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CSPL Canadian Society of Physician Leaders

SCLM Société canadienne des leaders médicaux

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Panarchy, the collapse of the Canadian health care system, and physician leadership

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Abstract

The structured part of the Canadian health care system — hospital and medical services — has probably reached maturity and is on a cycle toward collapse. However, the "creative destruction" that is part of the panarchy model may lead to transformation of the system, with survival of some components and the disappearance of others. Are we, as physicians and leaders, prepared to take on the challenges that will accompany the collapse of the system as we know it?

> *"Panarchy is the structure in which systems, including those of nature (e.g., forests) and of humans (e.g., capitalism), as well as combined human-natural systems... [e.g., the health care system], are interlinked in continual adaptive cycles of growth, accumulation, restructuring, and renewal."*[1]

If Canada's health care system is indeed complex and adaptive,[2] it will evolve according to the panarchy renewal cycle, first described for natural ecosystems.[3] The evolution and sustainability of complex adaptive systems include the natural and necessary processes of destruction and renewal. The panarchy model helps leaders think about what they need to stop doing as part of the destruction phase to facilitate renewal of their work in health care. The evolutionary renewal cycle of the health care system and what we, as physician leaders, can learn from understanding this ecocycle are the focus of this paper.

System boundaries

A system is complex when there are a large number of relations and connections between the interdependent agents that make up the system.[2] It is adaptive when, in response to internal pressures and external events, it has the capacity to change, the ability to learn from the experience, and to self-organize.[2]

To define these adaptive elements and processes, and to determine whether influences are internal or external, we need to define the boundaries of the system of interest. However, in health care, those boundaries may be ill-defined and changing.[4] Easiest to identify are those of the acute health care system, structurally defined by the Medical Health Act in 1967 and redefined in the Canada Health Act in 1984.[5,6] The two components of the structured health care system are the health care services provided in hospitals and the medical services provided by physicians in hospitals and private offices (Figure 1, circle 1), and they consume the bulk of the Canadian health care budget.

The boundaries of the co-evolving larger system of less-structured elements of health care (circle 2) and the very large system of all elements that affect health in general (circle 3) are more difficult to define. A recent study from Saskatchewan[8] indicates that the structured health care system ranks only tenth among factors affecting health, and is preceded by nine other key health determinants, all included in circles 2 and 3 of Figure 1. Clearly, these multilayered systems influence each other and experience different stressors, continuous changes, and multiple equilibria.

The renewal cycle

Depending on the boundaries, change can then be viewed in two ways: the internal dynamics and stresses of the evolving system and the external influences and events pressing on the system. When a complex, adaptive system adjusts to internal and external dynamics, it follows a renewal cycle within the three dimensional space of the panarchy model: capital, connectedness, and resilience (Figure 2). Capital is the amount of material accumulated, such as

biomass, physical structure, and nutrients in a forest, or accumulated physical, human, and technological resources in human-made systems. Connectedness means the number of links and separation distance between agents. Resilience, the opposite of vulnerability, indicates the capacity of a system to adapt to change and withstand shock without catastrophic failure.[3,9,10]

Within that three-dimensional frame, the renewal cycle of the panarchy model contains a slow front portion (green part of the cycle in Figure 2) representing the dominant paradigm, i.e., the way we see and have seen health care in Canada for the last 50 years, and a fast back portion (red part of the cycle) involving creative change. Together, these contain four stages: exploitation (birth) and conservation (maturity) in the slow portion, and release or collapse (creative destruction) and reorganization (renewal) in the fast part of the cycle.[3,11] There is no beginning or end to this infinite cycle, and the destruction of what was the previous cycle forms the beginning of a new one, but at a different, transformed level.

Panarchy and the Canadian health care system

After the turmoil that accompanied the Medical Care Act in 1967,[5,6] the Canadian health care system entered the front part of the renewal cycle and grew. It was designed and structured to deliver acute care to a young population, for whom the almost exclusive emphasis on hospitals and physician care was sufficient at that time.

The era that followed was also one of great medical advances and boundless promises, when adding more and more, but similar types of resources, more technology, and more hospital care meant better care. However, there was no real innovation during this growth phase. As a result, despite the increase in resources and funding, wait times to see a general practitioner or specialist, to access operating rooms, and to be treated in emergency departments did not improve proportionally, nor have other benchmarks.[12,13,14]

Although changes in capital, connectedness, and resilience have increased the internal stresses in the structured acute care system, external pressures are building too.

Moving up the front portion of the cycle, the system grows toward a climax state, developing more and more connections between an increasing number of agents, leading to less and less resilience. Increased vulnerability resulting from this over-connectedness leads to system collapse, as experienced in several economic systems over the last decade.[15] Cumulative growth continued after the Canada Health Act in 1984, moving the health care system into the mature conservation phase of increasing specialization and resource accumulation.[9]

Accumulating more and more similar rather than innovative material during the slow phase of the cycle leads to an increase in capital and more and more rigidity in a complex system, in general, as it did for the Canadian health care system. Some have argued that the Canada Health Act itself contributed to the rigidity of the structured component of the Canadian health care system[16] (Table 1). Public fear of changing what is considered the only way to deliver health care adds to the rigidity.[17] Vested interests of professional organizations and politicians, who act as mechanistic experts to give some satisfaction to the public during very short election and budget cycles, have all added to the loss of resilience in the Canadian health care system.[18] With an increase in specialization and technology, the need to restructure and integrate the acute care system also increased, which added layers of bureaucracy and amplified the level of government involvement,[19] thereby increasing the degree of connectedness and rigidity.

Although changes in capital, connectedness, and resilience have increased the internal stresses in the structured acute care system, external pressures are building too. The system fulfills fewer and fewer of the needs of the changing population, in which aging baby boomers are increasing utilization because they suffer from multiple chronic diseases and demand health services with a consumerism mentality. Unfortunately, there is a conflict between a universal, publicly funded health care system and the expectation that all care must be provided to every Canadian free of charge at all times.[5]

Figure 1. Elements of health and the Canadian health care system. The circles represent interactive complex systems at different scales and time frames.[7]

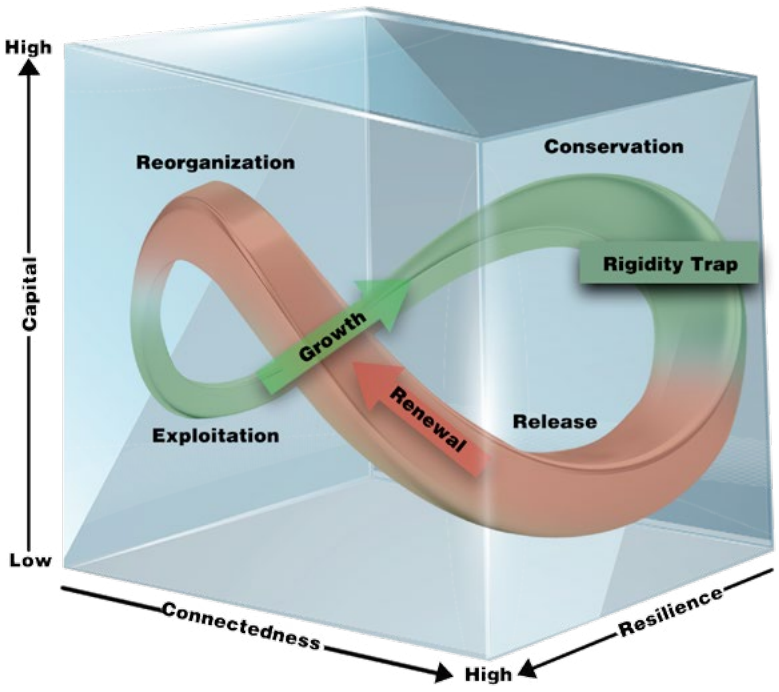
Because the same, large segment of the population has started to retire, the tax base to support the health care system is also shrinking.[17] Today 30% of Canadians pay less in taxes than the cost of the health care services they consume in a lifetime (more than $220 000), and that percentage continues to increase.[5]

Other factors also add to the external pressure on the structured health care system: the increasing cost of human resources, the increasing cost of medications, partly because of unethical practices in certain segments of the pharmaceutical industry, unfounded diagnostic and therapeutic practices, increasingly complex and expensive technology and procedures, biased and sensational news reporting by social and other media, and the increasing prevalence of chronic diseases, such as obesity and diabetes, resulting from the increasing power of an unhealthy food industry. Additional external pressures include reduced government revenues because of low natural resource prices and recession in the global economy. Finally, the ultimate external crisis can be triggered at any time by an economic collapse or a global pandemic disease.

Eventually, any adaptive complex system breaks down under high internal stresses combined with external pressure and/or some trigger event, similar to a forest fire after an ongoing drought. Whereas the growth part of the cycle progresses slowly, breakdown happens quickly, resulting in decoupling of the system and a loss of connectivity, allowing for reorganization of the system's remaining components.[10,11] Breakdown or creative destruction is a vital part of adaptation and innovation.[3,10,11] However, although the renewal cycle is normal in eco-systems, it is rarely acceptable in our human-made economic or political systems, which is why people try to extend the growth portion indefinitely and avoid the inevitable breakdown. Such practices simply increase the probability of an even more serious crisis and breakdown in the future.[10]

The 2004 Canada Health Accord has prolonged the growth portion of the structured Canadian health care system, as it has not led to the innovative changes that were expected.[13,16,20,21] As we continue to tinker with the system rather than innovate, we are prolonging the front portion of the cycle and have probably become locked in a "rigidity trap" where we see things only one way.[3] Characteristics of systems stuck in a rigidity trap include being heavily rule-bound, unresponsive, resistant to change, and having too many resources tied up in non-productive components.[3,22] Some of these are recognizable in the Canadian health care system. Will this rigidity trap and the perpetuation of the front portion of the cycle ultimately lead to a more serious crisis, and will that crisis occur in the structured health care system only (circle 1 in Figure 1) or at the level of all systems affecting health (circles 1, 2, and 3)?

