CANADIAN JOURNAL OF

Volume 3 Number 4
2017

Physician Leadership

THE OFFICIAL MAGAZINE OF THE CANADIAN SOCIETY OF PHYSICIAN LEADERS

In this Issue

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

Contents

Contact Information:
Canadian Society of Physician Leaders
875 Carling Avenue, Suite 323
Ottawa ON K1S 5P1
Phone: 613 369-8322
Email: carol@physicianleaders.ca

ISSN 2369-8322

Rudeness in health care is harmful

Johny Van Aerde, MD, PhD

Rudeness can have serious consequences in health care. Although rudeness has been studied mainly in the context of sustained, abusive behaviour and incivility by a subgroup of medical practitioners, recent evidence indicates that even more subtle incidents of rudeness displayed by any member of the health care team, the patient, or the patient's family affect team performance and patient safety and outcomes. This paper reviews the psychological and sociological consequences of rudeness in the health care setting, and offers suggestions on how physicians can step up as leaders to prevent or handle such situations.

KEY WORDS: disruptive behaviour, incivility, disrespect, team performance, patient outcomes

Definition

Rudeness is insensitive or disrespectful behaviour by a person who displays a lack of respect for others.[1] Respect can mean many things, and the wide spectrum of behaviour showing disrespect ranges from deliberate offensiveness as part of an abusive behaviour pattern to unintentional negative comments made during stressful moments and seemingly innocent words that are derogatory in certain circumstances.[2-5] In this paper, rudeness is defined as speech that is confrontational at its core, demonstrating disrespect, and disturbing to the social equilibrium. It does not include persistently disruptive behaviour, as dealing with such problems requires different skills.

Rudeness decreases cognitive ability, team performance, and patient outcomes

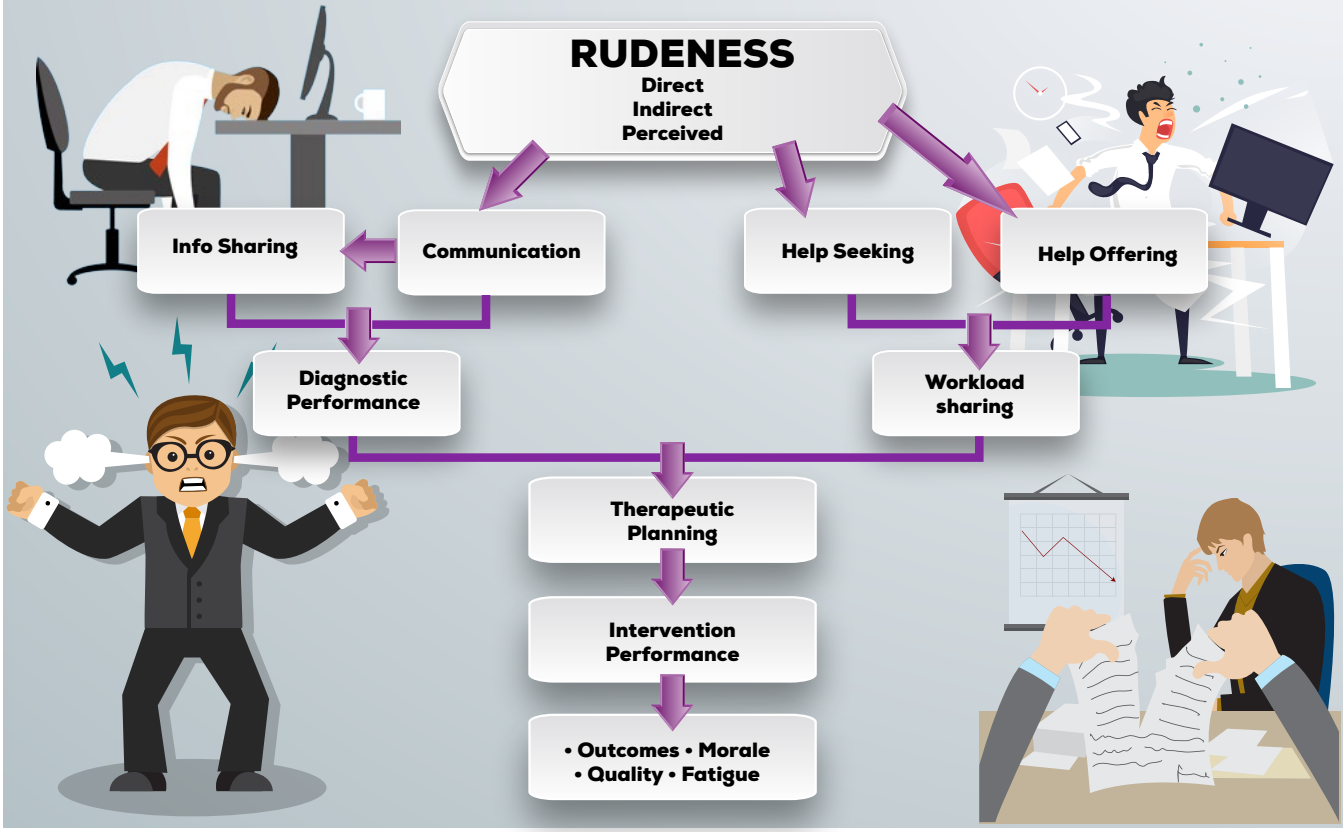
Physicians can be at both the receiving and giving ends of rudeness. In the United Kingdom, one in three physicians experiences dismissive communication at least once weekly.[2] For medical trainees, as many as three out of four are affected weekly, some even daily.[2]

In a United States study published earlier this year, the effect of physician rudeness on patient outcomes was estimated by analyzing unsolicited observations from 32 000 patients, involving 800 surgeons at seven academic sites.[6] Patients described disrespectful or rude interactions of physicians with patients or members of the team that caused distraction, made people feel embarrassed or intimidated, and deterred communication. Surgeons in the highest quartile in terms of number of observations of rudeness had a postoperative complication rate that was 14% higher than surgeons in the lowest quartile.[6] The association may not be directly linked to these surgeons' technical skills; e.g., abusive surgeons may attract lower-quality teams of people, who may be less skilled technically or in terms of collaboration and communication, leading to low morale.[6, 7]

Not only individuals, but also entire teams can be affected by rudeness. During handovers, such as those between a stressed transport team and an anxious accepting team or between an ICU team and an OR team, hostile comments can lead to cognitive disruption and reduced performance.[8] In such stressful situations, simple comments such as, "Who told you to come to resus?" or "We were told the child was three, not two," can be perceived as hostile,[8] even if they were not intended to be.

Rudeness in the form of negative comments from the patient, family members, or outsiders can also diminish diagnostic and procedural performance. Recent neonatal studies not only showed cognitive inhibition of individual team

Figure 1: Negative effects of rudeness on individual performance and team function



members after negative comments from a visiting outsider,[3] but also impaired diagnostic and intervention performance of the entire team after negative comments by an infant's mother.[9] In addition, team processes, such as information and task sharing, were decreased. Even a mildly rude statement such as, "I knew we should have gone to a better hospital where they don't practise third-world medicine," reduced the team's scores.[9] In the long-term, team members can experience fatigue and the team might develop low morale. Figure 1 summarizes the effect of rudeness on individual cognitive performance, team function, and patient outcomes.

Rudeness is also contagious, so much so that people may not even be aware of the original source of their own aggressive behaviour.[10] As rudeness is repeated in an organization, there is a risk of it becoming a cultural or hierarchical norm.[2,5]

Not surprisingly, just witnessing (indirect) or recalling (perceived) rudeness can disrupt cognitive processes and creative tasks as much as being the direct recipient. In a series of studies among business students, the results of standard cognitive function tests deteriorated in each of three groups: direct victims of rudeness in the moment, those who witnessed rudeness toward someone else, and those who had to recall an instance of being treated rudely in the past.[4]

In short, no matter which partner in the patient–health care provider relationship displays disrespect and no matter whether the rudeness is direct, indirect, or perceived, individual cognitive performance and patient outcomes are affected negatively, and health care team members are less willing to share information or offer help.

Neurophysiology of negative interactions

The physiological experience of an interaction affects the resonance or dissonance of a relationship. Resonance is physiological attunement and interpersonal synchrony. Resonant relationships are characterized as positive emotions, a subjective sense

of being in synchrony with one another, and with physiological effects of the parasympathetic nervous system. These effects expand one's attention, enabling more creative thinking and learning.[11] A dissonant relationship produces negative emotions, interpersonal discord, and sympathetic nervous system activation.[11] Dissonant memories, like rudeness, move one's thoughts more toward "self-pain" than toward thinking of others and narrow one's attention.

fMRI studies have shown that recalling resonant experiences activates brain areas associated with social networking and positive affect; recalling dissonant experiences activates regions associated with avoidance, narrowed attention, decreased compassion, and negative emotions.[11] These neuro-imaging findings help explain cognitive inhibition, impaired diagnostic and intervention performance, and reduced willingness to offer information or help.[9] They further explained poor performance on cognition tests in a study involving business students.[4] The association also means that previous negative interactions with someone, if unresolved, are likely to reduce the potential results of any future working relationship.

What can we do about rudeness? As a physician leader or a member of a health care team, how can we help those displaying rude behaviour, including ourselves (the instigators), and how can we immunize ourselves and our team (the receivers) against the effects of rudeness?

Causes of rudeness

First, consider why the rude event may have occurred. If you know the instigator, is the rudeness a pattern or an unusual occurrence? If the former, then rudeness may be part of the instigator's values and vision of the world — part of who he or she is. Luckily, rudeness as part of a disruptive behaviour pattern is the rarest cause. Unfortunately, it is also the most difficult for the physician leader to handle, often requiring help from other professionals to support the person displaying the disruptive behaviour pattern. As indicated above, this article does not deal with the complexity of persistently dysfunctional behaviour.

Sometimes, we see negative behaviour as part of someone's character, when it may simply be a way of hiding insufficient or missing skills. This is called a fundamental attribution error.[12] Rude comments may be a way of hiding lack of competence and shifting blame. For those with limited coping skills in stressful situations, rudeness may be an expression of ambiguity toward the unknown and the unpredictable, perhaps aggravated by fatigue or feelings related to unfulfilled physiological, safety, or social needs according to Maslow.[13] If those needs remain unfulfilled, the person may experience complete disengagement and burnout. Sometimes, the missing skill is simply an inability to communicate appropriately or function optimally in stressful situations.

If a rude comment is rare and out-of-character, or if you don't know the instigator, always wonder whether that person might be suffering from HALT (hungry, angry, lonely, and tired) syndrome. Many of us have been in situations, particularly at 3 am, when we have felt all of those conditions. Physically, the executive prefrontal cortex is disengaged, leaving the reptilian amygdala wide open to be activated. When encountering the resulting rude behaviour, ask yourself whether the instigator could be tired, or why s/he might be angry and frustrated. What time of the day is it? Might s/he be at the end of a long and stressful shift? By using iSTAT (see below) in your

inquiring conversation, you are likely to make the instigator aware of his/her intended or unintended rudeness and re-engage his/her prefrontal brain function.

What to do if you are the instigator?

Mindless interactions can lead to disrespectful behaviour, particularly when we find ourselves in pressured, emotionally charged situations. Self-awareness and self-management are foundational leadership capabilities in those situations. In addition to unfulfilled physiological, safety, and social needs from Maslow's pyramid, our physical and emotional state, personality, and communication style, attitudes and assumptions, knowledge gaps, and personal values can all influence our behaviour subconsciously, unless we remain fully aware and manage ourselves accordingly.[14] Given the contagion of rudeness,[10] our behaviour and interactions are also influenced by external norms and expectations from the organizational culture. Thus, in addition to remaining self-aware, we must also be aware of the culture around us; are disrespect and rudeness "the way things are done around here"?[14]

The ABC strategy helps with awareness during stressful moments, where A stands for awareness, B for breathe, and C for communicate effectively.[14] Be aware of early physiologic warning signs, such as teeth clenching, tightness in neck or shoulders, sweating, fast heart rate, churning in your gut. Also, notice how others are reacting. Take a few mindful breaths, four seconds to breathe in and four to breathe out, allow a brief pause to reflect on the situation, and create a moment to re-engage the executive part of your brain for critical appraisal of what comes next. Communicate effectively, using directive but respectful language to motivate appropriate responses in an efficient and timely manner.[16] Slow the pace of your speech, adjust the volume, and be clear and concise in your choice of words. Watch your body language and facial expressions. Explain what is happening and, if possible, hold a debriefing session after the crisis to further add clarification. Be prepared for and remain open to comments from others.

