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Followership

When it is good to follow the leader

In this Issue

CSPL Canadian Society of Physician Leaders
SCLM Société canadienne des leaders médicaux

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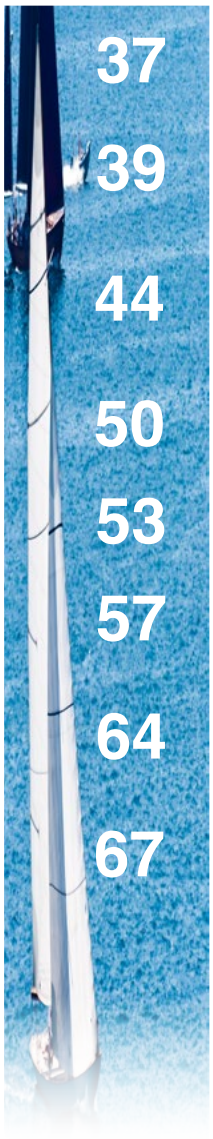

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EDITORIAL

Embedding trust in the Canadian health care system

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Of the four characteristics of leadership culture, trust is by far the most important. Without it, other aspects of the leadership environment cannot flourish.

When the work environment provides the conditions that nurture growth and development, people thrive. When the opposite is true, people resist change, they don't reach their full potential, and sometimes they can even experience ill health.[1,2] The epidemic number of burned out physicians and their lack of engagement in system transformation[3,4] hint that the work environment in the Canadian health care system is less than nurturing. In contrast, when a rich culture of leadership is embedded in an organization or a system, leaders emerge, grow, and succeed.[2]

Some health care organizations espouse the idea that every physician is a leader.[5] Does the Canadian health care system engender leadership in physicians and other stakeholders? How can we create or strengthen a culture in which physicians can emerge and grow as leaders?

In their newest book, *Learning Leadership*, which is based on decades of research, James Kouzes and Barry Posner (who was a keynote speaker at the 2016 Canadian Conference on Physician Leadership) identify four characteristics of leadership culture: opportunities for learning, support for risk and failure, models of exemplary leadership, and trust.[2] Of those four, trust is by far the most important characteristic of an organizational or systemic leadership culture; without it, none of the other three characteristics can flourish.[2]

For people to grow and thrive, for leaders to emerge, we have to trust one another.[2] Without trust, the environment is not safe enough to allow openness and honesty, collaboration suffers, and respect for differences in points of view is limited. Distrust of administration and government is one of the barriers for physicians who want to become engaged at a systemic level.[6] In some provinces, that trust has been undermined even more during recent conflicts.[7] Luckily, pockets of a trusting culture exist in other provinces.[8,9]

Trust is the foundation of effective relationships, and collaboration occurs through those relationships. Trust is a complex and emotionally provocative concept with different meanings for different people. There are certain core behaviours that build trust, and the "transactional trust" model, developed by Reina and Reina,[10] describes a set of behaviours that generate and maintain trust. The model is transactional because it is reciprocal in nature: you have to give in order to get. Its three pillars — contractual trust, communication trust, and competence trust — each has its own trust-building behaviours.

Contractual trust is the starting point and establishes the parameters for collaboration.[10] Managing expectations, keeping

agreements, encouraging mutually serving intentions, and ensuring consistency all build contractual trust. When people understand their responsibilities and what is expected of them, they feel empowered and supported to be successful, which encourages new ways to collaborate.

Physicians have a social contract to advocate and care for patients, and the government has to create frames for providing that care to achieve optimal health of individuals and the population within the bounds of available financial resources. However, there has never been a clear understanding of what both parties are responsible for together, i.e., stewardship of the Canadian health care system. If and when leaders start the conversation around contractual trust, the first and most fundamental issue to be addressed is a clear understanding of what health care means in Canada. Do all the parties of the collaboration actually know what we are trying to achieve with our health care system? Does the Canada Health Act provide clarity by defining what health and care mean? Without a clear agreement on what the system's fundamental purpose is, contractual trust, the starting point for trusting and collaborative relationships, will never exist.

Communication trust, the second pillar of trust building, is the ongoing fuel supply for collaboration.[10] It contributes to the safety of the environment for sharing information, admitting mistakes, speaking with good purpose, and giving or receiving feedback. It contributes to an environment where risk taking and failure lead to learning. On the opposite side, when the system we created is not forthright in providing that safety, communication breaks down and trust is harmed. Is there communication trust among the stakeholders in the health system we have created? How safe is it to communicate honestly, to talk about mistakes, to give feedback? How do we improve communication trust?

The third pillar, *competence trust*, exists when those collaborating have the ability and the skills to do what needs to be done and, if they don't, to acquire those skills.[10] Do physicians with their expert medical school training, elected and non-elected government officials, and patients have the ability to have the needed conversations around health care and the Canadian system? Do all parties understand the elements of societal and individual health needs, the archetypes and principles of sustainability of a complex system, and the concept of stewardship that goes with all of it? Do all stakeholders have the skills to take the appropriate actions once we have determined what they are? If those skills are not in the system, where can we, together, learn them?

In short, the most important characteristic of a leadership organization or system, trust, is missing in the Canadian health care system. Trust can be built or rebuilt transactionally by

- agreeing clearly on what we want to accomplish collaboratively and what each party's responsibilities are toward that agreement
- communicating frequently and openly, clarifying the deeper meaning behind all shared information
- ensuring that all stakeholders acquire the skills to understand the complexity of our health care system and the principles of sustainability and stewardship

Only then will leaders, including physicians, emerge, grow, and succeed in the Canadian health care system for the benefit of us all.

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OPINION

Leadership, followership, and peak team performance

David R. Williams, MD, CM, and Sandra J. Smith, MA, CHE

Most health care professionals are very effective at building technical competencies and expertise, but many opportunities to prevent clinical error require them to use non-technical behavioural skills that focus on leadership, followership, and team skills. This opinion paper connects the constructs of leadership, followership, and peak team performance in aviation and space flight with health care teams and organizations.

The challenges confronting health care leaders are growing in parallel with the needs of an aging population and rising economic pressures. Many leaders are focused on achieving broader system goals, such as integration, collaboration, and the creation of value in the delivery of safe, high-quality patient-centred care. Arguably, there has never been a greater need for leaders to help organizations transform into new models of health care delivery, and the increased focus on health care leadership is not surprising.

Although leadership is a critical element of system change, the desire for stronger collaboration, coupled with a growing awareness of the importance of interprofessional models of care, emphasizes the need for health care leaders to consider the role of followership in the creation of peak-performing clinical teams. Given the interdependence of leadership and followership in achieving sustainable organizational change, an exciting opportunity arises for leaders to incorporate the concepts of followership into health care.

In complex changing environments, learning organizations are able to adapt to the unpredictable faster than others.[1] Garvin and colleagues[1] describe the key attributes of learning organizations in which team members continually create, acquire, and transfer knowledge, empowered by leaders who build a supportive environment, develop concrete learning processes, and provide leadership that reinforces learning. For example, applied to safety and quality, a key opportunity to learn from failure is to create an environment of psychological safety that fosters open reporting, active questioning, and frequent sharing of insights and concerns.[2] This approach aligns with the creation of an environment where followership thrives.

Based on my experiences as a leader and a member of peak-performing teams participating in human spaceflight, my definition of followership is a courageous commitment to contribute and collaborate in an interprofessional

team environment. Followership is an active, not passive, process that starts with a personal commitment to bring one's best to the team environment. Although leaders play a critical role in creating a safe environment for team members to contribute, members still need an element of courage to overcome feelings of vulnerability associated with sharing their ideas.[3] Interprofessionalism is changing the power imbalance that currently exists in the hierarchical nature of relations among health care team members, enhancing quality outcomes through effective contributions of all team members.

Recently, there has been growing interest in bringing the principles of high reliability organizations into health care. Although the focus has been on achieving sustained quality, reliability, and performance, there are also opportunities to consider the principles of high reliability leadership and how high reliability organizations embrace followership and peak team performance. Humans performing complex tasks will make mistakes. Leaders in such environments can optimize team performance by developing a learning culture that builds followership skills and effective communication skills within teams to reduce the probability and consequence of error.

Human spaceflight takes place in an extremely harsh environment in which time-critical decisions with potential life or death consequences must be made. Once made, a decision cannot be reversed, although the outcome may be modified by subsequent decisions. Similarly, the delivery of health care depends on skilled professionals working together in complex resource-constrained environments using sophisticated technology to care for patients who often have multiple challenging clinical issues. Creating a culture of trust where followership is embraced and team members communicate openly helps achieve high-quality outcomes in situations that are intolerant of error. Although individuals may make mistakes, error trapping occurs at the team level to ensure the mistakes do not affect the desired outcome.

Many consider the essence of leadership as the ability to influence others. Leadership training often emphasizes the need to develop and expand a repertoire of leadership styles[4] to be effective in a breadth of different situations. Traditional approaches to leadership are associated with a hierarchical model of downward influence in an organization. However, in high reliability organizations, effective leaders understand, empower, and defer to the expertise of team members. Influence in such organizations is multifaceted: it includes the traditional downward influence of leadership as well as the upward influence of active followership and the horizontal influence associated with peer relationships. The concept of leadership–followership continues to evolve as further research is conducted. For example, Vielmetter and Sell[5] assert that "leaders and followers are not distinct entities but different relationships in different circumstances."

