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# Physician Leadership

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# Small "p" Political Skills

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**In this Issue** EDITORIAL: Why are we not achieving lasting results in reforming the Canadian health system?

Introducing a formative approach to developing better leaders in academic medical institutions

Evaluating a continuing education workshop as a strategy to address disruptive behaviour in postgraduate medical education



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EDITORIAL

# Why are we not achieving lasting results in reforming the Canadian health system?



Johny Van Aerde, MD, PhD

Almost daily, there is a news story about interactions between a provincial government and physicians or their representative organizations. The variety is striking, ranging from collaborative conversations around what a sustainable health care system might look like to openly hostile confrontations.<sup>1-5</sup> Why such a wide spectrum? Why are tangible results for sustainable

transformation of our health system absent to limited, even in provinces where dialogue continues? A new vision for the Canadian health care system is urgently needed, a vision that is both inspirational and truly owned by each and all.

“Where there is no vision, the people perish” (Proverbs 29:18). Since the introduction of medicare, and even more so since the inception of the *Canada Health Act*, the vision of what health care means for Canadians has become more and more muddled. All stakeholders — government, citizens, patients, physicians, and other health care professionals, alike — have different agendas. To set a common direction for the health care system in provinces and territories, Canadians urgently need to redefine the purpose of medicare and determine what health care and its supporting system mean.<sup>6</sup>

LEADS makes it very clear that, without a vision that sets direction, results cannot be achieved. LEADS is a leadership framework with five domains: lead self, engage others, achieve results, develop coalitions, and systems transformation.<sup>7</sup> Each domain has four capabilities. The first capability under achieve results is “set direction,” which is defined as “inspire vision by identifying, establishing and communicating clear and meaningful expectations and outcomes.”<sup>8</sup> The gridlock in many jurisdictions of our country is simply due to a lack of common vision. As a result, there is no inspiration and no ownership by stakeholders.

Canadians have inherited a health care system from the past — one that none of us owns today. “Vision can be leader-driven... or created collaboratively by engaging members of the organization; the latter approach is generally the most effective way to win broader acceptance for a vision.”<sup>8</sup> Indeed, we own what we help create.<sup>7</sup> By collaborating to revisit the vision and direction of the Canadian health care system, we, the





stakeholders, would truly own what we help create.

Therein lies a double problem: we fail in our efforts to recreate a common vision on what health care should look like and we rely on something we don't own, because we didn't create the present system which is based on last century's needs. What worked 50 years ago for care in local hospitals and physicians' offices no longer applies in the health care world of the 21st century. Today's demands have changed under pressure from an aging population, from patients with multiple chronic rather than acute diseases, and from a huge health care industry driving the system's costs into oblivion.<sup>9</sup>

Ownership involves engagement at a systemic level, and that systemic engagement is lacking among all stakeholders. Politicians "own" health care only for the duration of a short election cycle; thus, long-term sustainable visions and

changes lose to quick fixes to please the electorate. Over the last few decades, evidence indicates that governments are one of the two biggest obstacles to health care policy reform.<sup>10</sup>

The provincial organizations representing physicians are the second biggest obstacle.<sup>10</sup> Whereas physicians are the best advocates for each patient's care, one at a time, they rarely engage in their patients' care at a systemic level.<sup>11</sup> Physicians don't act as if they have much ownership of the system.

Finally, as tax payers, Canadians may "own" the system, but as consumers, they don't. Indeed, citizens and patients want to ensure that their individual needs are served first, irrespective of the effect on the community. In an attempt to apply the principles of consumerism in a universal health care system and encouraged by an entire health care industry that contributes to employment

and the economy, the system is moving toward a "tragedy of the commons."<sup>12</sup> The lack of feeling of personal ownership of the resource is leading to overuse, eroding it until it becomes unavailable to anyone.<sup>12</sup>

Visions must be inspirational to trigger our passion for pursuing a better world.<sup>7</sup> How inspiring is the 50-year old vision of our Canadian health system? How can we become passionate about something in which stakeholders in many provinces cannot find common ground or when consumers take its existence for granted? Many Canadian jurisdictions default to an American vision of health care: "triple aim,"<sup>13</sup> i.e., better care, improved health, lower costs. Although attempts are being made to adhere to this view, the self-interests of stakeholders prevent those values from translating into the inspirational common vision needed to generate passion and set a direction toward action and real results.

Without a vision, the conditions for three further capabilities under LEADS's achieve results domain cannot be met. Vision is needed to set direction, decisions then have to be strategically aligned with that direction and the available evidence, then action must be taken to implement those decisions, while, in the meantime, assessment and evaluation are needed to monitor the long-term outcomes. Until we practise the leadership skills necessary to achieve results, we will continue to tinker with issues, such as wait times and unproven practices of regionalization, rather than deal with the sustainable system transformation needed to improve Canada's ranking in OECD health statistics.

According to the LEADS framework, one of the basic leadership skills needed is "set direction to achieve results."<sup>7</sup> As long as we avoid the conversation on the purpose of our health care system, it will continue to move toward collapse.<sup>14</sup> As physician leaders, elected leaders, and citizen-patient leaders, it behooves us to have those difficult conversations. Will the real leaders step up?

## References

1. Mark D. Another vote for "no" in Ontario. Toronto: Canadian Healthcare Network; 2016. Available: <http://tinyurl.com/huuveaf> (accessed 16 July 2016).
2. Collins L. The "new" anger among Ontario physicians (editorial). *Medical Post* 2016; 21 June.
3. Jayabarathan A. Taking one for the team: why I voted yes to the Nova Scotia fee deal. Toronto: Canadian Healthcare Network; 2016. Available: <http://tinyurl.com/zwm9us8> (accessed 2 July 2016).
4. The future physician role in a redesigned and integrated health

- system. Saskatoon: Saskatchewan Medical Association; 2016. Available: <http://tinyurl.com/hf22c3x> (accessed 28 July 2016).
5. Supporting facility-based physicians. Vancouver: Doctors of British Columbia; 2016. Available: <http://tinyurl.com/zdmpfac> (accessed 2 July 2016).
  6. 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).
  7. Dickson G, Tholl B. *Bringing leadership to life in health: LEADS in a caring environment*. New York: Springer; 2014.
  8. O'Connell D, Hickerson K, Pillutla A. Organizational visioning: an integrative review. *Group Organ Manage* 2011; 36(1):103-25.
  9. Reinhardt U. Why we should bend the cost curve and how. In: Marchildon G, Matteo L, editors. *Bending the cost curve in health care*. Toronto: University of Toronto Press; 2015.
  10. 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.
  11. Bujak J. How to improve hospital-physician relationships. *Front Health Serv Manage* 2003; 20(2):3-21.
  12. Meadows D. *Thinking in systems*. Vermont: Chelsea Green; 2008.
  13. Triple aim for populations. Cambridge: Institute for Healthcare Improvement; 2016. Available: <http://tinyurl.com/zmgzmg3> (accessed 28 July 2016).
  14. Van Aerde J. Panarchy, the collapse of the Canadian healthcare system, and physician leadership. *Can J Phys Leadership* 2(4):103-9.
  15. OECD health statistics 2016. Paris: Organisation for Economic Co-operation and Development; 2016. Available: <http://tinyurl.com/m4xzg8> (accessed 29 July 2016).

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# Introducing a formative approach to developing better leaders in academic medical institutions



Peter S. Craighead, MD

The quality of medical leadership in academic institutions has been the focus of increased interest for the past 20 years, with many claiming that we are in a crisis because of an insufficient number of high-quality leaders. Alberta's medical landscape has changed significantly over the past 8 years after super-regionalization of the entire province, which

led to serious challenges in attracting leaders and convincing them to stay. This study shows that, by establishing a Leadership Development Office, supported by a formal advisory board, the Department of Oncology in Calgary has been able to lead succession planning, develop skills in a large cohort of emerging leaders, and attract broad-based interest in leadership at all levels. A description of the practical steps required to integrate leadership development within a department and the limitations of this approach in smaller departments is included. This study demonstrates that integration of leadership development within large academic medical departments is both practicable and economical, and integration has enabled the oncology department to stabilize the medical staff environment in cancer services in Calgary.

**Key words:** leadership development, academic medicine, integrated leadership program

Society talks openly about the absence of strong leaders and their importance to communities and organizations. At the World Economic Forum in 2015, 86% of several thousand attendees agreed that the world was in a leadership crisis, with evidence suggesting that it was not confined to government and public circles, but extended across all sectors.<sup>1</sup> Several academic think tanks have also raised concerns about leadership gaps in medical schools.<sup>2</sup>

Although these pronouncements have been interpreted as showing that there are insufficient numbers of leaders, the crisis is more likely related to poor quality of leadership. Quality of leadership has been broadly defined by Feigenbaum<sup>3</sup> as the ability of leaders to perform superiorly, because of developed personal traits, characteristics, values, and behaviours. Major leadership training centres have quantified this quality by linking competencies with superior performance.<sup>4</sup>

Is mediocrity in leadership performance prevalent in academic medical institutions, and can it be remedied by developing certain skills in leaders? Given that medicine faces the same societal challenges as other industries, it is probable that academic medical institutions are as threatened by poorer quality leadership as other domains. Whereas industry and larger medical schools strongly support the notion that leaders

become better by being trained in certain competencies, this concept has not been widely embraced by all medical institutions.<sup>5,6</sup> Others in health care have postulated that increasing these critical competencies or skills is the first step to raising the overall quality of leadership.<sup>5</sup>

In 2010, two years after Alberta's health system had been coalesced into a single entity, the Tom Baker Cancer Centre/Department of Oncology (TBCC/DOC) in Calgary was forced to address the challenge of finding and recruiting leaders. Between 2008 and 2010, it had been difficult to attract senior leaders, and there was a risk that it could lose current leaders. The organization recognized the need for regular succession planning, the importance of skills training for emerging leaders, and the need to improve its ability to identify potential leaders.<sup>6</sup> The TBCC/DOC also reached agreement on the skills and competencies required of leaders at various levels by using a Delphi method that tested members' expectations across the department. It became clear that TBCC/DOC could not address this task within its administrative structure and, therefore, it formed a task group to start the process by conducting a needs assessment and environmental scan.

One of the major decisions made early on was to consider leadership at TBCC/DOC at three levels: emerging, mid-level, and senior leaders. Emerging leaders are potential leaders, most of whom come from generation Y (and are technologically savvy). Mid-level leaders are those who have some

experience leading small groups. Senior leaders are those who have led large (or strategically important small) groups, including regional and provincial entities. Although TBCC/DOC considered hiring an external agency to tailor programs to address its needs, the expense made this prohibitive. The original task group, which began work on the needs assessment, eventually evolved into the Leadership Development Office (LDO).