Rude behaviour, real or perceived, is never acceptable. To apologize requires humility, one of the values of great leaders, according to Collins.[15] A humble person has an open mind, recognizes her/his limitations, and is willing to consider other ways of thinking or behaving.[1] "I am sorry, can we start over?"

helps to defuse a situation and redirect the interaction.

There is never room for retaliating, even when you are unable to respect the instigator of rudeness for whatever reason. Self-respect is important in all civil interactions

How can we help others when we are exposed to rudeness?
Some elements of the five fundamentals of civility for physicians[1,14,16-18] are useful in response to rudeness, not only from colleagues, but also from others. There is never room for retaliating, even when you are unable to respect the instigator of rudeness for whatever reason. Self-respect is important in all civil interactions: how will you feel about yourself if you respond with rudeness? How will others perceive you as physician or as leader in the future, and will the role model you provide affect the culture of your team and organization? This is an opportunity to show leadership by demonstrating assertive and courteous communication skills.

Be in the moment and ask yourself whether the HALT syndrome could be influencing your interpretation of the rudeness: is it real or perceived, could it be unintentional? Might the instigator be the one suffering from HALT? To find out and communicate in a non-threatening way, use iSTAT (an acronym modified from VitalSmarts[19]) to guide the inquiring conversation. Like the hand-held, point-of-care blood analyzer with the same name, iSTAT provides an immediate tool to guide difficult conversations and minimize the chance of escalation.

The i stands for invitation, "Can we talk about something for a moment?" S is for state the facts, "I notice that…." T stands for tell your story, "It makes me think that….. It makes me worry that…." A is for ask the other's story, "Is that what is going on? Can you help me understand? What do you think is happening?" The second T is for tentatively, meaning that the tone of the conversation is inquiring and tentative, without judgemental words or phrases. Active and deep listening will help make using iSTAT successful. The tool also improves our emotional intelligence skills by raising self-awareness and self-management and by allowing us to practise empathy to understand another person's issues better. Ask yourself why a reasonable human being would act like that.[19]

Ignoring rude behaviour may send a signal that you condone it or add to the contagion of the behaviour; addressing it might be an opportunity to provide support and help to the instigator. Deal with the culprit directly, preferably in private, while not ignoring the impact on the team. In an informal debrief, share with the team that rudeness is unacceptable and that the event will be addressed with the rude individual. Always keep in mind that the rudeness can be an expression of a wide variety of stresses, from a one-time event caused by a long nightshift to lack of resilience and burnout.

How to prevent or immunize against direct, indirect, and perceived rudeness
The best preventive measure is to create a culture of respect and civility. This is where great leaders act as role models and help others develop the skills needed to create such an organizational culture. How do we behave with our colleagues, trainees, and patients? Are we as respectful as we could be? Are we always aware in the moment of some things that may be derogatory in certain circumstances? Do we contribute to the contagion? Have we developed skills that strengthen our emotional intelligence, such as active or deep listening, self-awareness and management, empathy, and communication under stressful conditions?[20] Increasing psychological capital further contributes to respectful teams and organizations: offer praise for things well done, listen to staff, build resilience through informal debriefs after difficult events, and maintain a culture of learning and improvement.

Recently, several hospitals in Canada have begun to adopt and adapt psychological training, originally developed by the United States Navy SEALs to increase resilience in stressful situations.[21] In a four-hour session, participants learn simple skills that allow them to stay calm in the face of fear, overriding the amygdala and controlling the hormonal response to stress and fear. These skills are variations on the four ways Navy SEALs acquire mental toughness: set very short and very specific goals, repeat mental visualization frequently, exercise positive

self-talk, and control your mental state and arousal.[22]

A recent study evaluated cognitive bias modification (CBM) by giving practitioners and teams skills that allowed them to reframe derogatory comments in terms of the context of the situation. CBM helped to maintain concentration on the problem at hand, rather than on the rudeness.[9] The interventions involved brief, computerized cognitive training modules to promote a more positive and benign, rather than a threat-based interpretation of ambiguous information or stimuli.[9] With CBM, people learned to interpret interpersonal emotional expression as less hostile, such that their cognitive resources were less affected by the disruption and were instead applied to the tasks at hand, including providing clinical care.

In summary

Health care supposedly takes place in a caring environment. We must remove rudeness from the health care world, as it has too many negative consequences for all stakeholders in the caring partnership. Each and all of us are responsible for the culture we create in our health care system. Each time we encounter an act of incivility, a rude comment, or disrespectful behaviour, real or perceived, it behooves us to act skillfully and empathetically, because failing to do so impairs our cognitive performance and patient outcomes.

References

1.Kaufmann M. The five fundamentals of civility for physicians. 1: Respect for others and yourself. *Ont Med Rev* 2014;81(5):19-21.

2.Bradley V, Liddle S, Shaw R, Savage E, Rabbitts R, Trim C, et al. Sticks and stones: investigating rude, dismissive and aggressive communication between doctors. *Clin Med* 2015;15(6):541-5.

3.Riskin A, Erez A, Foulk T, Kugelman A, Gover A, Shoris I, et al. The impact of rudeness on medical team performance: a randomized trial. *Pediatrics* 2015;136(3):487-95. doi: 10.1542/peds.2015-1385

4.Porath C, Erez A. Does rudeness really matter? The effects of rudeness on task performance and helpfulness. *Acad Manage J* 2007;50(5):1181-97.

5.Platt MW. Rudeness. Arch Dis Child 2017;online Feb. 24. doi:10.1136/*archdischild*-2017-312733

6.Cooper W, Guillamondegui O, Hines OJ, Hultman CS, Kelz RR, Shen P, et al. Use of unsolicited patient observations to identify surgeons with increased risk for postoperative complications. *JAMA Surg* 2017; Feb. 15. doi:10.1001/jamasurg.2016.5703 [Epub ahead of print]

7.Kachalia A, Mello M, Studdert D. Invited commentary: association of unsolicited patient observations with the quality of a surgeon's care. *JAMA Surg* 2017;Feb. 15. doi:10.1001/jamasurg.2016.5705 [Epub ahead of print]

8.Al-Rias A. Why we should avoid handover hostility. BMJ 2017; 356:j1272. http://www.bmj.com/content/356/bmj.j1272

9.Riskin A, Erez A, Foulk T, Riskin-Geuz KS, Ziv A, Sela R, et al. Rudeness and medical team performance. *Pediatrics* 2017;139(2):1-11. doi: 10.1542/peds.2016-2305

10.Foulk T, Woolum A, Erez A. Catching rudeness is like catching a cold: the contagion effects of low-intensity negative bahaviors. *J Appl Psychol* 2016;101(1):50-67. http://dx.doi.org/10.1037/apl0000037

11.Boyatzis RE, Passarelli AM, Koenig K, Lowe M, Mathew B, Stoller JK, et al. Examination of the neural substrates activated in memories of experiences with resonant and dissonant leaders. *Leadersh Q* 2012; 23(2):259-72. https://doi.org/10.1016/j.leaqua.2011.08.003

12.Grenny J, Patterson, K, Maxfield D, McMillan R, Switzler A. *Influencer: the new science of leading change* (2nd ed.). New York: McGraw-Hill; 2013.

13.Maslow A. Hierarchy of needs. Anstey, Leicester, UK: Businessballs.com; 2014. Available: http://www.businessballs.com/maslow.htm (accessed 12 Apr. 2017).

14.Kaufmann M. The five fundamentals of civility for physicians. 2: Be aware. *Ont Med Rev* 2014;81(8):32-5.

15.Collins J. *Good to great: why some companies make the leap... and others don't*. New York: HarperCollins; 2001.

16.Kaufmann M. The five fundamentals of civility for physicians. 3: Communicate effectively. *Ont Med Rev* 2015;82(1):24-7.

17.Kaufmann M. The five fundamentals of civility for physicians. 4: Take good care of yourself. *Ont Med Rev* 2015;82(6):12-5.

18.Kaufmann M. The five fundamentals of civility for physicians. 5: Be responsible. *Ont Med Rev* 2015;82(11):12-4.

19.Patterson K, Grenny J, McMillan R, Switzler A. *Crucial conversations: tools for talking when stakes are high* (2nd ed.). New York: McGraw-Hill; 2012.

20.Bradberry T, Greaves J. *Emotional intelligence* 2.0 . SanDiego: TalentSmart; 2007.

21.Bigham B. MDs under pressure: U.S. Navy SEAL training adapted to help Canadian doctors fight stress. Ottawa: CBCNews.ca; 2017. Available: http://www.cbc.ca/beta/news/health/doctors-military-training-pressure-stress-1.3994718 (accessed 14 Apr. 2017).

22.Aw B. 4 ways to acquire Navy Seals' mental toughness. Singapore: Scientific Brains; 2014. Available: http://scientificbrains.com/4-ways-to-accquire-navy-seals-mental-toughness/ (accessed 14 Apr. 2017).

Author

Johny Van Aerde, MD, MA, PhD, FRCPC, is editor-in-chief of the *Canadian Journal of Physician Leadership* and past-president of the Canadian Society of Physician Leaders.

Correspondence to:
johny.vanaerde@gmail.com

This article has been peer reviewed.

PERSPECTIVE

An ideal future for Quebec's health care system

The desire for a state of equilibrium

Ruth Vander Stelt, MD

In the first article of this series, I sketched a portrait of the current reality on Quebec's health care scene, describing the symptoms of deep affliction within our system. Here, I envision a desirable future: a health care system that would be balanced with respect to quality, accessibility, safety, and affordability. In the next issue, I will propose a way to achieve the desired result, using an evidence-based approach.

KEY WORDS: provincial health care system, Quebec, accessibility, costs, clinicians, managers, common goals, co-management

In the first article in this series,[1] we saw that Quebec's health care system is in a state of major turmoil. It is far from sustainable and barely meets the expectations of the population. Physicians and managers have a common goal of offering quality, accessible, safe, and affordable care to the people of Quebec, and they are striving to achieve this goal with good will.

However, both physicians and managers have to deal with daily priorities that are often conflicting or parallel. Managers are constantly scrambling both to reduce the costs of the health care system and to make it more accessible. Physicians feel torn between their responsibility to meet the needs of individual patients, who require treatment now, and the obligation to address the needs of the larger population, who will need our health care system sooner or later. We have seen, however, that these two professions are beginning to work together more closely, as they both value accessibility and the interests of the community. We have also seen how the concept of medical and administrative co-management could provide a glimmer of hope.

Considering the different dilemmas faced by clinicians and managers, I have proposed that the solution to problems in Quebec's health care system be based on four principles:

- A clinically-led, patient-oriented approach
- The primary objective of improving patient flow
- A focused process of ongoing improvement
- Removal of local measures of optimization

In the first article in this series,[1] I concluded that any solution should simultaneously:

- Create an ever-flourishing health and social services system
- Rapidly improve the quality, safety, and timeliness of care provided to patients
- Rapidly improve the affordability of care
- Not create more complexity for staff

I sketched a portrait of the current reality on Quebec's health care scene, describing the symptoms of deep affliction within our system. In this second article, I envision a desirable future: a health care system that would be balanced with respect to the objectives listed above. In the next issue, I will propose a way to achieve the desired result, using an evidence-based approach. The method is similar to that used by a clinician who observes the symptoms of a disease, takes a comprehensive approach to determining the etiology, prescribes a remedy proven by science, then makes conclusions based on the evidence at hand.