Successful followership has many attributes, including competency-inspired self-confidence, effective communication skills, respect, a desire to take on challenging tasks and see them succeed through collaboration, as well as a willingness to actively engage with others and to speak up. Yet, there are still many reasons why health care professionals do not speak up or, when they do, they are not heard.[6]

It can be intimidating for senior team members to express an opinion that differs from that of the CEO. Similarly, staff report that it can be intimidating to speak up

to a physician. In a hierarchical leadership model with inherent imbalances of power, it is easy to understand that courage is often needed for followers to speak up. Many leaders understand the importance of engaging and listening to front-line team members and actively solicit input by asking questions and encouraging team members to speak up. However, even when empowered to do so, people find speaking up difficult.

Positive peer pressure, also known as horizontal organizational influence, is based on a willingness to speak up to a colleague to ensure that best practices are followed.

At Southlake Regional Health Centre, speaking up has been become one of the corporate values that make up our culture: *The Southlake Way*. Our culture defines the way we work together as we undertake the mission and vision of the hospital in delivering shockingly excellent experiences to our patients, our people, and our partners.

When first implemented, many felt that the new corporate value would immediately empower all team members to speak up, yet we found that many staff either still felt intimidated or felt they wouldn't be listened to. Our team realized that to truly embrace *speaking up* as a corporate value, it was critical to teach how to *listen up*, as well as how to speak up with respect. Both of these skills helped with understanding and acknowledgement of the potential imbalance of power that exists between staff, front-line care providers, and administrative leaders — and, perhaps most important, between patients and providers. Successful communication is a key element of followership and an important learning opportunity for the entire team.

Leaders in operational environments frequently say to team members, "If anyone sees anything of concern at any point in time let me know." It is a statement that I have heard and used repeatedly as a commercial pilot and astronaut; it leverages the power of followership, yet is rarely used in clinical environments. Imagine the potential impact on intraoperative safety if a surgeon were to empower team members to speak up by including that statement at the end of the safety surgical checklist. Imagine the passion and creativity that emerge when leaders defer to the expertise of clinical team members by ensuring they are included in and listened to in meetings. Peak team performance thrives in an environment of trust and open communication through creatively sharing ideas.

The challenge of hand hygiene compliance by health care professionals is widely recognized as one of the contributing factors in hospital acquired infections; yet, there is still an opportunity to improve compliance rates. Is this a leadership or followership issue? Are there health care professionals who don't understand the impact of poor hand hygiene or don't know appropriate hand cleaning procedures? The responsibility of leaders starts with ensuring appropriate staff training, providing hand hygiene solutions, and measuring compliance. The responsibility of followers is to honour their commitment to use best practices, to ask questions if they are unsure what to do, to speak up to leaders about their concerns, and to be willing to speak up to peers about safety and quality issues.

Positive peer pressure, also known as horizontal organizational influence, is based on a willingness to speak up to a colleague to ensure that best practices are followed. Speaking up for safety should be easy to do in health care; yet, even between peers, it can be a challenge. Learning how to speak up respectfully and how to listen up appreciatively are critical skills for everyone in the organization.

In operational settings, such as flying high performance jets, communication of important information can be critical. In a two crew member situation, the workload is divided between the pilot flying "PF" and the pilot not flying or "PNF." PNF duties included navigation, communication with air traffic control, and monitoring the flight instruments.

In one instance, as the aircraft approached the airport on the downwind leg getting ready to land, the PNF called the tower for landing clearance and informed the PF that no flaps were selected, the landing gear was down and locked, and they were cleared to land by saying: "no flaps, three green, cleared to land." The crew had not discussed

a no-flap landing ahead of time and, while safe, the procedure would normally include a briefing about approach and landing speeds. As the PF turned toward the airport on the base leg, the PNF once again called, “No flaps, three green, cleared to land.” With no acknowledgement from the PF and as the turn was made onto the final approach, the PNF repeated the two previous calls.

Deference to expertise is one of the characteristics of high reliability organizations.

During the debrief after an uneventful no-flap landing, the PF asked the PNF why they had not said that the flaps weren’t down. The PNF pointed out that they had made the call three times, but it was quite evident the PF had not heard the calls. This was a clear team and followership moment. On reflection, the third call by the PNF could have been, “No flaps selected. Do you want to do a no-flap landing? Three green, cleared to land.” Rephrasing the statement in the form of a question that required an answer could have resulted in a discussion and briefing for a no-flap landing. Although there was no mission impact, the debrief learnings included the importance of acknowledging calls between pilots and verifying that information is heard and understood.

Effective followership comes from developing a repertoire of communication styles to effectively contribute in a dynamic team environment. In some situations, particularly those that are time critical, a leader must use a directive style of leadership. With relatively inexperienced team members the outcome depends on the expertise of the leader to effectively direct the team. In this situation, followership is based on doing one’s best to do what the leader asks.

In highly experienced teams, members also follow the directions of the leader but may choose to speak up if they believe the directions may adversely affect the desired outcome. Respectfully explaining why they are making the recommendation, highly experienced followers can give feedback to the leader on an alternative course of action. If the leader thoughtfully considers the input, with or without further team discussion, and decides to pursue the original decision, it is the followers’ responsibility to accept the leader’s decision and do what they are asked to the best of their ability. Followership can also include speaking up if the situational awareness of the team leader is affected by distractions. In time critical situations, effective team performance is based on communication, trust, and deference to the expertise of the leader and that of the team members.

Deference to expertise is one of the characteristics of high reliability organizations. For leaders, it is an opportunity to create a culture of continuous improvement while building the expertise of team members to ensure they are provided every opportunity to develop their personal competencies. Optimum outcomes are typically achieved with highly experienced leaders and team members working together in a manner that effectively uses individual competencies and expertise. Organizations that invest in talent management and building individual and team competencies are creating conditions that favour optimum outcomes. Those that do not may find themselves forming teams that spend a significant amount of time in the “storming” phase[7] of team performance before moving on to “norming” and “performing.” Through an ongoing commitment to building expertise, organizations create an environment where teams move rapidly from forming to performing, thereby efficiently achieving peak team performance.

Most health care professionals are very effective at building their technical competencies and expertise through continuing medical education and experience. Yet many opportunities to prevent clinical error require non-technical behavioural skills. The application of the human factors is well known in aviation and spaceflight. When applied to health care, it focuses on optimizing human performance through a better understanding of the behaviour of individuals, their interactions with each other, and with their environment.[8] Behavioural competencies are as important as technical competencies in achieving high-quality outcomes, reducing error, and optimizing safety in clinical care.

Health care leaders may also consider the importance of developing individual and organizational resilience by building behavioural competencies. The

demands associated with working in an ever-changing, complex, resource-constrained environment can have an impact on career satisfaction and lead to burnout.[9] Supporting staff when medical error causes an adverse event is critical, as team members often internalize emotional responses with the potential for long-standing consequences. Building resilience is a continuous process; it can be a challenge for health care teams and is, ideally, one of the elements of learning organizations.

Positive emotional energy and relentless optimism are important attributes of astronauts participating in long-duration missions. The same attributes are desirable in health care and can be developed within an organizational culture. Individual and team well-being can be enhanced by teaching emotional resilience and optimism through the application of the principles of positive psychology[10] to help everyone flourish. Given the inherent challenges in health care, perhaps there is an opportunity for leaders to create a culture where everyone is treated with compassion, empathy, dignity, and respect, where there is a commitment to build behavioural competencies and team skills to ensure quality outcomes and higher levels of staff satisfaction.

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Exploring the relation between Canadians' values and health system costs

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Abstract

There is a clear misalignment between what Canadians value and how the performance of Canada's health care system is measured and funded. Survey data suggest that Canadians value greater autonomy and empowerment in managing their health care. They value more "personalized" care that engages every individual patient in a collaborative partnership with health care providers to make decisions that support health, wellness, and quality of life. Yet, health care systems focus on performance management in terms of costs; operational inputs, such as services delivered; or quality measures, such as medication errors, readmissions to hospital, and mortality rates. Their effectiveness is not evaluated in terms of delivering value to Canadians. Although Canadian values are primarily outcomes-based, funding of the health care system is focused on service delivery volumes and provider-focused outcomes.

KEY WORDS: patient values, performance management, health care, metrics, outcome measures, service delivery

Health care spending in Canada has been rising steadily for well over three decades.[1] Canadians perceive health care as one of the most fundamentally important hallmark features of society,[2] and their support for their much-loved health care system is as strong as ever.[3,4] However, are Canadians' values aligned with current expenditures in health care and measures of health system performance?

The concept of "value" in this study is defined as a quality based on a person's principles or standards, one's judgment about what is valuable and important in life. Given public representation on boards and governance structures, the mission, vision, and value statements of health sector organizations serve as a proxy to examine Canadians' core health care values.

To examine what Canadians value, we first describe a synthesis of current studies, surveys, and

Table 1. Canadian health care values

Acute care	Community	Health professionals	System funders
Collaborative care	Community governed	Leadership	Patient experience
Partnerships	Community centred	Advocacy	Health teams
Quality of life	Integrated care	Professionalism	Health system stewardship
External image	Equitable and accessible		Innovation and collaboration
Quality work			
Team environments			
Discovery and knowledge translation			
Cultural/heritage values			
Health system level sustainability			

reports on the views of Canadians toward the current success and outcomes of the health care system. Then, we examine specifically what Canadians and key stakeholders in the health care sector (e.g., hospitals, community organizations, health care professionals, and policymakers) describe as important and valued from a health perspective. Finally, we report the findings of a qualitative analysis of the mission, vision, and value statements of major health organizations, provider groups, and policy organizations to further determine the values inherent in health care organizations.

What are Canadians' core health values?