The overall goal of this study is to show that the establishment of a departmental LDO has led to a more coordinated approach to recognizing gaps in leadership and developing leaders as early as possible. This report will allow TBCC/DOC to evaluate whether the LDO is an investment worth continuing and whether it is also a solution for other large academic medical departments concerned about future leadership challenges.<sup>7</sup>

## Methods

This qualitative study was undertaken in 2015 by the LDO, which had been established in 2010. It is based on the hypothesis that better coordination of leadership development provided by the LDO would result in:

- A significant increase in the number of emerging leaders receiving skills training
- A reduction in leadership vacancies within the department
- A willingness to fill external leader positions, shown by the increased number of Calgary academics in regional, provincial, and national roles

To test this hypothesis, the LDO obtained the following information from the TBCC/DOC:

- An analysis of department demographics, as part of a university-wide assessment in 2012
- An environmental scan of the essential components of a leadership development program, completed in 2012 by SCI Sargent Consultants
- Results from a 2012 department-wide survey to evaluate the needs of department members (providing a list of motivators and obstacles to integrating leadership development and the competencies needed for leaders to be effective)
- Estimates of leadership gaps provided by annual succession plans (2012–2015)
- The number of skills-training seminars offered to internal candidates and the number of people attending them
- An estimate of leadership vacancies between 2009 and 2015

The author then examined the factors that allowed the formation of an effective LDO, evaluating the challenges and steps to implementing such an office.

## Results

The LDO has facilitated a proactive approach to leadership development that involves data gathering, succession planning, skills training, coaching, and identification of people for both training and positions. Coordination of this leadership development

**Table 1. Motivators for establishing a formal leadership development strategy**

- **Low level of preparedness for senior leadership roles**
- **Insufficient funding for individuals to access leadership development programs**
- **Difficulty in attracting solid academic physicians to senior roles**
- **Lack of tools to evaluate and manage bad leadership behaviour**
- **Relative absence of funds to attract external candidates to vacant leadership positions, creating the perception that appointed internal candidates were mediocre**
- **Lack of orientation for new leaders in senior roles**
- **Insufficient number of coaches and mentors to support development of potential leaders**

function addressed the study hypothesis by demonstrating that there has been:

- **More emerging leaders receiving training:** Between 2010 and 2015, the department trained 90 emerging leaders internally, in two half-day seminars on six occasions. All attendees were able to create their own life plans during the seminars and completed “thinking style” assessments.<sup>8</sup> Before 2010, there were no formal leadership skills training courses for this group of leaders.
- **Coaching:** During the study period, formal coaching was coordinated for 25 senior leaders, increasing the number of people exposed to leadership coaching by 300%.
- **Reduction in leadership vacancies:** All senior leadership positions were filled over the past five years, with 10 internal and two external appointments. Since implementing this explicit approach to developing leaders, only one leadership position has remained vacant for more than four weeks. In comparison, between 2008 and 2011 the department was unable to fill three senior positions for more than a year, and four mid-level leader roles

were unfilled for two years.

- **Broader influence:** Since 2014, five members of the department have assumed major provincial, national, or international leadership roles, whereas in 2008–2013, there were only two such appointments. Several members have been appointed to executive positions in national oncology societies. This is a subjective assessment, as we are uncertain whether this outcome was merely a result of the creation of new roles.

### Steps required to establish an effective leadership development office

#### 1. Create a sense of urgency through data gathering and assessment of group perspectives

The department executive felt that, without data to demonstrate what needed to be done, it was

powerless to address inertia. Thus, the first step was to develop a comprehensive plan for moving forward, using data from:

- **Needs assessment survey:** Between May and November 2012, an online survey was undertaken to allow the LDO to understand the motivators and obstacles to leadership development (Tables 1 and 2), as well as the competencies that people needed. This snapshot of development challenges within Alberta’s cancer centres provided an opportunity to look at the issues within the Calgary staff subset. In Calgary, 340 staff members participated in the survey, of whom 50% were academics.
- **Demographic analysis of oncology academic staff:** To understand the potential types of future leadership challenges, we used the faculty-wide assessment to examine the demographics of our department and show a breakdown of gender, age, and race in the clinical and academic streams.<sup>9</sup> In terms of gender, race, and age groups, the proportions in oncology mirrored those of the whole faculty for both clinical and academic groups. There were

**Table 2. Obstacles preventing faculty from moving ahead with a new leadership development strategy**

- **Insufficient funds**
- **No formal staffing or space from which to coordinate the activities**
- **Likely opposition from research institute directors and some department heads about the cost of investing in a formal structure**
- **Traditional preference to recruit external leaders**
- **Lack of interest in developing leadership skills by strong academic physicians who believe it is more important to develop and perform good research**
- **Lack of recognition of the value of leadership within the merit increment and promotions processes**
- **Perceived inattention to poor leadership behaviour of current leaders**



no significant differences in ethnicity, gender, or age between academic and clinical streams. The most striking finding in both academic and clinical streams was the dominance of people in the 55–65 years age category (47%), 18% of whom would be retiring in the next five years (Figure 1). In addition, 52% of our staff are 31–50 years of age, which augurs poorly for sustainability unless we encourage development of emerging leaders.

- *Environmental scan:* In 2012 an external consultant undertook a comprehensive overview of elements required for leadership development in academic medicine in cancer care. It used the experience from LEADS, the UK's National Health Service, and larger faculties of development in medical schools to show the importance of establishing a comprehensive approach to developing physician leaders.

## 2. Clarify the role of an LDO with the support of an advisory committee

Once there was a clear understanding of what had to be done, the LDO moved to coordinate succession planning, organize training of leaders, and negotiate with external programs.

- The department head attempted to garner interest from external agencies to address the areas identified. When this proved too costly, the department head hired a consultant to determine what could be done internally and

recommended that the division heads operate as an advisory committee for an expanded leadership development office. The advisory group agreed on the space needed, type of training to be offered, time required for support staff, and a budget for succession planning and skills training of emerging leaders.

- The staff worked cohesively in the first two years, allowing for annual succession planning and coordination of skills training to occur. In 2011, a major breakthrough occurred with the implementation of the Georgia State administrative services succession planning tool.<sup>10</sup> Between 2011 and 2015, this tool was used annually to identify gaps and highlight individuals ready for promotion. In 2013, the LDO expanded to support a resource library and oversee coaching opportunities for senior leaders.

## 3. Develop a module for formal skills training for emerging leaders

One of the important first steps for the LDO was to develop a module that would provide training in leadership skills to emerging leaders. A human resources consultant was hired to develop a module to be offered in a classroom setting.

Based on results of the needs assessment survey and recommendations from the consultant hired to provide advice on internal programs that could be offered, LDO created a seminar series for emerging leaders. These modules increase self-knowledge/

self-awareness and the ability to build teams, drive team effectiveness, lead change, and resolve conflict.

Although it is impossible to identify all aspects of these changes, it is relevant to describe briefly the major changes. A formative approach has been introduced in the TBCC/DOC, based on the principle that high-performing organizations should have strength at multiple leader levels, with an initial emphasis on emerging leaders. In terms of skills development, the major focus has been on teaching self-awareness, team-building, leading change, and resolution of conflict, with emerging leaders showing interest in attending such seminars.

LDO has yet to demonstrate that the skills taught have resulted in changed behaviour, although the TBCC/DOC has succeeded in attracting many of these “graduates” into leadership roles.

## Discussion

Integration of a leadership development service into a large academic medical department is achievable. In Calgary's Department of Oncology, the establishment of a dedicated office has increased interest in skills training seminars and coaching for leadership skills development, is associated with a significant decrease in leadership vacancies, and has interested more members in leadership roles outside the department. One of the major benefits of this integration has been the ability of the department to emphasize the importance

of academic leaders and their relevance to sustainability. In the local setting, significant momentum was gained by gathering baseline data, which catalyzed the drive to better coordinate leadership development.

Could the increased focus on gaining leadership skills, improvement in the leadership environment, and reduction in leadership vacancies in the department have been achieved without the integration of leadership development? It is quite possible this could have been achieved using other strategies; however, the relatively low investment needed to achieve the successful outcomes reported here — about 250 h of administrative time and about \$80 000 over five years — justifies the approach described in this report.

The cost, even conservative estimates, of providing these services by external agencies would have prohibited this

department from offering leadership development to as wide a group of leaders as was targeted in this initiative. For example, skills training seminars for 90 people would have cost \$270 000; executive coaching for 25 people would have cost \$150 000; and consulting costs for five years of annual succession planning would have been \$20 000. These estimates are likely low, as they do not include travel.

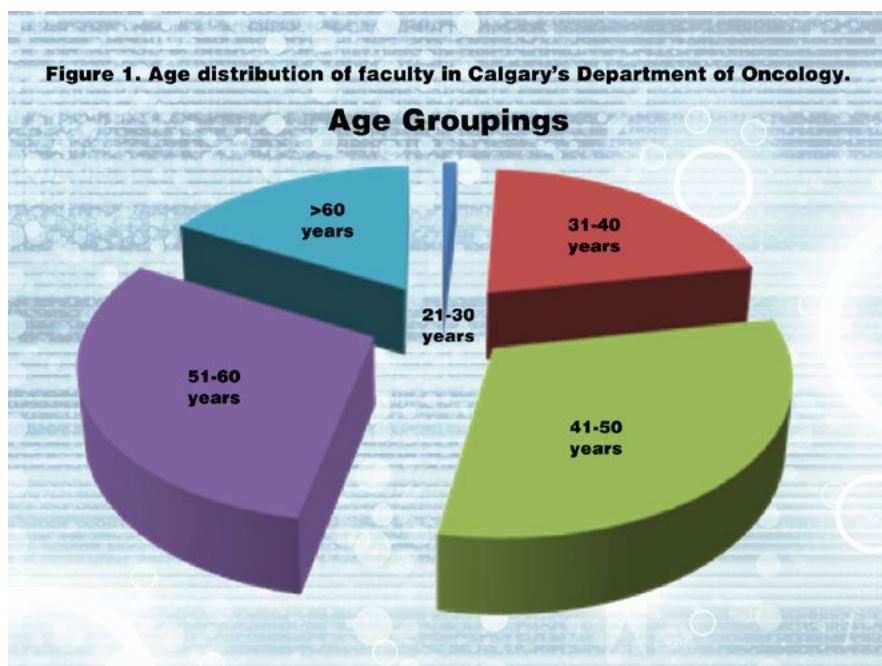
The strong connection between the sustainability of a healthy organizational culture and effective leadership makes it critical to develop strong leaders.<sup>11,12</sup> In mid- to large-sized medical schools, the best solution for individual departments is likely the establishment of a centralized faculty career development office that serves all departments. Many mature academic medical institutions have successfully created such offices and this would have been a preferred, less expensive solution for

TBCC/DOC.<sup>11-14</sup> Unfortunately, many medical schools have yet to arrange career development centrally. Large academic departments that are not supported by a central office should consider integration of leadership development in a manner similar to the one described in this report.

There are limitations to recommending this approach to academic departments. First, this study did not address mid-level and senior leader groups comprehensively, and it may be that the major benefits of this approach are to emerging leaders and in terms of long-term succession planning.

Second, smaller academic departments may not have sufficient administrative staff to accommodate the office workload generated, nor enough participants to make this strategy practical. The financial investment and time commitments likely make it feasible only in larger academic departments (with more than 200 members). The TBCC/DOC, with its 250 members, experiences sufficient transitions in leadership to make this approach viable. Nevertheless, smaller departments should perform succession planning regularly, so that they can identify gaps and solutions needing to be addressed by external agencies.

Third, a venture like this would not likely have gained momentum without senior leaders who were committed to push for this change. In groups where such synergy does not exist, it would be more prudent not to entertain such a strategy, but



rather develop budgets that support a narrower spectrum of identified individuals for leadership training by external agencies.

Finally, the approach we have described here should not be considered comprehensive, nor ideal for all departments. For departments ready to evaluate where changes are needed and able to coordinate initial changes, this approach will serve them well. However, it cannot be expected to address more complex issues (e.g., strategic planning, ethical issues, conflict resolution, negotiation techniques), and the department is now working directly with other executive bodies to offer programs for advanced mid-level and senior leaders.

