicians influence the performance of the health system, including outcomes and costs, and they remain one of the main obstacles to reform.[3] As long as physicians are not invited to be part of regionalization and health system reform, systemic and transformational changes cannot occur.[2,3,9,20,26] Examples of successes in this respect, such as Virginia Mason, Cleveland

Clinic, Intermountain Health, and Kaiser Permanente, are widely published.[20,27,30,31,34]

Second, because expectations of citizens in general, and of patients specifically, also drive part of the cost and outcomes, those stakeholders have to be closely engaged in design and implementation for real transformation to occur.[9,20,27] By doing this, the Cleveland Clinic has become one of the most successful organizations in the world as demonstrated by their health outcomes and scores on patient experience.[35]

Third, the research community has been overlooked too often in decision-making. Strategies to maintain closer connections among the research community, health policymakers, politicians, and ministries, as well as with providers and consumers, would likely have produced demonstrable results. It is not too late to start building those relationships, as has been suggested in several reports.[5,20,26]

Many more elements than the provision of acute and primary care determine health and, therefore, have to be considered to make regionalization work. Socioeconomic factors, public health care, protective interventions, and prevention were not included in the initial regionalization models.[36,37]

A recent comparative study,[38] the first of its kind in Canada, measured the efficiency of regions in producing health gains and the factors associated with increased efficiency. The results were not surprising: outcomes were not affected by the main targets of regionalization, i.e., acute and specialized care. Instead, obesity, smoking, income, and inter-regional variations in hospital readmissions were the most important influencing factors, indicating that investment in primary care, public health, and non-medical factors is most likely to improve outcomes of treatable conditions.

Whereas factors such as drug costs and coverage and integrated information systems have been missing, the largest element needed to make systemic reform possible has been the socioeconomic aspects of health.[9,20]

With so many stakeholders and elements missing, health system transformation cannot occur, and we must ask ourselves whether real, systemic regionalization ever took place.

## What type of leadership is needed for systemic reform?

The challenge of creating large-scale change, such as regionalization, requires levels of strategic and systems thinking and leadership development and self-leadership that supersede the capacity of many formal leaders, including physicians, who have been conditioned to approach regionalization from the perspective of expert-knowledge-based systems only (i.e., mechanical systems).[22,35] The real leadership challenge, particularly for physicians, is finding an appropriate balance between responsibility, identity, loyalty, commitment, and values at the level of the individual provider, the profession, and the organization on one side, and those same factors at the level of the health care system on the other side.[39] What Marchildon calls "the central leadership conundrum in complex systems" is how to manage those inherent tensions between the singular professional identity and the larger systemic identity.[39] This tension can lead to demoralization and disengagement of our profession from the system, while, at the same time, physicians are expected to demonstrate servant-leadership.

After 20 years, we don't know whether regionalization has resulted in better health, better health care, or better value for Canadians. Data are limited, there is no information system to support and integrate what should be measured, and the already unclear set of goals changes too frequently. From a systems perspective, many stakeholders and elements that are essential for the transformation of the health care system are missing. If physicians want to be engaged in real transformation of all the systems that affect health, health care, and its value, then do we, as a profession, have the courage to take up the gauntlet of that leadership role?

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# Part-time practice, full-time safety for physician leaders

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## Abstract

Physicians who accept leadership responsibilities and activities may choose to limit their clinical work. By paying close attention to how they arrange their practice to meet their responsibilities in areas such as coverage, handovers of care, referrals, and follow up on test results, physicians can minimize risks and provide effective care to patients. Physicians also have a responsibility to maintain a commitment to professional development to ensure quality and safety of care.

**KEY WORDS:** part-time medical practice, obligations, patient coverage, referrals, handovers, transfer of care, competence, test results

Physicians generally work more than the typical 35–40 hour week, and many work well beyond that. However, some physicians limit their clinical work to accommodate other responsibilities, including leadership roles. Many physician leaders who blend their administrative responsibilities with their clinical practice feel that there is value in participating on both sides of the health care equation and helping to close the divide between clinicians and administration.[1] Whether scaling back on clinical hours to lead an entire clinical department or service or to participate on committees or organizational projects, reduced clinical workload does not diminish the obligation to provide safe patient care.
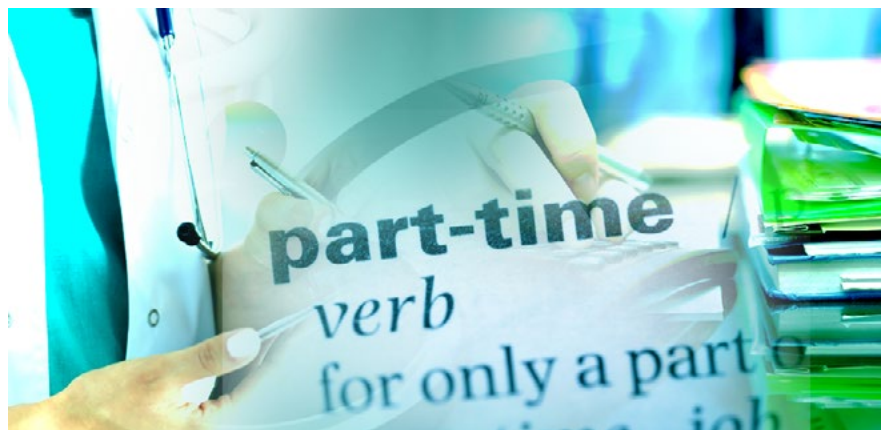


## Practice arrangements

Part-time clinical work can translate into a reduced work day or week; shift restrictions (only days or only nights); weekend hours or alternate weekend coverage; or job sharing with another physician. On one hand, physician leaders, who practise in a broad specialty but only see patients with certain specific, non-acute illnesses, may find it fairly manageable to limit

their clinical work. On the other hand, physician leaders working in a surgery subspecialty may find that the difficulties of complex operations or treatments make part-time practice less likely. Shift-oriented settings, such as emergency rooms, may lend themselves to reduced hours for physicians. Large group practices may be more amenable to reduced hours than small practices because coverage by other physicians may be more easily accessible.

## Coverage

Physician leaders seeking to limit their clinical workload will want to determine what after-hours coverage is most appropriate for their practice and patients, and

make the necessary arrangements. Some medical regulatory authorities (colleges) outline what coverage is expected of physicians and physicians' obligations to arrange after-hours, weekend, and holiday coverage for their patients. For instance, the College of Physicians and Surgeons of British Columbia expects physicians to make specific arrangements to transfer the care of a patient, whether it is to a physician working in a nearby

emergency department or another practitioner in private practice.[3] As the requirements will vary from province to province, physicians should check with their college.

Hospital-based physician leaders providing clinical care on just a day or so per week will have different coverage needs than those providing clinical care part-time in clinics or office-based practices. Some leaders may have off-hour coverage arrangements built into the practice model, while others may not. Where applicable, physician leaders with set clinical hours may inform their patients about their schedule and how to obtain care in their absence.

## Handovers and transfers

Anytime the responsibility for a patient's care is handed over or transferred from one provider to another, there is a risk that essential clinical information may be missed or will "fall between the cracks." When physician leaders work limited hours, the number of patient handovers may increase.

To combat risks to patient safety, physicians providing clinical care on a part-time basis will want to be particularly vigilant about developing good communication and documentation habits. Relevant patient information must be available to any physicians providing coverage and to members of the health care team involved in the patient's care.

Physicians should also be aware of possible barriers to an effective handover and consider how to avoid them. Ensuring that the

medical record includes all relevant information is essential, particularly regarding tests, medications, and the professional responsible for follow-up care.

**Hospital-based physician leaders providing clinical care on just a day or so per week will have different coverage needs than those providing clinical care part-time in clinics or office-based practices.**

To further strengthen continuity of care, physicians may consider whether it is appropriate to involve the patient (and with the patient's permission, the family) directly in the handover process. This approach informs the patient that there is a change to a new team or most-responsible physician, allows for clarification of the patient's history and correction of any misinformation, and provides an opportunity to address questions or concerns.

## Referrals

Doctors working a reduced number of clinical hours and involved in a referral, either as the referring physician or the consultant, have the same responsibilities toward a patient as a full-time practitioner. They should respond in a timely fashion when a referral is initiated, and they must be vigilant when a patient needs an urgent referral.