Figure 2. The renewal cycle of complex adaptive systems (modified figure[2])



To get out of the rigidity trap means stopping doing what we have done for years and decades and abandoning an approach or a system that has served us well. Unless we release the resources of time, energy, money, and skills that are locked up in our routines and institutions, we will have difficulty creating new things or looking at things from a different perspective. Without new perspectives, novelty, and innovation, our organizations and systems lose resilience and become more rigid.[22] For example, despite resource accumulation of all kinds, wait times from referral by a primary care physician to treatment have doubled in the last 20 years: from a mean of 9.3 weeks in 1993 to 18.3 weeks in 2015.[23] What do we have to stop doing to allow for innovative and transformational change?

Stresses in the front portion of the cycle also accumulate when a system (e.g., circle 1) learns to displace much of its problems into the external environment, beyond its own boundaries into the hierarchically adjacent systems that have less clear boundaries (circles 2 and 3).[10] The system might become increasingly competent at managing everything within its boundaries by pushing away components that it cannot manage well.[10] For example, the structured acute care system is taking up larger and larger fractions of available resources, leaving fewer resources for creativity and innovation in the less-structured health care system, as well as other aspects of social service: primary care, home care, long-term care, prevention, and health promotion. The structured acute care system even takes resources away from the outermost circle, including funding for education and other determinants of health.[10]

When the tipping point is reached, the rapid-release phase of creative destruction leads to real transformational change of the system. Creative destruction is one of the necessary elements of complex adaptive systems. The word “transformation” has been frequently linked with reform of the Canadian health care system,[24] but, according to the panarchy model, transformation does not occur without some kind of system collapse, away from its present state. The ensuing transformational organization involves the appearance or expansion of opportunities through innovation and restructuring. During the reorganization phase, depleted resources then become available and certain agents of the system are selected for their ability to survive and innovate.

Creative destruction

In human-made systems, the creative destruction phase may require dismantling systems and structures that have become too rigid, have too little variety, and are no longer responsive to the current needs of the community. The eco-cycle model uses the concept of creative destruction and crisis to explain the necessary periodic destruction of forms and structures to maintain the long-term viability of the overall system. In it, crises are opportunities to remove unnecessary forms and structures, and to enable the substance to be renewed and continue to evolve.[11]

What does this mean for organizations or human systems, such as health care? Forms and structures that no longer support the work or mission of a system need to be destroyed in a manner that does not destroy the substance of the system. Forms and structures are necessary to enable the work to be accomplished, but they are not the essence of the work. In health care, this has become a major issue. The substance of health care is not the structures of hospitals and clinics or even the professions of physicians and nurses. Rather these are forms that have enabled health care work. As enablers, they are crucial, but they are not the substance of the work; forms and structures are ephemeral, as they support the work but are not the work itself.[11]

Personal mental models and cultural beliefs make people cling to the old forms because they were the keys to success as they moved up toward the system's maturity.[11] As a result, creative destruction is threatening to the clinical professions, the institutions, politicians, and the public. Health care leaders, particularly physicians, need to learn this concept to ensure that the substance of health care is not lost but renewed. As in a forest fire, creative destruction is designed to release nutrients so that new life can indeed emerge. Therefore, creative destruction is positive and not synonymous with devastation where not only the forms and structures but also the substance is destroyed. In the case of Canada, this could mean the destruction of our values supporting the essence of disease prevention, health care, and health.

Questions around the sustainability of the Canadian health care system

Because agents of the system will be selected for their ability to survive and innovate, leaders need creativity during the release phase of the renewal cycle. Difficult decisions have to be made, because doing more of the same is untenable and we have to shake off old entrenched wisdom and culturally engrained models that lead to maintaining the status quo, fear, and conservatism. Some "wicked questions"[25] that must be asked include, "What is the purpose of our health care system? What does sustainability mean? What do we want to sustain, and how do we make it sustainable? How do we influence the structured health care system (circle 1) by improving the less-structured health care system (circle 2) and global health determinants (circle 3)?

One big challenge as a society is to decide what we will say no to and to provide transparency and evidence for our decision. What must we stop doing, and how are we perpetuating what we must stop doing?[11] We will also have to find ways to say yes to the right, evidence-based services that provide good outcomes and then amplify that return on investment[5] — some of those yes items will likely be outside the boundaries of circle 1. Whatever the transformed system will look like, the Canadian values of fairness,

Table 1. Stresses in the structured acute health care system

INTERNAL STRESSES	EXTERNAL STRESSES
Capital/accumulated resources • over-specialization • physical and human resources • increasing technology • structures, equipment > services **Rigidity** • bureaucracy • politics (short election cycle) • vested interests (provincial medical associations, nursing unions, politicians) • federal vs provincial governments • mechanistic experts **Resilience** • Canada Health Act • change fatigue, burnout, no time • professional isolation • public perception and fear • fragmentation of care coordination	**REAL** • demographics (aging, high utilization) • diminishing tax base (retirement) • consumerism (increased utilization) • more chronic diseases • clinical practices not based on evidence • ethics of pharmaceutical industry • media sensationalism • cost of human resources • expensive technology and lab tests **POTENTIAL** • collapse of natural resource prices • global economic recession • overwhelming pandemic disease

equity, and compassion must be sustained at all cost.

Capabilities of physician leaders within the panarchy renewal cycle

Practising distributed and collaborative leadership,[26] physician leaders can prepare themselves and support each other during the creative destruction phase, while reaching out to every group and sector in our Canadian society. The four capabilities in the "Systems transformation" domain of the LEADS framework[27] provide some of the tools leaders need, no matter what phase of the renewal cycle we are in, and they prepare us somewhat better for the transformational changes that occur during creative destruction.

1. Demonstrate systems thinking
One of the challenges for leaders during dramatic change is to maintain a balance between a mechanistic approach to a technical or simple problem and an organic adaptive approach to a complex situation.[28] That balance may be a function of our need for control. In a complex situation with innumerable variables, control is virtually impossible.[27] Adaptive leaders who practise distributive leadership attempt to achieve a balance between giving people some freedom to create the future and total lack of coordination resulting in confusion and chaos.[28]

Another challenge for adaptive leaders is the fact that big change may not be incremental, but rather sudden and dramatic. If we as leaders are blind to the forces driving change, we won't be prepared when they reach the tipping point and rapid transformation occurs. Because of the interdependency and non-linearity of a complex system, we need to be aware that we don't control change, we simply have some influence over it.[27]

2. Encourage and support innovation
Innovation cannot take place without unleashing potential and creativity. Letting go and stopping some existing tasks opens up possibilities for starting new initiatives or amplifying what is working well, while measuring outcomes. For example, in the 2014 Physician Master Agreement, Doctors of BC let go of the traditional fee negotiations and, instead, signed a facility-based physician initiative to improve the quality of service to patients and the work environment for physicians, in collaboration with their health authorities.[29] Giving up the 50-year-old tradition of negotiating an increase in physician fees in favour of an agreement on facility engagement has led to many new physician-led initiatives throughout the province.

Many professional sub-cultures are often stronger than the prevailing system-wide culture. Physicians are accustomed to their autonomy and to putting allegiance to professional values ahead of the needs of the system as a whole. Because physicians play a unique role in the health care system, they must be involved in changes and innovation. To engage physicians in the change process, leaders need special strategies and tactics.

3. Orient strategically toward the future
Leaders often have to act before they have all of the information: they cannot rely on certainty, nor can they eliminate risk. Being able to live with uncertainty is one thing that separates those who are leaders from others. Enhancing our environmental awareness, using tools and techniques to scan the environment, developing information and communication systems, and deliberately contemplating the future in the context of the complex, adaptive health care system all help leaders orient toward the future and be adaptive to the shock that large system changes can trigger.[27]

4. Champion and orchestrate change
Physician leadership shows up in how actively we work to support and implement system change. To champion something is to advocate, support, and fight for it. To orchestrate change is to shape and combine agents in the hope of achieving a desired effect or learning from failure. Both verbs emphasize inclusiveness and connectedness, re-emphasizing the principles of distributive problem-solving and collaborative leadership.[27]

Summary

Health care systems are complex and adaptive. The structured component of the Canadian system, i.e., in-hospital and medical care, has probably reached the top of its maturity phase or is stuck in a rigidity trap in the renewal cycle.

The resulting loss of resilience has led to high internal pressure and a high risk of collapse or creative destruction. External pressures from the less-structured health care system and the global determinants of health also heavily influence the resilience of our structured health care system, as it was defined in legislation. Creative destruction will lead to transformation of the system, leading to the survival of some sustainable system agents and the disappearance of others. Are we, as physicians and leaders, prepared to take on the coming challenges that will accompany the collapse of the system as we have known it?

References

1.Book description. Washington, DC: Island Press; n.d. Available: http://tinyurl.com/zfr9ca8 (accessed 14 June 2016).

2.Begun JW, Zimmerman B, Dooley KJ. Health care organizations as complex adaptive systems. In Mick S, Wyttenbach ME (editors). *Advances in health care organization theory.* San Francisco: Jossey-Bass; 2003. pp. 253-88.

3.Gunderson LH, Holling CS. *Panarchy: understanding transformation in human and natural systems.* Washington DC: Island Press; 2002.

4.Hollnagel E, Braithwaite J, Wears R. *Resilient health care.* Surrey, UK: Ashgate; 2013.

5.Picard A. The path to health care reform: policy and politics. Ottawa: Conference Board of Canada; 2012. Available: http://tinyurl.com/p4y9grn (accessed 22 Jan. 2016).

6.Simpson J. *Chronic condition: why Canada's health-care system needs to be dragged into the 21st century.* Toronto: Allen Lane; 2012.

7.Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health.* Final report. Geneva: World Health Organization; 2008. Available: http://tinyurl.com/zmgtcyy (accessed 2 April 2016).

8.Neudorf C, Fuller D, Lockhart S, Neudorf J, Plante C, Williams-Roberts H, et al. Changes in social inequalities in health over time in Saskatchewan; 2016. Available: http://tinyurl.com/zafx65d (accessed 3 April, 2016).

9.Stange K, Ferrer R, Miller W. Making sense of health care transformation as adaptive-renewal cycles. *Ann Fam Med* 2009;7(6):484-488.

10.Homer-Dixon T. Complexity science. *Oxford Leadership* J 2011;2(1):1-15.