The primary objective of the health care system

In any society, the primary objective is to have fewer and fewer

residents using the health care system for the simple reason that they have less and less need for it. When citizens do find themselves in need of care, they wish it to be, ideally, of high quality and delivered in an accessible, safe, and sustainable environment. Furthermore, as taxpayers in a fair and just society, they would like to feel proud about contributing to a system they care about and that is indispensable to their individual and collective well-being.

Health care users also expect representatives of the system, namely clinicians, managers, and support staff, to speak with one voice. They expect the flow in the system that receives them, treats them, and returns them to their homes to be as pleasant as that of their favourite café or restaurant.

The desired future of a health care region

In the system we seek, it is the patient — as an individual as well as a member of a community — who is the central concern. It cannot be otherwise, as, without patients, there is no system. This fundamental idea is above all a clinical one. In this desired future, it will be clinical physicians who establish diagnoses with the help of efficient tools and techniques. These same physicians will make full use of their skills by treating patients at a time that suits each individual need, while continually re-evaluating clinical evolution and prescribing the required treatment at the right time.

In the meantime, managers will follow the trajectory of care for each patient in real time and in perfect harmony with patients' clinical needs. When a particular test or consultation is needed, managers will work closely with physicians in a co-management environment to ensure that each intervention is performed according to a medically required timeline. For patients in hospital, any examinations or consultations will be performed within 24 hours. For outpatients, consultations will take place immediately, in the case of an emergency, or within a week or a month for non-urgent cases. Clinical teams and managers will pay constant attention to ensure that disruptions in the flow of patients are resolved in a manner consistent with patients' needs. By identifying which task or resource is most often the cause of delays and by constantly optimizing the synchronization of resources, teams will quickly improve patient flow, most often without the use of additional resources. Clinical administration meetings will continually aim to answer this essential question: of all the things we could try to improve, which should we improve first?

Once we become accustomed to keeping pace with patients' clinical needs, the cultural environment will become one in which any wait time in addition to that which is clinically required will be collectively deemed harmful, not only in terms of the patient's diagnostic trajectory, but also in terms of the flow of other patients through the system, the safety of the health care environment, and the quality of care provided. Thus, there will be no need for clinical requirements to be subject to administrative delays. Instead, management will adapt to the clinical reality and treat each patient appropriately, thus mobilizing the medical team's skills in an optimal fashion.

Physicians and managers will be continuously supported in their close monitoring of patient trajectories by a dynamic information technology (IT) system that delivers the required information in real time to pertinent stakeholders and managers. In addition to purely logistical data,

health care workers will continually provide the clinical data required to identify any and all constraints to patient flow.

The higher the position a manager holds in the hierarchy of the system, the more access the IT system will give them to data that will allow them to see all the dynamics at hand

Given that, in each trajectory, there is often a predominant obstacle or bottleneck, the IT system will show what actually happens in real time, beyond hearsay, rumours, personalization, and blame. Bottlenecks will sometimes be occasional and, at other times, recurrent; but in all cases, physicians and managers will work closely together to identify places where action is required to accelerate patient flow. This process will also allow for impact assessment of any improvement attempted in the field.

Although the situation in Alma may differ from that in the Outaouais region, the key element is that partners in co-management will apply the same method, that is, they monitor patient flow so that health care users can exit the system as quickly as possible, after being treated in a humane and professional fashion, consistent with the expectations of a so-called developed society.

The higher the position a manager holds in the hierarchy of the system, the more access the IT system will give them to data

that will allow them to see all the dynamics at hand, and the more able they will be to make informed decisions based on real wait times, for everything from an MRI scan to a coronary angiogram to a social work referral. Decisions made at the collective level will, thus, be based on solid numbers related to real, not perceived, individual needs. Data revealing both interesting and relevant conclusions will be available for comparison among the various regions of the province. As for the Ministry of Health and Social Services, it will be able to apply solutions based on conclusive data from each region, while taking into account how data differ from one region and one health care team to another.

Because co-management teams will have a thorough understanding of all that is blocking patient flow, it will be easier at all levels of the network to eliminate local optimization measures, as these act like brakes on overall fluidity.

If accelerating the passage of a particular patient from one place in the system for a given cost has no impact on the patient's trajectory or on health care outcomes, the effort will not be recommended. In fact, attempts to improve certain steps of a trajectory without affecting the trajectory as a whole will increasingly be recognized as local optimization efforts, which have every chance of increasing cost and workload without having a positive impact on the lives and health of patients.

Similarly, clinician and management teams outside institutions will work to provide appropriate and timely care, based on clinical need. They will, thus, manage to avoid having some patients enter the health care system. These teams will ensure that trajectories of care outside hospitals are working well, taking into account various risk factors as well as the role that social determinants of health in play in different regions of the province.

Natural repercussions of this future system

By following this approach, health care workers everywhere will help create a flourishing health and social services system, where accessibility will go hand in hand with clinical necessity. This system will rapidly improve the quality, safety, timeliness, and accessibility of patient care.

It is of utmost importance to note that these improvements will not produce increasing complexity for staff. Rather than being considered the culprits of the system's failures, health care workers will be viewed and treated as valuable sources of information and improvement. After all, the workers themselves only stand to benefit from a healthy, rational, and fulfilling work environment in which they are proud to evolve.

With more fluid trajectories of care, bed shortages and wait lists will become rare, health care workers will be called on for less and less overtime work, and staff will have more time to improve the quality of care. Furthermore, staff retention will increase with subsequent reductions in training costs, and any recruitment will be made substantially easier.

On the management side, costs engendered by the health care system will noticeably and progressively decrease until such time as patients remain in the hospital for clinical reasons only. The continuous synchronization of care trajectories will also allow costs to be precisely calculated and compared. Health care institutions will have more balanced budgets, and savings resulting from improved management will be available for reinvestment in prevention.

As for members of Quebec's councils of physicians, dentists and pharmacists, they will be increasingly able to make full use of their expertise. Their hard work will be even more rewarding, as they will have helped optimize the fluidity of care trajectories. This new situation will contribute to creating a happier, more committed, motivated, and productive medical profession.

The councils will acquire progressive knowledge as to their members' contributions to management, their need for training, the time required for further education, as well as the associated costs. They will, thus, be able to offer detailed recommendations to their boards of directors. They will also be able to provide improved guidance to their members in terms of their obligations toward quality of care and the cost of treatment. As these environments become more focused on the quality of care, they will attract practitioners and researchers with complementary areas of expertise.

Regarding the training of future physicians and continuing medical education, more and more emphasis will be placed on the role and responsibility of the physician with regard to care management

and the costs engendered by medical prescriptions, including diagnostic tests and treatments. A change in culture will come about gradually. Physicians will thus be increasingly aware of the impact of their professional actions on the trajectory of care and on systems operations costs.

In this future health care system, patients will benefit from their clinicians' professional expertise.

The role of IT workers will constantly adapt to real patient need. These technicians will learn to detect bottlenecks and apply the most suitable solutions possible while meeting the requirements of clinicians and managers. Appropriate components of big data collected across the province will be compiled and compared, allowing for an overview of the entire system and providing experts with relevant population data. Governmental policymakers will, thus, have the necessary evidence to make appropriate health decisions, and the government of Quebec will claim its place as a leader in health IT.

The societal impact of a flourishing health region

Once health care institutions begin providing more and more high-quality, accessible, and affordable care for the population of their area, they will be able to place more focus on prevention. Population health will improve, the Ministry of Health and Social Services will meet its objectives more easily, and society will likely be more productive. Treasury Board might decide to redistribute money otherwise spent on health care to other social or governmental services. Quebec society will be healthier and more fulfilled and, thus, better equipped to take on other ongoing challenges.

The prerequisites

At first glance, the desired future as described in this analysis might seem elusive, a future that will come to pass the day pigs fly. However, on closer examination, we can see that we are fully capable of translating this ideal into reality. We have the expertise we need to respond positively to society's expectations, which demand first-class performance from their system. To achieve these aims, we need to follow a series of logical steps specifically designed to create a system in which we all want to work or receive care. The third article in this series will address the prerequisites for building this system.

Conclusion

We have laid the groundwork for the future we desire for the Quebec health care system. By following the principles of a clinically based, patient-centred approach, by focusing on trajectories of care, by following a process that allows for continuous improvement, and by systematically avoiding local optimization, we will be able to design a high-performance health and social services system. Any solution must simultaneously create an ever-flourishing health and social services system; rapidly improve the quality, safety, and timeliness of care provided to patients; and rapidly improve financial accessibility to the care offered without creating more complexity for staff.

In this future health care system, patients will benefit from their clinicians' professional expertise. Clinicians will work alongside managers, using powerful and dynamic technological systems that shed light on the elements that prevent patients' trajectories of care from being clinically appropriate. Together, clinicians and managers will work to find solutions for each problem they encounter, while constantly re-evaluating the impact of the measures they apply on the lives of patients and the experience of employees.

This improvement process is based on the concrete results of our actions in each of the province's regions. In this system, all health care workers will be part of the solution and will be able to treat all patients with care and compassion.

Reference

1. Vander Stelt R. The currrent reality in Quebec's health care system—auscultation of an ailing system: the symptoms and their causes. *Can J Physician Leadersh* 2017;3(3):91–5.

Author

Ruth Vander Stelt, BA, MD, CMFC, MM, is a family physician practising in the Pontiac region of western Quebec. She has also served as president of the Association médicale du Québec.

Correspondence to:
ruthvanderstelt@gmail.com

Note: The original version of this article appeared in the November/December 2016 issue of Santé Inc. **(http://santeinc.com/2016/11/futur-recherche/)**.

This article has been peer reviewed.

Complexity leadership offers the right fit for physicians

Colleen Grady, DBA,
and C.R. (Bob) Hinings

Current leadership culture is based on an outdated command-and-control model that is familiar to all and not inspiring to any. The complex health care system requires a different leadership mindset and physicians who will lead. Complexity leadership may present a palatable alternative for physicians. This model encompasses operational, entrepreneurial, and enabling leadership. Enabling leadership, the focus of this article, encourages space for adaptation between formal and informal processes to allow unique solutions to emerge. Leadership for the knowledge age emphasizes the capacity to engage, encourage creativity, value innovation, and even prompt a healthy tension that capitalizes on knowledge gaps and learning opportunities in a team. Challenging our leaders to adopt a style more appropriate for today's workplace may result in better alignment with how physicians already function. We need physicians with an enabling leadership style to bridge the formal and informal systems of health care so that the collective intelligence of the team can affect patient outcomes in the best way possible.

KEY WORDS: complexity leadership, physician leader, adaptation, enabling leadership

Numerous forces are converging in Canadian health care to create what some might call a "perfect storm," which can help or hinder system transformation. Health care spending within provincial budgets has reached untenable peaks, the aging population is beginning to bulge, there is continual pressure on scarce resources, and, in some areas of the country, the relationship between payer (government) and payee (physicians) has soured significantly. This storm cannot be lulled without the active participation of physicians leading the way. Not only can physicians be strongly influential in this transformation when they embrace complexity leadership, but this leadership style also aligns better with the profession than the oft-employed style that may have worked in the machine age but is no longer valuable.

Most physicians don't enter the profession to become a leader, yet their role in the health care system positions them to act as one. Their knowledge of patient care and health care issues gives them a powerful opportunity to have influence within their practices, their organizations, and their regions; yet, only a minority willingly embrace leadership. Those who do are often highly valued.