Physicians with a reduced clinical workload must consider how they can arrange their practice to meet their patients' referral

needs. Providing complete and clear information in the referral or consultation report is the first step. Further, physicians providing clinical care on a part-time basis should ensure that the other health care provider participating in the referral knows their working hours, who is providing coverage during any absences, and how the replacement can be contacted, particularly in an emergency.

Other health care team members should also be informed when a referral is urgent and given instructions on how to contact the physician or the doctor providing coverage.

Finally, giving patients information about the referral may help keep the process on track. Patients may be told why the referral is being made, whether there is any urgency, and what they should expect to happen next. If the referral is not proceeding as explained, patients should be told whom to contact for assistance.

## Managing test results

Irrespective of their clinical workload, physicians who order tests or investigations are expected to follow up on the results in a timely manner. This can prove more challenging for physician leaders with clinical hours that are intermittent.

Physicians will want to determine, in advance, how they will follow up on results. They may begin by considering what a timely response to test results means for their type of practice. When the patient population is vulnerable to

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rapid changes in clinical condition and the work schedule creates significant lag times, a mechanism for timely follow up of results is important. Would a "buddy system" be effective, where test results are checked by a colleague in the physician's absence? Or would it be necessary to check in regularly in person to retrieve and review test results? Could the covering physician review test results?

After determining how they will handle test results in their practice, physicians with part-time clinical hours should decide how they can communicate that information clearly and in a timely manner to their patients and families, as well as to the other doctors, health professionals, and support staff involved in their patients' care.

## Clinical competence

Depending on the number of hours worked and the extent of engagement in continuing medical education, physicians who limit their clinical working hours may find it more challenging to maintain clinical skills in some aspects of

their practice. Physicians with reduced clinical work have the same responsibility as full-time physicians — to practise in clinical areas in which they are competent. With fewer opportunities to practise certain skills, physicians will want to think about the skills they want to retain or develop and the kind of clinical work that would allow them to achieve this.

Physicians working in both clinical and leadership capacities may need to focus on the most convenient and efficient continuing medical education delivery options, which may include online education, self-study courses, participating in communities of practice, and leveraging preferred social networks for doctors.

## Medical–legal protection

The Canadian Medical Protective Association (CMPA) recognizes that physician involvement in leadership activities is valuable, and members remain eligible for medical-liability protection for their clinical work. In addition to CMPA protection, physicians who are

employed by a hospital, clinic, or regional health authority should ensure that their employer provides adequate professional liability protection in the event of medical-liability difficulties arising from the application of organizational or business policies or procedures.[4]

Physicians who do not provide clinical care or patient advice but instead work in an administrative capacity related to health care should consider retaining their CMPA membership under the administrative medicine work category.

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# Balancing patient satisfaction and quality of care

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## Abstract

Although measures of patient satisfaction contribute valuable feedback, they do not represent the complete picture. Use of a more balanced scorecard — including accessibility, continuity of service, effectiveness, and appropriateness, for example — to plan, manage, and monitor health care activities and performance will yield more useful information to assist in continuous improvement in health care.

**KEY WORDS:** patient satisfaction, outcome measure, balanced scorecard, continuous improvement, quality of care, quality improvement, healthcare, Choosing Wisely

Since the 1980s, patient satisfaction has been recognized as a critical outcome measure of the quality of health services.[1] A strong case was made for including patient satisfaction in quality assurance programs, including ethical issues, philosophical changes in the health care field, and clearly defining the impact of patient satisfaction on quality of care.[2]

## The value of patient satisfaction data

There is no doubt that patient satisfaction surveys are important in shaping health care delivery, as they offer important and timely feedback from patients themselves and the ability of health care providers and administrators to see care through patients' eyes.[3] Survey results have been used for benchmarking and quality improvement,[4] and to enable accountability.[5] In the United States, patient satisfaction scores have been incorporated into pay-for-performance agreements.[6] In 2012, the Centers for Medicare and Medicaid Services finalized details of a new reimbursement method that adjusts payments based on patient satisfaction scores. Enhancing meaningful patient engagement and improving our understanding of the patient experience will assist ongoing continuous improvement efforts to provide quality patient care. In addition to patient surveys, we see positive results from asking more open-ended questions and holding patient focus groups,[7] forming patient and family advisory councils,[8] and including the patient voice in hospital and medical organization committees to redesign care.[9] Bate and colleagues[10] proposed a comprehensive continuum of patient involvement in health care improvement in a range of activities: complaining, giving information, listening and responding, consulting and advising, experience-based co-designing.

## Rising concerns about patient satisfaction as the ultimate metric of quality care

Yet, my discussions with medical colleagues across North America consistently reveal concerns about using patient satisfaction ratings as a marker of quality of care. In the emergency department, patients who come in seeking antibiotics for their sore throat will not be easily satisfied with an explanation of why this is not indicated. Patients who smoke do not feel satisfaction when their family doctor tells them, yet again, that they should consider quitting smoking. In hospitals in communities with high drug use, refusing to prescribe narcotics at a patient's request does not lead to satisfaction.

Some of my colleagues in psychiatry tell me they could not work if they focused primarily on creating satisfied patients. "When I

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have to restrain a patient, or tell him that I cannot prescribe more pain medications, or tell an older man he can no longer drive, or admit someone involuntarily, I usually do not have a satisfied patient. I am consoled by reminding myself that I did the right thing."

It is not just a few individuals with such concerns. The idea that we may need to re-evaluate patient satisfaction as the main metric of health care quality is growing. The Canadian Foundation for Healthcare Improvement published a "Mythbusters" article to debunk the common misconception that high patient satisfaction means high quality care.[11]

Researchers at Johns Hopkins University School of Medicine[12,13] found no link between patient satisfaction scores and surgical care quality scores. Of interest, they did find a correlation between patient satisfaction scores and employees' feelings about teamwork and the safety climate in their hospital, suggesting "improvement of workplace culture"

as a potential area of focus. Overemphasis on patient satisfaction may lead to harm. Many physicians tell me that they feel that they would have to cater to "patients' wants, not their needs," in attempts to keep them satisfied, and have expressed concerns that patients may be harmed unknowingly. Patients would receive unnecessary testing when requested, be prescribed specific drugs they may not need, not receive health counseling they require simply because it may upset them, or not realize how serious their situation is in an attempt to avoid telling them bad news.

An article in *The Atlantic*[14] discusses how health care is now focused on "making people happy, rather than making them well... [on] smiles over substance." It suggests that "by attempting to satisfy patients, healthcare providers unintentionally might not be looking out for their best interests."

Researchers at UC Davis conducted the first national study that showed that an overemphasis

on patient satisfaction can actually lead to unanticipated adverse effects.[15,16] They found that people who are the most satisfied with their doctors are more likely to be admitted to hospital, and accumulate more health care and drug expenditures than patients who are less satisfied with their care. Satisfied patients also had higher death rates: For every 100 people in the least satisfied group who died over an average period of nearly 4 years, about 126 people in the most satisfied group died, despite the fact that the more satisfied patients had better average physical and mental health status at baseline. Although no definitive cause and effect relationship could be inferred, the higher death rates were not because these patients were more ill. Although many studies have found higher patient satisfaction associated with favourable outcomes,[17,18] this remains a cautionary reminder of the old adage that "more is not better."

## Looking ahead

Measures of patient satisfaction and experience remain useful and contribute valuable feedback on how we can continue to improve quality of health care. Yet, on their own, they do not represent the complete picture.

Use of a balanced scorecard to strategically plan, manage, and monitor health care activities and performance and identify and track more metrics than just patient satisfaction and patient experience will yield more useful information to assist in continuous improvement in health care. Other dimensions that

**The Choosing Wisely initiative has helped to create and advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures in both Canada[20] and the United States.[21]**

can be tracked include population focus, accessibility, safety, continuity of services, effectiveness, efficiency, and appropriateness.[19] These can be selected to best meet the needs of a specific health care organization. Once developed, these metrics require careful and regular tracking and reporting. Even if pay-for-performance exists, all of the metrics on the balanced scorecard are assessed and incorporated into such agreements.