What are the alternatives to using the described approach for larger departments without central offices? Some people suggest that all development programs overestimate benefit, as all leadership roles eventually get filled, with or without developed individuals. Others contend that good leaders rise to the occasion spontaneously when needed, or that external executive programs are better at leadership development than internal approaches, such as the one described. Some assume that “someone else” in their institution is responsible for this development activity and do not concern themselves with succession issues.

Evidence shows that relying on any single one of the above approaches is likely to fail and that providing multiple elements within an office is far more likely to succeed.<sup>15,16,17</sup>

The LDO in Calgary should be regarded as a hybrid approach to providing a career development focus within an academic medical department. It now offers multiple elements, starting with the classroom teaching/experiential learning and qualitative feedback approaches described in this report, but it has expanded to offer coaching and strategic planning training through external agencies. The major benefit of the office is its ability to coordinate both internal and external elements. It also relies on some services provided by the medical school.

The TBCC/DOC takes the mandate to prepare young leaders for the future seriously. It believes that, if it is to advance medical sciences, care for patients, and lead teams, then the development of leaders has to be at the forefront of its consciousness.<sup>7,12</sup> Ultimately, our ability to develop leaders will enable our departments to be places where academics make a global contribution. Large academic departments must consider their responsibility to develop potential leaders, and consider the formative approach described here as a possible model.

## References

1. Gore A. Top 10 trends of 2015. Geneva: World Economic Forum; 2015. Available: <http://tinyurl.com/z7h3npe>
2. Awasthi S, Beardmore J, Clark J, Hadridge P, Madani H, Marusic A, et al. The future of academic medicine: five scenarios to 2025. New York: Milbank Memorial Fund; 2005. Available: <http://tinyurl.com/hm8hq89>
3. Feigenbaum AV. Changing concepts and management of quality worldwide. *Qual Prog* 1997;30(12):45-8.
4. The leadership development roadmap. Greensboro, N.C.: Center for Creative Leadership; 2015. Available: <http://tinyurl.com/zawk9ms>
5. Leslie JB, Chandrasekar A, Hannum

- K, Ruohong Wei R, Zhang Y, Joseph D. Understanding the leadership gap: a quantitative analysis of leadership effectiveness. Greensboro, N.C.: Center for Creative Leadership; 2008. Available: <http://tinyurl.com/jv9ycnc>
6. Kirkpatrick SA, Locke EA. Leadership: do traits matter? *Acad Manage Exec* 1991;5(2):48-60. Available: <http://tinyurl.com/h4rjmr>
7. Cacciope R. An integrated model and approach for the design of effective leadership development programs. *Leadership Organ Dev J* 1998;19(1):44-53.
8. Bramson RM, Bramson S. What kind of thinker are you? *Readers' Digest* 1987;131(788):149-151.
9. Craighead PS, Anderson R, Sargent R. Developing leadership within an academic medical department within Canada: a road map for increasing leadership span. *Healthc Q* 2011;14(3):80-4.
10. Workforce planning. Atlanta: Department of Administrative Services, Government of Georgia; 2015. Available: <http://tinyurl.com/jn9wsws>
11. Mallon WT, Buckley PF. The current state and future possibilities of recruiting leaders of academic health centers. *Acad Med* 2012;87(9):1171-6. Available: <http://tinyurl.com/jnn8z6a>
12. Charan R, Drotter S, Noel J. *The leadership pipeline: how to build the leadership powered company*. New York: John Wiley & Sons; 2001.
13. Cumming School of Medicine: strategic plan 2015-2020. Calgary: University of Calgary; n.d. Available: <http://tinyurl.com/z74md92>
14. Ready-now leaders: 25 findings to meet tomorrow's business challenges. Global leadership forecast 2014-2015. Pittsburgh: Development Dimensions International; n.d. Available: <http://tinyurl.com/hwqpuwy>
15. Souba C. Do deans and teaching hospital CEOs agree on what it takes to be a successful clinical department chair? *Acad Med* 2011;86(8):919-1057.
16. Souba C. The science and practice of leading yourself (course material). Hanover, N.H.: Geisel School of Medicine; June 2013.
17. Hernandez-Broome G, Hughes R. Leadership development: past, present, and future. Greensboro, N.C.: Center for Creative Leadership; 2014. Available: <http://tinyurl.com/qfzed>

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This article has been peer reviewed.

## POSITION PAPER

# More effectiveness, not more competencies

A Canadian perspective on the role of political skills in developing physician leaders



Scott Comber, PhD,  
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Physician leadership is crucial for success in the Canadian health care system. However, LEADS in a caring environment, CanMEDS 2015, and other competency-based frameworks related to physician leadership development have, thus far, failed to create measurable and perceivable outcomes. Current frameworks do not properly address the complexity of the environment, are neither proven nor designed

to create effective leaders, lack direction in the acquisition and tangibility of these skills for physician leadership, and fail to provide physician leaders with effective foundational skills. In this paper, we explore the political skills inventory and argue that this new competency framework provides four clear, foundational competencies needed by all physicians to be effective: social astuteness, apparent sincerity, interpersonal influence, and networking ability. The integration of these skills into the training of physicians, at any point in their career, would provide physician leaders with the skills they need to effect change in their complex environment.

**Key words:** Canada, political skills, health care, physicians, effective leadership

### Context

The Canadian health care system suffers from a lack of effective physician leadership. The Health Association of Nova Scotia<sup>1</sup> notes that the health care system and

health outcome standards are not being met and points to diminished leadership capacity as a key factor.

Competency- and curriculum-based leadership frameworks and their lengthy lists of competencies and skills form the basis for most physician leadership development programs, yet they have shown limited success because of a lack of focus. Nova Scotia and other provinces that employ these frameworks are experiencing insufficient physician leadership capacity.<sup>1</sup> LEADS in a caring environment — used by the Canadian Medical Association's Physician Leadership Institute and other health authorities across Canada<sup>2</sup> — and CanMEDS 2015's competency framework for the roles of leaders<sup>3</sup> do not provide a clear path for the acquisition of these skills or a deadline or timeframe for when the skills are acquired. Most important, they have not proven effective in building physician leadership.

These frameworks focus on individual competencies, but fail to provide measurable outcomes in a complex environment, provide a set of foundational leadership skills to physicians, or lay out an effective path for attaining these proficiencies. The solution to effective physician leadership development may not be found in a diverse array of leadership skills or more competency frameworks, but rather in very specific competencies, such as the political skills inventory (PSI).<sup>4</sup> We propose that a more concerted focus, specifically on political skills as foundational leadership skills for

all physicians, may hold some of the answers to the question of how to achieve more effective physician leadership.

This paper is an exploration of the potential benefits of incorporating a specific, foundational set of four skills that:

- have been assessed and proven to make leaders effective
- provide a clear process for development of these skills at any time in a physician’s career
- provide physicians with skills they currently lack
- are finite and understandable
- craft leaders who lead effectively in a complex environment

These five factors support the contention that political skills are useful for physicians in their increasingly complex environment and help them provide effective leadership.

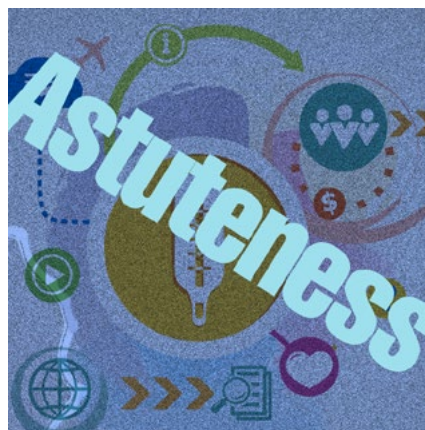
### Political skills

The PSI differs from traditional competency frameworks, as it includes a set of four, foundational, focused competencies that aim to increase effectiveness. According to Ahearn et al.<sup>5</sup> political skills are the “ability to effectively understand others at work, and to use such knowledge to influence others to act in ways that enhance one’s personal and/or organizational objectives” (p. 311). As such, politically skilled individuals combine four key competencies<sup>4</sup>: social astuteness, apparent sincerity, interpersonal influence, and networking ability (Table 1).

Political skill	Description
<b>Social astuteness</b>	Leaders must be adept at reading others’ behaviours and motives, influencing others to achieve important goals, building diverse relationship networks, and interacting genuinely with others.
<b>Apparent sincerity</b>	Leaders with apparent sincerity are often seen as having integrity and authenticity; they are not suspected of manipulating people for their own ends.
<b>Interpersonal influence</b>	Leaders must be able to influence the people around them and be flexible to achieve their desired outcome.
<b>Networking ability</b>	Networking ability enables leaders to maximize and leverage their relationships to get things done efficiently and effectively at work; it includes the ability to lead teams and cooperate with others generally.

#### Social astuteness

This political skill combines the expertise and perception skills of, in this context, physicians. This links to serving patients by reading their language and non-verbal



cues and also by building relations with others to achieve the highest possible level of patient care. In a leadership context, physicians with this skill are able to build meaningful and genuine relations with their non-physician and physician colleagues. This allows politically skilled, socially astute physicians to craft the outcomes they desire through leadership of a diverse range of actors, at the systemic level, and in their interactions with patients.

#### Apparent sincerity

Apparent sincerity is crucial for leaders, as it is at the crux of successfully influencing others without ruining relationships or giving offence. The sincerity, honesty, and integrity of leaders with apparent sincerity enable them to effectively influence within their organization, across professional boundaries, and outwardly in a public-facing capacity without being perceived as power hungry, manipulative, or having other negative characteristics.<sup>6</sup> This skill enables leaders to lead effectively while still being perceived as genuine and without ulterior motive.



### Interpersonal influence

Leaders with interpersonal influence are able to create coalitions and appeal upwardly (i.e., to superiors) by exercising their will to adapt their behaviour and appeal to the audience to “elicit particular responses from others.”<sup>4</sup>



For physicians, this would take the form of leading physician and non-physician colleagues (including internal administrators and external agents) in a context-sensitive way to accomplish their goals (i.e., better patient outcomes).

### Networking ability

This skill enables leaders to build a diverse network of colleagues and leverage it to achieve their goals. Leaders with networking ability are often seen as “highly skilled negotiators and deal makers, and



adept at conflict management”<sup>4</sup> — skills that physician leaders have noted as crucial for their position but that have not been recognized in the current leadership frameworks.<sup>7</sup> These networks are necessary in an increasingly complex health care environment that calls for alliances between physicians and non-physicians to meet such health challenges as an aging population and more prevalent chronic disease. These complex problems call for physicians to work together and across professional boundaries with other stakeholders, such as administrators and government agencies. Stronger networks are essential to achieving positive outcomes in the current context.