11.Zimmerman B. From lifecycle to ecocycle: renewal through destruction and encouraging diversity for sustainability. In Zimmerman B, Lindberg C, Plsek P (editors). *Edgeware: lessons from complexity science for health care leaders.* Bordentown, NJ: Plexus Institute; 2008. pp. 171-84.

12.Commonwealth Fund. International survey of primary care physicians in 10 nations. New York: The Commonwealth Fund; 2015. Available: http://tinyurl.com/hylthht (accessed 9 April 2016).

13.Wait times for priority procedures in Canada, 2016. Ottawa: Canadian Institute for Health Information; 2016.

14.Benchmarking Canada's health system: international comparisons. Ottawa: Canadian Institute for Health Information; 2013. Available: http://tinyurl.com/n2zptap (accessed 30 Sept. 2015).

15.Davidow WH. *Overconnected.* Harrison, NY: Delphinium Books; 2011.

16.Clemens J, Semail N. *First do no harm: how the Canada Health Act obstructs reform and innovation.* Ottawa: MacDonald-Laurier Institute; 2012. Available: http://tinyurl.com/jl6oj9y (accessed 9 April 2016).

17.Marchildon GP, Di Matteo L (editors). *Bending the cost curve in health care: Canada's provinces in international perspective.* Toronto: University of Toronto Press; 2015.

18.Lazar H, Lavis J, Forest PG, Church J. *Paradigm freeze: why it is so hard to reform health-care policy in Canada.* Kingston: McGill-Queen's University Press; 2013.

19.Gerein K. Former executives suggest ways to halt revolving door at top of Alberta health services. *Edmonton J*;2016:April 7.

20.Progress report 2013: health care renewal in Canada. Toronto: Health Council of Canada; 2013. Available: http://www.healthcouncilcanada.ca (accessed 8 April, 2016).

21.Simpson J. Still stuck on the health-care treadmill. *Globe and Mail*;2016:April 8.

22.Westley F, Zimmerman B, Patton MQ. *Getting to maybe: how the world is changed.* Toronto: Vintage Canada; 2007.

23.Barua B. *Waiting your turn: wait times for health care in Canada.* Vancouver: Fraser Institute; 2015. Available: http://tinyurl.com/hln2kyy (accessed 8 Jan. 2016).

24.Unleashing innovation: excellent healthcare for Canada. Ottawa: Advisory Panel on Healthcare Innovation, Health Canada; 2015. Available: http://tinyurl.com/qx2cf8z (accessed 18 Dec. 2015).

25.Zimmerman B. Wicked questions: surfacing differences. In Zimmerman B, Lindberg C, Plsek P (editors). *Edgeware: lessons from complexity science for health care leaders.* Bordentown, NJ: Plexus Institute; 2008. pp. 150-4.

26.Swanson RC, Cattaneo A, Bradley,E, Chunharas S, Atun R, Abbas KM, et al. Rethinking health systems strengthening: key systems thinking tools and strategies for transformational change. *Health Policy Planning* 2012;27:iv54-61.

27.Dickson G, Tholl B. *Bringing leadership to life in health: LEADS in a caring environment.* New York: Springer; 2014.

28.Heifetz R, Grashow A, Linsky M. *The practice of adaptive leadership.* Boston: Harvard Business Press; 2009.

29.Webb C. Physician engagement in our health facilities. *BC Med J* 2015;57(9):379.

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This article has been peer reviewed.

Mediocre leaders fix weakness, great leaders leverage strengths

Paul Mohapel, PhD

Abstract

This article explores strength-based approaches to physician leadership. The nature and impact of strengths are addressed and differentiated from those of weaknesses. Recent research demonstrates how paying attention to intrinsic strengths is the key to exceptional performance and innovation, while the conventional wisdom of fixing weaknesses is ultimately ineffective and leads to mediocrity.

KEY WORDS: physician leadership, strengths, weakness, excellence, high performers

The truth about exceptional performers

In the 1990s, the Gallup polling organization became very interested in understanding what differentiated mediocre from exceptional leaders. Using their well-established polling apparatus, they systematically investigated over 80 000 managers to see if they could find the essential attribute(s) of high-performing leaders.

Unexpectedly, in virtually every profession and career, the best discriminator of outstanding performance was not a character attribute, but simply came down to how people spent their time. Specifically, compared with mediocre performers, exceptional leaders invested a greater proportion of their time engaged in activities that energized and fulfilled them.[1]

Compared with average leaders, it seems that exceptional leaders have a greater awareness of their natural talents and spend proportionally more time leveraging these strengths and less time addressing their weaknesses. In fact, exceptional performers were not good at many things but excelled at just a few select things, which runs against the conventional wisdom that values well-roundedness.

Gallup's research on top achievers can be distilled into four principles:

1. High performers fully *recognize* their talents and can articulate them in great detail.
2. High performers structure their *time* to develop their talents into strengths.
3. High performers find roles that best support the *application* of their strengths.
4. High performers invent *novel ways* to apply their strengths in various situations to enhance achievement.

Defining a strength

When I ask leaders to define a strength, the most common response is: "something you're good at" or "someone who is very competent or skilful." Although these perspectives are not wrong, they are incomplete. First, being good or competent is not the same as being exceptional; a strength implies a level of performance that most do not achieve. Second, these definitions don't tell us where a strength comes from or the conditions that must be in place for exceptional performance to appear. Skills and knowledge are important components of a strength, but they tell us nothing about why some achieve exceptional performance, despite having the same access to knowledge or training as others who do not.

Recent research has offered a more complete understanding of strengths. The Gallup group asserts that strengths are derived primarily from innate dispositions, or *talents*, which are "naturally recurring patterns of thought, feeling, or behaviour."[2] A strength can be viewed as "a pre-existing capacity for a particular way of behaving, thinking, or feeling that is authentic and energising to the user, and enables optimal functioning, development and performance."[3]

If we were to drill down to the essential innate quality that exemplifies a strength, it would be the experience of feeling energized when one engages in a particular, focused activity.[4] Being energized implies experiences that are associated with strong positive emotions that are linked with deeply rooted yearnings and satisfactions.[1] When playing to talents, one feels empowered, which prompts one to move to higher levels of excellence. Playing to one's talents is a positive reinforcer, and doing it continuously is energizing and motivating. Indeed, when people focus on developing their strengths, we find that their learning curve is much more rapid than that of the average person.[2]

Strengths need to be cultivated

Gallup discovered that each person has a limited, specific number of naturally occurring talents, which represent the unique and authentic aspects of one's personhood. There is a direct connection between one's talents and their achievements, where "a talent is… productively applied" to produce a strength.[2] As such, a strength may be something that one is not necessarily good at in the moment but has the potential to lead us to becoming outstanding, i.e., when one reaches consistent, near-perfect performance in a given activity[5] (Figure 1).

Linley and colleagues[3] point out that strengths come in two forms: those that are consciously known to us because we use them frequently in our lives (realized strengths), and those that are unknown because there is little opportunity to use them (unrealized strengths). The underlying message is that strengths need to be developed and, if they are ignored, then they lie dormant and underused. Therefore, the greatest barrier to our living to our fullest potential and becoming exceptional may lie in the fact that we do not focus a sufficient amount of time on nurturing our strengths.[6]

Honing one's own innate talents through focused development is a necessary condition for talents to emerge into strengths. One cultivates a strength by learning *knowledge* (facts and information) and practising *skills* (the steps in an activity). To use an analogy, talents can be viewed as "diamonds in the rough," whereas strengths are diamonds that show brilliance after they have been carefully cut and polished.

The limitations of weaknesses

Several years ago, Gallup asked the following question of managers around the world: "Which would help you be more successful in your life — knowing what your weaknesses are and attempting to improve your weaknesses or knowing what your strengths are and attempting to build on your strengths?" Those who chose to focus on their strengths were a minority in all countries examined.[2]

This speaks to a powerful assumption that underlies most organizations: each person's growth is in their areas of greatest

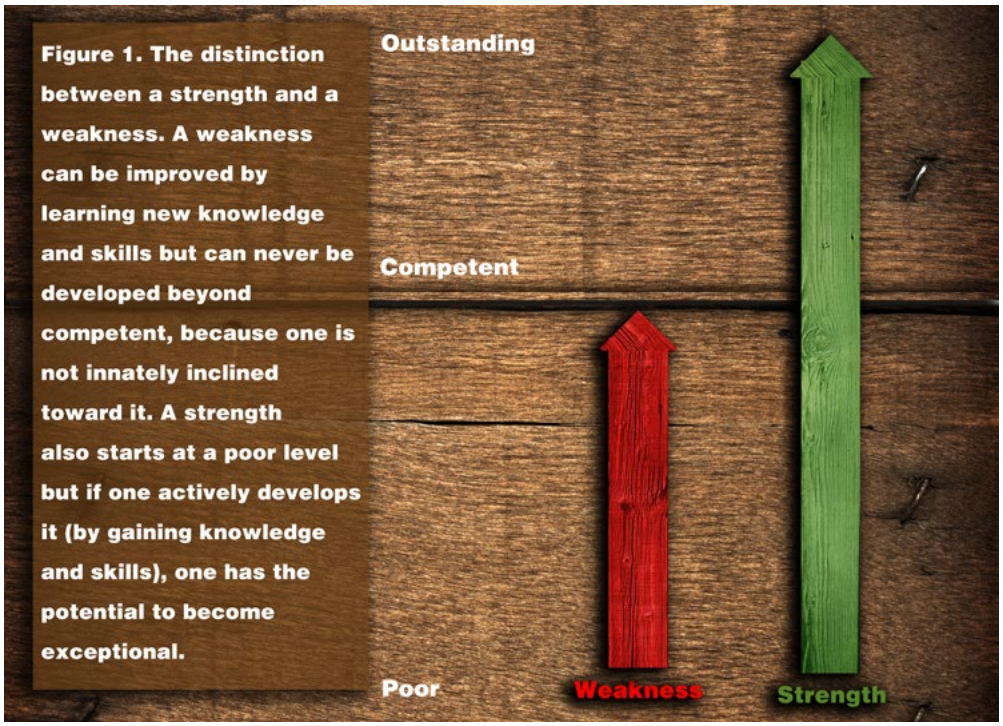

Figure 1. The distinction between a strength and a weakness. A weakness can be improved by learning new knowledge and skills but can never be developed beyond competent, because one is not innately inclined toward it. A strength also starts at a poor level but if one actively develops it (by gaining knowledge and skills), one has the potential to become exceptional.

weakness. This is particularly evident in our common language, which is richly detailed in weaknesses. For example, there are overwhelmingly more terms to describe weakness in psychiatry (neurosis, psychosis, depression, mania, hysteria, panic attacks, paranoia, etc.) than there are terms to describe strengths, which tend to be more vague and general, such as "happiness." Moreover, Seligman and Csikszentmihalyi[7] reported that there are over 40 000 studies on depression and only 40 on happiness, joy, and fulfillment. Embedded in this assumption is that "good" is the opposite of "bad," or "strengths" are simply the inversion of a "weakness." The extension of that thinking implies that to enhance strengths, one simply needs to focus more on improving weaknesses.