Health care has a very important purpose and meaning in the lives of Canadians; however, Canadians are also aware of the challenges health care systems face. Canadians support increasing the quality of the health care system even in the face of increasing cost and, in particular, see value in the funding of services focused on promoting wellness and quality of life.[5] Canadians believe that the job of the health care system is not only to treat disease, but also to improve the overall health of Canadians, and they believe that a fundamental change in the system is needed, in particular investment in long-term prevention to strengthen population health.[6]

Significant shifts in values over time have resulted in Canadians' preference for greater autonomy and empowerment and the desire to make decisions, manage their own health information, and engage health providers as partners "on a level playing field" in managing their own health and wellness.[7]

How values differ across the continuum of care

Values emerged from the analysis of the mission, vision, and value statements across each type of health organization: hospitals, community organizations, ministries of health, professional organizations (Table 1).

Hospitals

The most dominant theme in hospital mission, vision, and value statements focused on excellent care defined by collaborative partnerships between patients, their families, and the health care team whereby human dignity is honoured and respected to achieve the best possible quality-of-life outcomes for patients. Organizational reputation was a second key value, defined in terms of how hospital image and profile is a reflection of community identity, which reflects the values toward accountability of hospitals to the communities they serve. Quality work environments, new knowledge, and discovery emerged as necessary ingredients to support the delivery of quality health care services. For some hospitals, cultural and heritage values that respect diversity and community spirit were acknowledged as a key value in hospital mission, vision, and value statements. The responsible and accountable use of resources was also valued as

a necessary component of health system sustainability by hospital organizations.

Community organizations
The values of community organizations were strikingly different in focus from those expressed in the hospital sector; empowerment and engagement to strengthen population health and the social determinants of health were their most central values. The concerns of community organizations focused heavily on the link between social determinants of health and overcoming barriers to health and wellness care. Somewhat similar to hospitals, community organizations valued partnerships between interprofessional teams and the community population they serve to deliver integrated and comprehensive care and strengthen population health and wellness.

The concerns of community organizations focused heavily on the link between social determinants of health and overcoming barriers to health and wellness care.

Health professionals
Health professionals expressed values that reflect their unique role in providing care. They view the health system as a workplace that shapes and influences their professional practice. A dominant focus of the values of health professionals was leading and advocating health systems that support professional practice, which was viewed as a key ingredient for delivering quality health care. A common theme across all health professional organizations was the value of leadership, i.e., leading health service delivery or advancing health professional practice roles to achieve quality outcomes. Interprofessional approaches to care, integration of care, and collaborative partnerships with patients in communities were less clearly evident in this analysis.

Policymakers and funders
The values of policy organizations and system funders were, again, different from the other stakeholders. Here, the most dominant value focused on patient experience and the provision of compassionate, respectful, whole person care that meets individual patient needs. The values of funder organizations also focused on health teams, identifying key strengths that are highly valued, such as accountability, respect, integrity, courage, and trust. Health system stewardship was a third value, unique to funders, that focused on judicial and prudent use of resources. Finally, the only stakeholder that identified innovation and collaboration consistently across all organizations as a key value was funder organizations, such as ministries of health. Innovation and collaboration were evident in these values as a strategy for sharing knowledge and being a catalyst for change.

Values are deeply embedded in the perspective of Canadians. Community values that focus primarily on community empowerment and engagement, population health, and social determinants of health are not evident in hospital mission, vision, and value statements. Yet, hospitals and community organizations both serve the same communities where they are located, just from vastly

different value-based perspectives. Integration and coordination of care was referenced by both hospital and community organizations; however there was no evidence that these two sectors envision each other as partners working together to achieve integrated, coordinated care. Rather, each holds values focused on their specific and distinct mandate, with no reference to their position or role in the larger health system context, in which patients and families are part of a community and a population, and each subsector plays an important role in achieving population health and wellness.

The relation between Canadians' values and health system costs

Health care costs are related to what we can immediately see or experience as consumers (e.g., equipment, pharmaceutical costs, treatment costs, human resources). The major costs identified and measured by health systems include hospital costs, other institutions, physicians, other professionals, home care, drugs, and "other expenditures."

It is clear from examining spending patterns that Canada funds health care organizations and health professionals, not the health services or quality of health outcomes that reflect Canadians' values. This is because the Canadian health care system is input-focused; we measure the total costs of inputs (e.g., how many physician consultations, the cost of drugs prescribed, and the cost of hospital services) and equate this to total expenditures, often ignoring opportunity costs or benefit savings. In addition, the value or impact of resource use is not examined, despite the importance of values embedded in health systems.

Table 2 profiles the structure of health costs in Canada; there is no clear articulation of these costs with the values depicted in Table 1. For example, the engagement and empowerment of communities in their agencies or in collaborative partnerships with health providers in hospitals to achieve quality-of-life outcomes are not captured in how health system costs are measured and evaluated. In other words, the cost of inputs is clear, but the degree to which these investments align with Canadian values is less clear. Costs are not associated with outcomes of health systems that may reflect or align with Canadian values.

In addition, there is little evidence that health system funding is linked directly to, or travels with, a patient within Canada's health care system. Nor is there a link between funding models and population health outcomes. Indeed, across the spectrum of acute care and community agencies, values favour such health outcomes as quality of life — of either the individual patient or community — whereas priorities for health care funding are structured and focused on the services provided by organizations and professionals.

Despite public dialogue about moving funding toward supporting integration and coordination of care and providing incentives for collaboration among health care professionals to shift to a more patient-centric model, a significant shift must occur within system funding structures to align current values with costs. Such structures must focus on funding health and wellness outcomes, rather than services rendered, to drive system change toward patient-centric

Table 2. Per capita health care costs in Canada

Category	Per capita cost $	%
Hospitals	1804	29.5
Physicians	946	15.5
Prescription drugs	815	13.3
Other institutions	651	10.7
Dental services	379	6.2
Public health	360	5.5
Other health spending	270	4.4
Capital costs	243	4.0
Administration	177	2.9
Non-prescription drugs	145	2.4
Vision care services	120	2.0
Health professionals	112	1.8
Health research	109	1.8

Table 3. Health system performance measures versus values

Category	Value	Performance measures
Hospitals	Excellent care	Quality of life — no metric Safety — infections, falls, pressure ulcers, mortality metrics Integrated care — readmissions, ALC metrics Person-centred — patient satisfaction surveys
	Organizational reputation	Patient satisfaction surveys
	Discovery and knowledge translation	None
	Heritage/cultural values	None
	Sustainability	Total margin, current ratio
Community organizations	Community governed/centred	No standard measures
	Equity and access	Wait times for service in emergency department/surgery
	Integrated health care	Readmissions to hospital
Health professionals	Leadership	No standard measures
	Advocacy	Staff satisfaction measures (no standardized survey)
	Professionalism	No standard measures
Health policymaker/funder	Patient experience	Patient satisfaction surveys currently being developed nationally (CIHI)
	Health team collaboration	Readmissions to hospital: ALC
	Health system stewardship	Health care expenditures as % of GDP
	Innovation and collaboration	No standard measures

Note: ALC = alternative levels of care, CIHI = Canadian Institutes for Health Information, GDP = gross domestic product.

models of care focused on what Canadians truly value.

In addition, the narrow focus of current funding structures on health organizations, providers, and products precludes Canadians from understanding or identifying the value of health system costs. Thus, Canadians have few opportunities, if any, to be aware of, or judge whether their health care systems are delivering on the value proposition related to health care that the Canadian public strives to achieve.

How are Canadians' values aligned with measures of health system performance?

Many jurisdictions across Canada are making great efforts to develop measures of health system performance, and much of this work is based on the premise that measures of performance can be used to support funding decisions. We examined health system performance indicators used by policymakers and system funders, considering how they relate to what Canadians value. Clearly there is a misalignment (Table 3).

Current measures of health system performance focus primarily on access to care and quality outcomes that identify, primarily, hospital-related adverse outcomes, such as hospital-acquired infections, mortality, and readmissions to hospital. In many instances, there are simply no metrics for Canadian values, such as innovation and collaboration, quality of life, organizational reputation, or community engagement.

Many performance measurement systems tend to measure and profile patient outcomes that are focused primarily on adverse events or factors related to mortality. Little attention is paid to measures important to patients, such as wellness, quality of life, and personal satisfaction. However, this may be shifting as there is an emergent trend in health system performance measures away from health-provider-centric transactions toward more patient-centric metrics focused on patient experience and more closely aligned with Canadian values.

In Canada, health system performance measures are clearly

linked to funding and allocation of health resources in each jurisdiction. Thus, the challenges of moving from a traditional model of measuring performance in terms of services provided to a system that examines performance based on values, such as quality of life, are substantial, complex, and will continue to evolve over time. The intense competition for funding among organizations and providers may limit the ability of health systems to quickly and effectively move toward integrated and coordinated models of care that are highly valued by Canadians, as such a transition would require collaboration and cooperation among these organizations rather than a competitive dynamic. Thus, to effectively manage a health care system, leaders and decision-makers must find ways to measure system effectiveness and performance in terms of the degree to which they deliver value-based outcomes to the Canadian public. In particular, creating measures of performance in terms of collaboration and cooperative approaches to integrated health care services will be a considerable challenge for years to come.

Although performance measures are evolving, substantial progress is needed in the development of measures that capture the values Canadians expect. For example, despite the value of collaborative partnerships with health care providers and the importance of community engagement and empowerment, these factors are simply not reflected in health system measures of performance or cost effectiveness. Provincial and territorial health systems are striving to transition from a highly health-provider-centric (i.e., physician, organization) model of health care toward a more patient-centric (i.e., quality outcomes) model.

Much of this work is considered somewhat of a "moving target." However, early trends in achieving the transition are evident in some Canadian provinces. For example, Alberta and Ontario are implementing patient-based payment strategies, which may offer greater opportunity to link health system costs to population health outcomes based on quality of health services provided to patients.

How do we achieve greater value for Canadians?