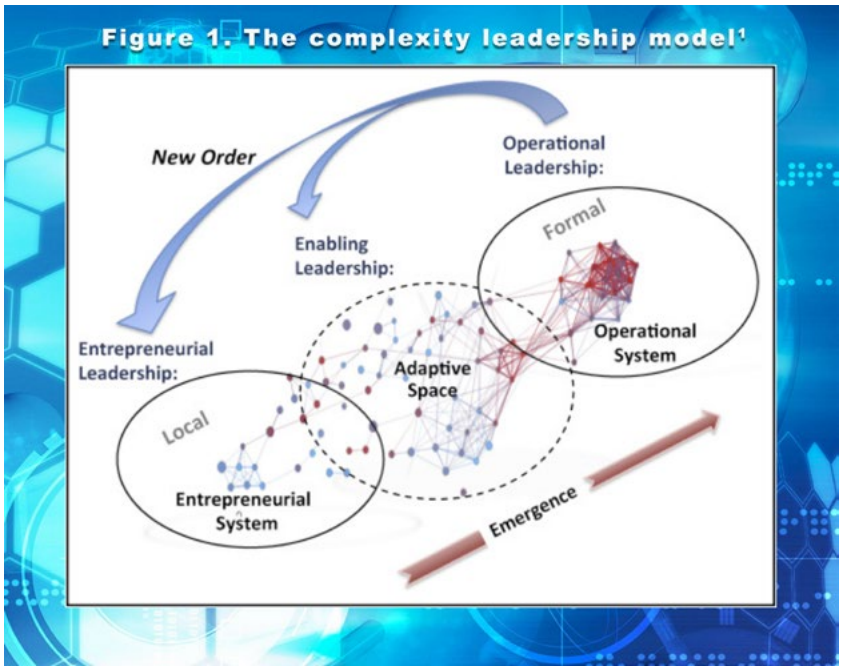
There are several reasons why physicians resist leadership. A significant one may be that current leadership culture is based on an outdated model, a command-and-control style that is most familiar to all, not inspiring to many, yet dominant in many organizations. The complex system of health care requires a very different leadership mindset. Complexity leadership is better suited for today's workplace and presents an alternative that is understandable to physicians.

Leading in a complex world

Uhl-Bien and Arena[1] describe

complexity leadership as encompassing three types: operational leadership, entrepreneurial leadership, and enabling leadership (Figure 1). They position operational and entrepreneurial leadership at opposite ends of the model with enabling leadership between

system, and the recognition that variety in outcomes is desirable. The authors make reference to an order that is new and different from the usual hierarchical responses to managing change to allow something that didn't exist previously to emerge from novel ideas.



these extremes. This model presents the formal and defined function of leading as operational in nature, relevant to structure, policies, and processes. Opposite that, entrepreneurial leadership encourages growth, exploration, and innovation within an organization.

The critical space in between is where adaptation occurs, where structure and innovation meet and where formal and informal processes combine to allow unique solutions to emerge, cultivated by an enabling leadership style. It is in this space that leadership fits with the dynamics of a complex system, the capacity of the agents in that

The complexity leadership model provides a good analogy to position physician leadership in the context of the current workplace. Operational leadership represents the primarily formal nature of the business of health care, the administrative side focused on the financial viability of the organization and adherence to necessary structure to achieve that. Entrepreneurial leadership allows for physician autonomy, independent decision-making, and the ability to focus on innovative practices.

Both formal (operational) and informal (entrepreneurial) components are valued in organizations; however, the adaptive space in between is likely where the most critical patient care discussions and decisions happen. This space is where care teams collaborate, generate ideas, and use their collective knowledge to have the greatest impact on patient outcomes. A leader who can "foster generative relationships between agents" within that space may very well be the physician who consults, coordinates care, and guides clinical decision-making.[2] Two conditions in health care teams already exist to encourage generative relationships: common direction (best patient outcomes) and heterogeneity of participants (different knowledge sets).

In health care, ambiguity prevails and the pace of change is unrelenting. Complex systems are not responsive to the linear leadership models that were effective in the industrial age. Bureaucratic-age leaders managed output; the knowledge age requires leaders who can nurture the collective capacity of others to achieve success. Leaders in the industrial era were concerned with technical proficiency of workers, increasing output, and reducing variation, whereas knowledge-era leaders must be catalysts of innovation and continual learners and they must value the adaptability and creativity of workers.[3]

Drucker[3] defines what he refers to as "the next society" as no longer based only on workers' manual skills to operate machines in factories or in agriculture, but an environment where knowledge is the primary value of workers. Knowledge is distributed among

workers, and employees are no longer dependent on what comes from their superiors. Knowledge workers have a new autonomy, and their expertise empowers them in new ways. This new society requires a different type of leadership, one that values the social capital or collective knowledge in an organization rather than just assets and physical capital.

Health care is delivered by a team of professionals, with a level of autonomy according to their skill set. It is a very different environment from one in which workers perform similar tasks on a timed assembly line to ensure a consistent product. Although natural complex adaptive systems are composed of seemingly similar agents (e.g., a hive of bees, a flock of geese) all working toward a shared goal, it is the interdependencies and interactions between agents that affect the entire system and can produce unique outcomes each time.

Leadership for the knowledge age emphasizes the capacity to engage, encourage creativity, value innovation, and prompt a healthy tension that capitalizes on the knowledge gaps and learning opportunities in a team, effectively adapting in each situation. Knowledge workers are not easily replaced; their strength lies in their unique knowledge. Leadership in this age is critical to attracting, nurturing, and retaining those who add value to the collective intelligence of the health care team for the most effective patient care. Uhl-Bien and Arena[1] refer to the "new reality" of complex systems and note that "it is more essential than ever for organizations to adapt — to pivot in real-time with the changing needs of the environment."

Complexity in the physician's world

The principles of complex systems are not foreign to physicians who deal with biological systems every day. Brains, bacteria, and immune systems are all complex adaptive systems that are navigated to find solutions to problems. The process is made more complex by the added dimension of compliant or non-compliant human behaviour and acceptance or resistance based on biological factors. It is recognized that physician expertise is limited in some situations when previously successful remedies have not worked. For example, when patients do not take an active role in disease prevention and when biological systems interact to produce undesirable results that defy expectations. Regardless of their significant expertise, physicians are accustomed to not getting it right every time and are familiar with the fragmentation of the broader health care system that presents less-than-ideal resolution for patients with complex issues.

Patient expectations have changed as well, also increasing complexity. Wearable devices, technology that has the capacity to merge patient records for integrated care, and patients who do their own research to add to the dialogue with their provider have an impact on the role that physicians play. Patients expect members of their health care team (doctors, nurses, dietitians, psychologists, etc.) to work together to provide care. Doctors must work as a member of an interdisciplinary team dealing with increasingly complex patients with plans of care that take social determinants into account.

Like all complex systems, biological systems present unpredictability and surprise. Physicians are continual learners accustomed to a variety of outcomes. In Senge's ground-breaking work *The Fifth Discipline*,[4] he notes that our "mental models" keep us from being able to view things differently and that our assumptions and internally held beliefs limit our capacity to learn and grow. As lifelong learners,

doctors seek answers on behalf of their patients and don't assume that each patient's response to treatment will be the same as the last. Although they may be similarly trained in the techniques of clinical care, physicians are innovative in their application of care, as no two patients are alike.

Challenging the mental model of leadership to adopt a style more appropriate for today's workplace can encourage increased interest in physician leadership, especially if it is better aligned with how they already function. A recent white paper by Van Aerde and Dickson[5] that outlined the collective responsibility for health care transformation suggests that physicians must "challenge their personal mental models" of leadership to realize their leadership potential.

Rethinking leadership

Weberg[6] identifies the limitations of traditional leadership thinking, specifically addressing three: linear thinking, lack of awareness of organizational culture, and not being prepared to innovate. He purports that traditional leadership assumes that the world is predictable and that, if leaders are unable to acknowledge the impact that the formal, informal, internal, and external environments have on organizational performance and they are unwilling to adapt through innovative techniques, they are ill-suited to work in today's complex organizations.

In addition to Weberg's[6] list of limitations, we add another: leaders operating within what is thought to be traditional ways can be blinded by their own thinking that they are in control and that they bear ultimate responsibility for outcomes. This attitude, naturally, can sway a leader's thinking and perhaps assign greater importance to their role and influence. Uhl-Bien and Arena[1] describe enabling leaders as those who are also capable of combining "deep conviction with humility," as their role is partly to allow for risks to be taken within the adaptive space but also to know when to "step back so others can step forward."

Challenging the mental model of leadership to adopt a style more appropriate for today's workplace can encourage increased interest in physician leadership

In the classic book *Good to Great*, a study of organizations that made that leap to great, Collins and his team[7] found that the type of leader associated with great companies exhibited an interesting blend of ambition and humility called "level 5 leadership." He hadn't intended to look at leadership associated with these companies, as he was not interested in crediting (or blaming) any one person for company performance. However, the researchers couldn't help but see that those leaders were able to "channel their ego needs away from themselves and into the larger goal of building a great company."

Although physicians take active lead roles in patient care, they also take into account the expertise of others on the care team to achieve a comprehensive understanding of the numerous factors and barriers affecting the patient's recovery. The space between operational policies, clinical guidelines, and their own capacity to provide innovative answers is often where solutions emerge, as dialogue among professionals leads to improved learning and best outcomes. It is within this adaptive space that complexity leadership enables the collective intelligence of many to share responsibility for positive results. Physicians already play a critical role in this space. Honing the skills that can improve interactions between knowledge workers in this context may allow physicians to view their leadership role differently and as less of the "straitjacket" that Ford[8] refers to when describing the focus on the heroic leader.

Shifting the focus from lone hero to catalyst of change may make leadership seem less daunting and more intriguing, particularly for physicians in whom disdain for administration and bureaucracy has cultivated an atmosphere of leader aversion.

Physicians as leaders

Physicians who were part of a recent study were fervent in their assertion that physicians need to develop leadership skills, embrace leadership as an opportunity, and, according to one, "recognize that if we as physicians don't get prepared and develop credibility for leadership roles the system won't change without us."[9] Physicians work "at the coalface," have the greatest understanding of what

the well-being of patients looks like, and have the most critical knowledge of how to improve patient outcomes.

However, physicians are challenged in their acquisition of leadership skills: from a dearth of leadership training in medical school to an overwhelming clinical practice that leaves little time for leadership courses. Organizations often do not prioritize leadership development for physicians. Therefore, physicians are not drawn to leadership roles or may be reluctant to acknowledge the inherent responsibility that comes with the profession.

Leadership frameworks identify different skill sets as the ideal, and it can be a challenge to prioritize the most important types of leadership competencies required. Enabling leadership, that which provides adaptive space within the complexity leadership model, requires relationship management skills; communication skills that include active listening, reflecting, and providing feedback; and an ability to tolerate the flux and instability that can generate novel outcomes.

The complexity of health care requires leadership that recognizes and works with that complexity.

Conclusion

Like the conductor of a symphony, guiding and prompting instrumental accomplishments through tempo, timing, and volume, the physician leader provides skilled clinical guidance to an interdisciplinary team, harnessing collective knowledge to achieve a successful finale (or outcome for the patient). But just as each musician imbues his or her music with a passion and style that goes beyond just following the musical score, health care professionals adapt to the needs of each patient and each situation.

The complexity of health care requires leadership that recognizes and works with that complexity. Complexity leadership enables space for collective intelligence and acknowledges that fluctuations in outcomes are not only expected but desired. Leadership in complex systems must recognize the many moving parts yet create the conditions for adaptive solutions to be found while working within the formal structure that is the organization, regional government, and practice guidelines. Just as we can no longer exact the same performance from different people to create assembly-line results, we require intelligent, self-directed individuals capable of contributing to uniquely designed solutions for different outcomes each time. We need physicians with an enabling leadership style to bridge the formal and informal systems of health care so that the collective intelligence of the team can affect patient outcomes in the best way possible.

References

1.Uhl-Bien M, Arena M. Complexity leadership: enabling people and organizations for adaptability. *Organ Dyn* 2017;46(1):9-20.
2.Lane D, Maxfield R. Strategy under complexity: fostering generative relationships. *Long Range Plann* 1996;29(2):215-31.
3.Drucker PF. *Managing in the next society*. Oxford: Butterworth-Heinemann; 2003.
4.Senge PM. *The fifth discipline: the art and practice of the learning organization*. Santa Fe, N.M.: Random House; 1990.
5.Van Aerde J, Dickson G. Accepting our responsibility: a blueprint for physician leadership in transforming Canada's health care system. White paper. Ottawa: Canadian Society of Physician Leaders; 2017. Available: tinyurl.com/ht2ykoq
6.Weberg D. Complexity leadership: a healthcare imperative. *Nurs Forum* 2012;47(4):268-77.
7.Collins J. *Good to great: why some companies make the leap… and others don't*. New York: Harper Collins; 2001.
8.Ford J. Going beyond the hero in leadership development: the place of healthcare context, complexity and relationships. *Int J Health Policy Manag* 2015;4(4):261-3.
9.Grady C. Exploring physician leadership development in health-care organizations through the lens of complexity science. PhD thesis. Faculty of Business, Athabasca University, Alberta; 2015. Available: http://hdl.handle.net/10791/177

Authors

Colleen Grady, MBA, DBA, is associate professor and research manager with the Centre for Studies in Primary Care, Department of Family Medicine, Queen's University. Her research is primarily in the areas of physician leadership development and complexity science.