The Choosing Wisely initiative has helped to create and advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures in both Canada[20] and the United States.[21] Informed by the evidence-based recommendations of more than 70 specialty society partners, recommendations have been released to facilitate wise decisions about the most appropriate care based on a patient's individual situation.

Such recommendations would be incorporated into deciding what care is safe, effective, efficient, and appropriate. Ideally, the Choosing Wisely lists can be used effectively by health care providers to explain to the patients why they may not receive the care, tests, or medications they want, as well as in more effectively balancing patient satisfaction ratings with quality of care received.

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# OPINION Advocacy in one's own practice: appropriateness in ordering investigations and management decisions

**Kathryn Andrusky, MD**

Physicians must be advocates within their own practice, ensuring that appropriate investigations and management decisions are made with consideration, not complacency. Inappropriate ordering may lead to patient harm via anxiety and unnecessary further investigations. Both the clinical context and the "why" to justify the actions taken need to be at the forefront of a physician's decision-making processes.

**KEY WORDS:** appropriateness, advocacy, clinical guidelines, Choosing Wisely

The phrase "physician advocacy" conjures many images: It could mean lobbying on behalf of one's own patients to obtain a certain test, medication, or procedure; for fair compensation of physician colleagues; for comprehensive and team-based care; or for system changes to improve transitions and continuity of care for our patients. According to Isaacs,[1] advocacy means, "stating clearly and confidently what one thinks and why one thinks it."

**There is an initial inner rebellion against the concept of physicians as "gatekeepers" of health care; we would do our patients a disservice by not ordering every possible investigation or intervention.**

For physicians, the word advocacy also brings to mind promotion of a concept to initiate a new project, to create improved policies and procedures — essentially, to do more. Yet, one of the healthiest ways we, as physician advocates, can contribute to the sustainability of the health care system is to consider just the opposite and proactively ask ourselves when can we do less?

There is an initial inner rebellion against the concept of physicians as "gatekeepers" of health care; we would do our patients a disservice by not ordering every possible investigation or intervention. Physicians are not economists or elected officials, and the Hippocratic Oath does not mention accountability for the public financial costs of what we recommend for our patients. Yet, although physicians must continue to staunchly advocate investigations or procedures a patient needs, evidence is mounting that much of what has traditionally been done or ordered in medicine is not in keeping with our holy grail of being "evidence-based."[2,3] In fact, sometimes just the opposite is true: some of what we do and order may, in fact, be inadvertently harming our patients.[3]

One of the best lessons provided by some of my preceptors during my training was the habit of challenging the notion of automatic ordering. They would ask why I was doing or ordering something and how that would change my advice or treatment. Although vexing at the time, and equaling frustrating to my learners when I ask those same questions today, it has become an invaluable check on why I order or prescribe something. I admit that my hand is still tempted to order a urinalysis or ECG for an otherwise healthy elderly patient, a mammogram for a 40 year old woman, transaminases for patients on statins, or do a digital rectal exam of a 50 year old man. Asking myself "why" each time and the presence of students, to whom I am trying to teach the same habits, (usually) stays my hand.

There is increasing evidence

that this non-evidence based ordering may be not only financially costly and noncontributory to improvements in patient morbidity and mortality, but, worse, it may also cause harm to our patients by leading to unnecessary anxiety and potential complications from resulting investigations or interventions.[4,5] So, why is it that we continue to do and order what the evidence tells us we should not?

I suggest there are multiple reasons. First, it is difficult to change behaviour. What we were taught and have practised for years or decades is difficult to challenge and unlearn. Yet, as we tell our patients that change is possible, we cannot remain in a pre-contemplative stage.

Second, evidence-based clinical practice guidelines for groups of patients are cold, abstract words on paper or on a computer screen, disconnected from the concrete patient in front of us. All physicians have seen or heard about the "exception to the rule," and these anecdotes carry emotional weight that can easily trump a scientific guideline.[6]

Third, it takes more time to explain why one is not ordering or doing something, than to create a requisition or make a referral. This is compounded by the way we have conditioned our patients to expect certain things, which, for example, explains the sceptical looks I receive when I explain that a clinical examination is not recommended for an asymptomatic patient at low risk for breast cancer. The Cleveland Clinic has been successful in influencing such expectations and patient experiences.[7,8]

Fourth, one has to actively and continually seek out updated guidelines and re-assess "routine ordering." Add to this the fact that it is easier to get groups of physicians to agree on ordering additional investigations than to agree on removing not-indicated tests. A physician making a referral may also worry that his or her patient will not be seen or receive the required investigation or procedure

if all the pre-work requested by the consultant has not been done, even if it is not in keeping with guidelines.

Finally, it is challenging when the guidelines do not agree and one is inundated with a plethora of contradictory recommendations. Whether the disagreements occur between specialty groups or associations, or whether the differences are at a provincial, national, or international level, the fact remains that there is no single source of truth for everything when it comes to guidelines.

With all of these challenges and obstacles, how can we, as physicians, advocate health care sustainability and appropriateness in ordering investigations and interventions? As individual physicians, we need to continue to push ourselves to ask those "why" and "how does this change my management" type of questions. We need to stay updated on current and changing guidelines and use resources such as Choosing Wisely Canada[9] and provincial and national screening guidelines, drawing from the expertise of physician colleagues who have weighed the evidence and provided guidelines that promote health rather than cause harm.

As a profession, we need to promote the dissemination of best practices through clinical guidelines readily available via electronic medical records and improved data sharing and integration. We need to measure whether what we do is achieving what is intended, rather than create unintended issues. Finally, appropriate ordering of investigations and treatments is a huge issue and will become even

more so as governments seek to control health care costs, while we, as physicians, seek to continue honouring our traditional dictum: "first, do no harm."

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# Strategic leadership development for physicians – Evaluation of the Physician Leadership Development Program at Schulich

Peter Dickens, PhD,
Sandra Fisman, MBCh, and
Kathi Grossman, BA (Hons)

## Abstract

Spearheaded by the Ontario Medical Association and created by a number of dedicated individuals, the Physician Leadership Development Program has "changed the lives" of its participants. Results of a survey and interviews with physicians from the first four cohorts reveal the program's key strengths and how it is beginning to have a significant impact on the province's health care system.

**KEY WORDS:** physician leadership development, systems change, program design, Schulich Executive Education Centre, evaluation, Ontario, action learning, complexity

In 1999, a dialogue began at the board of the Ontario Medical Association (OMA) about the need for enhanced leadership skills among physicians across the province. Historically, medical school training contains little or no information on the subject, leaving physicians in leadership roles to fend for themselves and learn from their predecessors as best they can. The Canadian Medical Association (CMA) offered specific skills development through its Physician Management Institute (PMI), but what was lacking, according to Dr. Janice Willett, past-president of the OMA, whom we had an opportunity to interview early in our research project, was formal training for leaders who could have an impact on the larger health system.

Despite some early resistance from board members who did not feel that leadership development was their mandate, the OMA set out to identify a respected provider who could develop and deliver a program that went beyond simply developing skills of participants to

one that was focused on system transformation. They also preferred a "made in Ontario" solution and one that would ensure broad representation both geographically and based on physician specialty. According to Willett, they wanted to break away from the traditional system that focused on high-profile association members and seek out emerging leaders from across the province. From the beginning, they were intentional about limiting the involvement of board members and put a rigorous screening process in place.

## Program design

After a lengthy process, the OMA, in partnership with the CMA, selected the Schulich School of Business, York University, through the Schulich Executive Education Centre (SEEC), to design and deliver the program. Designed by Brenda Zimmerman, the Physician Leadership Development Program (PLDP) had elements that lined up with the OMA's desire for systems-level leadership.

- **A complex, adaptive systems approach:** Zimmerman was a thought leader in seeing organizations as complex, adaptive systems rather than

industrial-age "machines". Order in complex adaptive systems emerges when the system has the space for self-correction and when change and compliance are self-generated, based on clearly defined "boundaries". This approach leads to the sorts of systemic changes the OMA sought. It also leads to the reduction of quick-fix problem-solving as people learn to listen much more closely to the system and to each other.[1-3]

- **Collaboration:** Zimmerman worked closely with the OMA and CMA during all phases of program design. She also drew on an expert faculty, as well as global thought leaders, who could interact with participants in person as well as through video interviews.