To achieve greater value for health system costs in Canada, health system values should be aligned with Canadians' values — making a shift from a predominantly provider-focused, performance-based system to one that is focused on strengthening health and quality of life. Furthermore, health system performance metrics and funding models should be aligned more closely with Canadian values, which are more focused on health and wellness as a central mandate. Finally, we suggest a re-examination of health workforce values relative to the needs and values of Canadians, who strive for personalized and collaborative relationships with health care providers to achieve health and wellness.

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OPINION

Good leaders create followers, great leaders create leaders

Peter Lees, FRCS

Effective leadership is not coercive, but rather authoritative, affiliative, democratic, and coaching. However, the complexity of our current health care system is now so great that a leader cannot have the skills needed to lead all of the time. Instead, we need teams of insightful, empowering leaders who can promote the right culture, ensure high standards of care delivery, and pass the baton of leadership between themselves to ensure that staff and patients benefit.

KEY WORDS: followership, teamwork, leadership styles

If you have no followers, you are not a leader. If you have no willing followers, you are not a good leader.

The essential prerequisite for leaders to have followers causes some to argue that we have enough of the former, not enough of the latter, and a pressing need for training in followership. Some clearly have doctors in their sights in this regard — if only they would simply do as they are told! Sometimes I wish they would, often I am glad that they do not.

There is the danger in the followership argument of reducing the art of leadership to a simple case of one individual in charge of a group of people following orders. That over-simplification is, of course, the essence of coercive leadership and undoubtedly has a place in more extreme circumstances. Sadly, however, in my career, it has all too often been the default approach of many doctors, and anecdote suggests this may not have changed much. It should surprise few that Goleman[1] found that the coercive leadership style correlates negatively with results, and his more persuasive styles (authoritative, affiliative, democratic, coaching) correlate positively with results. However, the latter are more time-consuming and require greater skill, which may partly explain any over-reliance on coercion.

Coercive leaders need to reflect on what happens when they are not present. Fear of what one's senior will make of a decision and second-guessing their foibles were ever-present drivers in my training, but the Goleman evidence (and common sense) would suggest this is a poor and ineffective approach. Furthermore, other evidence shows a correlation between leadership and results with the creation of a positive climate, not fear, as the intermediate step.[2] Good organizations and good leaders rely on building the right culture such that, whoever the leader is in a particular circumstance, the actions are in line with the ethos of the organization and led by engaged individuals who feel supported, enabled, and competent.

Another inadequacy of the simple leader–follower model arises with the scale of modern leadership. Pendleton and Furnham[3] argue convincingly that complexity is now so great that the contemporary leader cannot have the skills to lead all of the time, an observation that also has echoes in the UK King's Fund report, subtitled No more heroes.[4] It seems logical to conclude, therefore, that the successful modern team, rather than a collection of followers and a leader, is instead a collection of leaders with the sophisticated ability to pass the baton of leadership to the most appropriate individual at the appropriate time. Some may lead more than others and one will usually be primus inter pares and hold ultimate accountability, but all team members will lead some of the time. Flatter hierarchies are, therefore, essential — perhaps another lesson the medical profession needs to learn?

Continuing with the complexity theme, the world facing the modern leader is neatly summarized in the acronym VUCA: volatile, uncertain, complex, ambiguous.[5] Research suggests that success in the face of VUCA requires increasing levels of leadership sophistication. Torbert and Rooke[6] describe seven levels. Depressingly, in their global study, 55% of leaders resided in the three least successful levels.

For doctors it is interesting to reflect on the most prevalent level within the bottom three, the expert, characterized by an overriding focus on knowledge and expertise. Watertight thinking is extremely important and experts rely heavily on hard data and logic to secure buy-in with little sensitivity and little time for those they deem less able. The obvious paradox is that, within that definition, there are undoubtedly attributes that one wants in a physician, but, historically, the system and the profession have been overly tolerant of the less attractive aspects. In short, technical brilliance does not excuse poor behaviour nor poor teamwork.

Furthermore, as doctors almost inevitably rise in seniority as their clinical competence grows, those stuck in the expert level will have serious shortcomings when faced with the inescapably greater leadership and management responsibility for which the profile of the expert has significant shortcomings. Leadership development must address this necessary progression and must toe a careful line, promoting clinical excellence without accepting poor behaviour. Some, perhaps many, make this progression organically but the stakes would seem too high to adopt a hit-and-miss organic approach.

Research on teamwork suggests that good decisions come from freedom to debate and freedom to challenge. In the seminal work linking teamwork and mortality,[7] a key positive discriminator is the permission for team members to challenge the leader; the dangers of blind obedience, potentially reinforced through training in followership, are obvious. This too has major implications for leadership development.

It is time to question the value of the common approach of supporting the development of single individuals out of context and away from their fellow team members[8]; instead there is a need to address the complexities of the model of multiple leaders within a single team. Although logistically less convenient, leadership development has to get close to individuals who work together and focus on their issues and their challenges. Considering the practicalities of this, it seems inevitable that the focus must shift from national, even

regional leadership development bodies to building local expertise at the organizational level. In short, leadership development needs to be as embedded in everyday practice as clinical development.

In conclusion, the concept of followership is outdated and fails to recognize the complexities and challenges of modern-day leadership. Globally, health care systems are facing major challenges and evidence suggests that good leadership offers solutions through improved performance.

Furthermore, in health care, better leadership is also associated with reduced mortality and better patient experience.[9] Medicine has been slow to understand this crucial association and slow to embrace leadership development and to support its medical leaders. We need little short of a revolution in which leadership is recognized as a core skill of the good clinician. We need a medical workforce that is self-aware, focused on effective team working and knows the kind of leadership that promotes good care.

The days of the allegedly all-knowing autocratic senior doctor must be replaced by teams of insightful, empowering leaders who can promote the right culture to ensure that high standards of delivery are maintained and appropriately pass the baton of leadership between themselves to ensure that staff are fulfilled and patients get the best deal.

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IN THEIR OWN WORDS

Exemplary practices of medical leaders in Australia

Graham Dickson, PhD

Australian physician leaders share their insights into why they believe physicians make good leaders, the skills they need, and how to make the transition from clinician to leader.

KEY WORDS: physicians as leaders, clinical background, collaborative skills, transition to leadership

Recently, I had the unique opportunity to interview a number of exemplary medical leaders in Australia. The occasion was provided by the Royal Australasian College of Medical Administrators (RACMA) in anticipation of their 50th anniversary in 2017. Although the interviews had the clear purpose of celebrating and showcasing exemplary leadership, they also provided deep insights into a number of issues that are high profile in the medical leadership field internationally.

Of particular interest are why physicians should be in leadership roles; the collaborative leadership skills physicians need to take on leadership roles; and the challenges of transitioning from clinical expert to medical leader. Through a combination of stories and reflections, physicians provided some fascinating insights on these three topics.

Why physicians should lead

Only a few substantive studies show that, when physicians lead health care organizations, results improve.[1-3] Although common sense suggests that a physician — with an appreciation of the challenges of medical practice along with excellent leadership skills — would outperform a non-physician with equivalent leadership skills, little evidence backs up that statement. However, let's explore the "common sense" argument a little further as it relates to what some RACMA leaders had to say on this issue.

Credibility builds trust; trust builds relationships. And the relationship is not between physician colleagues; it is between a physician leader and his or her clinical colleagues.

It is common sense to recognize that maintaining strong relations with practising physicians in one's organization will facilitate their engagement in health improvement efforts. Dr. Andrew Johnson, executive director Medical Services at Townsville Hospital in Queensland, said this about how physicians, in leadership roles, retain credibility with their physician colleagues:

> [T]he way to maintain credibility is to remember that you're a doctor, and treat your medical management leadership practice as a doctor. You talk to doctors about doctor stuff, you constantly link what you do back to the patient and patient care, and you demonstrate to your colleagues that you're interested in what they do. I encourage them to bring the latest and greatest of their thoughts in their field, I remain deeply interested in the clinical practice side of what they do, and I'm very, very careful to not have my own clinical opinion anymore.

As Dr. Johnson goes on, it is clear that he has thought deeply about this issue and has combined common sense with experiential wisdom:

> So one of the ways that you lose credibility enormously is if you pretend that your clinical knowledge is up to the same level as the people you're attempting to lead and manage. If you recognise that... whether or not you were a great clinician... you are moving into a different skillset.... I work on the basis that I'm no longer entitled to my own [clinical view]. I use my clinical background as a way to detect anomalies, and because I remain interested in the clinical practice side, I'm very able still to

pick up when people are being disingenuous, or I can apply relative weight to their various views and opinions.

Credibility builds trust; trust builds relationships. And the relationship is not between physician colleagues; it is between a physician leader and his or her clinical colleagues. They do come at the world differently, as Dr. Johnson suggests; but the ability to respect the other's point of view, to acknowledge its importance, and to hear the motive behind its articulation is key to effective decision-making. Credibility and trust grow the "zone of acceptance" of decision-making. As the zone grows, there is greater likelihood that when decisions are made, they will be implemented. That's the whole point of having a medical director, isn't it?

Dr. Taffy Jones, a retired medical leader, gave a second perspective on the importance of physicians being in leadership roles. He emphasized the quality of patient care perspective:

Relationships are key." But collaborative leadership is more than just relationship building: it is also the ability to act as an independent agent to fulfill one's role and responsibility as a medical leader

If you're going to have any hope of preventing or helping to prevent adverse clinical events, then you need to have your antennae up to pick up any potential problems early in their development rather than wait until the final disaster

happens. And the most effective way of doing that is through clinical audit. I used to go to all these medical and surgical clinical audit meetings.... It did alert you early in the piece to problems that were likely to arise unless you'd been forewarned that someone was not managing cases well.... I think this is where my continued clinical work was very helpful.