C.R. (Bob) Hinings is a professor emeritus in the Alberta School of Business, University of Alberta. He is a fellow of both the Royal Society of Canada and the United States Academy of Management and an honorary member of the European Group for Organizational Studies. Bob received an honorary doctorate from the Université de Montréal for his contributions to the discipline of organization theory.

Correspondence to:
colleen.grady@dfm.queensu.ca

This article has been peer reviewed.

Leading complex change: go slow to go fast

Michael Gardam, MD, and
Leah Gitterman, MHSc

In this article, we bring a complexity science perspective to health care leadership challenges, using hospital mergers as an example. In this case study, we draw heavily on our own experience working with organizations struggling with change. Unlike the traditional top-directed approach, we recommend starting slowly and engaging those affected by the coming changes to enable co-creation of the eventual solution.

KEY WORDS: change management, complexity approach, staff engagement

You have just been hired as medical director of a large clinical program that is delivered at two acute-care hospital sites. The two hospitals have recently been merged, and the mandate of the new leadership team is to "streamline and harmonize" clinical activities across your program to eliminate redundancy and improve quality. You have been brought in from another organization as a "neutral third party."

During merger discussions, it became clear that one site, which is the larger of the two, seemed to have a relatively well-functioning care delivery model based on reported metrics. It is hard to say how well the smaller site's program is functioning as it does not use similar measures; however, the physicians tell you the program is well designed to meet the needs of its patient population. You have called together team members from both sites to a meeting to discuss next steps.

A traditional approach

In our experience, the above scenario is common in Canadian health care. In the name of efficiency and economies of scale, provincial governments may require organizations or even health regions to merge. Physicians representing the smaller hospital likely fear what might be coming next: namely, that they will be forced to adopt the practices of the larger site. After all, the program at that site is larger, more sophisticated in the use of metrics, and appears to be doing well. Conversely, physicians at the larger hospital may be feeling more secure, sensing that their program model is likely going to be preferred.

Imagine how this scenario might be even more challenging: what if the two hospitals were well-known competitors or if the merger were between an academic centre and a local community hospital? A well-traveled path suggests that you, as the leader, should gather as much information as possible from each of the programs and perform some strategic analysis to arrive at options. With this information in hand, you will then be able to make firm decisions, seek buy-in to your plan from physicians and other team members by communicating your message and rallying them around a burning platform for change, and then act on merging the programs.

This planned-out way forward, first described by Kotter[1] four decades ago appears both straightforward and logical; yet we know that most change initiatives fail to meet their original goals.[2] In our experience, one common reason for failure involves treating a problem as a simple one, for which solutions can be planned and executed, when it is in fact complex. In the world of complexity science, a complex problem is defined as one for which there is neither agreement on the best solution, nor any certainty that any one solution will be successful.[3]

Thinking in complexity terms requires a shift away from focusing on the parts of the system toward the interactions of the components and people within the system. This distinction matters because the tools and approaches used to successfully tackle complex problems are often counter to prevailing health care culture which tends to be top-down directed.

A complexity perspective

In the above example, is the selection of one program's model over the other necessarily the best way forward, i.e., does the future program have to be either/or? We suggest there is another way forward that accepts, rather than downplays, the complex nature of the merger. This will undoubtedly mean that the way forward will be far less clear at the outset and will be more uncomfortable for you as the leader.

Why would we suggest such an approach? As Karen Phelan[4] in her book, *I'm Sorry I Broke your Company*, explains:

> We have been led to believe… that businesses are logical and run by the numbers and that their models and theories will provide step-by-step instructions on how to succeed. But businesses are people — irrational, emotional, unpredictable, creative, oddly gifted, and sometimes ingenious people who don't operate according to the theories.

An inconvenient reality about leading complex change initiatives

is that they involve people, not robots or cogs in a machine. People, even highly trained physicians, react emotionally to change, and especially to change being forced on them. People being asked to "buy-in" to a change that they had no role in designing will typically push back, drag their feet, use other ways to delay or derail it, or simply quit their positions. They may also tell you why your plan will not work and how they are different from other groups.

Another inconvenient fact is that they may well be right: as the people working in their area day after day, they have accumulated detailed knowledge and insight that a leader is unlikely to have.[5] Their knowledge is more than just the metrics; it is an understanding of the unique social networks and personalities that make their group function.

Medical staff have additional, valid reasons for resisting change. We are trained to be cautious, which, while undoubtedly protects patients from untested approaches, also tends to make us more comfortable with incremental change rather than creative destruction and rebuilding. Furthermore, unlike most administrators and other health care professionals, those of us practising in a fee-for-service model may feel a direct impact on our income as a result of changes to organizations and processes. In addition, those dependent on billing income will understandably find it difficult to become heavily engaged in a change process, as they may have to lose income to participate.

Of course, the fact that the two merging organizations do things differently and have distinct cultures is not unique to the medical staff. For every reluctant doctor, there are likely many more apprehensive

administrators and front-line staff who also fear the merger.

Some early first steps

Although the ultimate look of the program is not yet knowable, we can plan some initial steps. Change in complex adaptive systems can occur through seemingly small tweaks to parts of the system, with special focus on the relations between the parts.[6] Thus, we suggest that the next step is to sit down with team members and engage them in discussion regarding the key overarching goals or "minimum specifications" of the future program and set boundaries for what is in and out of the scope.[6,7]

We further suggest that the team does not mean just medical staff: we would invite all team members who are "touching the problem," including carefully chosen patient and family representatives.

Rather than a traditional brainstorming session during which, in our experience, most participants may remain silent, we would use simple engagement techniques termed "liberating structures" to hear from all members of the group.[8] One of our favourite liberating structures is called "What, so what, now what?" which forces the group to pause after information gathering and fully explore the situation at hand before moving on to action.

The importance of diverse opinions

Especially early on in the change process, the leader needs to hear the diverse opinions of the team. In our experience, this is one of the most frequent stumbling blocks in leading change initiatives: in the interest of moving a project forward, leaders may try to drive consensus by shutting down discordant opinions (or even by not inviting people with different ideas to the meeting).

Forcing convergence of ideas and actions too early in the process will make people feel they have not been heard and they will likely disengage from the process. Furthermore, not allowing others to hear different ideas that may shift their own opinions may stifle the creation of generative relationships — important interactions that "produce new sources of value that cannot be seen in advance."[9] It is important to recognize that, as the leader, you may have a clear sense of where you think the group needs to get to at the outset; however, you too need to listen to the divergent opinions and be on the lookout for novel ideas that emerge through engagement.

We call this early phase "going slow to go fast," and it is often when the leader feels the most uncomfortable and may feel that they are losing control of the process. It may also feel as if the group is "spinning its wheels" or wasting time; however, it is critical to allow the group to work through the issues before moving ahead. As a plan starts to coalesce, it is our experience that the improvement work will move much more quickly.

Your role as the leader in this approach is to shift from telling people what to do to facilitating: helping the group determine the best ways forward for the project and helping push the boulders out of the way so they can achieve their goals. This does not mean abdicating responsibility for the change process: you will need to make the boundaries of the work clear, including the fact that the change goal not optional, e.g., the merger is going to happen, the leadership team requires the program to streamline, etc.

This work also does not exist in a data vacuum: regular data collection and feedback must occur as with any quality improvement project, so that the group can determine whether it is heading in the right direction. Data feedback can occur in many forms, including less-traditional approaches, such as social media. One group we recently worked with in Ireland relied heavily on WhatsApp to communicate progress.[10]

Modern health care strives to be highly linear and predictable; hence, this approach can significantly clash with other leadership styles and agendas

In our experience, groups that are not used to being listened to may only weakly engage with a facilitator at first. With repeated engagement that is focused on including everyone, accompanied by evidence that the leader is truly listening, we have found that at least some members of the group will become highly engaged and become change leaders. These early adopters will begin to pull most peers along with them in the change process. As the group begins to take steps toward its goal, they are co-creating the future program with you, rather than buying into your vision. The more they have a stake in its creation, the more the group members will own the changed program down the road.

Not an easy path

This approach is not easy. We know from our own early experience using a complexity science-based approach called "front-line ownership"[11] that giving ownership of the process to the people you are trying to help change can feel like the opposite of what a health care leader is supposed to do. Furthermore, the feeling of lack of control and the lack of traditional clear timelines and milestones can be unnerving. However, this uncertainty is a necessary part of the iterative nature of the change process. Instead of determining up front what needs to be done, the group learns and course-corrects as the process unfolds.

Finally, modern health care strives to be highly linear and predictable; hence, this approach can significantly clash with other leadership styles and agendas. As the leader, you will need to walk a tightrope between engaging your teams and allowing them to create while meeting the deliverables of your masters. Rarely, if ever, is a leader going to be afforded the luxury of spending as much time as they need on completing a project. However, should the administration drive the change process too quickly and not allow time for engagement, the process may fail to reach its goals.

Those of us who have worked in health care administration long enough also have experienced what is perhaps the most difficult challenge. As you work in the direction set by your leadership team, there is a very real chance that your goal is going to change, either because of external (e.g., government mandate) or internal factors (e.g., change at the senior leadership level). If you have been developing a linear process to get the team from A to B, and B suddenly becomes W, you will be ill-equipped (less resilient) to make changes. This is in sharp contrast to the complexity science approach, where your team will tend to be far more resilient and able to adapt to the change while maintaining its core purpose.[12]

We came to use this complexity approach after years of failure trying to bring about change by following a more traditional, linear model where we were the experts with the ideas who sought buy-in from others. Others have had a similar experience and have, after the fact, realized the importance of engagement when trying to change health care organizations.[13] We readily acknowledge that top-down strategies have their place in health care, and we are not advocating that all challenges require this level of engagement. Furthermore, there are many parts of health care that could be improved through standardization and the elimination of waste, where methods such as Lean clearly have a role. That said, the more the people you are trying to change can be consulted, regardless of the process used, the more likely the change will be both successful and sustained.

Returning to our hypothetical program merger, we clearly see the challenge as a complex one involving people, behaviours, and relationships, rather than components of a complicated machine or assembly line.

We are reminded of the experience of a participant in a leadership

program we are involved with in Ontario, who needed to improve access to cancer treatment in smaller towns roughly 100 km away from where he worked at an academic centre.[14] Rather than trying to recreate the academic program in these centres, his initial approach involved listening and engaging the teams at the smaller centres, to understand their unique circumstances. His way forward involved working with the teams to determine the barriers to care and then help them create solutions that would work for them. Two years later, new treatment programs have been created that meet the needs of the local population, with more improvement on the way, all supported by local and regional leadership alignment (Jason R. Pantarotto, Chief, Division of Radiation Oncology, University of Ottawa, personal communication, 11 April 2017). He went slow to go fast.

References

1.Kotter J. 8-step process for leading change. Boston: Kotter International; 2017. Available: **https://tinyurl.com/k5xh6wf** (accessed 7 April 2017).

2.Aiken C, Keller S. The irrational side of change management. *McKinsey Q* 2009; April. Available: **https://tinyurl.com/ha5evqs** (accessed 7 April 2017).

3.Snowden D, Boone ME. A leader's framework for decision making. *Harv Bus Rev* 2007; Available at: **https://tinyurl.com/neslybs** (accessed 10 April 2017).