- **A cohort-based learning environment:** Participants met with subject-matter experts six times over 10 months to expand their awareness and understanding of various aspects of leadership. The structure of each module was built around Mintzberg's "five minds of the manager,"[4] which ensured a balance among the reflective, analytic, collaborative, systems, and catalytic mindsets.

- **Self-reflection and mindfulness:** Through journaling, dialogue, and other approaches, participants engaged in various processes to help them think through their learning and make conscious choices about change.[5]

- **Action learning projects:** Participants were required to apply their learning to specific change opportunities that could then be operationalized

to improve areas within their span of control. Criteria for the projects were that they presented a systems-level challenge; they were projects in which the participant could take an active leadership role; they had observable milestones; and they would stretch the participant as a leader. This approach was aligned with the concepts of action research as a prime leadership development strategy.[6]

- **Coaching:** Effective coaching was a critical implementation mechanism for the new learning because, in combination with the modular content and individual reflection, it helped each participant make effective choices.[7-9]

## Orienting the research and researchers

The purpose of this research initiative was to examine the impact of the PLDP on participating physicians in terms of individual self-awareness and reflective capacity as well as broad systems impact. The hypotheses going into the initiative were:

1. When physicians actively engage in a multipronged leadership development strategy, transformative learning takes place that manifests itself in changes in workplace behaviour.
2. As physician leaders change their approaches and patterns of interaction, they learn to think at a much more strategic and system level.
3. Higher and broader levels of

systems thinking lead to a more significant and sustained systems impact. We

**We received 60 responses from the 100 physicians who participated in the first four cohorts; three were incomplete, leaving 57. Participants were asked to rate a series of statements on a six-point Likert scale.**

conducted a mixed methods study that included a survey of participants from the first four cohorts of the PLDP. We also interviewed 12 of the participants, selected to achieve maximum variety in terms of geographic distribution, specialization, and year of participation. Finally, we interviewed OMA leaders who had been involved in the initial design of the program.

Of the researchers, Dr. Sandra Fisman was a participant in cohort one; Peter Dickens has been a coach and a facilitator in the program from the initial cohort; and Kathi Grossman has been the program coordinator for SEEC from the outset. We acknowledge that there is likely some researcher bias in our perspective, but we believe that our experience and knowledge of the program are important lenses through which to view the outcomes.

Schulich was approached about the use of an ethics review board but indicated that, since the research was not being done under their auspices, such a review would not be appropriate. Hence, no ethics review was done.

**Table 1. Summary of survey responses from participants in the first four cohorts of the Physician Leadership Development Program ($n = 57$).**

| Statement | Agree or strongly agree (%) |
| --- | --- |
| I am conscious of balancing reflection and action in my leadership practice. | 93.22 |
| I am aware of the strengths and limitations of my personal learning style. | 85.00 |
| I am comfortable using "wicked questions" within my group. | 71.18 |
| I encourage my group to use positive deviance approaches to identify opportunities for change. | 59.32 |
| I consistently engage in reflective practice. | 59.32 |
| I apply ecocycles to strategies, structures, and systems. | 55.93 |
| I encourage my group to engage in scenario thinking. | 50.85 |
| I use the STAR* Model[10] to make sense of group dynamics. | 33.89 |

*Situation, task, action, result.

## Results of the survey

We received 60 responses from the 100 physicians who participated in the first four cohorts; three were incomplete, leaving 57. Participants were asked to rate a series of statements on a six-point Likert scale. The statements related to specific concepts taught in the program (Table 1).

When given the opportunity to comment on how they had applied key concepts from the program, many participants spoke about the value of a complexity perspective, which was new for many of them. One suggested, "While it may seem simple, the complex system framework continues to be one of the key takeaway messages. It is one that I continue to use in discussions with physician groups.

Surprisingly, while physicians deal with complex adaptive systems all the time (humans, hospitals, practices) few of us take that reflective time necessary to realize that these systems are complex and adaptive."

Several of the "liberating structures"[11] to which participants were introduced were also identified as useful, including TRIZ, 1-2-4-All, and Min Specs. These are simple facilitation approaches, many of which were designed by Brenda Zimmerman, that are intended to minimize structure and control and maximize a group's freedom to generate novel ideas and solutions.

## Findings from the interviews

We conducted 12 telephone interviews with participants from the first four cohorts. Several potential interviewees self-identified as willing, and we identified other candidates to ensure a balance geographically and in terms of specialty, age, and gender. Each semi-structured interview took about an hour and was framed by the following questions:

1. In what ways did the PLDP change your approach to leadership?
2. How did it change you as a person?
3. One of the goals of the program was to help you think as a leader in a more systemic way. What evidence have you seen in a change in your own systems perspective?
4. What has been the long-term impact of your action learning project?

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5. Did you see evidence of the action learning project scaling up? In ways you had not expected?

Three strong themes emerged from the interview data: self-awareness and the power of reflective practice; a growing sense of self-confidence; and the ability to see multi-level systems.

## Self-awareness and the power of reflective practice

Several interviewees pointed out that the sorts of physicians who are drawn to a program like the PLDP have a self-admitted pattern of saying "yes" to a wide variety of invitations to leadership roles that are ultimately dissatisfying. Two important and related themes that emerged from the interviews were a new-found ability of participants to focus on strengths and the value of self-reflection, both gleaned from the "reflective best self" (RBS) exercise.[12] This, then, gave participants a better method for assessing leadership opportunities in terms of fit.

**Several interviewees pointed out that the sorts of physicians who are drawn to a program like the PLDP have a self-admitted pattern of saying "yes" to a wide variety of invitations to leadership roles that are ultimately dissatisfying.**

RBS is a multi-step process that facilitates an understanding of oneself at one's best, based on reflective analysis of feedback from a diverse group of people who know the individual well. As one interviewee pointed out, "Early in the course, this set the stage for using the self and self strengths to build collaborative relationships." Another commented, "The RBS was unexpectedly powerful — it provided a lot of rich free-text data." This suggests the sort of nuanced information that is often difficult to get from surveys or scale-based assessments.

RBS was linked with another main theme: enhancement of self-confidence. "The RBS assessment gave me a lot of confidence; a sense of self and how others see me." Another perspective was insight into some areas for improvement: "I appreciated the RBS exercise, both for helping me see my strengths [through others' eyes], but also because it pointed to some of my gaps, which created a framework for learning."

Continuing beyond the course, the application of self-reflection and use of personal strengths continued to influence the personal and professional lives of many of those interviewed. "As a person, I have become much more reflective, I am much more intentional about listening and sensing other people's emotions, then adjusting my stance so I can best communicate with them." "I pause to write what I did and what I notice; take a breath." "I spend less time worrying about my own weaknesses," and "I am more in touch with my own feelings: I can now label them and thus deal with them more effectively." One participant commented that, "As a person, self-reflection was very helpful; I learned what makes me tick aside from my professional development."

Professionally, "the power of reflective practice" enabled "movement from a diagnosis and treatment mindset. I learned to get out from behind my own assumptions and to live a more balanced life."

The prescriptive use of RBS as a foundation of the course's design had an engaging effect: "It was clever how the program got very bright, but often stubborn people to engage in self-reflection.

Part of that was creating a safe environment for dialogue." The RBS exercise laid the groundwork for another major theme, the value of collaborative relationships, particularly in team building and system change. An interviewee, who was lead in his family health team, said the RBS exercise helped him recognize his strengths and those of others.

Several participants contributed variations on the following comment: "I have learned to lead from my strengths and to offset my weaknesses by collaborating with others in order to effect change. I no longer stress about my weaknesses; there are others out there who can do what needs to be done. I used to be the sort of person who would take on more and more stuff, but the program taught me to think in terms of my strengths. That has helped me to let go of the doing that is my instinctive response. I am better able to identify others' strengths and then encourage/support them in taking on projects that suit their strengths."

Finally, one early participant noted, "I am more observant of my colleagues' patterns, and I have learned to be more intentional about celebrating successes: both my own and others'."