In today's modern health care environment, quality and patient safety are the purview of effective clinical governance. Without the ability to know and identify issues relative to enhancing quality improvement and patient safety, a leader is handicapped in fulfilling his or her leadership role. Having a clinical background clearly contributes — from a common sense perspective — to the ability to do that.

The need for collaborative leadership skills

In the literature, discussion about the skills physicians need to be active leaders of health system change revolves around the broad notion of collaborative or shared leadership.[4-6], The emphasis is on the ability of doctors to build relationships through which energy and knowledge can flow across boundaries that otherwise create barriers to a patient's journey.

As Dr. Sara Watson, program leader, Women's Health Strategy Unit, Department of Health, Northern Territory, stated, "Relationships are key." But collaborative leadership is more than just relationship building: it is also the ability to act as an independent agent to fulfill one's role and responsibility as a medical leader. Relationships facilitate the second ability; but collaborative leaders must also have the ability to reflect, to know their values and how they must shape decisions, and also have the strength of character to act when necessary. Balancing the need for interdependence (relationships) with the need to be true to the unique challenges of one's role (independence) is the true challenge of collaborative leadership.

Dr. Watson provided insights into the skills needed to balance independence and interdependence in two contexts. The first was when, as a medical leader, she had to deal with colleagues who had been referred to an Australian Health Practitioner Regulation Agency (AHPRA) review (the sort of review that, in Canada, would be undertaken by the provincial College of Physicians and Surgeons). Stating that such cases "are immensely complex and are embedded within issues of conflict and relationship issues," Dr. Watson indicated that, as a result of the lengthy processes involved in resolution of these cases, "the clinicians who had raised the concerns, when that case went to AHPRA, their concerns changed from the act of the clinician to the act of the management." Consequently, it "does make you reflect very, very deeply on the issues of accountability, performance, training, and early intervention." Her advice is that early intervention is absolutely necessary "when there are clearly signs of difficulty in... [clinical] relationships."

This story clearly demonstrates how the skill of deep reflection in her role as an "independent" medical leader has prepared her for similar responsibilities in the future. She also suggests that early intervention — for example, in the form of constructive but difficult conversations to address issues of poor performance or disruptive behaviour — might facilitate a better result in similar instances.

A second area for collaborative leadership by medical leaders is in policy. In this context, "setting the vision of where a service or where our particular policy or strategy should go" is a key skill. In particular, Dr. Watson says, medical leaders have the ability to establish visions based on evidence. "Whether it be in acute [care]... or in a community-based setting" physicians have the ability to establish evidence-based policy. She believes "that is very much the role in the future," and clearly a role she feels physician leaders are well-positioned to take on — and in need of mastering.

Dr. Michael Cleary, executive director, Medical Services, Princess Alexandra Hospital, also pointed out the importance of collaborative leadership in terms of a policy role. In a recent phase of his career as medical leader, Dr. Cleary took on the position of deputy director general for policy, strategy, and resourcing in Queensland Health and was responsible for the implementation of national health reform, "the biggest change in health in Queensland in 50 years." He described the fundamental importance of collaboration as:

> [S]kills in terms of being able to link in with clinicians and other groups, community and others... the behaviours that you'd like to see in the way you interact with people.... If you've got to bring organisations along with you, be they big or small... [the] ability to have good relationships with people so... the values that you have line up with the values that they or their organisations aspire to; things like trust, respect, professionalism, performance accountability, capability development, team building... working in a collaborative manner.

Both Dr. Cleary and Dr. Watson highlight three fundamental skills needed to enable the physician leader to be a collaborative leader, able to facilitate policymaking and implementation. The first is the skill of visioning: being driven by the desired future state of a policy change. The second is the "natural" ability to bring evidence to the table. Physicians do that in their clinical work; they have a predisposition to do so in policy work, once they understand the nature of the evidence needed and its relevance to policy issues. The third is the ability to find an intersection of values: of self, colleagues, and the organization as a foundation for positive relationships and for good policy that will be accepted and implemented. Underlying the ability to do all three is the skill of reflection; the ability to look inward, know what one believes in and stands for, and to be able to bring those skills to the table in both relationship-building and policymaking.

Transition challenges: from clinician to medical leader

Moving from clinician to medical leader is not necessarily an easy transition.[7] As Dr. Donna O'Sullivan, executive director, Medical Services, The Prince Charles Hospital and Metro North Hospital and Health Services, said in her interview, "not everyone can just be thrown in the deep end and swim; some people sink.... That's really, really distressing and disturbing."

So what advice do the interviewees give aspiring leaders in terms of facilitating the transition? Dr. Michael Walsh, chief executive

officer, Cabrini Health, would say that his most important lesson was to learn to delegate responsibility rather than try to do everything himself. His story:

> I became the director of Acute Health Services [in Victoria].... I remember... after three months' probation, going to speak to the then-secretary of the department.... The thrust of the discussion was... [a] sort of performance agreement, if you like.
>
> He said, "Look, I think things are going very well, I'm very happy with the way you've settled in, but you're working yourself into the ground. Now, in a way that's not my problem, the job's getting done, but you'll burn yourself out!" He said, "and when I look at your next line down, the people who are supposed to be supporting you, none of them are working the sorts of hours that you're working.... Some of them, I think... are not up to the mark, and... I think you need to manage them, and I think you need to get rid of the ones who aren't carrying their weight, and get some people in who are going to add value, because you are not going to be able to do it all yourself... you're not really concentrating on the more important strategic and policy things that really we want you to do."
>
> As I reflected on that comment, it was probably the first time I recognised that I was in a place where I needed to move from doing it myself, if you like, to doing it through others. I think from that time I've been passionate about delegation.

Dr. Lee Gruner, director, Quality Directions, stated that doctors need to cultivate the passion they have for quality improvement, as well as the patience needed to persevere over time. She said, "It's really hard to be a leader in anything unless you have a passion for it... be a leader in that."

Developing patience for the long term is also important. She added, "When we're trying to implement change, it takes months, years to do these things... [that's what] we have to teach people. In fact, when I was running a workshop on management one time, a doctor actually stood up and he said to me, 'You're really saying that some of these changes might take years and that's okay?' I said, 'Yes. That's okay if it's the right thing to do and you need to work it through.' That is a new concept to doctors who are used to getting results very quickly."

Conclusion

These interview snippets—organized, as they are, around the three themes why physicians should lead, the collaborative leadership skills physicians need to take on leadership responsibilities, and transitioning from clinician to medical leader — are a small sample of the wealth of responses on the same themes. They provide a fascinating look into the career paths of some of Australia's medical leaders, and, through the rich stories and interview responses, the over-30 transcripts provide an insight into the scope and breadth of the challenges of medical leadership and how to prepare for those challenges.

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Development of physician leadership: a scoping review

Luljeta Pallaveshi, RN, LLB, and Abraham Rudnick, MD, PhD

Abstract

Introduction: Physician leadership is required for transformation and improvement of health care organizations and systems. However, although development of physician leadership is presumably helpful, there is no clear evidence base for such development. Thus, our study aimed to answer the questions: What evidence-based interventions are used to develop physician leadership for health care transformation and improvement? What are the outcomes of these interventions? What are the enablers of and barriers to these interventions and their outcomes?

Methods: We conducted a systematic scoping review of scientific and grey literature, using key words to search databases and other sources. Two raters reviewed the literature and resolved any disagreement by discussion.

Results: No randomized controlled trials were found. Other studies were clustered into five themes: Physician leadership development programs (developing programs and creating new positions); Physician "leadership inclusiveness" (leaders' behaviours, quality traits, collaborative relationships); Training in physician leadership skills and competencies; Evaluation of physician leadership development programs; and Barriers/challenges to and enablers of physician leadership development.

Conclusion: There is no rigorous research on physician leadership development, although various themes related to the topic have been described. More research is needed to address physician leadership development and related matters, such as physician leadership involvement.

KEY WORDS: physician leadership development, healthcare organizations and physicians leadership, effectiveness of leadership development program, leadership development program evaluation, health system reform/transformation, skills and competencies, physician inclusiveness

There is a need for programs that are focused on providing physicians with the requisite technical knowledge, skills, and competencies to build leadership capacity within organizations.[1,2] Such development can promote organizational change, a culture of accountability, strategic alignment, and successful planning and help the organization reach its goals.[1,2] The process of preparing clinicians to be administrative leaders is challenging, because physicians seldom receive training in the managerial and leadership skills needed to influence others and develop relationships.[3,4] Indeed, physician leadership development may require clarification of first principles.[5]

The process also requires transformational change.[6] McAlearney et al.[7] note that the "transformational change required for physicians to develop and appreciate business and leadership skills can be supported and encouraged in a leadership development program that includes the components of careful curriculum design, program monitoring, and opportunities to apply new skills in practice" (p. 18). Transformational leadership also suggests organizational change to promote a culture that recognizes and supports physicians' contributions to hospital leadership and one in which medical staff and hospital administrators work collaboratively and share accountability.[8]

The purpose of this scoping review — a systematic review of literature where not much, if any, rigorous research may exist[9] — was to try to identify research and related evidence addressing interventional programs that support physician leadership development. Specifically, we asked: What evidence-based interventions are used to develop physician leadership for health care transformation and improvement? What are the outcomes of these interventions? What are the enablers of and barriers to these interventions and their outcomes?

Methods

We searched a wide range of electronic databases (PubMed, MEDLINE, EMBASE, Cochrane Database of Systematic Reviews, CINAHL) and a variety of health management and leadership journals (*Health Care Management Review, Journal of Organizational Behavior, Canadian Journal of Physician Leadership, Journal of Healthcare Management, Journal of Health Services and Research Policy, Healthcare Management Forum*, and *Journal of Healthcare Organizational Management*) that address this topic. Key words were: "physician leadership development," healthcare organizations and physicians leadership," "effectiveness of leadership development program," leadership development program evaluation," health system reform/ transformation," "skills and competencies," and "physician inclusiveness."