Taking a political skills approach is innovative because of its focus on four key skill areas that enable physician leaders to be effective in influencing change in the diverse, systemic networks of health care. The PSI is focused on effectiveness; thus, these skills enable leaders to maximize and leverage their relationships to get things done effectively.<sup>6</sup> Considerable research has examined organizational politics, but a serious omission has been the failure to evaluate the political skills of the influencer, which leaves a knowledge gap when trying to understand the “how” of the leadership process.<sup>6</sup>

The PSI is a multi-dimensional construct that addresses this “how” and has been shown to be associated with effective leaders.<sup>6,8,9</sup> As an example of the measurability of the PSI, Douglas

and Ammeter<sup>9</sup> examined a leader’s political skills and their effect on ratings of leadership effectiveness for public school administrators and supervisors, while Ferris et al.<sup>6</sup> studied political skills at work and their impact on work effectiveness in managerial or administrative positions at a large university. Braddy and Campbell<sup>8</sup> asked approximately 200 leaders in mid- and upper-level management to rate the extent to which they used each of the four political skills in their own leadership roles. Collectively, these studies showed that political skills permit leaders to exert greater influence on others and help teams increase their efficiency and productivity. This emphasizes the fact that political skills — unlike those of the competency frameworks used in the physician-leadership world — have proven to be effective in impacting the complex organizational network in which physicians exist; they are designed for effectiveness, are measurable, and are perceivable. These skills are grounded in solving problems and guiding organizations, small or large, in complex environments.

The PSI presents a multi-faceted, network-based set of competencies designed for effectiveness in a complex environment. Unlike other methods of leadership development that currently exist in the physician-leadership world, political skills are proven to craft effective leaders in these environments. This is fundamental, as a framework ought to be developed for and aligned with the environment in which it is operating. Aligning framework with environment is likely to ensure

that the leaders acquiring these competencies will be most effective. The emphasis on measurable effectiveness of these competencies sets PSI apart from other leadership development frameworks. Neither CanMEDS 2015 nor LEADS has proven to be effective nor were these frameworks designed with effectiveness in mind. PSI, however, is both designed and proven to create effective leaders in a diverse, complex, and multi-faceted environment.<sup>6</sup> In addition, political skills are finite, specific, and fundamental and can be developed at any stage in a physician's career (preferably throughout their career).

### Acquiring political skills at any career stage

Political skills may be acquired in three steps: self-assessment and understanding; facilitated learning; and evaluation and feedback.<sup>10</sup> For leaders, a strong sense of self is driven by a deep understanding of one's own personality and how one is perceived by others. Personality tests (such as Myers-Briggs Type Indicator, the Five-Factor Model, or the Sixteen Personality Factor Questionnaire) serve as instruments for leaders to self-assess and understand how they work, which political skills they need to focus on, and what skills they are most likely to have a predisposition for.<sup>6</sup> Also, 360-degree reviews help leaders understand the perceptions of those above, below, and around them in their professional world. This helps them determine what skills they already possess or what ought to be the focus for future professional development.

The development of political skills comes through various facilitated learning exercises. Experiential learning (e.g., role-playing in a difficult health care situation), case analysis (e.g., evaluation of a scenario depicting someone using — or failing to use — political skills), vicarious learning (e.g., observing/shadowing someone else), general communication skills, or even dramaturgy (teaching the skills of theatre and how to display emotions and execute roles) are all ways in which political skills can be cultivated and acquired.<sup>10</sup>

Although this is by no means an exhaustive list, it does illustrate the variety of ways in which these skills can be acquired and practised and, more important, that they can be cultivated at any point in a physician's career. As these are foundational skills, physicians should learn them early and throughout their education and career. For example, medical schools and residency programs could incorporate political skills training and assessment into their programs. Continuing professional development offers another access point for training.

Finally, evaluation of physicians' political skills and feedback form the third pillar of effective training. This comes in the form of a 360-degree formal and/or informal review of the individual by their supervisor, clients, colleagues, and/or other persons they interact with, to allow the leader to collect the perceptions of those around them and make adjustments or undertake new learning to strengthen their skills.<sup>10</sup> Political skills are simple and perceivable, making the

exercise of collecting feedback easier than in other existing models of physician development.

### Conclusions

The current system of physician leadership development in health care is not as effective as it needs to be. A re-imagining of the competencies needed in all physicians is a first step in closing this leadership gap. The PSI presents a structured, foundational approach to providing physicians with key competencies that will help them navigate their complex environment. Namely, the PSI diverges from previous approaches because:

- it is focused on effectiveness
- it has been proven to craft effective leaders in a complex environment
- there is a clear process for the acquisition of these competencies and it can be done throughout a physician's career
- these skills are finite and simple compared with those of other competency frameworks (there are only four competencies and they are simple to understand and explain)
- it provides structure and a solution for physicians who have determined that they lack certain integral skills to operate effectively

These five factors support the PSI as a means to equip physicians with the core competencies they need to effectively impact their environment and be successful leaders in the health care world.

**References**

1. Health Association Nova Scotia. Leadership in health care in Nova Scotia. Bedford, NS: HANS; 2012. 47 pp.
2. CCHL (Canadian College of Health Leaders). LEADS in a caring environment framework. Ottawa: CCHL; 2016. Available: <http://tinyurl.com/j2fbqek>
3. Frank JR, Snell L, Sherbino J (editors). CanMEDS 2015 physician competency framework. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015.
4. Ferris GR, Treadway DC, Kolodinsky RW, Hochwarter WA, Kacmar CJ, Douglas C, Frink DD. Development and validation of the political skill inventory. *J Manage* 2005;31(1):126-52. Available: <http://tinyurl.com/hsy3uvt>
5. Ahearn KK, Ferris GR, Hochwarter WA, Douglas C, Ammeter AP. Leader political skill and team performance. *J Manage* 2004;30:309-27.
6. Ferris GR, Davidson SL, Perrewé PL. *Political skill at work: impact on work effectiveness*. Lanham, MD: Davies-Black; 2005.
7. Comber S, Wilson L, Crawford KC. Developing Canadian physicians: the quest for leadership effectiveness. *Leadersh Health Serv* 2016;29(3):282-99.
8. Braddy P, Campbell M. Using political skill to maximize and leverage work relationships (white paper). Greensboro, N.C.: Center for Creative Leadership; 2013. Available: <http://tinyurl.com/zk2yww2>
9. Douglas C, Ammeter AP. An examination of leader political skill and its effect on ratings of leader effectiveness. *Leadersh Q* 2004;15(4):537-50.
10. Ferris GR, Perrewé PL, Anthony WP, Gilmore DC. Political skill at work. *Organ Dyn* 2000;28(4):25-37. Available: <http://tinyurl.com/grdq9xg>

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# How conversations become culture: physicians leading in complex times



Darren Larsen, MD

It is not becoming easier to either practise or manage our careers in the current health care system. How can physicians best show leadership in times of great uncertainty? How can they generate a new conversation that keeps them positive, hopeful, and energized in front of their patients, peers, and in their own thoughts? What follows are nine proposals to ensure that physicians remain the best leaders

possible and to help move the profession along in a proactive and constructive way.

**KEY WORDS:** physician influence, conversations, communication, complexity, advice

Physicians are part of an influential community, one that initiates, influences, and perpetuates important conversations. These conversations are noticed. They are witnessed publicly when doctors are in positions of leadership, and they occur privately with peers, at meetings, during teaching, and when physicians speak, write, and blog.

Doctors can maintain an extraordinarily calm external face. This is the one they put on in front of their patients and practices. With patients, in many cases physicians' professionalism ensures that the conversation never strays to the negative and stays focused on the needs of the patient and the clinical population. Doctors place their patients' needs before their own, as they always have.

With their peers, however, conversations are somewhat more private, and pessimistic thoughts flow more freely. Here is where stories are told about the challenge of practising medicine in a new era. Physicians express their worries and doubts. In difficult times, the profession's perspective and level of positivity change. A new critical tone enters private conversations with peers. It is also expressed more commonly in the very public diaries that are accessible on social

media and in the blog space. These sour conversations can pose a real threat to physician leadership.

What are physicians saying to each other? They speak of being burdened by the increasing demands placed on them in looking after patients as well as being accountable to the health care system. There is dismay at the loss of professional autonomy. Physicians are increasingly being made to feel that they are no longer valued in the system in which they work. They question the value of quality improvement and population health, things for which they are seen to be responsible but over which they have little control.

In the press, more and more statistics are presented regarding the "burned out" physician. Research has claimed that, at any given time, up to 50% of resident doctors show one or more symptoms of burnout.<sup>1</sup> Other less formal surveys, such as the one publicized recently by a grassroots collective called Concerned Ontario Doctors, state that 78% of Ontario physicians are currently burned out.<sup>2</sup> These rates may point to a lack of resilience, which can affect leadership. Different conversations can form part of that resilience.

It is not becoming easier to either practise or manage our careers in the current health care system. Physicians — as scientists — are happiest with a certain degree of predictability in their world. They become confident in their clinical skills and the experiences that allow them to make educated informed decisions in guiding patients in battling illness or toward



improving health. They understand that the practice of medicine is complicated. What they are perhaps less prepared for, however, is its complexity. The world in which they live and work is becoming increasingly complex.

### Complicated and complex

The difference between complicated and complex systems was fully explored in Zimmerman and colleagues' book *Edgeward*.<sup>3</sup> A complicated system is one where the success of an outcome is highly predicted by the outcomes of events that came before it. A perfect example would be launching a rocket into space. Successful launches occur only when modeled over and over again, with each iteration informing the next. Many technical aspects of physicians' work are complicated. Surgeons, for instance, perform procedures again and again to become adept at the technical aspects and speed required to treat a trauma patient or suture a wound. All specialization

depends on complicated issues being mastered through residency and years of work that follow.

A complex system is the opposite. The success of one outcome cannot be predicted by the success of any trials that preceded it. An example of complexity is raising a child. The issues surrounding a second child are in no way predicted by the path taken by the sibling that came before.

Not only are our health care systems complex, but they are also adaptive.<sup>4</sup> Complex adaptive systems are not like throwing a baseball, where practising again and again to know exactly how much power, spin, and curve are needed to strike out a batter would predictively yield success. They are more like throwing a bird. Once the bird has left your hand, you have no control whatsoever over where it flies.

Our health care systems are increasingly becoming more

complex and adaptive. Physicians plan programs for which budgets may be approved months later. Hospitals amalgamate and completely reorganize medical staff structures. Patients consult search engines before they trust their doctor. Sometimes the generalist fares better in this environment, as he or she sees much more in clinical work that is undefined or unpredictable, but even these physicians are challenged in current times.

### Advice for leaders

How can physicians best show leadership in times of great uncertainty? How can they generate a new conversation that keeps them positive, hopeful, and energized in front of their patients, peers, and in their own thoughts? What follows are nine proposals to ensure that physicians remain the best leaders possible and to help move the profession along in a proactive and constructive way.

#### Show up

When physicians feel as if they are over a barrel for any reason, we hear calls from them to withdraw or reduce services, stop attending meetings, and quit providing system advice. However, when under duress, it may behoove the profession to double down in its activities. A truly adaptive response to leading in this space would be, not just to send one physician representative to meetings that require a voice, but rather two or three! The time to be most present is the time when one's presence is most threatened.

Withdrawal accomplishes nothing other than allowing others' voices

to be heard in one's place. Change is happening whether individuals like it or not. One can only hope to influence the outcome if one is present and commenting. Absence from discussion and dialogue diminishes physicians' voices to the point of irrelevance. Clinical service withdrawal is rarely contemplated, thankfully, and in most jurisdictions is highly discouraged by provincial colleges.<sup>5</sup>

### Remain optimistic

In *Better under pressure: how great leaders bring out the best in themselves and others*, Justin Menkes states: "One of the qualities that sets great leaders apart is their belief that their own actions make a difference — that they can influence outcomes."<sup>6</sup>

It is possible to be critical and still maintain an air of optimism. Constructive and reasoned criticism is warranted and, indeed, needed when contemplating large-scale transformation. Careful consideration of possible outcomes with an educated eye and from the front line is always important. But optimism, or hope for the future of these changes, is ultimately required to ensure that others listen to what doctors have to say. Pessimists are frequently ignored and their opinions cast aside as others assume "that doctor never has anything good to say." Optimists are listened to far more often, and, even when others disagree with them, they do so after listening, hearing, and examining the idea. They are more educated as a result.