## A growing sense of self-confidence

A second theme that emerged from the interviews was the impact of the program on individuals' confidence. This was particularly noted by many women. As one person said, "that alone was worth the whole

course." Another put it this way. "The program gave me confidence in myself. Women in leadership often doubt themselves, but the program gave me a sense of inner credibility. I also see these changes in me in my personal life: increased confidence and a willingness to pursue things I might have avoided in the past."
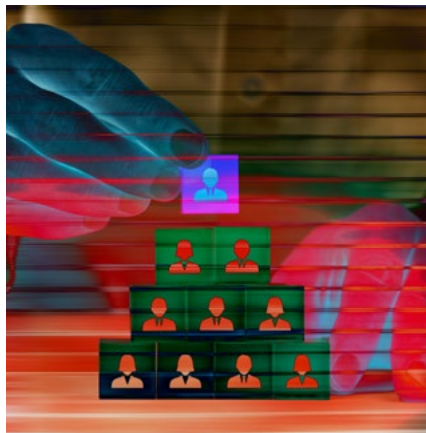


Several people noted with surprise that one can be an introvert and still be an effective leader. "Yes it did [change me as a person]. One of the most significant things was that I realized that I am an introverted leader — seeing how I can effect change and that I can still be a leader with my style."

For several participants, an observable change was an awareness of their expanding circles of influence, as they learned to actively and intentionally engage others. Virtually every interviewee came to the realization that building relationships is the heart and soul of leadership. For people who are used to thinking and working in a very individualistic way, that was quite revelatory.

One summarized it quite nicely: "I learned that 'me [alone] as the leader' wasn't the answer. I had to

form connections, build networks, and learn that building support was critical to any change initiative. I will never again just take on a change by myself! It is vital that you really understand the perspectives of others and... their needs. Change requires a significant investment in the social system around the change."

This revelation about themselves and the capacity of others transformed many participants' approach to leadership and change. Another noted a vital, new question that dramatically increased her confidence: "With whom do I need to engage [regarding a specific initiative]? I became intentional about broadening my scope beyond physicians to other health professionals, the government, and local, provincial and even national associations. By clarifying everyone's needs, we were able to develop much richer outcomes."

## Seeing multi-level systems

Question 3 led participants to think about the difference the program made in how they view their work. As one family physician noted, "I would have said I used to be much more focused on the micro-system: the one around the patient. I didn't really think beyond that level."

Heifetz and colleagues[13] offer a useful metaphor to help us make a shift in our thinking. They suggest that effective leaders need to be both "on the dance floor" where they are in direct contact with people and processes and "up on the balcony" where they can see the patterns of change in the whole system.

This is what family physicians and others noted: they were more and more comfortable being up on the balcony, observing not only their own system, but that system nested within other systems that impact and influence each other in multiple, non-linear ways. Their patient, the microsystem, was nested within a department or family health team, which was nested within a hospital or local health integration network, which was nested within broader social, economic, and political systems. One ignores the influence of these systems at one's peril. Instead, they had to learn that "me alone as the leader wasn't enough," as one interviewee put it. They had to learn to connect with and truly listen to and understand all parts of the system.

As another suggested, "I had to take a macro view and look at various positions, power structures, and governance models. I had to truly understand multiple accountability systems. I had to discern what partnerships I needed to influence. I really needed to appreciate the place others are coming from so that, together, we might adapt change to meet all our needs." This perspective led a participant to realize that, "I had to have facts about the other systems in which I was embedded. That meant, obviously, getting to know them and understand their different perspectives."

For many, this was a powerful insight, and they realized that their training and experience had led them in the opposite direction. They had been very comfortable in the solitary leader role, and it was a bit

jarring for some to realize how vital true engagement really is. Although they acknowledged that it took more effort initially, all of the participants commented on the fact that the systems approach led to much more sustainability.

Several commented on the fact that they had seen various projects and initiatives move far beyond the original parameters because of a systems approach. For many, the key takeaway was learning to ask new questions, often the "wicked questions" that exposed a paradox and forced new ways of thinking. For one, it was questions about the scalability of change; for another, "The key question is, how do we mobilize the right elements of the system for change?" In other words, questions about connectivity and collaboration have become central to their thinking.

One of the complex systems approaches that resonated with several of the interviewees was what is often referred to as the "butterfly effect" (first described by EN Lorenz in 1963). That is, the notion that small actions, especially in the early stages of a change, can have disproportionate impact. In other words, systems behave in unpredictable and non-linear ways. As one interviewee commented, "the complexity of health care can be overwhelming but then I remind myself that small changes, sustained over time, can lead to big changes." In several of the action learning projects discussed, participants saw evidence of this effect as small changes, such as providing colleagues with regular data on their performance, began

to have significant impact on departmental behaviours and results.

## Outcomes of the action learning projects

Although not the most important aspect of the PLDP, the action learning projects gave participants the opportunity to apply their learning to a specific systems challenge and present the results to their colleagues and guests in a poster format. The range of subjects was enormous: some had immediate impact, a few had little impact, and several others had a significant long-term effect on the system. The latter included:

- Dramatic growth of a complex care clinic, attracting ministry funding and spinning off several new clinics based on the original model and learning
- New patterns and attitudes toward prescribing opiates to people with chronic pain
- A dramatic reduction in avoidable Caesarean sections through an approach based on individual physician accountability that has been replicated in other programs and hospitals
- A new way of thinking about Health Links (an Ontario program to coordinate care) in a rural setting that focuses on vertical integration and has actively engaged the OMA and the Ontario Hospital Association

Space does not permit us to list all the outcomes of the projects. Perhaps what is more important

is to recognize that program participants now believe that they have the skills, perspectives, and commitment to establish multilateral relationships that will help them push forward with any number of initiatives that will have a significant and sustained impact on the Ontario health system — which was at the root of the intent of the program.

## Conclusions

The PLDP appears to have been a life-changing experience for many of the participants. Those who were involved in medical education lauded the structure of the program, and the many participants who had never had any form of leadership development are demonstrating ongoing commitment to the learning they acquired.

The OMA has been front and centre in organizing annual reunions to provide ongoing education and support for alumni. In several locations, most notably Ottawa, graduates have self-organized into a learning group that continues to find new ways to work together. It would be worthwhile for the CMA and OMA to look for ways to extend the impact of this sort of program to reach a critical mass of physicians as change agents.

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# Measuring physician performance using the CanMEDS framework: proposal for an innovative approach



Kiran Rabheru, MD

## Abstract

GRASP (Global Review and Assessment of Staff Physicians' Performance) is a proposed new tool for assessing physician performance. Integrating the familiar CanMEDS framework with the global assessment scale, Observed Structured Assessment of Technical Skills, it uses milestones to measure the progress of all physicians. Readers are invited to comment and participate in further development of GRASP.

**KEY WORDS:** CanMEDS framework, physician performance, performance appraisal, assessment tool, Observed Structured Assessment of Technical Skills, OSATS, LEADS, GRASP, Global Review and Assessment of Staff Physicians' Performance

## The need for a tool to measure physician performance

Physicians have a profound impact on patient safety, quality of care, team function, and overall costs to the health care system. However, monitoring and evaluating physician performance in today's complex health care environment can be a daunting task. A universally accepted tool that can be used to evaluate systematically the performance of physicians across all groups is needed. Such measures can then be used in decisions regarding the granting of institutional credentials and privileges.

A thorough review of the literature and consultation with many senior physician leaders across Canada revealed that there is an urgent need for a performance evaluation tool, and physician leaders are enthusiastically seeking one.[1,2,3,4,5] To have universal utility and acceptability, such a tool must be based on a well-defined framework, which itself is created by and for physicians. To resonate with all physicians and be accepted, the tool must be deeply rooted in an inherent set of core values.

This paper is an introduction to work in progress to develop such a tool and an invitation to the reader to collaborate further on researching the proposed model for evaluating physician performance.

## Overview of the GRASP

GRASP (for Global Review and Assessment of Staff Physicians' Performance) was produced by adapting and integrating the well-known CanMEDS framework[6] and physician milestones[7] with the global assessment scale, Observed Structured Assessment of Technical Skills (OSATS).[8] The main goal was to help standardize the process of performance evaluation and credentialing of all physicians for institutional privileges. The GRASP has the capacity to make the evaluation process physician friendly, fair, clear, transparent, and predictable. Most important, it is based on the CanMEDS framework, with which every physician is already familiar, making the process of life-long learning an integral part of each and every physician's daily life.