The search was conducted to identify articles published from earliest until June 2016 (inclusive) in relation to physician leadership inclusion in health care transformation and improvement, training in leadership skills and competencies, and physicians' leadership development programs. In addition, we manually searched such sources as the reference lists of relevant articles and Google Scholar, as well as grey literature (reports, white papers, conference proceedings, websites, and policy documents) to find additional information on networks, coalitions, and policies existing in the area of health care organizations and systems as related to the development of physician leadership for health care transformation and improvement.

Identified articles were independently reviewed and rated for relevancy by two reviewers. Any disagreement between the reviewers was resolved by discussion between them. Synthesis of the studies was conducted using a realist review. A realist review is an approach used for review and synthesis of evidence, focusing on understanding the mechanisms by which an intervention works or not.[10] A key principle of realist reviews is the assumption that a specific intervention produces specific change, which can be more or less effective in producing intended outcomes, depending on interactions with various factors in particular settings.[11] This type of literature review is particularly useful when assessing the complexity of implementing health services interventions, as the social context of service delivery is complex, diverse, and dynamic; thus, the same intervention seldom works in the same way in different social contexts.[12-14]

Extracted data were summarized and organized into categories and question-related topics. These data were then themed, the themes were challenged, and contrary evidence was sought. In relation to the characteristics of change or outcomes, a number of themes emerged. To confirm themes, connections were looked for across data to establish the existence of interventions, outcomes, and their barriers and enablers.

Results

No randomized controlled trials (RCTs) were found in relation to physician leadership development. Hence, we post hoc reviewed case studies, qualitative studies, pre- and

post-study design and systematic reviews (n = 94).

During the synthesis of the selected articles, five themes emerged: Physician leadership development programming (developing in-house leadership programs and creating new physician leadership positions); Physician "leadership inclusiveness" (leaders' behaviours, quality traits, collaborative relationships); Training in physician leadership skills and competencies; Evaluation of physician leadership development programs; and Barriers/challenges to and enablers of physician leadership development. The latter domain is also interwoven throughout the other themes. Key examples from each theme are provided below.

Most existing physician development programs are based on traditional managerial training and focus mostly on improving managerial skills and on-the job performance rather than quality and efficiency improvement...

Physician leadership development programming

Most existing physician development programs are based on traditional managerial training and focus mostly on improving managerial skills and on-the job performance rather than quality and efficiency improvement,[15,16] which might substantially affect organizational dynamics, climate, and culture.[17]

Physician leadership development programs should be designed to enhance effectiveness and/or improve the organizational culture.[18] They should include developing the individual leader, socializing company vision and values, strategic leadership initiatives, and action learning.[1] Examples of such interventions are developing in-house leadership programs[8,19-22] and creating physician leadership positions.[23,24]

Evidence indicates that an in-house leadership program that uses in-house instructors and intends to promote a culture that recognizes and supports physicians' contribution to hospital leadership and in which medical staff and hospital administrators work collaboratively and share accountability has the largest impact on organizations and the highest level of physician engagement.[7,25] The greatest challenges in implementing an in-house leadership program are the need for resources, the capacity to deliver such programs, and the difficulty of promoting them, particularly when physicians do not have formal continuing education programs and are not compensated for their time for this.

To address the low level of physician engagement in quality improvement, several hospitals have established formal physician leadership positions, such as the physician quality officer (PQO).[23,24,26] The key to the success of such programs is that physician leaders are involved in all important corporate initiatives, can set objectives, and are given protected time and remuneration.

However, implementation of this program highlighted three main challenges that had to be overcome. First, the quality improvement structure of the medical system had to be changed from the financial, reporting, and project selection perspectives and buy-in of the chairs had to be gained. Second, as a new enterprise, details of the PQO system had to be worked out. The PQOs grew into their roles as they gained knowledge and experience. Third, the program had to be presented in a way that engaged the medical staff in quality improvement.

Physician "leadership inclusiveness"

Behaviour of a team leader can substantially influence the climate and dynamics of the team.[27-31] Nemeth[27] stated that "people are reluctant to voice novel or deviant views for fear they will be ridiculed. Thus, the diversity of viewpoints is unexpressed in most groups, and therefore there is a reduced likelihood of finding creative solutions" (p. 29). Research has shown that such feelings of threat or risk hinder professionals' willingness to voice their concerns or ideas.[32,33]

In the same context, team members tend to speak up less often if a team leader displays authoritarian, unresponsive, or defensive behaviours, but they tend to be interactive and feel involved if the leader is open-minded, supportive, and proactive, has the ability to share and encourage new ideas, and is open to constructive criticism or voiced challenges. These behaviours and qualitative traits constitute what has been termed leadership inclusiveness, which facilitates team processes and provides elucidation and positive responsiveness.[29] According to Nembhard and Edmondson,[34] leadership inclusiveness refers to "words and deeds by a leader or leaders that indicate an invitation and appreciation for others' contributions. Leadership inclusiveness captures attempts by leaders to include others in discussions and decisions in which their voices and perspectives might otherwise be absent" (p. 947).

Leadership inclusiveness is necessary in health care settings not only because it provides an opportunity for low-social-status professionals to be proactive through their contributions, but it also creates a psychological safe environment that allows people to speak up and overcome communication boundaries.[34] In contrast, deference to power status substantially influences the process of quality improvement and, as result, can lead to poor decision-making and be detrimental to achieving the organization's goals.[27,35-37]

Training in physician leadership skills and competencies

Physicians may have high academic achievements, clinical expertise, and some traits of leadership, e.g., compassion, caring, integrity, passion, judgement, and critical thinking. However, they may not have the knowledge, skills, and competencies — in strategic planning, organizational management, finance, regulation, problem-solving, emotional intelligence, conflict resolution, effective communication, and network development — needed to lead organizations toward building strong alliances and partnerships, making strategic decisions, and ensuring effective and efficient high-quality care.[3,38-41]

...organizations largely ignore evaluation of leadership program outcomes and processes nor do they investigate whether the programs they offer have a positive effect on improving the organization's performance.

Several core competencies for physician engagement and leadership have been proposed,[42-44] and a variety of training courses, seminars, and workshops are offered for physician leadership development. Yet, an important question is often ignored, i.e., what are the skills/competencies and appropriate training that have been measured or otherwise evaluated and are deemed to be a good fit for a physician leader to have.

Pfeffer[31] highlights two general ways to understand leadership failures: 1. organizations have done a poor job of selecting the right people for leadership roles, schools have failed to instill ethical leadership behaviours in their students, and some leaders have developed the wrong values; 2. systemic processes produce leaders who often behave differently from what most people may like or expect. In addition, there is little evidence that research-based recommendations have positive impacts, and there is scarcely any evidence that all the spending on leadership development is producing better leaders.[31]

The greatest challenges to health care organizations are their complexity

Evaluation of physician leadership development programs

Evaluation of the effectiveness of initiatives to improve care is crucial for health care system transformation.[45] Leadership development programs have used Kirkpatrick's[46] evaluation model and are mainly focused on individual learning outcomes (reaction and self-reported knowledge), neglecting organizational performance. In fact, this model is not designed for nor is it effective in measuring organizational performance or the effectiveness of an organization in achieving outcomes as identified by its strategic goals, and it does not focus on return on investments.[47]

Indeed, organizations largely ignore evaluation of leadership program outcomes and processes nor do they investigate whether the programs they offer have a positive effect on improving the organization's performance.[15,16,31,48-50] It is clear from several empirical studies[15,16,49-52] that leadership program evaluation is of poor quality because of a high risk of bias.

It is imperative for organizations to evaluate the effectiveness of leadership development programs. Hence, before implementing one, developers should take into consideration the study design, define the target population and intervention, assess the outcomes blindly, use standardized and validated evaluation tools, and clearly define the competencies that are necessary for leaders to achieve organizational/system effectiveness. In addition, the experience of the trainer may be significant in influencing the effectiveness of the training program, and some management training methods may not lead to improved performance.[16]

Barriers/challenges to and enablers of physician leadership development

The greatest challenges to health care organizations are their complexity, e.g., involving various professions[2,53]; physicians not having the right skills for management[2,53,54]; addressing existing gaps in quality of care; the complexity of caring for aging patient populations with chronic diseases; the uncertainty about the appropriate use of new devices and medications; the rapidly rising costs of care in a constrained economic time[52]; reluctance to change despite investments and high demands for innovations and quality improvement[26,31,55]; and professional cultures that may obstruct best decision-making and resource allocation.[55]

Several researchers have suggested a variety of enablers that may enhance the integration

of physician leadership and physician leaders' engagement as facilitators of health care system improvement.[2,3,7,36,44,45,56-58] However, such factors and interventions should undergo rigorous evaluation.

Conclusions

Although physician leadership development is needed, this systematic review demonstrates the lack of rigorous research in this area and the paucity of other literature directly related to it. Only about half of the references we identified are from the last decade, further suggesting the need for more research.

There is a need to develop and rigorously evaluate standardized physician leadership development programs that are responsive to organizations' and systems' priorities. Admittedly, standard RCTs may not be adequate to study such complex interventions; hence, other forms of rigorous research may be needed, such as well-matched quasi-experimental, case–control or cohort studies and long-term evaluation of well-controlled quality-improvement initiatives. In summary, empirical research is needed on the processes and practices that can help involve physician leadership in transformation change and improvement.

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Coaching competencies for physicians: change the conversation, change everything

Nancy M. Merrow, MD

A coach is focused on building capacity in the person being coached, whether that person is a patient, student, or team member. A coach uses artful questions to clarify the goals of the person being coached, help align their aspirations with personal values, increase their commitment to action, and hold them accountable to their intentions.