### Never lose civility

In social media, especially, where

people feel protected by avatars and a sense of anonymity, they say things about each other that would never be uttered to another person's face. Private Facebook posts are easily seen by a much larger audience than intended and never go away. Cutting words disparaging a colleague, a bureaucrat, or a local politician will be permanent in this electronic age. They are searchable, saveable, archivable, and can be widely disseminated. Being trusted and heard involves doing a large amount of listening, and this includes listening to oneself. Again, civility is well coded in policies in our self-regulated profession.<sup>7</sup>



### Tell stories

Ensure that great ideas are celebrated and repeated as much as, if not more than, negative ones. Physicians' minds are a constant stream of consciousness, and stories told quickly become the reality one believes in and conveys to others. Even in difficult times, there are multiple reasons to be happy and trumpet successes that should be expounded upon. This provides necessary resilience to negativity that comes from outside.

### Innovate

Leaders must constantly be on the lookout for things that are new, for concepts that have never before been tried, and for creative "outside

the box" thinking. True leaders explore these and encourage them in others. They find excitement in building and creating. This excitement is infectious and has the advantage of strongly influencing the work of others. Emmanuel Agbor writes about the power of creativity and innovation in leadership, stating, "for an organization to become innovative and successful, it must benefit from the creativity of all its members. Organizations can achieve this by harnessing all its leadership abilities."<sup>8</sup>

### Fail

Then celebrate the failure by creating a space where the same failure cannot be repeated and others can learn from it. A start-up mentality is required here. Companies that innovate and create expect up to 92% of their big ideas to fall flat.<sup>9</sup> But when they fail, they constantly examine and pivot their thinking to move past failures quickly — to find the hot idea that takes off.

### Ask "why?" and ask it a lot

Physician leaders are often looked to for answers, and, more often than not, they pride themselves on being able to provide them. But frequently, they do better in difficult situations by asking questions rather than providing answers. This approach, which was explored by Simon Sinek in *Start with why: how great leaders inspire everyone to take action*,<sup>10</sup> is often the hallmark of an effective leader. He or she will not be quick to supply all the answers, which usually ends exploration of a topic, but rather allows it to go deeper by asking more questions for others to think about or respond to.

### Build a support system

Leading is tough work, and leadership is often a very lonely experience. According to acclaimed physician health expert, Dr. Mamta Gautam, having a circle of other physicians, not necessarily those who think exactly like oneself, but rather people one trusts, is paramount in ensuring that a physician can maintain the freshness needed to continue to lead well.<sup>11</sup> Connections occur in a myriad of ways: random telephone calls, email, quick lunches, or even emoticon-filled text messages! Reaching out to other leaders and sharing ideas is incredibly helpful in ensuring that you remain able to act in this capacity. And if a friend is under attack, this is even more important. Support in this way can be very private, or very public.

### Learn to be a good follower

Many physicians are used to and encouraged to be constantly at the front of the room or at a podium. Equally important, though, is the creation of a space where others can lead well. This means sitting back and often saying nothing, allowing people to shine in their own spotlight and then encouraging them by reinforcing the greatness you have just witnessed. According to Harvard's Barbara Kellerman, follower traits for great leadership include awareness, diplomacy, collaboration, courage, and critical



thinking.<sup>12</sup> Staying involved and following another's lead as a difficult project moves to completion can be a complete pleasure.

### Leading in complexity

Effective leadership in an environment of complexity, in a system that is rapidly changing around us, requires tremendous adaptability and resilience. Really great leaders influence more than they dictate. They remain open to new ideas and resist the status quo. They lead sometimes by doing, but often just by questioning and listening, then allowing others to move ahead. They remain eternally optimistic even in the face of great pessimism. They support their peers and, thereby, support the health system. And they rarely back away from adversity.

Most important, though, leaders in complex adaptive systems have given up their need to completely control every environment they work in. For them, leading is much more about the journey than the destination. They tell stories. Their stories are personal and actually change the greater conversation going on around them. Over time, these changed conversations become the culture in which all physicians work, practise, teach, and manage. Even when physicians are feeling the weight of the world on their shoulders professionally, this physician culture can remain imminently positive. It will prepare doctors for strong positions of leadership and ensure that the system represents not just their own best interests, but also those of their patients and the larger health system they work for. Everyone is listening!

### References

1. Fralick M, Flegel K. Physician burnout: who will protect us from ourselves (editorial). *Can Med Assoc J* 2014;2 June. Available: <http://tinyurl.com/gm2yxhh>
2. Levy SA. "Alarming" number of docs feeling burnout: Concerned Ontario Doctors. *Toronto Sun* 2016;29 May. Available: <http://tinyurl.com/z2lksb7>
3. Zimmerman B, Lindberg C, Plsek P. *Edgeware: insights from complexity science for health care leaders*. Irving, Tex.: VHA Inc; 1998.
4. Begun JW, Zimmerman B, Dooley KJ. Health care organizations as complex adaptive systems. In Mick SS, Wyttenback ME (editors). *Advances in health care organization theory*. San Francisco: Jossey-Bass; 2003. pp. 253-88.
5. Providing physician services during job actions (policy statement 1-14). Toronto: College of Physicians and Surgeons of Ontario; 2014. Available: <http://tinyurl.com/zx8ydxk>
6. Menkes J. *Better under pressure: how great leaders bring out the best in themselves and others*. Boston: Harvard Business Press; 2011.
7. Physician behaviour in the professional environment — discussion. Toronto: College of Physicians and Surgeons of Ontario; 2014. Available: <http://tinyurl.com/zkvw4ke>
8. Agbor E. Creativity and innovation: the leadership dynamics. *J Strategic Leadership* 2008;1(1):39-45. Available: <http://tinyurl.com/h5ck5ks>
9. Marmer M, Herrmann BL, Dogrultan E, Berman R. Startup genome report extra on premature scaling. San Francisco: Compass; 2011. Available: <http://tinyurl.com/jee77mo>
10. Sinek S. *Start with why: how great leaders inspire everyone to take action*. Toronto: Penguin; 2009.
11. Gautam M. *Irondoc: practical stress management tools for physicians*. Ottawa: Book Coach Press; 2004.
12. Kellerman B. *Followership: how followers are creating change and changing leaders*. Boston: Harvard Business School Press; 2008.

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*This article has been peer reviewed.*

## Evaluating a continuing education workshop as a strategy to address disruptive behaviour in postgraduate medical education



Christopher Simon, PhD, Derek Puddester, MD, MEd, and Colla J. MacDonald, EdD

The purpose of this study was to evaluate the efficacy of the use of Crucial Conversations workshops by the University of Ottawa's faculty of medicine as one strategy to prevent and manage disruptive behaviour. Data were collected using post-workshop quantitative evaluations and qualitative interviews. Nearly all participants agreed that the workshops would help them in their professional life, the skills they learned would help them resolve

issues they face in the postgraduate medical education (PGME) environment, and they would recommend the training to colleagues. Participants provided examples of new knowledge and skills they had attained as well as how their communications and behaviour in the workplace had improved. Moreover, participants reported that the workshops had a marked influence on the PGME culture — normalization of engaging in difficult conversations and the emergence of a common language around effective communication. We conclude that the workshops are an effective strategy to address and manage disruptive behaviour in a PGME environment.

**KEY WORDS:** Crucial Conversations, workshop, disruptive behaviour, postgraduate medical education, evaluation

The increasing amount of literature and growing professional concern over disruptive behaviour in the postgraduate medical education (PGME) environment has resulted

in efforts to enhance education and training for faculty, residents, and staff in this area.<sup>1</sup> At the University of Ottawa, one initiative has been the inclusion of Crucial Conversations (CC) workshops<sup>2</sup> to promote effective and healthy communication and address and manage disruptive behaviour. Other factors contributing to the introduction of these workshops included increasing sensitivity to cultural shifts in behavioural expectations of learners and health professionals in Ontario<sup>3</sup> and implementation of the University of Ottawa Faculty of Medicine Standards of Ethical and Professional Behaviour<sup>4</sup> and the College of Physicians and Surgeons of Ontario (CPSO) policy on Physician Behaviour in the Professional Environment.<sup>5-6</sup>

The purpose of this study was to evaluate the efficacy of the CC workshops as one strategy to assist medical leaders, faculty, residents, and staff to prevent and manage disruptive behaviour in the PGME workplace.

### Disruptive behaviour

Among the requirements for accreditation and certification, Canadian physicians must demonstrate commitment “to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health.”<sup>7</sup> This commitment involves exhibiting appropriate professional behaviour in practice and recognizing and responding to unprofessional behaviour in

physicians and other colleagues in the workplace.<sup>8-9</sup>

Disruptive behaviour, as defined in the present investigation, refers to, “a pattern of inappropriate conduct that has the potential to negatively impact the workplace and patient safety.”<sup>1</sup> It takes many forms: verbal (e.g., personal insults), physical (e.g., unwanted contact), environmental (e.g., gossip), and systemic (e.g., dominating meetings).<sup>10-11</sup> Physicians who engage in recurring incidents of disruptive behaviour face an array of consequences, including interpersonal tension, complaints, litigation, discipline, termination of training or privileges, and revocation of licensure.<sup>1</sup> Moreover, working in a disruptive environment has been linked to breakdowns in communication, which can lead to sub-optimal performance, medical errors, adverse events, and, ultimately, reduced quality of patient care.<sup>11-12</sup>

Disruptive behaviour can also negatively impact medical learning environments by modeling inappropriate behaviour for students and residents, impeding their ability to acquire clinical skills and undermining collaboration.<sup>8</sup> Indeed, a 2012 report suggested that 73% of residents have experienced such disparaging behaviour during residency.<sup>13</sup> As many as 5% of physicians demonstrate disruptive behaviour,<sup>8</sup> and nearly 25% do not feel comfortable or competent in confronting it in colleagues.<sup>1,10</sup>

The growing concern over disruptive behaviour has resulted in education and training with a

focus on teamwork, communication skills, and conflict resolution.<sup>1</sup> For instance, the CPSO and the Ontario Hospital Association co-developed a resource for managing disruptive physician behaviour<sup>6</sup> with similar approaches found in the physician health guide from the



Royal College of Physicians and Surgeons of Canada.<sup>8</sup> However, it has been recommended that additional in-depth training and resources are needed to address disruptive behaviour within the PGME environment.<sup>9</sup>

The University of Ottawa’s faculty of medicine also identified this need for training.<sup>10</sup> Based on selection criterion identified by the university, the CC workshop<sup>2</sup> emerged as a program with the required evidence-based, interactive, and structured skill-enhancing curriculum, and several faculty members were trained to facilitate CC workshops. Efforts were made to tailor workshop content to contexts commonly experienced and reported in the PGME environment. The two-day workshop was made

mandatory for program directors, program administrators, and chief residents. More recently, this training program has also been offered by several other Canadian health organizations, including the Ontario Hospital Association,<sup>14</sup> the Ontario Medical Association,<sup>15</sup> and

the Canadian Medical Association.<sup>16</sup>

In the context of the CC workshop, a “crucial conversation” is a discussion between two or more people in which stakes are high, opinions vary, and emotions run strong.<sup>2</sup> Training can help participants resolve disagreements, build acceptance rather than resistance, speak persuasively not abrasively, and foster teamwork.<sup>2</sup>

In this evaluation, the research questions addressed were:

- How did participants in the CC workshop describe their experience?
- Does the CC workshop contribute to the development of skills to address and manage disruptive behaviour in the PGME workplace?