4.Phelan K. *I'm sorry I broke your company: when management consultants are the problem, not the solution*. San Francisco: Berrett-Koehler; 2012.

5.Yoshida S. Quality improvement and TQC management at Calsonic in Japan and overseas. Presented at the Second International Quality Symposium, Mexico, 1989.

6.Zimmerman B, Lindberg C, Plsek P. Edgeware: insights from complexity science for health care leaders. Irving, Tx.: VHA Inc.; 1998.

7.Min specs. Liberating Structures. Available: **https://tinyurl.com/y8dphpta** (accessed 10 April 2017).

8.Lipmanowicz H, McCandless K. Liberating structures: innovating by including and unleashing everyone. *E&Y Performance* 2010;2(4):6-19. Available: **https://tinyurl.com/y8wzq9x2** (accessed 10 April 2017).

9.Lane D, Maxfield R. Strategy under complexity: fostering generative relationships. *Long Range Plann* 1996;29(2):215-31. **https://doi.org/10.1016/0024-6301(96)00011-8**

10.Gardam M, Gitterman L, Rykert L, Vicencio E, Bailey E, and the Front-Line Ownership User Group. Five years of experience using front-line ownership to improve healthcare quality and safety. *Healthc Pap* 2017, in press.

11.Zimmerman B, Reason P, Rykert L, Gitterman L, Christian J, Gardam M. Front-line ownership: generating a cure mindset for patient safety. *Healthc Pap* 2013;13(1):6-23. doi:10.12927/hcpap.2013.23299

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

13.Brickman J. How to get health care employees onboard with change. *Harv Bus Rev* 2016;Nov. Available at: **https://tinyurl.com/huw59vb** (accessed 7 April 2017).

14.Pantarotto J. Enabling equal access to radiotherapy across Champlain LHIN (action learning project). Toronto: Ontario Medical Association, Canadian Medical Association, Schulich Physician Leadership Development Program; 2015.

Authors

Michael Gardam, MSc, MD, CM, FRCPC, is chair of the Medical Advisory Committee and on the Board of Directors of the University Health Network. He is on the faculty of medicine, University of Toronto, and the faculty of the Schulich Executive Education Centre, York University, Toronto, Ontario.

Leah Gitterman, MHSc, is with the University Health Network and is on the faculty of the Schulich Executive Education Centre, York University, Toronto, Ontario.

Correspondence to:
dr.michael.gardam@uhn.ca

This article has been peer reviewed.

REFLECTIONS

Thirty-five years before the mast: learning to love the roiling seas of health, health care, and medicine

Peter W. Vaughan, MD,

In the midst of what seems to be a health care "train wreck," I hope to inspire others to see the great potential that lies ahead as health care continues to evolve rapidly. As medical leaders, we need the courage to meet the challenges and opportunities afforded by the convergence of biology and technology; yet we must also be realistic about mitigating the risks.

KEY WORDS: health care system, physician leader, change, collaborative leadership

Sometimes I feel as if I'm watching a train wreck — it's a horrible scene, but I can't avert my eyes. Doctors in one Canadian province are making headlines cyber-bulling each other, while there are calls from some provincial governments to "ensure that the rules governing self-regulating professionals do not put the interests of industry insiders ahead of consumers."[1,2]

I share these thoughts with the hope of inspiring others to see the great potential for change. We as medical leaders need to have the courage to speak up about the challenges and opportunities that the convergence of biology and technology affords, yet we must also be realistic about mitigating the risks. These are exciting times to be a medical leader — carpe diem!

For over a decade, the profession has been musing about its plight. In 2005, Dr. Glen Gabbard[3] penned a not so thinly veiled homage to Dr. Raymond Tallis' wailing lament for the past.[4] Gabbard blithely notes, "Few physicians are observed whistling down the hospital corridors." Although he observes most of us still view "medicine as a noble profession" (p. 1347).[3]

Finally, Gabbard lets out a long sob about how we "value autonomy and independence from external control, and the vast changes in the roles played by third-party payers, government regulatory bodies, and hospital/health care systems may have influenced physician discontent as well. Physicians frequently complain about being trapped in systems in which they have no say in what is being done to them by forces beyond their control, and loss of the traditional autonomy and control appears to be a factor that contributes to burnout" (p. 1348).[3] Physicians he says, feel like "a cog in a machine."

Medicine is at a crossroads. Biology and information technology are converging faster than our ability to understand the implications. No matter what country you look to, medicine has experienced a significant decline in autonomy in relation to the state.[3] Physician leaders are needed now more than ever, especially those with entrepreneurial skills who see the opportunities to improve access through creative social innovation.

Increasingly, as algorithms become the force behind the inevitable standardization of medical care, the role of physicians and other health care providers will change. Many physician leaders in health care today, in many organizations, embrace the future of heath, health care, and medicine — and seek to lead the profession in defining a new and important role for medicine in the 21st century.

It is time for bold, values-based conversations and collaborative leadership in the public interest. What is collaborative leadership?

Physician leaders who have a clear vision of what health, health care, and medicine will need to look like in five years and are willing to roll up their sleeves to work with other professions, governments, and the public to craft a "shared agenda" with timelines and resources committed to create the better future we want to see.

Now is the time for creativity, and by that I mean looking at opportunities to craft a collective social purpose for medicine building on the work already underway, to harness the potential of evolving technology, to lead the democratization of health care, to grasp the potential for disruptive distributive computing, connecting doctors and patients. And, finally, let's get on with e-prescribing, e-visits, e-consults, e-labs, and digital information, and in so doing transform access to care. Carpe diem!

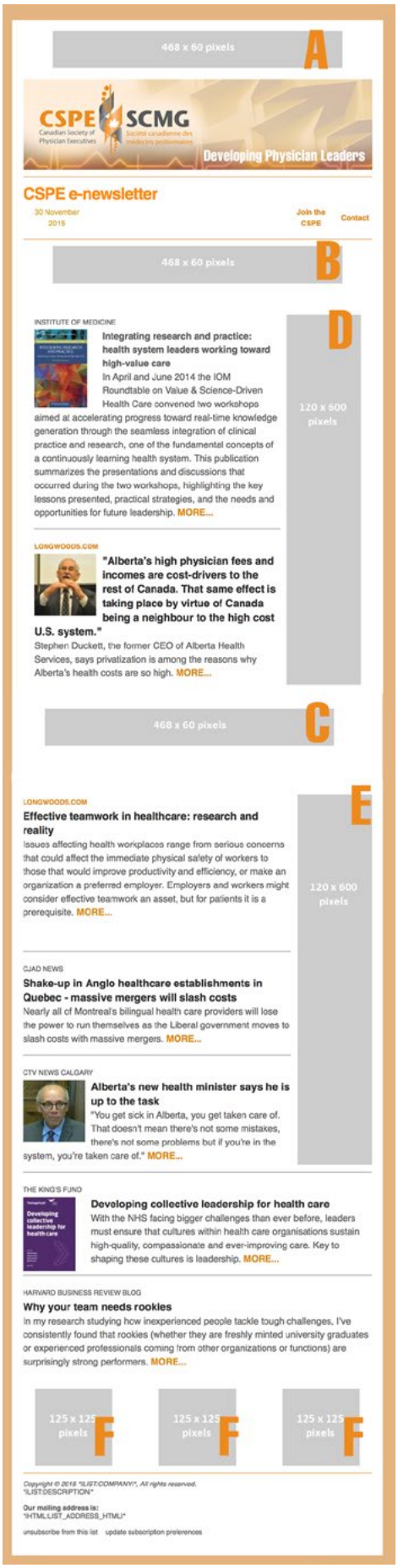
References

1.Boyle T. Ontario doctors 'distressed' over wave of bulling, infighting. *Toronto Star* 2017;Feb. 27. Available: https://tinyurl.com/gn484ze(accessed 27 Feb. 2017).
2.Mysicka R. Rein in self-regulated bodies. *Financial Post* 2014;Oct. 29. Available: https://tinyurl.com/kpcagok (accessed 27 Feb. 2017).
3.Gabbard GO. Medicine and its discontents (editorial). *Mayo Clinic Proceedings* 2013;88(12):1347-49. http://dx.doi.org/10.1016/j.mayocp.2013.10.007
4.Tallis R. *Hippocratic oaths: medicine and its discontents*. London, UK: Atlantic Books; 2004.

Author

Peter W. Vaughan, CD, MA, MD, MPH, has served as CEO of the Canadian Medical Association, CEO of Nova Scotia's South Shore District Health Authority, and deputy minister of Health and Wellness in Nova Scotia. In March, he was appointed chair of the board of Canada Health Infoway.

Correspondence to:
pvaughan@petervaughan.ca



CSPL bi-weekly e-newsletter

Health news delivered to the desktops of Canada's physician leaders

Our e-newsletter reaches over 400 CEOs, department heads, chiefs of staff, and other health care decision-makers. Our "open" rate is almost 3 times the industry average and our "click" rate over 7 times the industry average.

A. Top leaderboard 468 x 60 pixels	**D.** Top skyscraper 120 x 600 pixels
B. Top banner 468 x 60 pixels	**E.** Lower skyscraper 120 x 600 pixels
C. Body banner 468 x 60 pixels	**F.** Product spotlight 125 x 125 pixels

All ads must be 72 DPI, gif or jpg only, RGB. No animated ads.

Size	1 time	6 times (3 months)	13 times (6 months)	26 times (1 year)
A	$500	$2500	$4500	$7000
B	$400	$2400	$3600	$5600
C	$275	$1375	$2475	$3850
D	$500	$2500	$4500	$7000
E	$350	$1750	$3150	$4900
F	$200	$1000	$1800	$2800

Direct orders and enquiries
Carol Rochefort, Executive Director
Canadian Society of Physician Leaders
875 Carling Avenue, Suite 323
Ottawa ON K1S 5P1
Email: carol@physicianleaders.ca
Telephone: 613 369-8322

Payment

Payment must be made by cheque payable to the Canadian Society of Physician Leaders prior to the publication date. Taxes not included in the prices listed.

2017 CSPL Excellence in Medical Leadership Award (Chris Carruthers Award)

The CSPL presents this award annually to a physician who has made an outstanding contribution to the development and mentorship of medical leaders in the field of health services leadership and management.

Dr. Stewart Kennedy

Dr. Stewart Kennedy is executive vice president of Medical and Academic Affairs at Thunder Bay Regional Health Sciences Centre in Ontario. He is a member of the senior management team with responsibilities for medical affairs, pharmacy and academics, and interprofessional education. Dr. Kennedy is leading the development of a system-wide quality framework with a focus on enhancing the patient experience and developing a simulation program emphasizing quality improvement. He is introducing change into the organization and transforming a community hospital into an academic centre of excellence.

Dr. Kennedy is also working with the Northern Ontario School of Medicine and the Northern Academic Hospitals to enhance the governance structures of these organizations and improve the integration and accountability of the medical leadership. This work also includes development of an academic plan that will provide for protected time for clinicians to pursue their academic mission. As primary care LHIN (Local Health Integration Network) lead, Dr. Kennedy is spearheading the development of a medical model of governance for the region.

Dr. Kennedy developed the Enhanced Patient Care Clinic, which is responsible for caring for the most complex patients — those who use the top 5% of hospital health care resources. This has led to a reduction in hospital admissions and earlier discharges among this cohort of patients.

Dr. Kennedy was chair of the 2004–2005 OMA Negotiating Team, which established a landmark agreement that stabilized academic medicine in Ontario. It introduced family health teams, capitation models for family practice, enhanced physician payments for hospital work, and complex care and incentive payments.

Dr. Kennedy is a highly experienced and professional senior executive with a history of making positive change at both local and provincial levels. He faces challenges head on and is an exceptional role model for physicians and hospital staff. He accepts challenges and is a respected leader who believes in accountability, transparency, and evidence-based decision-making. He is able to build consensus, reach decisions, and solve complex problems with creativity and innovation. Dr. Kennedy has demonstrated outstanding skills in building relationships with colleagues, patients, and community members, and he understands the importance of working with a strong and dedicated team. He pursues excellence with integrity and passion and has proven his ability to work through challenges to achieve results in a complex health system.