KEY WORDS: coaching, physicians, mentoring, capacity-building, problem-solving, coaching in leadership, peer coaching

Whether you are managing patients, trainees, peers, or whole programs and departments, communicating in a way that inspires and enables behaviour change is a useful skill. Whenever you are faced with a person who wants things to change, there is an opportunity for coaching.

Coaching is not the same as mentoring. A mentor is someone who has traveled the path that the mentee is on or wants to be on. The mentor shares experiences and offers wisdom, advice, and connections that accelerate the mentee's achievements. A coach is focused on building capacity in the person being coached, such that the achievement of their goals is fully credited to their own commitment to action. A coach uses artful questions to clarify the person's goals, help to align their aspirations with personal values, increase their commitment to action, and hold them accountable to their intentions.

Use coaching competencies when the issue at hand will only be solved if the person takes action.

Unlike some other tools physicians are trained to use, coaching is not therapy. "Coaching is a creative partnership with your client, focusing on designing and implementing specific, meaningful changes in your client's personal and/or professional life."[1] In the world of medicine and leadership, your "client" may be a patient, a trainee, a colleague, or someone who reports to you as their boss or leader.

The fundamental premise of coaching is that the coach believes that the person being coached is fully capable of managing their own life and circumstances. The person is asking the coach to help them, and the coach takes a positive, appreciative, and curious approach to how the person is pursuing their goals.

The coach does not give advice. The coach presumes that the person being coached is fully capable of making choices and taking action.

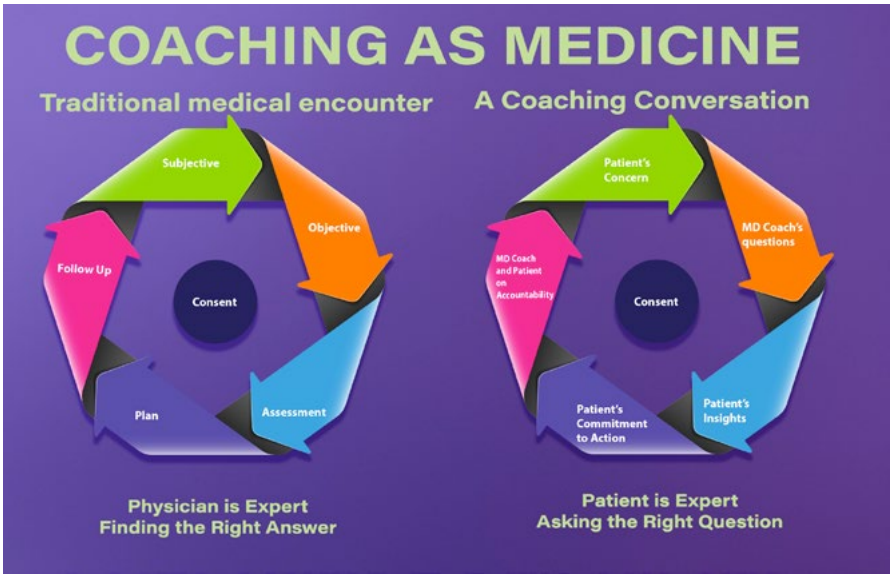
Coaching session versus traditional medical encounter

In any kind of "helping" encounter, the consent of the person being helped is essential and should be explicit. Confidentiality is respected, and both parties are committed to working toward the agreed goal of the session. The three "Cs" — consent, confidentiality, and commitment — are common to clinical work and coaching.

Using the "SOAP" format for a traditional medical encounter, the clinician gathers *subjective* information by asking specific questions to elicit and understand the patient's complaint. The questions are structured to add to the history of the complaint with pertinent positive and negative details. Generally, the clinician is using information to narrow down possible causes and form a differential diagnosis. *Objective* input is obtained by physical examination, observation, and various investigations as

appropriate. The *assessment* is reached by the physician using information, diagnostic acumen, and experience. A *plan* is proposed to the patient, and the next step is agreed to, including who will do what and how follow up will occur. In the sometimes hectic pace of clinical encounters, the rhythm of the cycle is often very rapid, but identifiable.

Figure 1. Similarities and differences between a traditional medical encounter and a coaching session.



In a coaching conversation, the cycle is also identifiable and can be closely aligned to the clinical skills physicians use every day. The person being coached brings a *concern*. The coach must focus very carefully on what the person wants and help them frame it as a goal. If the goal is not clear, the rest of the conversation will not likely yield a fruitful next step or plan. The clinician, in coach mode, uses *questions* to clarify the person's goal, and to help *insights* emerge from the person. Artful questions will cause the person to reflect on what they need to do and what needs to be different to make progress toward their goals.

The coach keeps a firm attitude of non-judgemental belief that the person can make choices and take *action* on their own issues. The coach ensures that the person, at all times, maintains ownership of the issue, the potential solutions, and next steps. The plan belongs entirely to the person, who takes away the tasks necessary to achieve the next step toward their stated goal.

The coach ends the encounter by establishing how the person wants to be held *accountable* for their commitment to next steps, and may participate in some way, such as agreeing to another session, or receiving a message about tasks accomplished.

In a traditional medical encounter, the clinician has most of the responsibility for flushing out the likely causes of the patient's complaint, for knowing the possibilities that need to be investigated, and for proposing plans of treatment. The clinician is the expert and is focused on finding the right answers. In coaching, the patient or person is the expert, and the coach's job is to ask the right questions. The responsibility for progress toward the person's goals rests completely with the person.

Coaching in practice

There is no need to spend excessive amounts of time to use the coach approach. It is just a different way of managing the structure of the conversation, and brief interactions no longer than the average office appointment can create the right atmosphere for change.

Our adaptation of coaching competencies to the clinical setting has a place in your toolkit of behaviour modification techniques, in the management of situations that depend on the patient or person making choices, decisions, and changes. The goals and the solutions are theirs. By acting as a coach when people bring you problems that are within their control, not yours, you build their capacity for problem-solving. Further, the relationship is clarified and strengthened, whether it is doctor–patient, teacher–student, or leader–team member.

The relief that you feel when you fully release the responsibility for change to the only person who can actually make it will increase your stamina and energy for your practice and your leadership duties.

Try these questions to change the conversations you have with people about their goals. Notice the coach generally does not ask why, as this requires the person to justify their approach. The best non-judgemental, open-ended questions start with what and how.

Sample coaching questions

- What will get you moving on this?
- What is getting in your way?
- What is keeping you from acting on this?
- How important is this to you on a scale of 0 to 10?
- How confident are you that you can make this change on a scale of 0 to 10?
- How can you clarify what you need to know?
- What resources will you need?
- What would change your attitude about this?
- What would make it easier for you to take risks?
- What do you believe will happen if you make this change?
- What would be different if you resolve this?
- What is the worst thing that could happen if you do that?
- What three things could you do to manage that scenario?
- Is there another way?
- What is most uncomfortable about this change?
- What if nothing changes?
- What is one decision you can make to get things going?
- What is one thing that would make the biggest difference in your life?
- What support do you have to address this challenge?

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The Coach Approach workshop will also be presented at the **2017 CCPL in Vancouver.**

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REFLECTIONS

On the shoulders of giants: inspiration for aspiring physician leaders

Vanessa E. Zannella and
Liza Abraham

Although the number of women in medicine has increased dramatically in the past two decades, this has not been reflected in physician leadership positions. The disproportionately fewer women in positions of leadership and administration has meant fewer opportunities for mentorship. This article presents words of wisdom and inspiration from 10 female physician leaders.

KEY WORDS: medical education, work–life balance, family, well-being, professional relationships, gender bias, mentorship

Medical training is a unique period in one's life. It's a time to become your own person, to grow into a professional, to conquer your craft, and to develop meaningful relationships with your patients and peers. It is the greatest time of your life, but also the most difficult. We've all had conversations with our mentors — about burnout, managing uncertainty, remaining humble — but for female medical trainees interested in leadership, talking about family planning, work–life balance, and job advancement may be more difficult. And the disproportionately fewer women in positions of leadership and administration has meant fewer opportunities for mentorship. Although the number of women entering a career in medicine has increased dramatically in the past two decades, this is not reflected in physician leadership positions. New research studies investigating the underrepresentation of women in academic medicine have revealed important themes, including experiences with gender bias, a lack of role models, and concerns about finances and work–life balance.[1,2]

Despite these challenges, trainees continue to be motivated to participate in leadership endeavours. To explore the perspectives of physicians on medical leadership, we sought the wisdom of 10 female physician leaders across various subspecialties — surgery, internal medicine, psychiatry, obstetrics & gynecology, family medicine, emergency medicine. Their words and stories offer inspiration that is worth sharing. We hope you find what follows as transformative as we have.

On time and work–life balance

- Worrying too much about [work–life balance] undermines the tremendous amount of joy you get from your work as a physician.
- We often categorize work as bad and life as good. I love my work and work is part of my life.
- Early on, you will say yes to more! But if you don't like something, you shouldn't stick with it. The only reason to do multiple jobs is because the outcomes are important to you.
- Balance comes over a month, where one week I focus intensely on one thing and then the next on other things. If you're going to be a high-level, high-functioning professional, you won't have balance every day.

On family

- My husband is a physician leader too. We didn't bake cookies together, but look how great our kids turned out!
- I think if you love your family and they know that you are doing something important, they will understand and love you anyways. I don't think that my children doubt that I love them.
- Have your baby now! Fertility is a feminist and a leadership issue. Biology is something you can't control. The perfect anything is never going to happen; don't put fertility on the back burner.