- In general, how can the CC workshop be improved in the future?

## Methods

### Research design

A mixed-methods research design, contrasting qualitative interview data with quantitative, post-workshop evaluations, was used to address the research questions. The findings were organized under the components of the W(e) Learn framework: content, media (delivery), service, structure, and outcomes.<sup>17,18</sup> Its emergent design focuses on program improvement in response to learner feedback.<sup>18,19</sup> An interactive version of the framework is available online.<sup>20</sup>

### Data collection

In all, 78 participants took part in this study. To develop in-depth accounts of participants' thoughts, attitudes, and experiences regarding the CC workshops, individual interviews were held with a convenience sample of 17 people<sup>21</sup> recruited from individuals who took part in the PGME's CC workshops at the University of Ottawa, between 2010 and 2015. They included three program administrators (PA), four residents (R), eight program directors (PD), and two workshop facilitators (F). Participation was voluntary; interviews lasted 45–60 minutes and were audio-recorded with participants' consent.

A voluntary, post-workshop evaluation form was distributed to each participant to complete anonymously at the conclusion of each workshop. It assessed

participant ratings of the workshops using Likert-scale survey questions (e.g., strongly agree to strongly disagree). Data from open-ended (qualitative) and Likert-scale (quantitative) questions were collected from the 61 post-workshop evaluations that the PGME office had on file from 2010–2015.

### Data analysis

After each interview recording was transcribed and filtered, a content analysis was carried out.<sup>22</sup> Transcripts were read and re-read and an initial list of emerging themes was developed (both from the deductive elements of the evaluation framework and the more open-ended, inductive data) until no new codes or sub-codes emerged. Codes were then regrouped under higher-order themes and sub-themes to obtain information that would answer the research questions.<sup>23-24</sup>

For the post-workshop evaluation, descriptive statistics were generated from the Likert-scale responses ( $n = 61$ ) and organized under the components of the W(e) Learn framework: content, media, service, structure, and outcomes.

## Findings

### Content

**Breadth and depth:** Most interviewees felt that the breadth and depth of the content presented in the CC course were acceptable: "I thought it was excellent – very comprehensive, timely, and appropriate to my role as a program director, and my position in the hospital" (PD2).

However, a few thought the content could be condensed and prioritized; they suggested the range of concepts presented to participants limited the depth needed for the audience to effectively assimilate the content.

**Relevance:** Most interviewees stated that the content was very applicable to their work in the PGME environment, in interactions with patients, in an administrative setting, or to facilitate conversations between and among colleagues.

[The workshop] is 100% applicable.... Most of the course was geared toward how to talk to colleagues.... As physicians, that is one of the more challenging parts of our job — actually [interacting in] the work environment, not necessarily patient care. (R1)

Participants also reported that the real-life scenarios helped to reinforce concepts. However, several also noted that additional examples tailoring more of the content to specific PGME audiences would be appreciated.

Finally, several participants stated that the information presented was a transferrable skill set, both in their professional practice and personal life. "It was very practical, and addressed how to manage difficult conversations in all spheres of life — professional and personal. That was my big take-away" (PD3).

There were no data from the post-workshop evaluations to support

the interview data with regard to content.

### Media

Teaching methods: Interviewees unanimously agreed that the CC workshops were interactive. A resident stated: “It was interactive and fun... great, real-life examples to explain the concepts and then incorporating activities” (R4).

Contributing to the interactivity was a balance of theory and practice. One participant reported: “It was structured in an educational way with delivery through a variety of methods” (PD1).

Most interviewees reported that the teaching strategies used in the workshops enhanced the learning experience. For instance, sharing with colleagues during the workshop was effective.

In the words of one program administrator, “You were able to share with your colleagues who are experiencing the same things ‘This is how I dealt with it,’ but then... we were able to see ‘This is how we should have dealt with it’” (PA1).

Similarly, most interviewees reported that the workshops catered to various learning styles, enhancing the quality of the learning experience. One program administrator commented: “It was a good mix... asking for individual responses, but also incorporating group work and self-reflection.... such a range allowed everyone to participate” (PA2).

Facilitators: Facilitators played a major role in determining participants’ perceptions of the overall quality of the CC workshops. Although most thought

the facilitators were a strength enhancing the workshops, there was variation in responses regarding their quality and effectiveness.

Being knowledgeable about the content was the dominant quality contributing to a facilitator’s effectiveness. One program administrator explained:

[The facilitator] really knew the information... they were able to help. It almost turned into little personal side-sessions during breaks as people approached [them] to [ask about personal contexts] and how to go about approaching them. (PA2)

Similarly, interviewees rated facilitators negatively when they perceived that they were disengaged, did not possess the requisite knowledge to lead the workshops, or if they failed to contextualize content. One resident expressed her concern regarding an ineffective facilitator: “[The facilitator] didn’t give off confidence and several times they took phone calls. This annoyed some of us. They didn’t give that personal feel, and didn’t really make the course [their] own” (R2).

Part of being considered knowledgeable was a facilitator’s ability to contextualize the content and concepts by describing real-life PGME experiences and examples. One interviewee explained how relying on personal experience made the facilitators seem more authentic: “The way they described the information was proof that they

are actively using those skills in their day-to-day life” (R4).

Other descriptors associated with effective facilitation included being adaptable (i.e., modifying cases and learning activities to the specific needs of the demographics of the group), engaging, passionate, enthusiastic, and dynamic. Conversely, ineffective facilitators were associated with an inability to adapt to the needs of the audience, for example, by spending more time on a concept when needed and moving more quickly through another when it was clear the audience already understood the material.

Post-workshop evaluation responses related to how content was delivered suggested that “delivery” was an area of strength for the workshop. Most participants (97%) either agreed or strongly agreed that the facilitators were able to contextualize the content, clearly articulated expectations, encouraged discussion through open-ended questions, communicated the concepts clearly, kept the course on time and on topic, and appeared to be knowledgeable about the content. These results reflected those from the interviews, which, with only a few exceptions, included considerable praise for facilitators.

### Service

*Resources:* Most interviewees said they appreciated and derived value from the CC materials provided to them during the workshops. One program administrator elaborated: “Sometimes I will bring [those tools] out if I know [a crucial conversation is] forthcoming. I refresh myself on



what was delivered at the course” (PA2).

Several interviewees reported that the CC resources were not useful, and they did not use them after the course. For instance, one program director stated: “I recall being made aware of these resources [post-course]. I even tried to go back to some of the tools, but have not found them to be useful” (PD6).

The post-workshop evaluation findings suggested that the services provided by the resources were excellent, with 98% of participants agreeing or strongly agreeing that the workshops will help them in their professional life. Similarly, 85% felt prepared to apply the strategies they learned in the workshops; however, 13% only “slightly agreed” with this.

### Structure

*Organization:* Most interviewees were pleased with the general organization of the workshops: “It was very well organized... and professionally delivered. This made it appealing to me” (R1). Many also lauded the pre-course organization:

The schedule [for the courses] comes out early in the year, so you can sign-up and make sure that we were free for the two days.... We were given the information [for the course] well in advance. That really helped. (PA1)

Group size and demographics were also important aspects of course organization. Having a small-group setup was preferable over a traditional classroom-style arrangement. One program

administrator explained: “A small group made it easier to have those practice conversations and to be able to share. It is not as intimidating” (PA1). Other participants said they preferred homogeneous groups: “I didn’t really feel comfortable discussing [my issue] with my partner whom I didn’t know and who was clearly high up in the university.... we all know we have intertwined lives” (PD6).

With regard to the structure of the workshops, many of the evaluation respondents agreed or strongly agreed (87%) that the facilities used for the workshops were pleasant, comfortable, and generally conducive to learning, while 13% only slightly agreed with this statement. With respect to the material provided to participants before the workshop, 97% agreed or strongly agreed that they met their needs. These results generally support the interview findings (e.g., learning resources provided).

### Outcomes

#### *Transfer of knowledge:*

Interviewees provided several examples of how they have used the knowledge and skills learned at the CC workshop in their workplace. Several program directors agreed that the workshops provided them with useful strategies and tools to assist with learners in difficulty.

One program director explained: “I have used the course for remediation purposes.... Often [for reasons] related to communication skills.... Our residents have found it useful for those who lack insight in communication” (PD6).

*Confidence:* Faculty, administrators, and residents all reported that the knowledge and skills learned in the CC workshops resulted in increased confidence when initiating difficult conversations: “Setting up that [conversation] is always the most difficult part.... I now don’t feel as intimidated” (PA1).

Similarly, one program director suggested that CC empowered residents to stand up for themselves:

[All] residents could really use these skills, not only because many have challenges in communication, but also because they are treated like crap sometimes in certain settings. They feel they have to suck it up and take it.... Learning those skills helps them understand they don’t have to. (PD5)

Residents reported similar results: “Our group [of residents] is definitely more confident in having [difficult] discussions, such as delivering feedback and standing up for ourselves. I noticed others taking initiative as well. It is something that overall has gotten better” (R2).

*Communication:* Several interviewees stated that the workshop helped them improve their awareness of when a crucial conversation was needed and increased their communication skills between and among peers and colleagues. One program director expounded: “One of the main things it [the workshop]

does is it makes communications conscious. Actually being able to be conscious of my own communication and how other people are communicating, I found that useful” (PD6).

A resident also acknowledged how being aware of emotions that affect CC has been one of the greatest benefits. “What makes [the conversation] crucial is an emotion on my side and the other person’s side.... now that I am aware and practising, that has been the one that I’ve had to work on the most” (R2).

Another reason interviewees gave for improved communication with peers, colleagues, and supervisors in the workplace was a common language they had developed during the CC learning experience. One faculty member testified: “People will say something like ‘you just crucial conversation-ed me,’ or ‘we need to have a crucial’” (F2).

*Environment:* Interviewees commented that the CC workshops could benefit any individual working within the PGME environment. One resident highlighted: “The skills in this course can singlehandedly change hospital and working environments. There is great potential here for these skills” (R1).

Several groups were identified as being able to benefit from the workshops. Although residents were the most commonly cited potential beneficiaries, namely chief and early-year residents, other groups included program directors, administrators, and international medical graduates.

### **Another reason interviewees gave for improved communication with peers, colleagues, and supervisors in the workplace was a common language they had developed during the CC learning experience.**

Some went so far as to suggest that the workshops should be mandatory for all involved in PGME — not only program directors and chief residents, as per current practice. One program director stated: “[CC should be] absolutely mandatory. It is very, useful. I could take the course frequently and have it be equally useful every time” (PD3). However, other participants felt that, although the workshops were useful, they should not be mandatory. One resident clarified: “You really only want people that have buy-in and want to do it.... I don’t think making it a mandatory thing would accomplish what you want to accomplish” (R3).

Interviewees identified common “crucial conversations” in the PGME environment, the most notable being those between residents, e.g., regarding call schedule and professionalism. Another was between residents and program directors, e.g., not meeting expectations, academic or professionalism issues, evaluations or feedback.