However, the positive psychology movement has pointed out fundamental flaws in the weakness approach, challenging the notion that strength and weakness are opposites existing on the same continuum.[7] For example, can one truly understand what it means to be healthy by only studying disease? Can one learn what it takes to have a successful marriage by simply knowing everything there is about divorce? To understand effective leadership, should we just examine poor leaders?

Buckingham[8] argues that focusing too much on weaknesses only reinforces mediocrity, as all you can learn from failure is how not to fail; it teaches us nothing about what it takes to be successful or excel. He argues that the primary reason we avoid focusing on our

strengths is the fear of failure. This is particularly true in health care, where we seem more focused on "surviving" emergencies and putting out fires, than on what it takes to thrive, innovate, and build on past successes. To ask people to build their strengths requires, first, a fundamental shift in one's perceptions and assumptions around weaknesses.

The strengths-based literature does not advocate completely ignoring weaknesses, but rather places less emphasis on them. If you have a limited amount of resources and time, you are better off focusing on what you do well and what energizes you than on something you find draining and unfulfilling. Weaknesses need to be seen as anything that gets in the way of excellent performance; therefore, the more effective strategy is to contain and work around them rather than making them a primary focus of our development. Some authors go as far as to state that true weaknesses do not exist, but what, in fact, prevents us from a higher level of performance is an imbalance of opposing strengths.[5]

The case for strengths-based approaches

Alex Linley and his colleagues[3] explored the connections among strengths use, goal progress, psychological needs, and well-being. They found that those who identify and develop their core strengths report greater progress on their goals, higher motivation, increased life satisfaction, more positive emotions, and fewer negative emotions. Moreover, greater life satisfaction and motivation are the result of creating greater self-concordant goals (i.e., goals that are consistent with who one truly is), reinforcing the notion that true core strengths align with one's authentic self.

The Gallup organization has conducted the bulk of research

on the benefits of strength-based approaches, with up to 10 million workers studied to date. Its research clearly demonstrates that strengths-based interventions have a profound positive impact on workplace performance and leadership.[1] Some of the common benefits of learning about one's strengths are greater self-awareness, teamwork, engagement, optimism, subjective well-being, and confidence.[9]

For example, a Gallup study indicated that employees who have the opportunity to focus on their strengths every day are six times as likely to be engaged in their jobs and more than three times as likely to report having an excellent quality of life.[10] Increases in employee engagement as a result of strengths-based development have been meaningfully linked to such business outcomes as profitability, turnover, safety, and customer satisfaction.[11]

Direct benefits of strength-based development have also been shown in the health care environment. For example, Black[12] examined the impact of strength-based interventions for nine hospitals over a three-year period and found a significant elevation in employee engagement. A recent study by Muller and Karsten[13] examined the impact of deploying a strength-based "leadership development inventory" to the entire population of a regional health care system and found that it enhanced awareness, employee satisfaction, employee retention, conflict resolution, inter- and intradepartmental communication, and overall organizational culture. To date, no studies have assessed the direct impact of strength-based inventories on physician performance.

Developing one's strengths

Marcus Buckingham,[8] one of the original researchers with Gallup, has found that the greatest barrier to developing one's strengths is a lack of awareness and an underdeveloped vocabulary to articulate strengths. He offers two approaches to discovering one's strengths: track daily activities for events that either energize or drain energy; and conduct a strength-based assessment.

The purpose of tracking one's daily activities is to raise awareness around one's intrinsic strengths in action. Just over the course of a week, recording specific work or personal activities that either energize or drain, can indicate patterns of strengths and weaknesses.[4,8] Another approach is to complete a strength-based self-assessment inventory. Unfortunately, almost all assessments on the market focus on and measure weaknesses (even if they claim to measure strengths, most just invert what you're not weak in and assume it's a strength). Proper strengths inventories need to provide, not just information about what one is good at, but also address those innate talents that are energizing, feel authentic to use, are consistently applied, and are used across multiple settings. Currently, there are only a small handful of inventories that directly assess strengths or talents. One example is the StrengthsFinder assessment by Gallup, which allegedly identifies one's top five signature strengths.[14]

On a final note, one of the greatest barriers to developing strength is the fear of "overdoing" one's strength, in that it becomes a liability. There does not appear to be any substantial evidence to support such a claim, and more likely this viewpoint reflects the pervasive weakness mentality discussed above.[6] Given that it is the application of our strengths that results in exceptional performance, the real issue is likely due to misattributions about our strengths. In fact, the real culprit is often an underlying weakness that is undetected or ignored. For example, if a physician is strong in empathy, yet finds that she is negatively impacted by her patient's emotional responses, she might interpret this as overusing empathy and decide that she needs to pull back. However, the real issue is that she may have an unaddressed weakness, such as being unskilled in setting boundaries with her patients. Thus, the effective solution is not to reduce her empathy, but to increase her skill in setting boundaries.

To conclude, the strengths-based literature indicates that talent is not something that is rare and restricted to a few. In fact, all of us are equally gifted with a unique set of innate qualities that predispose us to greatness. Therefore, the issue is not whether we have the potential to be outstanding but whether we are able to identify, appreciate, and nurture our gifts. We face an uphill battle to cultivate our strengths, as health care is predominantly concerned with fixing weaknesses. Perhaps, one of the most important steps we can take as physician leaders is to start paying greater

attention, not only to our own strengths, but also to the strengths of those we lead. As leaders, we need to start encouraging and appreciating the best that all of us have to bring, in the hope of better serving our patients and innovating the health care system.

References

1.Buckingham M, Coffman C. *First, break all the rules: what the world's greatest managers do differently.* Washington DC: The Gallup Organization; 1999.
2.Buckingham M, Clifton D. *Now, discover your strengths.* New York: The Free Press; 2001.
3.Linley A, Willars J, Biswas-Diener R. *The strengths book: be confident, be successful, and enjoy better relationships by realising the best of you.* Coventry, UK: Capp Press; 2010.
4.Robinson K, Aronica L. *Finding your element: how to discover your talents and passions and transform your life.* New York: Penguin Books; 2013.
5.Thomas JW, Thomas TJ. *The power of opposite strengths: making relationships work.* Tulsa, Okla.: Thomas Concept; 2006.
6.Kaplan RE, Kaiser RB. *Fear your strengths: what you are best at could be your biggest problem.* Oakland, Calif.: Berrett-Koehler Publishers; 2013.
7.Seligman ME, Csikszentmihalyi M. Positive psychology: an introduction. *Am Psychol* 2000;55(1):5-14.
8.Buckingham M. *Go put your strengths to work: 6 powerful steps to achieve outstanding performance.* New York: The Free Press; 2007.
9.Hodges TD, Clifton DO. Strength-based development in practice. In Linley PA, Joseph S. *International handbook of positive psychology in practice: from research to application.* New Jersey: Wiley and Sons; 2004: 256-68.
10.Sorenson S. How employees' strengths make your company stronger. Bus J;2014:Feb. 20. Available: http://tinyurl.com/hshmdfd
11.Harter JK, Schmidt FL, Hayes TL. Business-unit-level relationship between employee satisfaction, employee engagement, and business outcomes: a meta-analysis. *J Appl Psychol* 2002; 87(2): 268-79.
12.Black B. The road to recovery. *Gallup Manage* J 2001;1:10-2.
13.Muller R, Karsten M. The systematic deployment of a leadership inventory to an employee population. *Int J Knowl Culture Change Manage* 2011;11(1).
14.Rath T, Conchie B. *Strengths based leadership.* New York: Gallup Press; 2008.

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Leadership tools for transformation: complaints, conflict, and core motivation

Shawn Whatley

Abstract

Leaders often begrudge time spent on "negative" work, such as dealing with complaints. It steals resources from positive change efforts. This article explores how complaints, conflict, and core motivation offer powerful tools for positive transformation.

KEY WORDS: leadership tools, complaints, conflict, motivation, change, transformation

Transformative change requires enormous amounts of time and energy. At Southlake Regional, our team transformed the way we provide emergency services.[1,2] We went from chronic staff shortages with below-average wait time performance, to province-leading wait times[3] and an oversupply of people wanting to work at Southlake. The transformation stretched our leadership skills and forced us to take a different perspective on issues that used to frustrate us.

At times, our team forged ahead building positive change for patients. At other times, change stopped completely, mired in complaints, conflict, and a lack of motivation. Some of us grew frustrated at the waste of time and effort required to work through negative issues or to motivate the team to do something that seemed, to us, obviously better for patients. With time, we learned to see complaints, conflict, and core motivation as opportunities, not roadblocks to change.

Complaints

A serious complaint can make a leadership team stop everything and focus on it. Complaints can come from patients, staff, regional health authorities, or other departments in an organization. Each complaint heightens sensitivity. Sequential complaints make the most responsible leaders more desperate to fix them as soon as possible. Leaders worry about what other departments, or senior administrative teams, will think of them, if complaints become repetitive.

Some people in leadership positions develop immunity to complaints. They are not leaders; they present a risk for an organization, as complaints often mark early signs of bigger problems.