## CanMEDS framework

CanMEDS[6] is a framework developed by the Royal College of Physicians and Surgeons of Canada in the 1990s, and later adopted by the College of Family Physicians of Canada. Its overarching goal is to improve patient care by enhancing physician training.[9] The CanMEDS framework serves as a foundation for medical

education and practice in Canada. It has also been adapted around the world, both within and outside the health professions, and has become the most widely accepted and applied physician competency framework in the world. As every physician, who is trained, certified, and licensed to practise in Canada must comply with the CanMEDS roles, it seems logical that they should continue to ascribe to the same set of values as they continue in their career and train future physicians.

**The CanMEDS framework consists of seven physician roles, all of which are important in evaluating physician performance.**

and Systems transformation. Each of these five domains consists of four core measureable capabilities.

The LEADS framework has been endorsed by organizations such as the Canadian Health Leadership Network,[12] and adopted by the

evaluation, is that CanMEDS deals with professional *competencies* specifically tailored for physicians, while LEADS deals with *capabilities* for all health care workers.

The CanMEDS framework consists of seven physician roles, all of which are important in evaluating physician performance. Discussions with physician leaders and colleagues revealed unanimous agreement that all of the roles are critical in assessing each physician. There are no exemptions



The CanMEDS framework was chosen over the renowned LEADS framework[10,11] to develop the GRASP. The LEADS framework, which was developed through collaboration between the Health Care Leaders Association of British Columbia and Royal Roads University, identifies key leadership capabilities, and features five domains: Lead self, Engage others, Achieve results, Develop coalitions,

Canadian Society of Physician Leaders in collaboration with the Canadian Medical Association (CMA)[13] as a basis for leadership development toward the Canadian Certified Physician Executive (CCPE) credential.[14,15]

The core difference between the CanMEDS and LEADS frameworks, which helped refine the GRASP as a tool for physician performance

to achieving these competencies simply by virtue of area of special interest, expertise, or scope of practice.

A physician with limited clinical practice — a researcher, surgeon or anesthesiologist, for example — would still have to meet the requirements for the roles of Medical expert, Communicator, Collaborator, and Professional, in addition to those of Academic,

Scholar, and Advocate. The intent is not to minimize the importance of the latter three roles; on the contrary, it is to highlight the need for all physicians to meet acceptable standards in all seven roles, regardless of their area or scope of practice. All physicians would all have to abide by the same rules and be held to the same level of accountability.

## OSATS assessment tool

OSATS is a global assessment scale used to evaluate the performance of trainees.[16] The OSATS scale was chosen, as it integrates and synthesizes data collected from various sources to help form a comprehensive assessment. This usually includes a checklist of tasks successfully completed, attributes that the candidate must have, and multiple sources of feedback regarding each candidate. The final dichotomous outcome, e.g., granting or withholding of privileges, is based on a meta-observational global assessment of each candidate conducted in a semi-structured and objective manner, using milestones that are clearly articulated and understood by all.

The positive effect of OSATS on learning during formative stages and its relative superiority in the precise assessment of clinical skills compared with the traditional evaluation method has been well established.[17] Human behaviour is complex and involves integration of data from many sources over a prolonged period. The OSATS allows evaluators to be very flexible, but also precise at the same time. The evaluator can select data from

a wide range of sources, provide objective feedback based on serial incremental progression toward milestones that are well understood and accepted, *a priori*, and help poorly performing trainees take remedial action.

The OSATS template was selected based on these characteristics, as it seems well suited for measuring overall performance in complex environments of human interaction. It is to be used in synchrony with the CanMEDS roles, using physician milestones as behavioural anchors.

## Caveats for those using the GRASP

### Context
Physicians are held to a very high standard of moral, ethical, and professional accountability by virtue of their role in society and society's expectations. Personality traits are usually ingrained and stable, but may change to some extent, based on circumstances. Some are evident only when a person is undergoing unusual stress and, thus, may not reflect their usual pattern of behaviour. Such situations, especially negative behaviour, are often brought to leaders' attention by observers, who may not be familiar with the physician or the circumstances.

Thus, the context in which a particular behaviour is observed must be kept in mind. In most situations, the GRASP is used as a formative, not punitive, tool. Most infractions are remediable and the physician may benefit from support and mentoring to achieve better outcomes.

### Personality traits
Challenges arise when physicians demonstrate unprofessional behaviour and create repeated problems for others, including patients, their families, staff members, and colleagues. If such unacceptable behaviours are frequent, they may be reported by several reputable observers and have a significant impact on the smooth operation of the institution.

Routine and regular performance appraisals often do not address these issues, which arise in crises when there is a reported incident. GRASP provides an opportunity to incorporate these incidents into a systematic performance review process and evidence-based practice.

### Supportive work environment and formative opportunities
People cannot perform at their best in environments or under circumstances that are ambiguous. In a healthy workplace, clear achievable goals are defined, and resources and incentives are established to achieve them. All physician leaders must be able to provide a formative, supportive environment to manage expectations and help physicians achieve their goals.

For most physicians, performance evaluation will be a positive experience — a formative and goal-setting exercise. However, for a small minority who, despite every opportunity and support, fall below the standards expected of a physician, a universally accepted tool such as the GRASP may be invaluable in making the evaluation process less ambiguous.

## Sources of feedback for determining physician milestones

Including feedback from various sources in an objective way is critical when evaluating complex human behaviour. Well-accepted and standardized behavioural anchors, or physician milestones, for the GRASP were adapted from the Royal College's milestone document,[7] but are intentionally broadly defined.

The word "consistently," used in most milestones, is open to interpretation. In general, consistently means physicians maintain a particular standard of behaviour or repeat a particular task with minimal variation. The literature in this area[18] suggests that the question of what is "good enough" cannot simply be based on a single observation of an act or behaviour. Rather, it must take into account the

context, the motivation, frequency of occurrence, the connotation, and the consequences or impact of the act or behaviour.

It is vital to rely on multiple sources of objective, well-documented, unbiased, and impartial data about each physician's performance. Sources of feedback may include peers, patients, families, allied health professionals, as well as many of the usual institutional metrics. This feedback can then be viewed through the lens of the GRASP to evaluate each CanMEDS role and the physician's performance on each milestone over time.

## Insight and judgement

Finally, physician leaders must answer a key question in open dialogue with each physician they are evaluating: "Does this physician possess insight and reasonable

judgement relevant to his or her actions or behaviours in a given situation or scenario?"

Physicians who demonstrate good insight and judgement are generally the ones who possess mature and healthy defense mechanisms and have the mental flexibility to be able to perform some degree of meta-reflection on their own behaviour. They are also willing to acknowledge their contribution or role in a situation or scenario and take advantage of learning opportunities to improve their own attitudes, skills, performance, and behaviour.

Conversely, a physician who is unwilling to rethink components of his or her attitude, who demonstrates excessive defensive behaviour, who possesses a relative deficiency of mental flexibility, who is firm and rigid and

## GLOBAL REVIEW & ASSESSMENT OF STAFF PHYSICIAN'S PERFORMANCE (GRASP)

PHYSICIAN'S NAME: _____

EVALUATOR'S NAME: _____

DATE: _____

### INSTRUCTIONS

1. Circle the number corresponding to the staff physician's performance for each CanMEDS Role with respect to the Physician Milestone achieved.

2. The Global Review of Performance, integrated with assessment of the Physician's Milestones, serves as a guide for granting of institutional privileges.

3. Utilize the entire range of behavioral anchors (1-5), noting actual observations and comments as an appendix to this Assessment.

4. Detailed records are mandatory to support appropriate remediation measures taken when physicians Score 1 or 2 on any CanMEDS role.