On personal well-being

- Remember that it's a long career and you don't have to do everything all at once. You can have everything, just not all at the same time.
- Can you be at every car pool and soccer practice and be

baking? You can't! Decide what is important to you. It's all about your long-term goal. With everything you do, think "why am I doing this?"
- Learn how to say no.

On professional relationships
- Some women need to learn how to speak out, but are afraid of being labelled aggressive. It's your personal responsibility to overcome that fear if you want to be a leader.
- Taking a leadership role changes your professional relationships. It's hard to be friends with someone who is reporting to you.
- As you mature into your profession, you learn to carry yourself differently and command the room, especially as a surgeon. If I am not calm and in charge, then everything in the room feels off balance. That came later for me than some of the guys.

On gender bias
- There are differences in how men and women present and promote themselves. Men are more self-assured. Women are more introspective. If you are introspective enough, you will find reasons why you are not good enough for a leadership position. If you can't turn that voice off, you won't ever apply for the job.
- Most gender bias frequently comes from patients. You go through a whole spiel about the surgery, obtain consent from the patient, and, as soon as you walk out of the room, they turn to the nurse and ask, "That's the surgeon? Is she going to do the surgery?"
- As women, we don't promote ourselves very well. Men are more competitive in the workplace, and they are more comfortable doing things because they are right for them. Women are, generally speaking, more concerned about the whole team. Because of this, we sometimes do ourselves a disservice.

On mentorship
- Everyone you meet — every teacher, every shadowing experience, every clinical experience — take a few minutes to reflect. Is this someone who could be a mentor and in what way?
- I've had great male and female mentors. No question that female mentors have an intuitive ability to understand kids, family obligations, menstruation. But you don't need a gender-specific mentor. You need multiple types of mentors.
- I don't subscribe to the traditional model of mentorship — that you should get everything from one person. We all have people who we are close to and who can champion us. It's important to have a group of people in your life whom you can call for certain types of problems.

Conclusions

What we are sharing is honest and humble opinions of some of the most ambitious, kind-hearted, and loving female physicians we could find. Although this is certainly not a scientific, rigorous list, the advice is genuine, truthful, and thought-provoking.

What was so intriguing about this process was that these women — clinicians, administrators, researchers, teachers, mothers, daughters, sisters, and friends — could offer such a plethora of optimistic, enlightening, and hopeful reflections to young female physician leaders in training. Moreover, the opinions demonstrate

that our unique strengths as women position us perfectly to learn from and alongside our male colleagues.

If nothing in this piece resonates, remember to always embrace the fear, exhaustion, joy, and uncertainty associated with your unique path toward leadership. Consider physician leadership a privilege, an honour, and a blessing presented to few; it can either define you or be defined by you. So go on, enjoy the journey.

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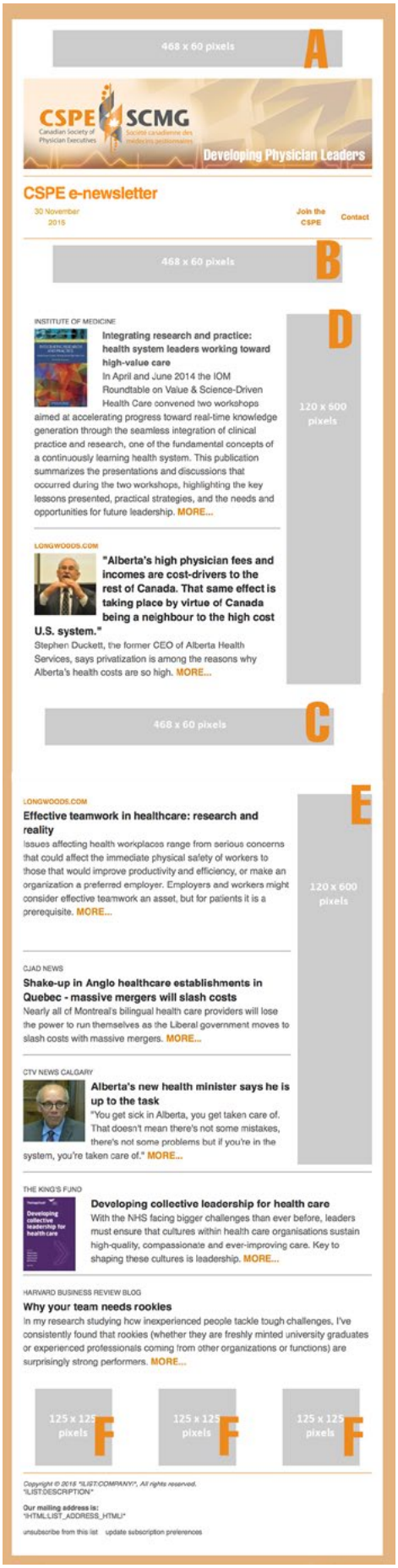

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BOOK REVIEW

Stop Physician Burnout: What to Do When Working Harder Isn't Working

Dike Drummond, MD
Heritage Press, 2014

Reviewed by Johny Van Aerde, MD, PhD

Research shows that 50% of physicians are suffering from burnout, and close to 100% have experienced some degree of burnout sometime during their career. *Stop Physician Burnout* is a great book in terms of prevention, but even those who have gone too far down the spiral and need professional help will find new habits to cultivate and maintain during the healing process.

After experiencing two episodes of burnout himself, Dr. Dike Drummond has spent thousands of hours helping hundreds of doctors. In *Stop Physician Burnout*, he elaborates on the causes, diagnosis, and pathophysiology of burnout, explaining in simple terms how to recognize it.

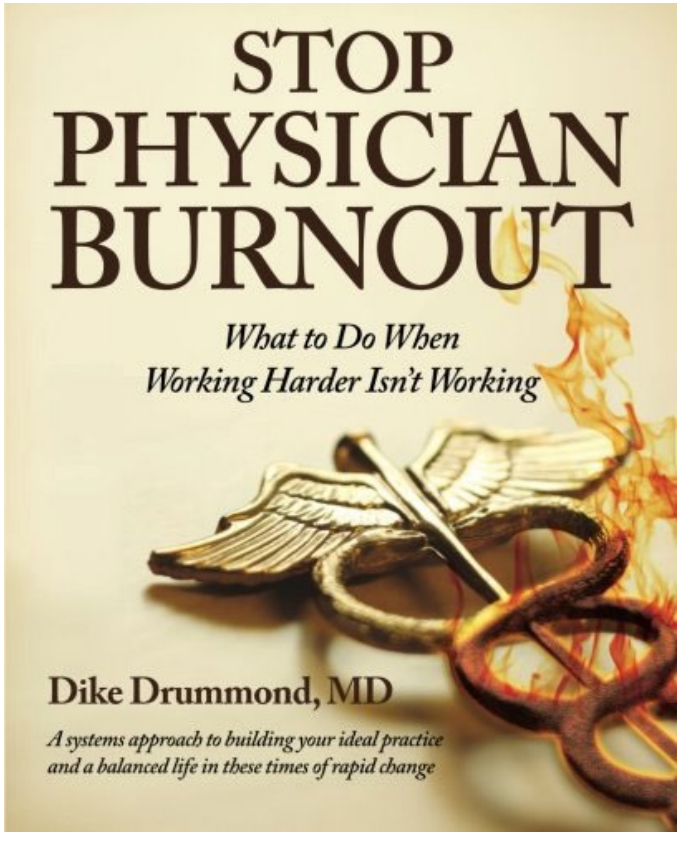
The selection process for medical school and the type of training we physicians receive as med students and during residency shapes us into perfectionists; the process is then reinforced continuously by the high expectations of patients and society. All these elements contribute to burnout, which appears as exhaustion, depersonalization (with lack of empathy), and low efficiency — all because our physical, emotional, and spiritual energy bank accounts are running a negative balance.

The book dives into treatment, starting with taking out the "head trash" that prevents us from even starting to heal. That "trash" is a set of five changes in awareness that must be addressed to enable the burnout prevention tools to work. For example, Drummond explains how to deal with the omni-present inner critic.

Another necessity is realizing that we are trained to approach everything as a problem that can be solved. Unfortunately, burnout is not a problem for which there is one solution; it is a dilemma and dilemmas are managed. This topic is difficult to grasp for "experts," but Drummond deals with it, nicely and comprehensively.

After helping us develop a blueprint for our life, a vision of our future, Drummond elaborates extensively on a series of tools to prevent burnout. All are simple, some have been proven by research to be effective. He organizes them into a "burnout prevention matrix," which has four categories: tools to decrease personal stress, tools for personal recharge, tools to decrease organizational stress, and tools to facilitate organizational recharge.

Most important, each tool is usable and understandable, not only for those who want to prevent burnout, but also for those who are already experiencing it. For example, the "squeegee breath," a mindfulness tool, does not require much effort to use, and, most important for busy doctors, it doesn't take much time. It has been tested in small groups, and preliminary evidence indicates that the stress level of those in the group decreased after eight weeks.



At the end of the book, Drummond presents a set of case reports with various scenarios. One

drew my attention, because it dealt with changes and stresses around the time of retirement. Drummond provides some good insights that made me see how our lifestyle as physicians, over the decades from entering med school until retirement, has also skewed our thinking about retirement.

The Canadian health care system does little to keep doctors healthy and reduce work stresses. In the years ahead, the most successful health care organizations, in the context of succession planning and sustainability, will be those who take excellent care of their providers and staff. How do we expect physicians to become engaged in the transformation of the health care system, if they barely have enough energy to be experts and advocates for their patients.

Stop Physician Burnout is a good read and a useful handbook, not only for physicians, but also for those who live or work with them.

Note: Dr. Dike Drummond will be a keynote speaker at the **2017 Canadian Conference on Physician Leadership**.

Author

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