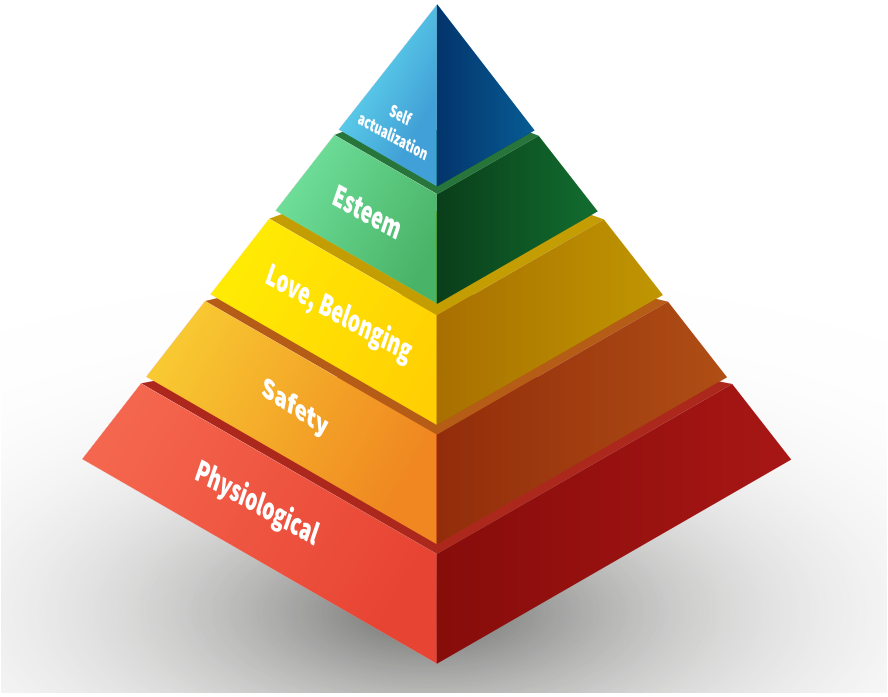
At the other extreme, weak leaders become hyper-sensitized to complaints. Hypersensitive "leaders" freeze at the thought of *another complaint*. They panic and search for safety in accepted practices: protocols, standards, and whatever all the other hospitals are doing. Their anxiety about new complaints gives enormous power to those who might threaten to complain. Staff picks up on this.

Staff members only need to hint at complaining to the board, and hypersensitive leaders will abandon change efforts.

True leaders function between immunity and hypersensitivity. They take a meta-level look at complaints, instead of treating all complaints with extremes of insouciance or dread.

Leaders need to frame complaints at a meta-level. They might ask, what kind of complaint is this? For example, complaints about safety should make leaders stop what they are doing and attend to the problem. Leaders can apply Maslow's hierarchy[5] as a heuristic to develop a meta-view of complaints (Figure 1).

Figure 1. Maslow's hierarchy of needs



Meta-view of complaints

In *Management of the Absurd - Paradoxes in Leadership*, Richard Farson[4] writes that leaders expect their improvement efforts to make people happier. We expect staff to value our efforts and complain less about work. But staff members often complain even more. Farson says it's the theory of rising expectations: "The better things are, the worse they feel" (p. 92).

Safety sits near the bottom of Maslow's hierarchy, and leaders must address safety first. But other complaints, for example complaints about resources and supplies, do not warrant the same immediacy.

As organizations improve, staff members eventually start complaining about not being able to apply the full scope of their training or not being able to volunteer for extra-curricular change efforts. Once staff members start complaining about self-actualization and the inability to fully contribute all they have to offer, leaders can celebrate. You have arrived. The complaints have not disappeared, but they have moved to the top of Maslow's hierarchy.

Conflict

Some leaders use one idea to explain too much. This happens often with personality conflicts. Carl Jung's paradigm of conflicting personality types,[7] for example introversion versus extroversion, offers an irresistible explanation to describe, and dismiss, conflict. Personality conflict gets used to explain too much.

Leaders miss a great opportunity, if they explain away conflict too quickly. Most courses on conflict management train us to handle conflict and work toward healing and unity. These have value, but they often miss a transformational secret: conflict tends to flare over ideological differences. Paradoxically, high-functioning teams use conflict to build unity.

Mine for ideological conflict

In *Death by Meeting*, Peter Lencioni advises leaders to "mine for ideological conflict."[8] He suggests that conflict offers teams a great opportunity to dig to the bottom of an issue. Encourage passion; do not jump to extinguish all conflict. Of course, people need to fight fair. They need to protect others' dignity. Leaders need to step in and referee as necessary.

Conflict foments over deep differences in opinion. For example, many providers believe that patients often attend the emergency

department for selfish reasons; they could seek care elsewhere. That belief makes it very hard to build a welcoming attitude for all patients, all the time.

Leaders should open themselves up to conflict, not just challenge. Nothing humbles us like defending our position with a team, only to have it exposed as a cover-up for some deeper idea. Nothing builds a team more than when leaders show their group that they can change their mind on a deeply held belief. Mine for ideological conflict; it offers a powerful tool to influence change.

Core motivation

Physicians learn to diagnose and treat. Treatment delayed is unethical, even heartless. Leaders enjoy finding solutions, building visions, and planning major changes. But teams need motivation to change. Clinical rationality applied to organizational transformation does not work. Teams need more than evidence and logic. Leaders must speak to all aspects of motivation.

Spheres of motivation

A mentor once shared a tip that his mentor had taught him: different things move different people.[9] Some people will change their mind if you show them a logical reason for doing so. Others will only change their mind if you convince them it's the right thing to do. He suggested that there are at least five spheres of motivation: reward, rules/punishment, concepts, social pressure, and morality.

Leaders think and speak to the sphere of motivation that means the most to them. We might develop iron-clad conceptual arguments, with supporting data, to show why our team should support change. But the argument will only move 20% of the audience. Most of the audience will remain unmoved, unmotivated.

This frustrates leaders. Faced with the same situation, many of us try harder. We build more elaborate arguments and collect better data. But 80% of our audience sits uninspired. We start to question whether our team conspires to block change for selfish reasons.

People support change when it means something to them. Leaders motivate change when they speak to all spheres of motivation, or levers of influence,[10] as much as possible. It might feel contrived to talk about aspects of social pressure, if you believe we should just follow the evidence wherever it leads. You might find it beneath you to appeal to your team's rational self-interest, to motivate change. But, as leaders, we will continue to struggle with "unmotivated" teams until we get used to speaking in terms that appeal to all spheres of motivation, not just our own.

Summary

Complaints, conflict, and core motivation offer non-intuitive tools for transformative change. They represent just three of the tools used to transform our emergency department at Southlake Regional Health Centre into a provincial leader (see *No More Lethal Waits: 10 Steps to Transform Canada's Emergency Departments*[1] for more). When handled well, these tools can turn a failed change effort into a successful transformation.

References

1. Whatley S. *No more lethal waits: 10 steps to transform Canada's emergency departments*. Toronto: BPS Books; 2016.
2. Whatley SD, Leung AK, Duic M. Process improvements to reform patient flow in the emergency department. *Healthc Q* 2016;19(1):29-35.
3. Murdoch J. Ontario Minister of Health Deb Matthews visits Newmarket to experience patient flow innovations at Southlake. Media release. Newmarket: Southlake Regional Health Centre; 2013. http://tinyurl.com/j6o9cuv (accessed 15 May 2016).
4. Farson R. *Management of the absurd.* New York: Free Press; 1997.
5. Zalenski RJ, Raspa R. Maslow's hierarchy of needs: a framework for achieving human potential in hospice. *J Palliat Med* 2006;9(5):1120-7.
6. Kremer W, Hammond C. Abraham Maslow and the pyramid that beguiled business. BBC News; Sept. 2013. Available: http://tinyurl.com/qcqzpgb (accessed 21 May 2016).
7. Chanin MN. A study of the relationship between Jungian personality dimensions and conflict-handling behavior. *Hum Relat* 1984;37(10):863-79.
8. Lencioni P. *Death by meeting: a leadership fable... about solving the most painful problem in business*. San Francisco: Jossey-Bass; 2004.
9. Michie S, van Stralen MM, West R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement Sci* 2011;6:42.
10. Martin W. The levers of influence. *Physician Exec* 25(6):8-14.

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Medical leadership: the case in the literature

Graham Dickson, PhD

Abstract

This look at three recent articles reveals the need for strong physician leadership. New models of physician involvement are required to engage physicians more in leadership roles, and robust physician leadership development efforts are vital.

KEY WORDS: physician leadership, expert leadership, health care reform, transformation

"Anyone can hold the helm when the sea is calm"— Ancient Philosopher

Recently, the concept of doctors moving into leadership roles has become a focal point in the literature. A primary reason for this

focus is the ongoing challenge of health system reform, sometimes called transformation. The health care seas are not calm. Should physicians take the helm?

It is clear to physicians that transformation will take place with physician involvement or without it. Clearly, if physicians' views, expertise, and intelligence are to influence the direction of reform, their participation as a partner is crucial. If they do not take the helm on their own, at least they should share it.

To do so, physicians must develop the skills of collaborative leadership: adopting a style that allows them to be, on one hand, the independent expert in medicine that they are and, on the other hand, the partner with a perspective, who must be included if reform is to be successful.

Recently, three articles have come to my attention that support this contention and highlight the rationale, challenges, and approaches that should be considered by physicians who are moving toward this expanded role. One article is from Australia, and the other two are from the United States, where major transformation is ongoing as a consequence of the *Patient Protection and Affordable Care Act* ("Obamacare"). Although both health care systems are contextually different from Canada's, it is important to seek out lessons from other jurisdictions that may be relevant to the Canadian context. I present a short précis of each and encourage you to access them for your further edification.

The "expert" leader

Amanda Goodall and colleagues,[1] in their article entitled "Expert leadership: doctors versus managers for the executive leadership of Australian mental health," argue that physicians — experts in their specific medical field, in this case, psychiatry — are best positioned to lead institutions dedicated to that medical field. The expert leadership theory proposes the existence of a first-order requirement — that leaders should have expert knowledge in the core business of the organization they

are to lead. Given two people with equal leadership and management experience, the one with expert knowledge will make the better leader.

The authors provide a number of examples from across the world to support this contention. Their argument in support of the expert leadership view is as follows. First, a psychiatrist executive is viewed as "first among equals," because he or she originated from among the collegial group. Having been "one of us" signals credibility, which can extend a leader's influence. However, it is important that the psychiatrist executive was/is a talented clinician and, ideally, also a researcher, in his or her prior career. An unaccomplished clinician who chooses the management route is unlikely to gain sufficient respect from physician colleagues.