“[The conversation] that happens fairly frequently is having to tell a resident they are not performing up to the expectations of the program” (PD8). Similarly, another program director noted that conversations with residents often became crucial

when they “show resistance to or lack of insight into feedback. The stakes are high, opinions are different, and they can get quite emotional.... [Residents] need to be able to understand how to navigate this” (F2).

Other common crucial conversations arise in general team settings (e.g., team dynamics in meetings, patient care approach); between residents and program administrators (e.g., rude, disrespectful behaviour from residents); program administrators themselves (e.g., role clarity and task sharing); and with patients and/or their families (e.g., managing expectations).

Finally, participants also noted that CC training is also helpful for physicians in managing difficult conversations with patients and/or their families: “I often encounter [crucial] conversations where a patient wants something very different than I clinically provide or feel is the proper approach” (R3).

*Follow-up:* Interviewees reported that CC is a useful workshop and many said they learned new knowledge and skills, including improved communications and behaviour in the workplace. However, many questioned the long-term use of the CC skill set in relation to attrition of skills over time. One program director suggested:

The “one and done” approach is something we need to re-think in order to make it more effective. Did I learn anything? Have I changed enough from the single course? I think I’ve become a

better communicator, but have I really? (PD7)

Similarly, interviewees were vocal about how difficult some of the skills presented in the workshops are to master. They commonly stated that proficiency requires ongoing commitment, practice, and effort. “No one is going to have the skill sets ingrained from a one- or two-day workshop. The course introduces the concepts and hopefully sends you on a path to improve yourself, your communication style and so forth” (PD2).

Regarding quantitative outcomes, 91% of evaluation respondents agreed or strongly agreed that the skills they learned will help them solve issues in the PGME environment, and 96% reported they would recommend the CC workshops to co-workers, friends, or family members. These results support several of the findings from the interview data, such as recommending the training to others (e.g., program directors), confidence, and transfer of knowledge.

## Discussion

Participants reported that the CC workshops were comprehensive, timely, and at an appropriate level of difficulty for the PGME audience. The range of material may have limited the depth needed to effectively assimilate the content; however, real-life scenarios helped to reinforce concepts. Although most participants said the content was relevant, a few thought it could be more tailored to the PGME audience and contain more context-specific scenarios. Contextualizing

cases is extremely important for face validity, learner application, and generalization. The workshops also provided tangible skills needed to address and manage difficult conversations (e.g., around disruptive behaviour) that affect personal and professional relationships, a healthy work environment, and personal health.<sup>1,12</sup>

Participants unanimously agreed that the teaching strategies enhanced the overall learning experience. Diverse and interactive teaching strategies that provided opportunities for colleagues to share experiences were appreciated and deemed effective. Consultation with colleagues has been cited in other reports as an ideal method of obtaining new information for many medical professionals.<sup>25-27</sup> Most participants reported that the workshop catered to different learning styles.

Some facilitators were far more effective than others in delivering the same content. Being knowledgeable about the content and able to contextualize the content and concepts by sharing and using real-life PGME experiences and examples, as well as being flexible and adaptable to the environment and audience, were characteristics participants associated with effective facilitation. Less effective facilitators tended to have difficulty adapting to the needs of the audience (e.g., moved too quickly through concepts to keep on-time), were disengaged from the audience, did not convey a sense of knowledge around the content, and largely failed to contextualize the concepts.

Participants appreciated and derived value from the resource materials provided (e.g., workbook, CDs, cue cards, web sites) for consultation after the course and to guide future learning and ongoing skill refinement.<sup>2,28</sup>

Positive outcomes included useful strategies and tools to assist with remediation of residents. Our findings suggest that the training enhanced effective communication within the PGME environment by providing tangible strategies, building confidence, and enhancing self-awareness.

The workshops had a marked influence on PGME culture, in terms of normalizing engaging in difficult conversations and the emergence of a common language around effective communication. Some participants provided examples of how they had improved their communications and behaviour in the workplace; however, they agreed that proficiency in these skills requires ongoing commitment, practice, and effort.

The University of Ottawa offers a follow-up course, Crucial Accountability, and a complementary course, Influencer, for those interested in further enhancing their skills.<sup>29</sup> However, there is also an appetite for more opportunities for reinforcement and practice, and the PGME should consider developing and implementing more tailored resources to complement those already available to facilitate ongoing skill development.

Participants identified a wide range of crucial conversations or

scenarios that are common in the PGME environment. Given that putting content into context was an area for improvement for some facilitators, the PGME program might develop a bank of relevant, targeted examples or cases and make it available to future facilitators. The wide range of such crucial conversations identified by the participants also reinforced both the findings of the original needs assessment and reports that all physicians are likely to experience or witness disruptive behaviour in the medical environment.<sup>1</sup>

CC workshops have helped, and can continue to help, faculty, residents, and administrators build skills to address and manage disruptive behaviour in PGME. It was clear that these workshops should continue to be offered, and the training should remain mandatory for those in positions of leadership (i.e., chief residents and program directors) to create a culture of respect and minimize the negative impact of disruptive behaviour.<sup>30</sup> This also resonates with the third edition of the CanMEDS framework, which reinforces the need for medical trainees to develop leadership competencies.<sup>31</sup> In terms of whether the training should be mandatory for all

residents, participants' views were mixed, although their main rationale was logistic (e.g., time commitment, scheduling) rather than conceptual in nature. Given the reported benefits of CC training in helping to address and manage disruptive behaviour, compounded by the identified need for residents to develop leadership competencies, the costs versus benefits of making the training mandatory for all trainees should be weighed and explored.

Although both interviewees and post-workshop evaluations agreed that the CC training had been largely successful, this study was limited to one faculty of medicine over a five-year period. Future research would benefit from replication at multiple sites, as well as exploring the viability of collecting data on rates of disruptive behaviour over time in relation to CC training.

Evidence of the usefulness of CC training provided by interviewees was based on personal examples and observations from a limited number of people. Post-study consultation with the University of Ottawa revealed that, since the inception of CC training, there has been a decrease in the number of cases referred to the PGME

Professionalism Committee, in the number of communication complaints resulting in dismissal, and in the number of cases proceeding to litigation in the faculty of medicine. However, as no comparison of pre- and post-course levels of complaints and litigation was made, a direct link cannot be established. As such, future study should focus on whether disruptive behaviour in a PGME setting can be reduced after a CC training program is introduced.

## Conclusions

Participants in the CC workshop at the University of Ottawa enjoyed the experience, felt it was relevant, timely, well delivered, and well organized. An overwhelming majority of participants agreed that the workshop would help them in their professional life and would recommend the training to colleagues. Participants reported that the training enhanced effective communication in the PGME environment by providing them with tangible strategies, building confidence, and enhancing self-awareness. In terms of how CC workshops could be improved, participants suggested developing and implementing more tailored resources to facilitate ongoing skill development, further adapting and tailoring workshops content for PGME-specific audiences, and encouraging workshop facilitators to contextualize concepts by using real-life examples and by being flexible and adaptable to the needs of the audience.

Physician leaders play a pivotal role in addressing disruptive behaviour and must be committed to creating a culture of respect within



institutions to minimize the negative impact such behaviour can have in the medical training environment. This study highlights that continuing evaluation of CC workshops is critical for design, improvement, and long-term success of the initiative. Finally, it also supports the ongoing commitment of the faculty of medicine, in collaboration with other stakeholders, to implement systemic efforts to reduce disruptive behaviour among physicians.

## References

1. The role of physician leaders in addressing physician disruptive behaviour in healthcare institutions (discussion paper). Ottawa: Canadian Medical Protective Association; 2013.
2. Patterson K, McMillan R, Switzler A. *Crucial Conversations: tools for talking when stakes are high*. New York: McGraw Hill; 2012.
3. Fonseca P. Bill C-168, Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace) 2009. Toronto: Legislative Assembly of Ontario; 2009.
4. Faculty of medicine standards of ethical and professional behaviour. Ottawa: University of Ottawa; n.d. Available: <http://tinyurl.com/jy8pf7x>
5. Physician behaviour in the professional environment (policy statement 3-16). Toronto: College of Physicians and Surgeons of Ontario; 2016. Available: <http://tinyurl.com/zq5olhs>
6. Guidebook for managing disruptive behaviour. Toronto: College of Physicians and Surgeons of Ontario and Ontario Hospital Association; 2008. Available: <http://tinyurl.com/z5wvg4y>
7. Frank JR (editor). The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: Royal College of Physicians and Surgeons of Canada; 2005. Available: <http://tinyurl.com/jsprem4>
8. Puddester D, Flynn L, Cohen J (editors). CanMEDS physician health guide: a practical handbook for physician health and well-being. Ottawa: Royal College of Physicians and Surgeons of Canada; 2009.
9. Disruptive behaviour (teaching modules). Ottawa: University of Ottawa; n.d. Accessed: 26 July 2016. Available: <http://ephysicianhealth.com> (click on Enter, then right-pointing arrow)
10. MacDonald CJ, Archibald D, Puddester D, Whiting S. Managing disruptive physician behaviour: first steps for designing an effective online resource. *Knowl Manag E-learn: Int J* 2011;3(1):98-109. Available: <http://tinyurl.com/hqkqnqt>
11. Kaufmann M. Recognition and management of the behaviourally disruptive physician. *Ontario Med Rev* 2001;68(4):53-5. Available: <http://tinyurl.com/ztyqa3k>
12. Leape L, Fromson J. Problem doctors: is there a system-level solution? *Ann Intern Med* 2006;144:107-15. Available: <http://tinyurl.com/hsm39ws>
13. Through the residents' lens: results from the Canadian Association of Internes and Residents 2012 National Resident Survey. Ottawa: Canadian Association of Interns and Residents; 2012.
14. VitalSkills series. Toronto: Ontario Hospital Association; 2016. Available: <http://tinyurl.com/ju86453>
15. Crucial Conversations. Toronto: Ontario Medical Association; 2014. Available: <http://tinyurl.com/jn33z9x>
16. Crucial Conversations. Ottawa: Canadian Medical Association; 2016. Available: <http://tinyurl.com/h54gonz>
17. MacDonald CJ, Stodel EJ, Thompson TL, Casimiro L. W(e)Learn: a framework for online interprofessional education. *Int J Electron Healthc* 2009;5(1):33-47.
18. Casimiro L, MacDonald CJ, Thompson, TL, Stodel, EJ. Grounding theories of W(e)Learn: a framework for online interprofessional education. *J Interprof Care* 2009;23(3):390-400.
19. Archibald D, Trumpower D, MacDonald CJ. Validation of the Interprofessional Collaborative Competency Attainment Survey (ICCAS). *J Interprof Care* 2014;28(6):553-8.
20. W(e)Learn (interactive model). Ottawa: MacDonald, Stodel, Thompson, and Casimiro; 2009. Available: <http://tinyurl.com/jgsabxn>
21. Khan EM, Anker M, Patel BC, Barge S, Sadhwani H, Kohle R. The use of focus groups in social and behavioural research: some methodological issues. *World Health Stat Q* 1991;44(3):145-9.
22. Potter WJ, Levine-Donnerstein D. Rethinking validity and reliability in content analysis. *J Appl Commun Res* 1999;27:258-84.
23. Merriam SB. *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass; 1998.
24. Bogdan RC, Biklen SK. *Qualitative research in education: an introduction to theory and methods* (3rd ed). Needham Heights, Mass.: Allyn & Bacon; 1998.
25. Kosteniuk JG, Morgan DG, D'Arcy CK. Use and perceptions of information among family physicians: sources considered accessible, relevant, and reliable. *J Med Libr Assoc* 2013;101(1):32-7.
26. MacDonald CJ, Seale E, Archibald D, Montpetit M, Tobin D, Hirsh D, et al. Site visits in family medicine: stakeholders perspectives on how site visits can be improved to maximize preceptor support and the quality of medical student and resident supervision. *Creative Educ* 2013;4(6):29-38.
27. Oshikoya KA, Oreagba I, Adeyemi O. Sources of drug information and their influence on the prescribing behaviour of doctors in a teaching hospital in Ibadan, Nigeria. *Pan Afr Med J* 2011;9(1):13.
28. VitalSmarts Crucial Conversations participant toolkit. Provo, Utah: VitalSmarts; 2006.
29. VitalSmarts Products + solutions. Provo, Utah: VitalSmarts; 2016. Accessed 26 July 2016. Available: <http://tinyurl.com/jaw7nuz>
30. Collier R. Physician codes of conduct becoming a norm. *Can Med Assoc J* 2013;183(8):892-3.
31. Frank JR, Snell L, Sherbino J (editors). CanMEDS 2015 physician competency framework. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015. Available: <http://tinyurl.com/j53ulbz>

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## Conflict of interest declaration

Drs. Simon and MacDonald declare no conflict of interest; Dr. Puddester is one of a group of certified trainers in Crucial Conversations at the University of Ottawa and the Ontario Medical Association.