5. The candidate must meet criteria (Score 3 or >) for all 7 CanMEDS roles to be granted institutional privileges.

6. The Physician being evaluated and the Physician Evaluator must sign and date this form.

### FINAL OUTCOME:

SUITABILITY
FOR INSTITUTIONAL
PRIVILEGES

NOT SUITABLE
for Institutional privileges

RESTRICTED Institutional Privileges

FULL
Institutional Privileges

### COMMENTS:

I have discussed the content of this assessment with my Evaluator.
Physician's Name: _____
Physician's Signature: _____
Date: _____

I have discussed the content of this assessment with the Physician being evaluated.
Evaluator's Name: _____
Evaluator's Signature: _____
Date: _____

Adapted from G.K. Grober ED, Hamstra SJ, Wanzel KR, Reznick RK, Matsumoto ED, Sidhu RS, Jarvi KA: Annals of Surgery 240(2):374–381, 2004.
Source: Frank JR, Snell L, Sherbino J, editors. CanMEDS 2015 Physician Competency Framework. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015 http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/framework/canmeds_full_framework_e.pdf Accessed January 15, 2016
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GLOBAL REVIEW & ASSESSMENT OF STAFF PHYSICIAN'S PERFORMANCE (GRASP)

lacks the ability to develop insight into improvement opportunities should raise a red flag that must be addressed proactively by the leader.

## High stakes

Although this proposed tool for evaluating physician performance holds great potential and has been described by physician leaders who have reviewed it to date as heuristic, innovative, and thought-provoking, its implementation faces many potential barriers. It also seeks to uncover relevant areas of physician competencies that have traditionally not been considered in evaluation of performance.

Thus, it is imperative that a concept such as this be considered with a great deal of care, thought, and reflection — and it must be scientifically rigorous. At this stage, it would be useful to approach the idea of using the GRASP to evaluate physician performance as an academic initiative and to establish validity, reliability, and end-user experience. To make this a high-impact tool, I believe that it must resonate with all physicians if it is to achieve the intended result, which is to make physicians' and patients' lives better.

## An invitation

I invite all interested physician leaders to provide comments and feedback about the concept of using the CanMEDS framework to evaluate physician performance, and, in particular, about the utility of using the GRASP at their institution. As part of this project, I also invite leaders to join me in conducting a pilot project to evaluate the utility of such a tool and refine it further.

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e.g., Choosing Wisely Canada. Ottawa and Toronto: Canadian Medical Association and University of Toronto. **http://www. choosingwiselycanada.org/** (accessed 12 Nov 2007).

**Archival or unpublished sources** — Surname Initials. Title of document. Unpublished manuscript, collection name, inventory record, name of archive, location archive.
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**BOOK REVIEW**

# Leaders Eat Last: Why Some Teams Pull Together and Others Don't

**Simon Sinek**
**Penguin Group, 2014**

Reviewed by Johny Van Aerde, MD, PhD

Very few ideas are actually new. In *Leaders Eat Last*, Simon Sinek reframes several concepts of the theory and practice of servant-leadership for current times and surrounds the new frame with great narratives. He submits that our anthropological neurochemistry makes it natural for us to protect each other and show empathy. This, in turn, leads to an environment of trust in which organizations can thrive. The "circle of safety" created as a result connects people to the greater purpose of the workplace.

Creating safety goes back at least 40 000 years and helped us survive in and for the group. The evolutionary neurochemistry of leadership and followership, on which the circle of safety is based, is the thread that Sinek weaves throughout the book. He calls endorphins and dopamine the selfish chemicals and serotonin and oxytocin the selfless chemicals.

Endorphins mask pain with pleasure, and dopamine creates a feeling of satisfaction; they are the incentive chemicals of goal achievement and task completion, of short-term gratification at the cost of long-term accomplishment. Those same chemicals spike our ego and trigger a command-and-control leadership style. Both substrates, particularly dopamine, are highly addictive.

According to Sinek, it is our chemical dependence on dopamine that plays a major role in creating or preventing a culture where employees feel trusted and safe. When an organization focuses heavily on performance by aiming exclusively at goals and bonuses, and if the dopamine fix of its members is the primary reward, then the organization becomes addicted to numbers and ignores the people.

In contrast, serotonin, the leadership chemical, and oxytocin, the chemical of trust and belonging, are the substrates leading to contribution and collaboration. Both encourage pro-social behaviour and help us form bonds of trust and friendship, so that we will look out for each other. Although the effects of oxytocin in maternal (and paternal) bonding and trust building
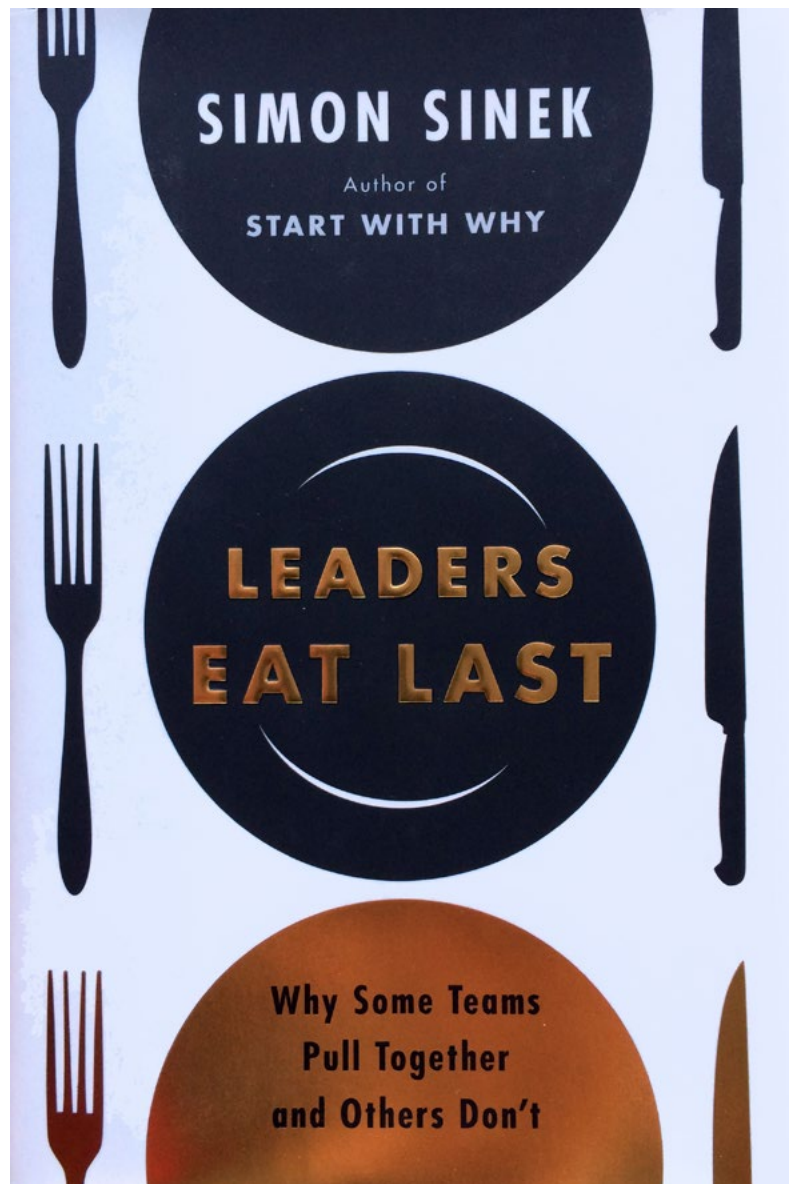
have been researched, the effects of serotonin on social behaviour are less known. Serotonin gives us a feeling of pride, of others liking or respecting us, making us feel confident and raising our status in the social group.

A healthy synergy between the four chemicals can be disrupted easily in today's business environment. Today's world focuses excessively on numbers, goals, and bonuses, and people have become generally dopamine-drunk, not just in business. That dopamine drunkenness short-circuits the human animal into looking out for itself, to being suspicious and non-supportive of others. The balance is disturbed even more by stress-induced production of cortisol, which further inhibits oxytocin production.

Consequently, people will invest time and energy in guarding themselves against politics and other dangers, trying to survive at the cost of collaboration. The absence of the circle of safety ultimately leads to the decline of the organization. Sinek submits that money and numbers have replaced people, flying in the face of the protection our leaders are supposed to offer us from an anthropologic point of view. He gives great examples of how firing people to meet short-term financial goals has rarely led to thriving companies, and how other companies have been successful in the long-term by focusing on people rather than those short-term goals.

Sinek cites General Electric (GE) as an example of a dopamine-driven organization, in which Jack Welch used to fire the bottom 10% of staff each year. As examples of organizations based on the anthropological, evolutionary concepts of collaboration and safety-creation, he mentions Costco, Southwest Airlines, and 3M (and some aspects of WestJet). Under the leadership of Jeff Sinegal, Costco's market value climbed steadily, unlike GE's rollercoaster performance, and its accomplishments now exceed those of GE.