Second, an expert leader, having grown out of the same environment, will be more able to understand the culture, values, incentives, and motivations of their psychiatrist colleagues and other core professionals.

Third, psychiatrist executives are uniquely placed to link clinical services with academic departments of psychiatry to provide a gateway for translational medicine, which is increasingly recognized as essential if health services are to improve.

Fourth, it is generally recognized that the success of any organization relies on the quality of its people. People who have excelled in their field of expertise (in medicine and beyond) can be expected to attract and hire others who are also outstanding in their field.

Finally, expert leaders can also signal various messages — about themselves and their organization — to their staff and outsiders. An accomplished clinician and researcher commands respect because of his or her proven track record.

Looking at the challenges

In the second article, Kathleen Sanford[2] explores the challenges that physicians face when moving into leadership positions. She suggests that although physician leadership is widely considered to be essential for success in next-era health care systems, there is a message in this intent that elicits a variety of responses from health care insiders, ranging from antipathy to fear, from resignation to anticipation.

In this article, she articulates five questions that must be addressed to understand the role of physician leadership in health care transformation:

- Why is physician leadership important?
- What needs to be done?
- How do organizations develop physician leaders?
- Who should lead?
- When should organizations develop physician leadership programs?

To answer the questions, she looks at some American health organizations that have embraced physician leadership development, including describing how dyad programs, i.e., pairing an administrator with a physician leader, at Palomar Health and Promedica are designed.

Also, she acknowledges that views among various groups in health care toward expanding physician leadership vary depending on personal experiences and biases, how leadership is defined, and how individuals believe their own career trajectories will be affected by possible shifts in power and influence. For example, most physicians would understand that moving into leadership will require major adjustments to relations between physicians and hospital

executives. However, others might be surprised to hear that some consumers are bemused: "Haven't doctors always been in charge?" Although all of these reactions to change are normal, it is vital for physicians moving into leadership roles to understand them and prepare for them.

Two leadership development approaches

The third article — by Sacks and Margolis[3] — explores how two American health organizations, buffeted by change internally, each forged a new vision and business model that made them stronger and positioned them to thrive and excel.

One organization experienced a void when its primary physician champion and thought leader left in the midst of great change, underscoring the need for ongoing physician leadership development. The departure also initiated a period of discovery on how physician leaders can best communicate with other doctors.

The other organization, through a series of transitions, created a leadership development model that teams physicians and administrative professionals throughout its organizational training and development modules. They work together on creating solutions to existing real-world challenges facing their organization, essentially forming a brain trust that constantly develops fresh ideas while fostering synergies between new leaders.

Throughout, this article explores how organizational change fostered cultural changes and how leadership navigated through those shifts. And it presents two different approaches to physician leadership development efforts.

All three articles represent a broad phenomenon that is emerging internationally, as a consequence of ongoing demands for health care reform to address the new and emergent health and wellness needs of developed-country populations. The seas are not calm. Strong physician leadership, based on an understanding of medicine's contribution to high-quality health care, is necessary. New models of physician involvement are required to engage physicians more in leadership roles. Robust physician leadership development efforts are vital. Both efforts will enhance collaborative leadership, positioning doctors as true partners in health care reform.

References

1.Goodall A, Bastiampillai T, Nance M, Roeger L, Allison S. Expert leadership: doctors versus managers for the executive leadership of Australian mental health. *Aust N Z J Psychiatry* 2015;49(5):409–11. Available: http://tinyurl.com/zyh4cuh

2.Sanford KD. The five questions of physician leadership. *Front Health Serv Manage* 2016;32(3):39–45.

3.Sacks L, Margolis R. Physician leadership in organizations undergoing major transformation. *Healthcare*; in press. Corrected proof available http://tinyurl.com/jtm294e

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2016 CSPL Excellence in Medical Leadership Award

(Chris Carruthers Award)

Dr. Gaétan Tardif
Physiatrist-in-Chief and Medical Program Director
Toronto Rehabilitation Institute
University Health Network

Dr. Tardif has excelled as a medical leader in many respects — as an academic physiatrist, a health care executive, and a system developer with experience in professional and not-for-profit organizations. As medical program director, Toronto Rehab, and professor in the Department of Medicine, Division of Physiatry at the University of Toronto, he continues to practice physiatry and promote patient safety and patient participation in all areas of the health care process.

Dr. Tardif, who was born in Saguenay, Québec, completed his medical degree at Université Laval. He holds specialty certification in physical medicine and rehabilitation, sports medicine, and electrodiagnostic medicine.

Dr. Tardif is very involved in leadership development and is on the faculty of the Physician Leadership Institute of the Canadian Medical Association. From 2009 to 2011, he was president of the Canadian Society of Physician Leaders. He recently obtained certification from the Institute of Corporate Directors.

Dr. Tardif's unique leadership skills extend to his many volunteer activities and he is an avid supporter of the paralympics. He has led or been a member of the Canadian Paralympic medical team for many years. He was a member of the team for the Sydney 2000 and Athens 2004 Paralympic Games, chief medical officer for Salt Lake City 2002 and Torino 2006, assistant chef de mission for Beijing 2008 and Vancouver 2010, and chef de mission for London 2012. In May 2013, he was elected president of the Canadian Paralympic Committee. He was also recently a member of the board for the Toronto 2015 Pan Am and Para Pan Am games.

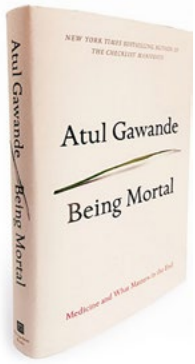
Dr. Tardif has been and remains an influential medical leader in Ontario and, indeed, nationally and internationally when he represents Canada. His curriculum vitæ is extensive, proof of his leadership skills academically, clinically, in research, and administratively. On a personal level, Dr. Tardif remains humble and empathic. He is always willing to provide assistance and always shows courage when needed —a powerful leadership trait.

BOOK REVIEW

Being Mortal: Medicine and What Matters in the End

Atul Gawande
Doubleday Canada, 2014

Reviewed by Chris Eagle, MBA, MD



As of the day I am writing this review, there are 4306 reviews of the hard cover version of *Being Mortal* on Amazon's website. Clearly, this book has had impact, both deep and broad. Is there more to this than Gawande catching the crest of the wave of aging boomers looking nervously into the mirror of mortality? The answer is yes.

In brief, the book explores a number of themes about aging and dying in modern societies. It brings with it the author's personal experience and insights gained from his patients and those who are close to the business and practice of aging and dying. As usual, Gawande uses his medical perspective to add depth, but also critical perspective.

The book is a careful mix of personal insight and philosophical and cultural reflection. It is an uncomfortable thesis about western culture's and western medicine's medicalization of aging, dying, and death, and their ultimate failure to deal with the consequent issues. It leaves a very unsettling picture, even for those who have become inured to the status quo.

Numerous examples are given where minor changes in the environment of the aging have made differences, to both quality and length of life. The point is that we do have options about how we support our families and ourselves in the final years of life.

Gawande talks about the "dying role." "People want to share memories, pass on wisdoms, settle relationships, establish their legacies, make peace with God, and ensure those who are left behind will be okay. They want to end their stories on their own terms." This perspective holds true for the elderly dying in nursing homes, for patients dying from terminal cancer, and for those dying in intensive care. The key is to "help people with a fatal illness have the fullest possible lives right now."

As caregivers, we need to focus on extending life while holding close an appreciation of the quality of the life we are extending. When is enough truly enough? Increasing specialization of care, with the numerous caregivers all contributing a part, does not make this conversation any easier to have. Our minds are full as we plan a technical plan of care. We must focus on the needs of the person as well as the body.

This has been said many times before. What Gawande brings and what is refreshing is the candor of his vision. It is a clear and direct challenge to health care providers and institutions. We can go further with those at the end of life, and that journey can start with small steps.

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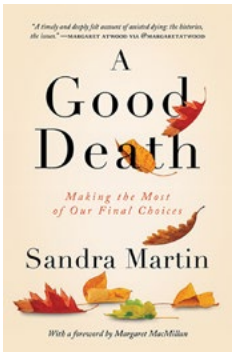
BOOK REVIEW

A Good Death: Making the Most of Our Final Choices

Sandra Martin
HarperCollins, 2016

Reviewed by Johny Van Aerde, MD, PhD



The release of this book could not have been more timely. With facts updated to February 2016, it was published two months later in April, quite unusual for a book to be so up to date.

This book is, without any doubt, a must read for physicians, if not every Canadian citizen. One may think that it is about Bill C-14 (the

medical assistance in dying bill). After all, author Sandra Martin is the journalist who wrote in the Globe and Mail, "Bill C-14... has far too little heart and far too much head. It is lodged firmly in the mindsets of risk-averse bureaucrats and politicians."[1]

The book goes much further than that; it is a compilation of philosophical, historical, legal, and international issues related to assisted death, assisted suicide, palliative care, and euthanasia. It is based on facts and hundreds of interviews with people close to the issue — doctors, patients, ethicists, activists, and underground suicide aides. The opposition to decriminalizing assisted suicide and death is powerful and sometimes moralistic, with religious groups, "experts," and palliative-care doctors sometimes raising a true panic. Martin parses through the arguments in a balanced way, without hiding which side of the argument she is on.

She gives an outstanding overview of the recent history of death, detailing legal skirmishes in Belgium, Luxembourg, Switzerland, the Netherlands, and parts of the United States that have drawn new boundaries in the battle for legalized death and euthanasia. However, it is Canada's struggle that dominates her book.

The evidence is clear, not only that Canada is not an international leader in the domain of assisted death, but also that there is no nationally united health care system, even in death. As in so many components of the Canadian health care system, this has resulted in each province dealing with palliative care, assisted death, and assisted suicide differently.