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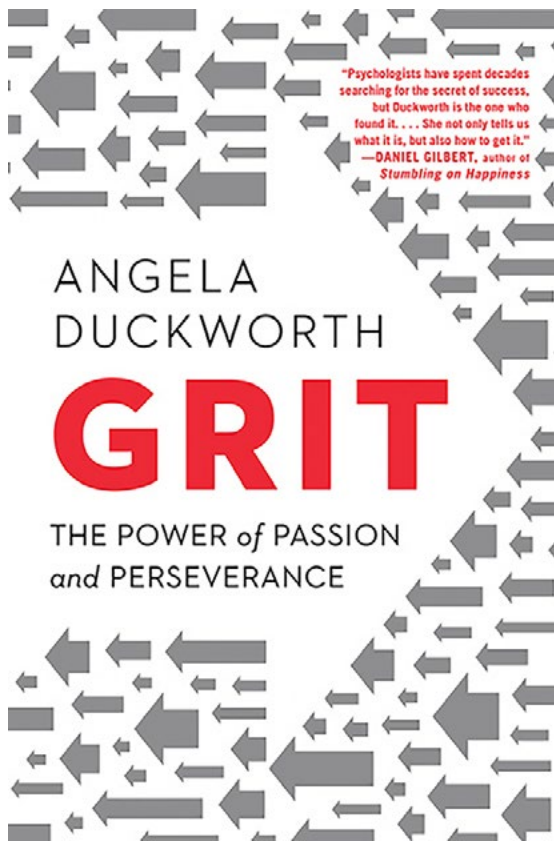
*This article has been peer reviewed.*

BOOK REVIEW

# Grit: The Power of Passion and Perseverance

Angela Duckworth  
Harper Collins, May 2016

Reviewed by Lara Hazelton, MD



theories, and approaches.

At the same time, there is growing recognition that burnout is a significant problem for many physicians and leaders. In the past decade, there have been increasing calls for “work–life balance,” as duty-hour restrictions for residents and wellness programs have been introduced. In addition to changes in the working environment, there

has also been more research on resilience and attempts to understand what factors contribute to the ability of an individual to persevere despite challenges.

Angela Duckworth is one of the leading researchers on this topic. A professor of psychology at the University of Pennsylvania, Dr.

Duckworth has published extensively on the topic of perseverance in the peer-reviewed literature. Based on her research, she has developed the Grit Scale to measure tendency to persevere toward goals. Now, she has published a book on the subject

intended for a general audience: *Grit: The Power of Passion and Perseverance*.

Grit is a topic that resonates with a lot of people, if the appearance of this book on the bestseller charts is any indication.

As Dr. Duckworth presents her research findings, she tells the story of how she became interested in the topic and the ways in

which her ideas have evolved. An important insight is that grit is more than just the capacity for hard work. It is also the ability to select and maintain goals over time and not to become distracted from them. Part of what facilitates this focus is the ability to identify and fix on topics about which one can be passionate. The many narratives throughout the book — of people who have displayed grit — make it engaging as well as authoritative. This book is essential reading for leaders who wish to develop an evidence-based understanding of the factors that contribute to perseverance and achievement. It contains many insights that will be useful for those who want to promote resilience in others, including readers who are parents interested in raising gritty children. I gave it to my teenage daughter to read, and she couldn't put it down.

It also led me to reflect on my own tendency to divide my attention between different topics and to switch goals to new areas that interest me. Turns out I am probably not as gritty as I thought, and while that may not be a bad thing, it does provide me with insights into why I may never achieve the level others will. Those who are interested can measure their own grittiness at <http://angeladuckworth.com/grit-scale/>.

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Achievement is a theme that appears, explicitly or implicitly, in almost everything that is written about leadership. Whether the focus is on the role of the leader in helping individuals and organizations achieve excellence or the imperative to set and meet one's own personal and professional goals, the concept of achievement and the related notion of success have been the drivers behind innumerable programs,

## BOOK REVIEW

# The Health Gap: The Challenge of an Unequal World

Michael Marmot  
Bloombury Press, 2015

Reviewed by Johny Van Aerde, MD, PhD

Dr. Marmot argues that health is directly related to societal issues, that inequities in power, money, and resources give rise to inequities in the conditions of daily living which, in turn, result in health disparities. His decades of research have generated shocking findings, which are described in individual chapters of *The Health Gap* on child development, education, employment and working conditions, and the situation of older people. The poorer you are, the more likely you are to live a shorter, less healthy, and probably less happy life. This is true between and within countries.

*The Health Gap* explores why this might be the case. First Marmot looks at the impact of early childhood development, at how maternal depression rates are highest among the poor, leading to less reading, encouragement, and social interaction for an infant mind. This leads to challenges in education, and evidence suggests that good schooling benefits health. After education comes work. It comes as no surprise that unemployment is bad for mental

health and it even raises the risk of earlier death. However, for those who have a job, evidence shows that jobs that combine high demand with little control and much effort with little reward increase our risk of heart disease and mental illness.

Dramatic differences in health are not a simple matter of rich and poor; poverty alone doesn't drive ill health, but inequality does. Indeed, suicide, heart disease, lung disease, obesity, and diabetes are all linked to social disadvantage.



In every country, people at relative social disadvantage suffer health disadvantage and have shorter lives. Within countries, the higher the social status of individuals, the better their health.

These health inequalities defy the usual explanations.

Conventional approaches to improving health have emphasized technical solutions and changes in the behaviour of individuals, but these methods only go so far.

What really makes a difference is creating the conditions for people to have control over their lives, to have the power to live as they want. Although poverty plays a significant role in health, Marmot makes it clear that empowerment is vitally important and that it is essential to reduce health inequality and improve health. Lack of control is key, according to Marmot. He knows this, bizarrely, because of his study of the British civil service, an extreme example of a stratified organization. In the civil service,

decreasing rank is a perfect indicator of lower life expectancy and greater ill health.

Marmot also gives possible solutions and, in the last few chapters, he demonstrates that a great deal can be done about the problem. He describes development of resilient communities, where changes would reduce health inequalities. It all seems rather obvious, but spending more money on society — financial and material support for parents, comprehensive education, good wages, job creation, a strong social security safety net — does the trick. That upfront investment results in less illness to be financed by the health care system later on and longer, productive lives.

With the moral authority of a physician, Marmot, who is the president of the World Medical Association, diagnoses an ill in society and proposes a remedy. As Canadians, we expect that treatment for the sick is a basic right we all pay for through universal health care. Why then should we as a society not fund the foundations for a life that minimizes the chance of becoming sick in the first place? And as physicians, is it our duty to advocate as much for those rights as we advocate for the one patient who needs rare gene therapy? This book is an eye opener.

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**BOOK REVIEW**

# In Search of the Perfect Health System

Mark Britnell

Palgrave, London, UK, 2015

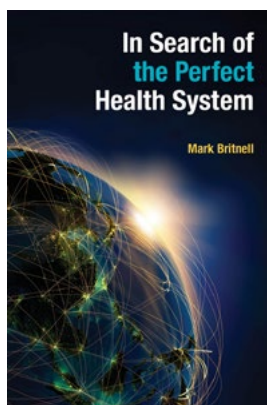
Reviewed by Chris Eagle, MD, MBA

In 225 pages, Mark Britnell, global chair and senior partner for health at KPMG and previously a senior executive in the UK's National Health Service (NHS), provides a terse travelogue of 25 health care systems, presenting the key features (good and bad) of each system based on personal experience and insightful reflection. Not only a travelogue, the author describes the common challenges found across all of the systems and the various solutions they offer.

Mr. Britnell has an evident passion for health care, which permeates his analysis and writing. Some of this enthusiasm is personal, arising from his own experiences as a patient with prostate cancer. Most of this passion is professional. Mr. Britnell has experienced health care at all levels, and that experience is evident both in his clear focus and friendly but challenging analyses. Although the book is, in part, a personal reflection, the author's thoughts are well referenced, reasoned, and balanced.

He starts the journey with the perspective that "there is no such thing as a perfect healthcare

system and it certainly doesn't reside in any one country." If this sounds nihilistic, it is quickly followed by key examples from health systems with components that are working extremely well. Some of these exemplars are not widely known. For example, Israel has excellent primary care. Mental health and well-being are key features of the Australian health care system. "Innovation, flair, and speed" describe health care delivery in India.



These initial rapid-fire examples provide the point of departure for the 25 health system reviews that follow. These reviews are short three- or four-page essays focused on the most salient features that distinguish each system. They

are neither comprehensive nor academic in nature but are practical and incisive. The countries covered are diverse, reflecting most sections of the globe, from Australia and Brazil to Russia and the USA. The final section of the book is focused on global health care challenges and how systems can and have risen to meet them. The issues include universal problems, such as clinical quality, engagement of patients as partners, and population aging.

An important chapter deals with the "paradox of change." The "lack of alignment between payers, providers, patients, professionals, policymakers and politicians, public and the press is a serious drag on innovation and progress." The author identifies 10 themes that various countries are employing

to tackle change. These are: health promotion; population segmentation; scaled-up primary care; clinical services that are both localized and distributed; clinical pathways; workforce development; tertiary centres that serve as anchors for local health systems; care for the aged provided from the home; community-based mental health services; and, above all, health systems that treat patients as active partners in their care.

Inevitably, brevity limits depth. A global perspective is not developed on some important issues, such as aboriginal health, early childhood development, or the link between health and social services. However, these issues are mentioned in specific country chapters.

There is much wisdom in this short book. The common themes in health care reform around the globe are identified and, from the 25 country examples, the key forces driving change emerge. Those interested in health care reform in Canada will find this book an exceptionally informed, readable, accessible, and incisive review of the responses to change in other health systems. It serves not only as a reference but also as a motivator for action.

I highly recommend this book. If we feel disturbed about the lack of progress in health reform in Canada, this book shows that clear remedies are within our grasp.

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