Dr. Kennedy was president of the Ontario Medical Association in 2011–2012 and has filled numerous roles within the organization, including a term (2005–2008) as co-chair of the Physicians Service Committee responsible for contract implementation with the Ministry of Health and chair of the Section of General and Family Practice. He served on the board of the Canadian Medical Association from 2012 to 2015.

Dr. Kennedy is currently a member of the board of Health Quality Ontario.

2017 Canadian Certified Physician Executives

Dr. Bruce Douglas Cameron
Chief, Pathology Service, Georges Dumont Hospital; President, Moncton and District Medical Society; President, New Brunswick Association of Laboratory Physicians
Dieppe, NB

Dr. Ian Digby
Chief of Emergency Medicine, Guelph General Hospital
Guelph, ON

Dr. Kevin Hildebrand
Section Chief, Orthopaedic Surgery, and Professor, Department of Surgery, Cumming School of Medicine, University of Calgary and Alberta Health Services (AHS)
Calgary, AB

Dr. William Krizmanich
Chief, Department of Emergency Medicine, Hamilton Health Sciences; Emergency Department Physician Lead, HNHB LHIN
Hamilton, ON

Dr. William Sischek
Vice Chair, Governing Committee Academic Medical Organization of Southwestern Ontario; Site Chief Anesthesia & Perioperative Medicine – St. Joseph's Health Care
London, ON

Dr. Preston Smith
Dean, College of Medicine, University of Saskatchewan; Vice-Provost Health, USask
Saskatoon, SK

Dr. Sharron Spicer
Medical Leader for Safety, Department of Pediatrics, Cumming School of Medicine, University of Calgary, Alberta Health Services; President, Calgary and Area Medical Staff Society
Calgary, AB

Dr. Dylan Taylor
Facility Medical Director, University of Alberta Hospital, Mazankowski Alberta Heart Institute and Kaye Edmonton Clinic; Associate Zone Medical Director, Alberta Health Services
Edmonton, AB

Dr. Andrew Travers
Provincial Medical Director, Emergency Health Services, Department of Health and Wellness, Nova Scotia; Staff Physician, Department of Emergency Medicine, Nova Scotia Health Authority; Professor, Faculties of Medicine and Community Health and Epidemiology, Dalhousie University
Halifax, NS

Dr. Dick Zoutman
Chief of Staff & Medical Affairs, Quinte Health Care; Attending Physician in Infectious Diseases & in Medical Microbiology; Professor, Pathology & Molecular Medicine (Medical Microbiology), Medicine (Infectious Diseases), Public Health Sciences and of Nursing, Queen's University
Kingston, ON

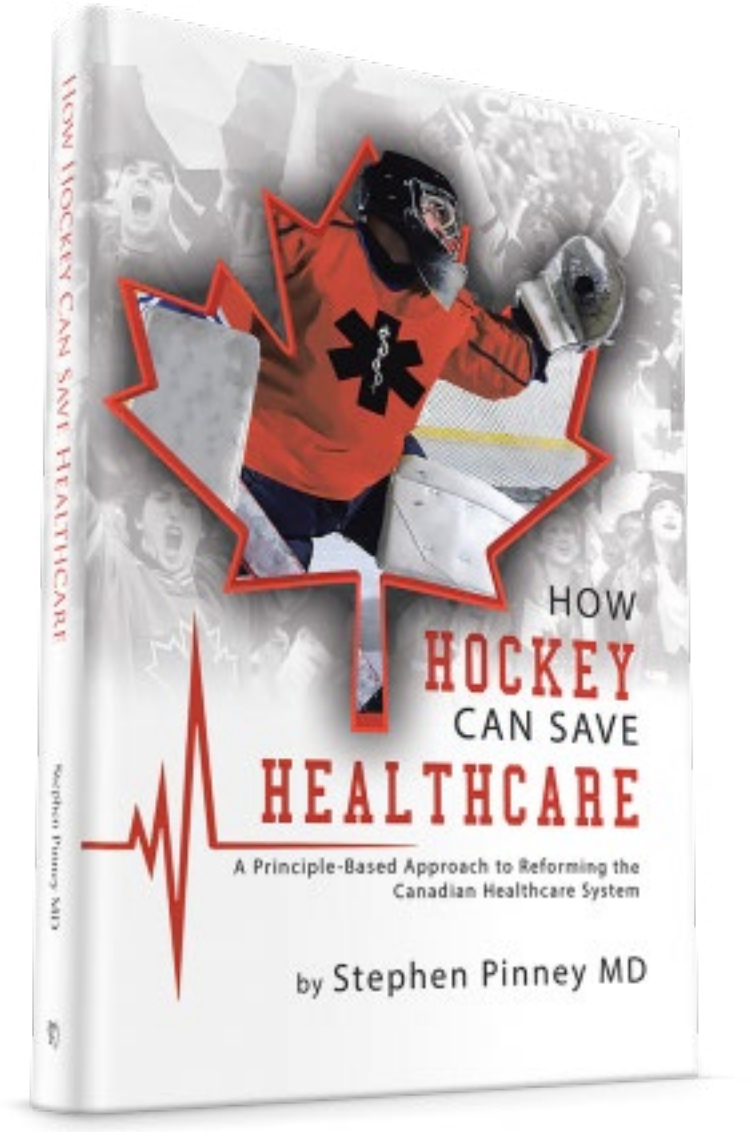
MÉDECIN GESTIONNAIRE CERTIFIÉ DU CANADA
CPE
CANADIAN CERTIFIED PHYSICIAN EXECUTIVE

BOOK REVIEW

How Hockey Can Save Healthcare A Principle-Based Approach to Reforming the Canadian Healthcare System

Stephen Pinney, MD
Lulu Publishing, 2016

Reviewed by Chris Carruthers, MD



Dr. Pinney is an orthopedic surgeon who graduated from McGill medical school in 1991. He practised academic surgery in the United States until August 2010, when he was recruited as the head of orthopedic surgery at St. Paul's Hospital in Vancouver. After only two years, he returned to the US. This book reflects his discouragement with the Canadian health care system, his insights, and his suggestions on how to improve it. He uses hockey as an analogy, comparing the principles and commitments required to run a professional hockey team and the health care system.

Like a successful hockey team, a successful health care system has to set clear goals, select and use players to achieve the best outcomes, closely measure the results, and make changes, including changes in personnel, based on overall performance. The goals of individual hockey players are subordinate to those of the team. Substituting doctors for hockey players, Dr. Pinney discusses how this is not what is happening in the Canadian health care system.

In the five years between Dr. Pinney's departure from Vancouver and the publication of his book, we have improved in several areas, but because we have not progressed far enough, many of his suggestions remain important today. Although he recognizes that Canadians pay a lot for a mediocre system, he also supports a publicly funded health care system with universal coverage. He does not promote an American-style system, but he does suggest that Canadians look at some of the systemic benefits of that system. In Canada, Dr. Pinney quickly became frustrated with the barriers

to practising efficiently and effectively and with the inability to change the system. One colleague said to him, “After 18 months, you will understand the system and you just need to determine if you can tolerate it for the rest of your career.”

He met and worked with other health professionals, but they were also trapped in a dysfunctional system. He highlights fragmented care, absence of valid and useful outcome metrics, and the lack of competition and accountability. He criticizes the fact that patients seeing their family doctor are only allowed one complaint at a time.

Dr. Pinney does not hesitate to criticize the medical profession’s shortcomings and resistance to change, which affect the performance of the system. For example, the lack of competition and accountability ensures that poorly performing physicians retain their positions year after year.

He also mentions, “lack of clinician input into hospital budgeting was one of the most surprising and disappointing features I observed.” He refers to fragmented payments for titled positions that physicians hold, payments that are often referred to as “shut up” money that buys silence from physicians and allows administrators to be in control. For these and other reasons, he supports physicians developing leadership skills to participate in system change.

Comparing health care to hockey, he writes, “There is no head coach to coordinate the team, and if there is a general manager, he or she is likely completely disconnected from what is happening.” He suggests that teams need clear goals and must work together to achieve these patient-centred goals and accurately measure and pay for results. He notes the lack of a single entity with the power to change the system and with accountability, particularly to population health metrics.

Dr. Pinney supports bundled payments, which is an effective way of paying for outcomes. This is a trend in the US, but has yet to be introduced in Canada. In Canada, bundling physicians’ payments into an overall payment would be met with significant resistance.

In Canada, Dr. Pinney identifies what he calls toll booths. For example, he cites the case where every year the anesthesia department in his hospital stated what days they would be available and what days they could not cover because of vacations. He finds this “toll booth” unacceptable.

Another good analogy is the 2 September 1972 Canada–Russia hockey game. Canada was outclassed; the teamwork of the opposing team was what defeated Canada. This loss lead to disruptive innovation in Canadian hockey. It took a generation for the changes to be implemented, but Canada became competitive and won.

Some key learning points: “

1. Facilities need to be customer centered.
2. Competition should drive the performance of healthcare facilities.
3. Cleanliness is the canary in the coal mine.
4. Equipment and physical plans must be kept up-to-date.
5. Facilities require strong leadership and skilled management teams.
6. Facilities must be financially viable.” His emphasis on competition is important. This has been contemplated for years in the Canadian system, but only timidly introduced.

Finally, a key point Dr. Pinney makes is how change will occur: evolutionary or disruptive. He supports a disruptive approach. Perhaps, we are seeing disruption today, driven by financial reality.

This is an excellent book. Chapter 8 is the key chapter that outlines the principles for running a successful health care system in Canada. If you only have time to read one chapter read this one.

My disappointment is that it would have been an advantage to the Canadian health care system if Dr. Pinney had remained in Canada to be a champion of change.

Author

Chris Carruthers, MD, is a consultant. He was founding president of the Canadian Society of Physician Leaders and the first winner of its award of excellence, which is named after him.

Correspondence to:
ccmd@rogers.com

BOOK REVIEW

Three books on influence and persuasion

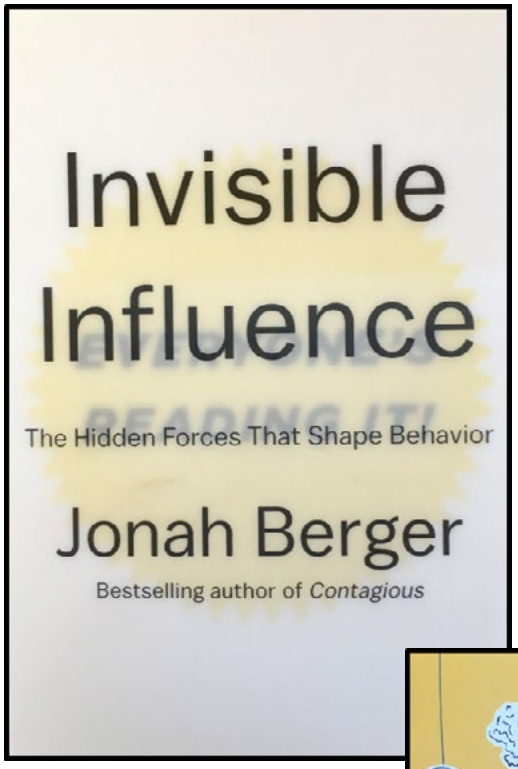
Reviewed by
Johny Van Aerde, MD, PhD

The LEADS framework states, "Leadership is the capacity to influence people to work together to achieve a common constructive purpose."[1] According to Grenny et al., "Leadership is influence."[2] Given that leadership and influence are closely aligned constructs, it is no surprise that the market has been flooded with books on influence and persuasion.* This is a brief review of three of them, all released last fall.