Quebec is the most advanced province, legislatively, thanks to Veronique Hivon with her nonpartisan and unrelenting efforts during and after her political career with the Parti Québecois. On the other side of the country, British Columbia was first off the starting blocks, going back as far as 1993 when Sue Rodriguez, a courageous woman, challenged the law. A few years ago, there was the now famous case of Kay Carter, another BC woman, resulting in the decisions by the Supreme Court that have led to the present struggles of our government with drafting appropriate legislation.

Indeed, in February 2015, based on the Carter case, the Supreme Court of Canada legalized physician-assisted death and gave the government a year to implement legislation. A handful of Canadians have already pursued physician-assisted death in the interim, but they had to present their cases before the courts. In that kind of legal limbo, the rights of both patients and doctors under the Canadian Charter of Rights and Freedoms are at issue, and doctors are wary of the uncertain consequences.

In 2015, Adam Gopnik[2] wrote in the New Yorker about radical reform as it pertained to gay marriage and argued that radical reform needs the underpinning of social consensus if it is to succeed peacefully and permanently. He submitted that an impossible idea becomes possible first, then it becomes necessary and, finally, all but a handful of diehards accept its inevitability. Making an impossible idea possible requires time, patience, and reasonableness. "The job of those trying to bring about change is... to move it into the realm of the plausible, and once it is plausible…, it has a natural momentum toward becoming real."[2] Martin makes the point that this is exactly what is happening with the assisted death issue.

Whether we like it or not, this pressing social issue is about to reshape Canada. Death must be allowed to evolve in tandem with our medical and demographic realities. Perhaps there was a time when assisted suicide or death did not reflect the moral or spiritual realities faced by most people. The issue has reached a tipping point, and Martin urges Canadians to get involved in the national dialogue on death with dignity. Reading this book is one way to start our fight for our final human right.

References

1.Martin S. The heart of dying: a personal journey. *Globe and Mail* 2016;April 16.
http://tinyurl.com/ha9aosy
2.Gopnik A. Trollope trending. *New Yorker* 2015; May 4.
http://tinyurl.com/lvzvmxj

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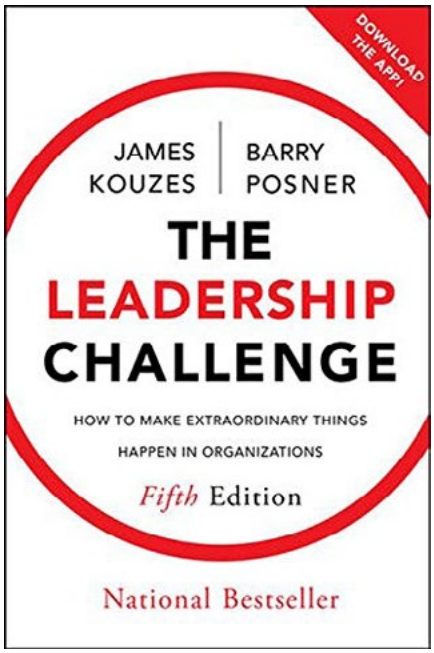
BOOK REVIEW

The Leadership Challenge: How to Make Extraordinary Things Happen in Organizations

James M. Kouzes and Barry Z. Posner
Jossey-Bass, 5th edition 2012

Reviewed by Johny Van Aerde, MD, PhD



Because Barry Posner was one of the keynote speakers at the recent 2016 Canadian Conference on Physician Leadership, this book review focuses on some of the work he has published with his business and research partner, James Kouzes. Their most famous work, *The Leadership Challenge,* is based on more than 30 years of research and data from thousands of personal best-leadership experiences throughout the world.

At the outset of their research, the authors administered a questionnaire to more than 75 000 people throughout the world, asking what qualities in a leader would inspire them to follow *willingly*. The results were striking in their consistency and have been confirmed recently in another analysis, 30 years later, for the 5th edition of *The Leadership Challenge*, and in follow-up books, such as *Credibility: How Leaders Gain and Lose It, Why People Demand It* [1] and *The Truth about Leadership: the No-fads, Heart-of-the-matter Facts You Need to Know.*[2]

Among characteristics of a leader people are willingly to follow, four rose to the top of the list, each receiving more than 60% of the votes: honest, competent, inspiring, and forward-looking. These attributes, particularly the first three, make a leader credible. Credibility is the foundation of leadership, because constituents must be able to believe in their leaders.

In a separate survey, Kouzes and Posner found that people who perceive their managers as having high credibility are more likely to:

- Be proud to tell others they're part of the organization
- Feel a strong sense of team spirit
- See their own personal values as consistent with those of the organization
- Feel attached and committed to the organization
- Have a sense of ownership of the operation

Based on the remarkably similar patterns they discovered across different cultures, the authors developed a model of leadership and came up with essential practices for exemplary leaders to achieve success: model the way; inspire a shared vision; challenge the process; enable others to act; and encourage the heart.

Model the way — This refers to the most fundamental way in which leaders earn and sustain credibility: they do what they say they will do. There are two parts to this practice. To model behaviour effectively, you must first *clarify your values*: find your own voice and then clearly and distinctly express your values to everyone in the organization. You must believe in the values you express, but those values must not be merely your own personal principles, they must also represent what the organization stands for. However eloquent your speech, you must then follow it with actions that reflect your expressed values. That is where the second part comes in: *set an example*. Your words and deeds must be consistent. Effective leaders set an example through daily actions demonstrating that they are deeply committed to their beliefs. If you're not willing to do a given task, why should others be willing?

Inspire a shared vision — This is also a two-part practice. First, you must *envision the future* by imagining and believing in an exciting, highly attractive outlook for the organization. Be confident that you can make that extraordinary future come true. An exemplary leader is exceptionally good at imagining a future that does not yet exist. But the vision in his or

her imagination is not enough to create an organized movement or to forge significant change in an organization. The second part of this action is to *enlist others* in a common vision. To do this, you must convince people that you understand their needs and have their interests at heart. Leadership is a dialogue, not a monologue. You must have intimate knowledge of people's dreams, hopes, aspirations, visions, and values. You will breathe life into these hopes and dreams and create a unity of purpose by showing constituents how the dream promotes the common good. You must make your own enthusiasm contagious.

Challenge the process — Most leadership challenges involve a change in the status quo. In fact, not one of the leaders interviewed by Kouzes and Posner claimed to have achieved a personal best by keeping things the same. All leaders must challenge the current process. The first step in doing this is to *search for opportunities* to innovate, grow, and improve. These opportunities come from listening and constantly looking outside yourself and your organization for new products, processes, and services. The second part of challenging the existing process is to *experiment and take risks*, despite the possibility of failure. Good leaders look for small victories, as each small win builds confidence in long-term success. Failure is also a valuable learning experience.

Enable others to act — Success requires a team effort. It requires group collaboration and individual accountability. Enabling others to act entails two things. First, *foster collaboration* and build trust. Engage all who must make the project work, including peers, managers, customers, clients, and suppliers. Trust is a central issue in human interactions. People who are trusting are more likely to feel happy and well-adjusted than those who view the world with suspicion, and they are more satisfied with their organization. By creating a climate of trust, a leader takes away the controls and gives people the freedom to innovate and contribute. Second, *strengthen others* by increasing self-determination and developing competence. Make it possible for others to do good work. Good leaders do not hoard power, they give it away.

Encourage the heart — This refers to genuine acts of caring to uplift the spirits of the people on the team. First, *recognize contributions*. Show appreciation for individual excellence by both expecting the best and personalizing recognition. Second, *celebrate values and victories* by creating a spirit of community. This serves to align behaviour with the cherished values expressed at the outset.

In summary, we are not born leaders; we become leaders by learning skills and abilities that can be strengthened, honed, and enhanced. The five practices of exemplary leaders form such a set of skills. Leaders who adopt these practices create higher-performing teams, increase customer satisfaction levels, and foster loyalty and greater organizational commitment. People who work with leaders who are honest, forward-looking, inspiring, and competent are significantly more satisfied, committed, energized, and productive.

The Leadership Challenge is a classic in the world of leadership and deserves a spot on your bookshelf. The other books by Kouzes and Posner[1,2] further expand on some aspects of the main book and don't deserve the additional investment.

The leadership challenge in the Canadian health care system

Why are the five practices of exemplary leaders not visible throughout our health care system? How can they be introduced into it? How can each of us apply and practise them in our own smaller component of the larger health system?

References

1.Kouzes JM, Posner BZ. *Credibility: how leaders gain and lose it, why people demand it.* 2nd ed. San Francisco: Jossey-Bass; 2011.
2.Kouzes JM, Posner BZ. *The truth about leadership: the no-fads, heart-of-the-matter facts you need to know*. San Francisco: Jossey-Bass; 2010.

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CCPL 2016 inspires and informs

Carol Rochefort and
Johny Van Aerde

With four top keynote speakers, a lively debate, 32 workshops to choose from, and plenty of time to network and chat, the 2016 Canadian Conference on Physician Leadership was the best in recent years.

Over 370 participants, mainly physicians, attended this year's Canadian Conference on Physician Leadership (CCPL 2016) at the Royal York in Toronto — an event that generated more than 2000 tweets over the two days. All workshops and keynote addresses were chosen around the theme, Leading Together: Achieving Results.

Barry Posner, PhD, professor of leadership at the Leavey School of Business, Santa Clara University, was the opening keynote speaker with "Becoming the best leader you can be." With Jim Kouzes, Posner is the co-author of *The Leadership Challenge*[1] (reviewed in this issue), one of the top 100 business books of all time and based on ground-breaking leadership research that has stood the test of time for three decades.

Posner began with recent research findings that 86% of people think that there is a leadership crisis in the world, and 97% of employers think that leadership development should start at the age of 21 (it actually starts in the mid-40s).

During his interactive presentation, Posner introduced us to the five principles of *Learning Leadership*,[2] the title of his latest book. The "five fundamentals of becoming an exemplary leader" are: believe you can, aspire to excel, challenge yourself, engage support, and practice deliberately. These principles seem to be an amalgamation of some of the concepts from The *Leadership Challenge*,[1] LEADS capabilities,[3] and the sources of influence described in *The Influencer*.[4]

Tim Magwood, a master storyteller, followed Posner's academic talk with an inspirational address, entitled "The mark of a leader," which had the audience up and clapping. He started by claiming that, if we show the world what is possible, the world will take over and make it reality. He used the dabba wala system in Mumbai as an example.[5] To delineate our personal "possibilities," Magwood asked what our 4-minute mile was? He then guided the audience through the five levels of leadership needed to make "the possible" happen and optimize our passion: spirit, imagination, intellect, heart, and hands.