Servant-leadership is a choice to serve others, and trust is the biological reaction to the belief that somebody else has our well-being at heart. When we feel the circle of safety around us, we work hard to see our leader's vision come to life.

Too many analyst-experts pressuring for short-term goals impede an organization's investment in long-term innovative projects and kill innovation and creativity in people who no longer feel they belong to the circle of safety. This leads to distancing and abstraction, and people no longer feel connected with each other or with the organization's purpose and vision.

In *Leaders Eat Last*, one recognizes elements of other well-written books and research studies, including *Great by Choice*,[1] *Generation Me*,[2] T*he Emotional Brain*,[3] and *The Social Animal*.[4] Sinek himself has no research or academic background, so he does not offer new elements, but he is very good at creating new frames by integrating and re-interpreting theories and concepts that already exist.

I hesitate to recommend this book to physicians, unless they are studying leadership. However, while reading the book, I was enticed to reflect on how some of Sinek's thinking applies to several components of our health care system. Have we also lost the balance of the four hormones in health care? Are too many analyst-experts pressuring for short-term goals, ignoring long-term needs and killing the innovation and creativity of people who no longer feel safe in their professional circles?

Sinek's book also makes us reflect on where our world is heading and how we can live more according to our anthropologic evolution. *Leaders Eat Last* is an interesting book that provides a new perspective on known concepts of leadership. However, it is not on my "suggested reading" list of books on leadership for physicians.

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## Author

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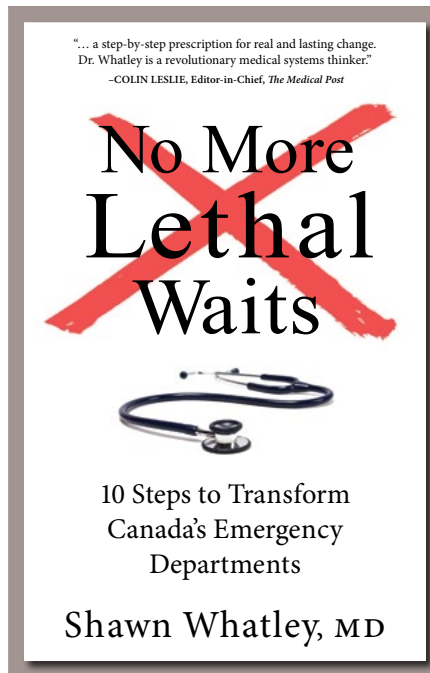
BOOK REVIEW

# No More Lethal Waits: 10 Steps to Transform Canada's Emergency Departments

**Shawn Whatley, MD**
**BPS Books, 2016**

Reviewed by Owen Adams, PhD

Emergency department (ED) wait times continue to be a pressing health issue in Canada. A search of the Canadian Business & Current Affairs database using four combinations of ED/ER and wait, both spelled out and abbreviated, yielded 321 articles in 2015. To put that into perspective, a search for pharmacare and related terms, a re-emerging hot topic in 2015, yielded only 107 articles.

*No More Lethal Waits* is a highly readable and compelling book about the experience and lessons learned from the transformation of the ED at Southlake Regional Health Centre during author Shawn Whatley's tenure as interim medical director of emergency services and physician leader of the Emergency Services Program in 2008–2014. Southlake is a full-service hospital located in Newmarket, Ontario; it has almost 400 beds, handles more than 100 000 ED visits annually, and serves more than a million people.

"… a step-by-step prescription for real and lasting change. Dr. Whatley is a revolutionary medical systems thinker."
–COLIN LESLIE, Editor-in-Chief, *The Medical Post*

No More
Lethal
Waits

10 Steps to Transform
Canada's Emergency
Departments

Shawn Whatley, MD

Unlike many studies of wait-time journeys, this one does not require postgraduate training in operations research or queueing theory to appreciate it, and Dr. Whatley uses several vivid analogies to draw key lessons. The book chronicles Southlake's 10-step journey that resulted in a fundamental revamping of its ED.

The 10 steps borrow heavily from and build on the experience of Toronto's St. Joseph's Health Centre, which transformed its ED under the direction of Dr. Marko Duic, who was recruited subsequently to Southlake as chair of Emergency Medicine. Some of the steps, such as 2, "Close the waiting room," and 4, "Use chairs and exam tables, not stretchers," will no doubt seem heretical to some!

Aside from a methodical and thorough exposition of the 10 steps, Dr. Whatley pays great attention to the motivations, thought processes, and attitudes of the physicians and

nurses in the ED, and the same elements are probably applicable in some measure to many other health care settings. Moreover, the treatment of nurses, physicians, other professionals, and staff seems even-handed. The book is as much a case study of change management in general as it is a guide to transforming the ED specifically. Throughout the book there was also emphasis on the importance of the patient.

By the time I had finished reading this book, my curiosity was piqued as to how Southlake is doing now, so I went to the Canadian Institute for Health Information's yourhealthsystem.cihi.ca to see the most recently posted results (time reference is not specified). They are impressive. The 90th percentile for ED wait time to initial physician assessment at Southlake is posted as 1.4 hours, compared with 3.2 hours at comparator large community hospitals, 2.5 hours for the Central Local Health Integration Network, 3.0 hours for Ontario, and 3.1 hours for Canada; in other words, about half the wait at these benchmark comparators.

In summary, *No More Lethal Waits* deserves to be widely read — not just in the ED community, but also by any health service where waiting is an issue. No More Lethal Waits is available at amazon.ca as well as barnesandnoble.com.
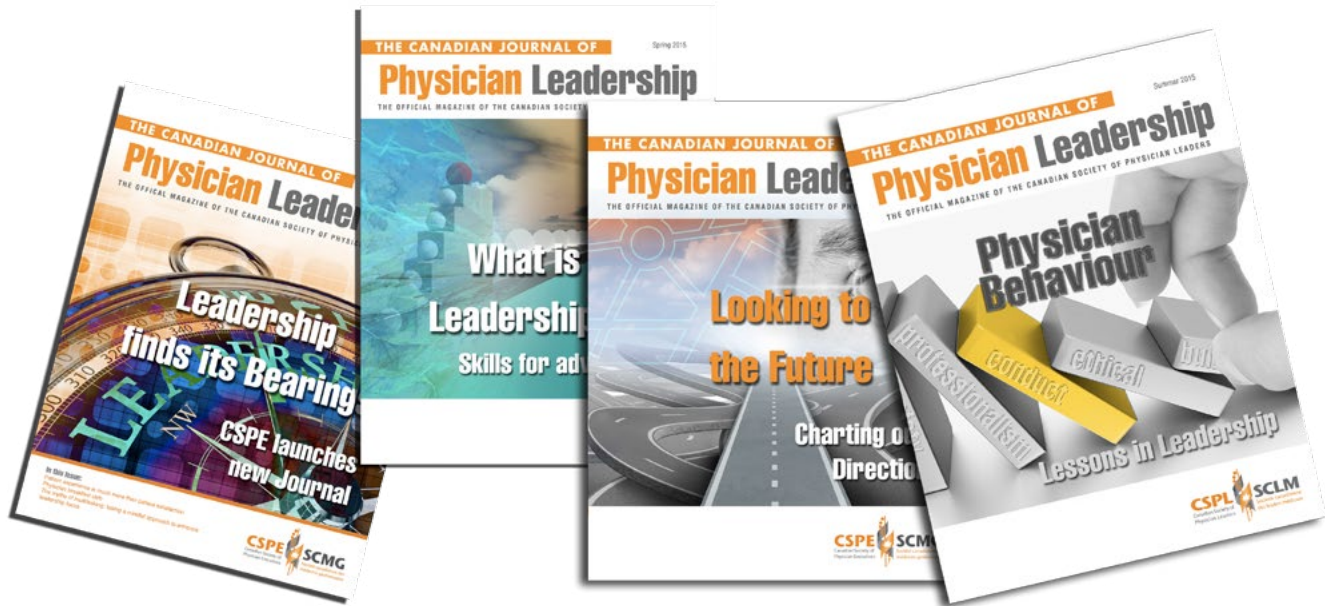
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