Invisible Influence: the Hidden Forces that Shape Behavior

Jonah Berger
Simon & Schuster, 2016

Invisible Influence deals with research on how social influences affect our decisions as individuals and as groups. Berger describes how most of us are in denial about our own shortcomings and don't realize that we are often being

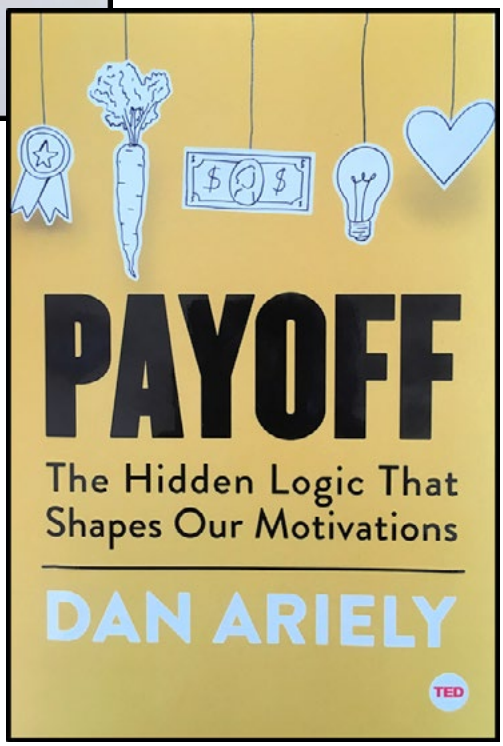


"herded." As a result, we believe that our ideas and decisions are completely our own when they are not. Berger offers advice on how to become self-aware and avoid such invisible influence and how to prevent "groupthink," a team's equivalent to invisible influence. Although entertaining reading, Berger's ideas and theories are not new or revelatory.

Payoff: the Hidden Logic that Shapes our Motivations

Dan Ariely
Simon & Schuster/TED, 2016

If Berger focuses on awareness of invisible influence, Ariely deals with motivating people. In Payoff, he is reflective, sometimes even philosophical, about how leaders motivate people (and self). One of the keys is giving people a sense that they have some say in what they do and that their own life matters. Perhaps, surprisingly, people are not as much motivated by money as we think; according to Ariely's research, after a brief spike in productivity



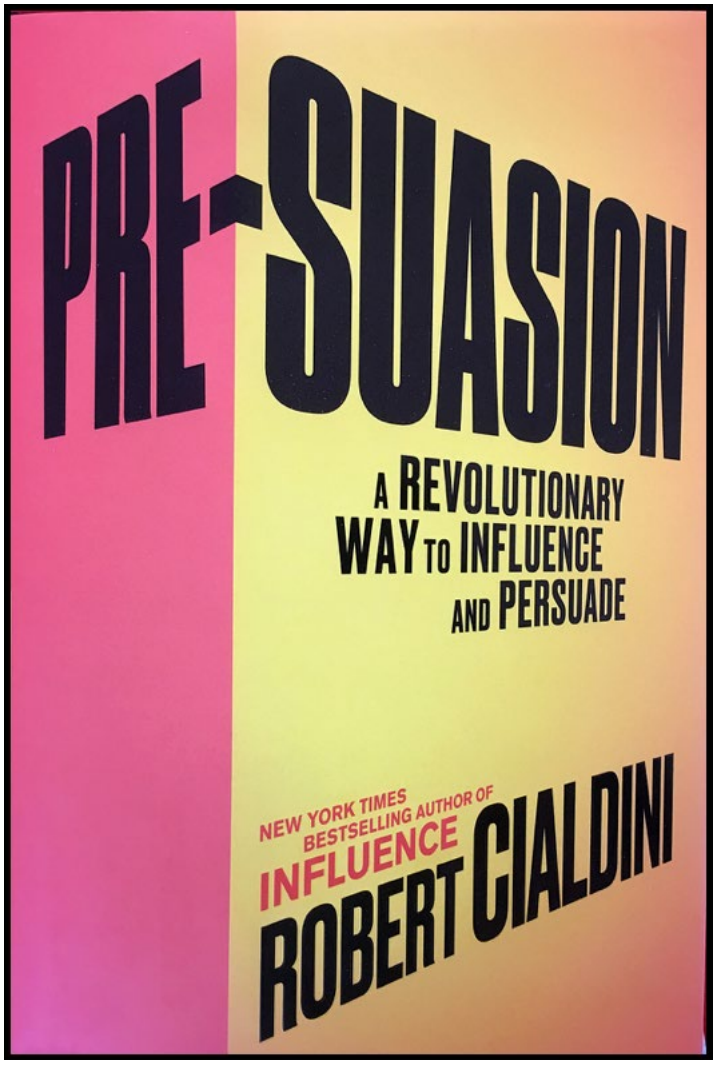
resulting from a bonus, productivity actually declines to below the pre-bonus level. Gratitude and compliments, even when expressed in unconventional ways, are better motivators. As Ariely puts it, "acknowledgement is a kind of human magic."

This book was worth my time for three unrelated reasons: it

made me reflect on how the research findings could be applied at different levels of our health system; the book's style and content made for enjoyable reading; it was only 100 pages long.

Pre-Suasion: a Revolutionary Way to Influence and Persuade

Robert Cialdini
Simon & Schuster, 2016



If Invisible Influence is about awareness and Payoff is about how to motivate others, then this third book is about learning how the other side operates. Cialdini, a social psychologist, pioneered much of the research on persuasion a few decades ago. In this latest book, only his second since the 1980s, he presents his research on pre-suasion.

This new term means that the most successful persuasion is not in the message itself, but in the key moment(s) before the message is delivered. He has found that altering the other party's attitudes and beliefs is not necessary; what is required is to alter the audience's focus of attention just before requesting a relevant action, not much different from a magician influencing the audience's attention just before a magic trick. Most examples come from marketing, and the book is of limited direct interest to physician leaders. However, if you want to become more aware of how we are duped, manipulated, and persuaded to do things we may not want to do or regret later, this fun and fast read is for you.

Berger and Cialdini's books help us better attune ourselves to the artful techniques used by master manipulators and may increase our chances of making good decisions without closing ourselves off to new ideas and views. Ariely's Payoff is worth considering for your reading list as an aid to reflect on some of the tools we may need to motivate ourselves and others.

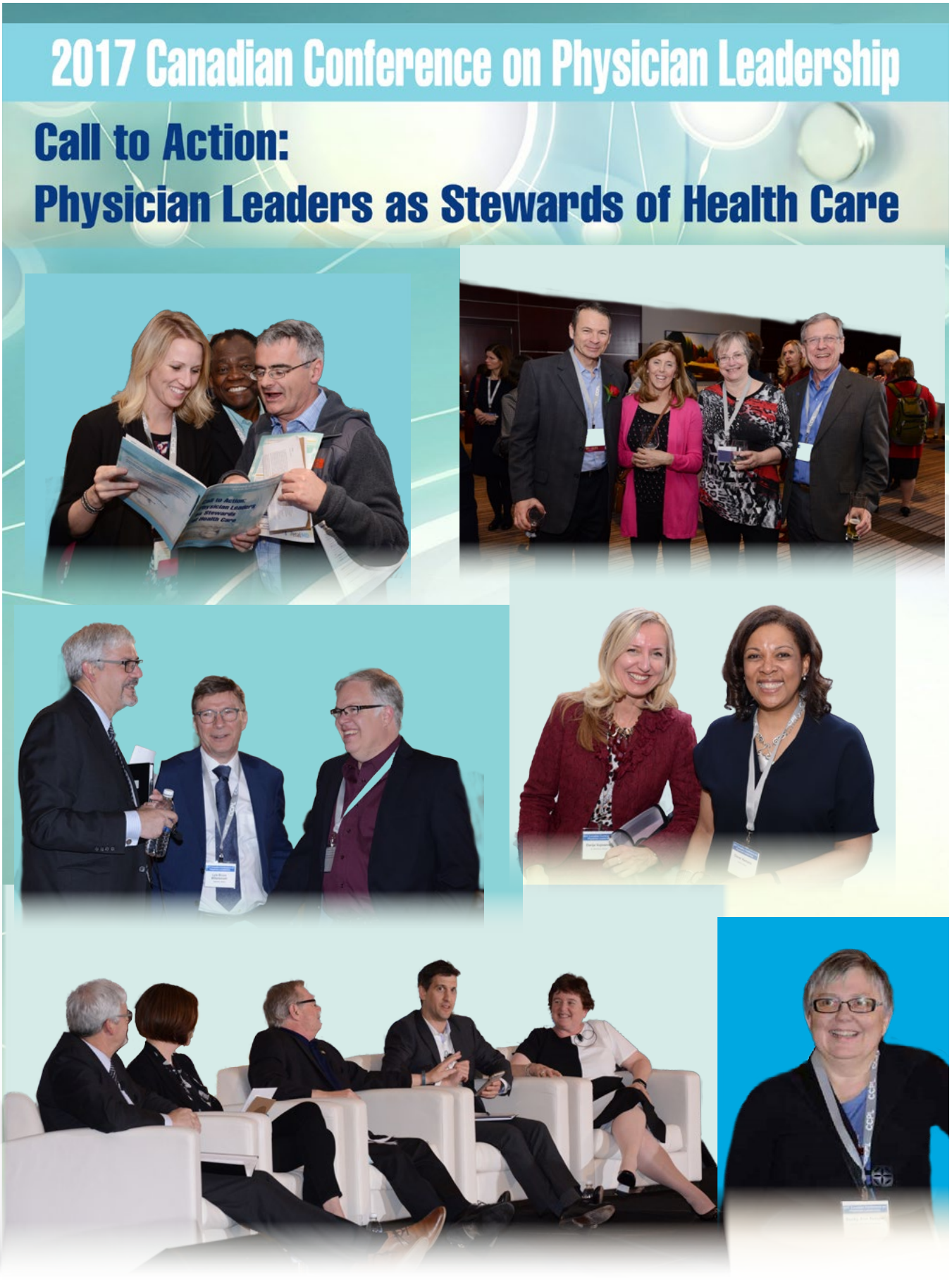
References

1.Dickson G, Tholl B. *Bringing leadership to life in health: LEADS in a caring environment*. London, UK: Springer-Verlag; 2014.
2.Grenny J, Patterson K, Maxfield D, McMillan R, Switzler A. *Influencer: the new science of leading change*. New York: McGraw Hill; 2013.

Author

Johny Van Aerde, MD, MA, PhD, FRCPC, is editor-in-chief of the Canadian Journal of Physician Leadership and past-president of the Canadian Society of Physician Leaders.

Correspondence to:
johny.vanaerde@gmail.com


2017 Canadian Conference on Physician Leadership
Call to Action:
Physician Leaders as Stewards of Health Care


joule

CANADIAN JOURNAL OF PHYSICIAN LEADERSHIP

ADVERTISING RATE CARD 2015/16

The Canadian Journal of Physician Leadership (CJPL) is a compilation of educational, informative, and thought-provoking articles aimed at physician leaders and potential leaders. The CJPL was established in the summer of 2014 by the Canadian Society of Physician Leaders (CSPL) and then-president, Dr. Johny Van Aerde, who remains editor in chief of the journal.

Dr. Van Aerde is pleased to see the journal moving forward into its second year of publication and that the CSPL Board has agreed to keep it open to the general public. The journal is published in electronic format only — PDF and ePub versions — and delivered to the desktops of over 2000 physician leaders across Canada. The latest issue of this quarterly journal can be viewed at **www.physicianleaders.ca/journal.html**

ADVERTISING RATES (taxes not included)

Size	1 time	4 times (1 year)	Dimensions
Full page	$950	$750	7”w x 9.5”h
1/2 page horizontal	$450	$350	7”w x 4.75”h
2 Column vertical	$550	$450	9.5” h x 4.6”w
1 Column vertical	$250	$150	9.5” h x 2.22”w
1/2 Column vertical	$150	$100	4.75” h x 2.22”w

Issue	Deadline for ad copy	Publication date
Fall 2015	November 15	December 1
Winter 2015/16	February 15	March 1
Spring 2016	May 15	June 1
Summer 2016	August 15	September 1

2018 Canadian Conference on Physician Leadership

Vancouver, April 20-21, 2018

Save the Date

Dialogue: A tool to lead action

Don't forget to enroll in one of our amazing
Pre-Conference Courses – April 18-19, 2018

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

www.physicianleadershipconference.com

joule
A CMA Company
Société de l'AMC