The keynote speakers were followed by two sessions of eight simultaneous workshops, for a total of 32 workshops over the two days. The only negative aspect of the workshops was that one could not attend all of them.

The first day ended on several high notes. This year's mock debate, "Be it resolved that politicians are an obstacle to health care reform," was moderated skillfully by Dennis Kendel, MD. He indicated that the topic was appropriate after last year's debate, which made us look inward, at ourselves as a profession, when we debated that *physicians* are an obstacle to health care reform.

Jeffrey Braithwaite, PhD, and Chris Eagle, MD, took one side of the argument, while Anne Snowdon, PhD, and Gillian Kernaghan, MD, took the other. The debaters delivered an amazing performance under Kendel's watchful and playful eye. The event was entertaining, yet followed debate rules. Just as evidence in the literature indicates, the audience voted affirmative in support of the resolution that governments (not necessarily individual politicians) are obstacles to the transformation of the health system.

The day ended with a celebration of the new recipients of the Canadian Certified Physician Executive designation and this year's winner of the CSPL's Excellence in Medical Leadership Award (the Chris Carruthers award): Dr. Gaetan Tardif (see page 121). The festivities continued during the reception, where old relations were nourished and new connections formed, all facilitated by a glass of wine and a wide variety of hors d'oeuvres.

Jeffrey Braithwaite kicked off the second day with his provocative keynote address, "Resilient health care: reconciling work-as-imagined (WAI) and work-as-done (WAD)." Braithwaite, a professor at Macquarie University in Sydney and director at the Australian Institute of Health Innovation and the Centre for Healthcare Resilience and Implementation Science, pursues two main streams of research: health care reform and resilience in the health care system. His talk focused on the latter and started with the assertion that, "Every time we hurt a patient, every tear is a waterfall."

He had the audience reflect on the difference between a "to-do" and a "ta-da" list, where the former is what we think should happen, as in rules and policies, and the latter is what we actually accomplish, usually not as planned. He then compared this with the blunt end of an organization, where policies and rules are made, and what actually happens at the front end, the "ta-da" list.

Braithwaite studies why 90% of care is delivered without harm despite the chaos in emergency departments and other parts of the health care system. On the flip side, he pointed out, despite all our efforts, the rate of harm has flat-lined at 10%. Although the "to-do" list, the rules and policies, represents a mechanistic view of the system, health care delivered at the front line by people who flex and adjust to the circumstances behaves as an adaptive complex system. In other words, the work gets done, often *despite* all the policies, rules, and mandates.

Braithwaite's final thought was that reconciling WAI and WAD is the responsibility of people at both the blunt end and the sharp end, and physician leaders constitute the only group that can do this.

Anne Snowdon, PhD, professor and chair of the International Centre for Health Innovation at the Ivey Business School, tackled "Global trends in health system innovation: opportunities to strengthen health systems." She opened by announcing that, without changes, the Canadian health care system as we know it will collapse by 2030. She talked about global trends in health care innovation, including the empowered consumer in a digital world who focuses on value and wellness, transparency, and outcome-focused funding models.

Although Canadians are more connected than any other population in the world — spending 45 hours a month online and checking their smart phones 127 times per day — as far as innovation in health and health care is concerned, Canada ranks low among its peers in the Organisation for Economic Co-operation and Development. What will health care look like when its connectivity reaches the level it has in other service industries, such as taxis and holiday travel? Uber is now larger than the taxi industry, yet it doesn't own one single car, just as AirBnB doesn't own any real estate. What will that look like for health care: personalized, individualized, and with immediate access?

That revolution will move us from "Triple Aim" to "Triple Value": convenience, choice, and cost. That revolution may not even wait until Gen Y becomes the next dominant generation, as seniors are the fastest-growing demographic group in the app market. And wouldn't it be nice if tracking and traceability would connect us and all our contact points with the health industry through bar codes — not different from what has been happening in most other industries for many years?

Space doesn't permit us to summarize the 32 informative and well-attended workshops that were offered. If you missed CCPL 2016, which was among the best physician-leadership conferences of the last few years, you can make up for it by coming to CCPL 2017 in Vancouver (April 28-29).
See you there!

References

1.Kouzes K, Posner B. T*he leadership challenge: how to make extraordinary things happen in organizations* (5th ed). San Francisco: Jossey-Bass; 2012.
2.Kouzes K, Posner B. *Learning leadership: the five fundamentals of becoming an exemplary leader*. San Francisco: Wiley; 2016.
3.Dickson G, Tholl B. *Bringing leadership to life: LEADS in a caring environment*. London: Springer-Verlag; 2014.
4.Grenny J, Patterson K, Maxfield, D, McMillan R, Switzler A. *Influencer: the new science of leading change* (2nd ed). New York: McGraw-Hill; 2013.
5.Karan. Dabbawalas: Mumbai, India (video). Geobeats. Available: http://tinyurl.com/hdrnead.

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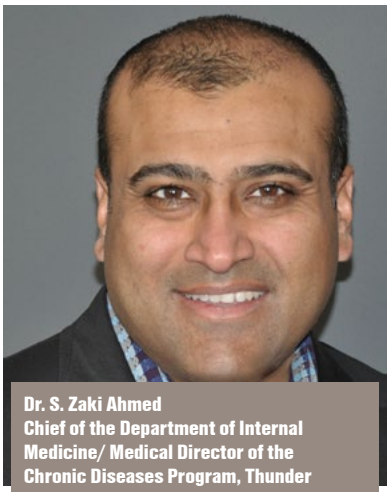

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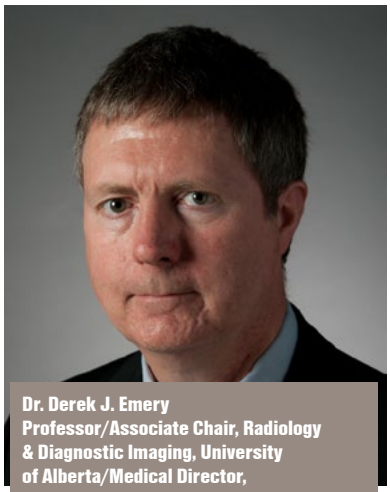

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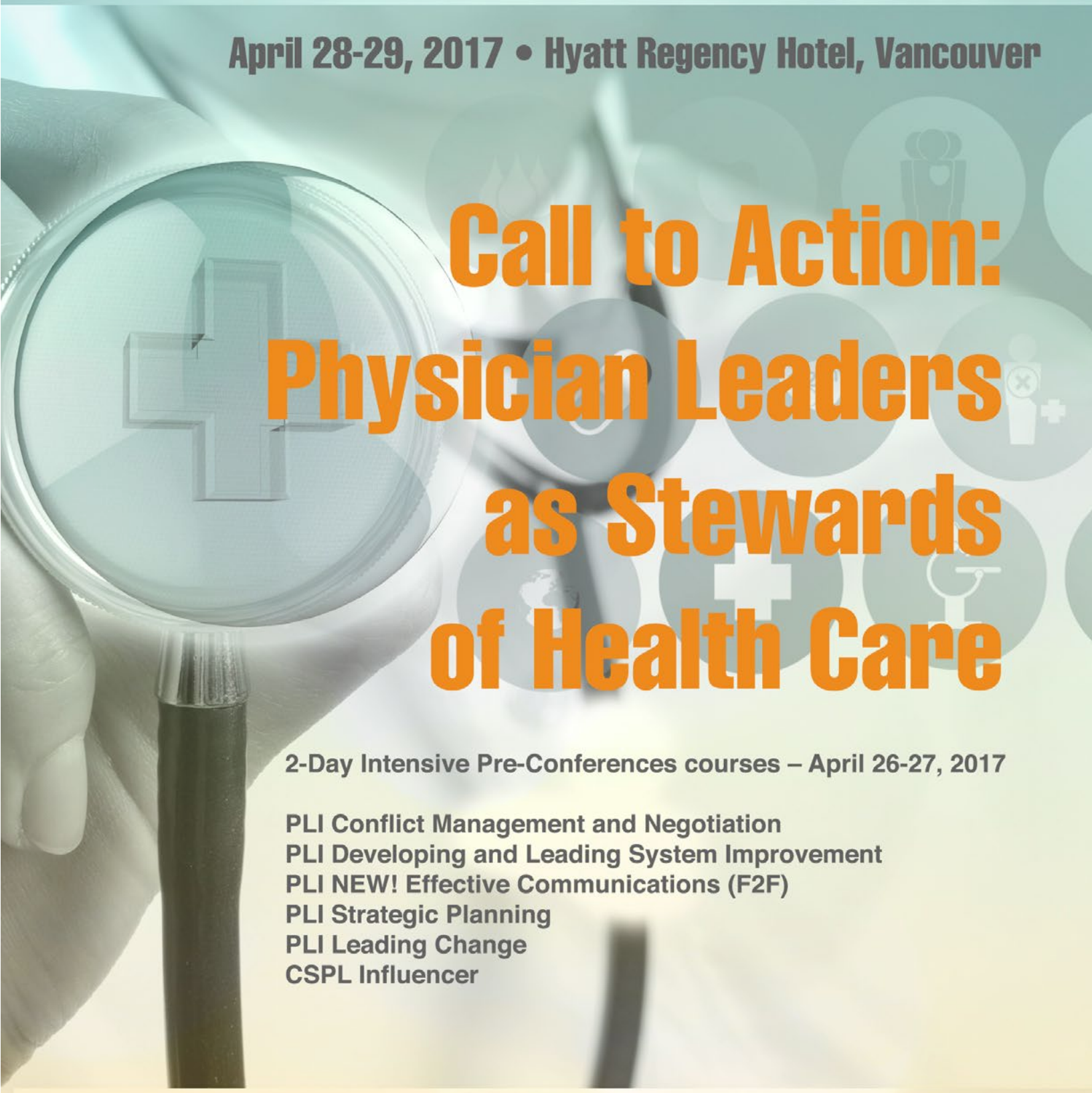

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