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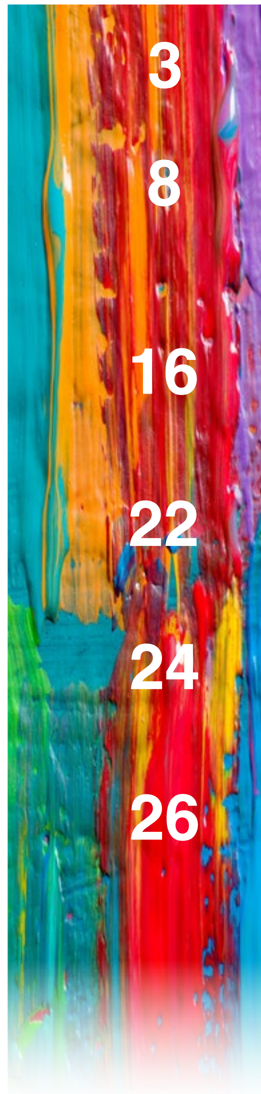

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Real dialogue: six conditions, six ground rules, three barriers

Johny Van Aerde, MD, PhD

Unlike debate and discussion, dialogue does not seek initial agreement, but rather a rich grasp of complex issues for which there is no certainty and no clear agreement, as is the case for many issues related to health systems. Leaders require not only good facilitating skills to guide dialogue successfully, but also the ability to move a group between dialogue and discussion, knowing that the rules and goals of both types of conversation are different.

KEY WORDS: dialogue, discussion, debate, complex issues, leading dialogue

Our society has lost the art of dialogue. For many complex and long-term issues facing our health system, we rely mostly on discussion and debate, rarely engaging in true dialogue.[1] Because these are incomplete tools for dealing with problems around social complexity, the solutions we end up with are mostly of limited value. As a result, the same problems keep recurring.

To explore large systemic questions around the purpose of the Canadian health care system, how we incorporate socioeconomic components of health into our system, or how we rejuvenate the *Canada Health Act* to serve our needs in 2020, dialogue is a more appropriate conversation tool. Physician leaders might also consider dialogue to explore complex questions related to their profession, questions without a straightforward answer. For example, how have our working conditions affected trust building and patient care service? Given the differences in scope of practice between physicians and nurse practitioners, how might we approach service delivery as a team? Given the funding model for primary care setups, how can we deliver team-based care for patients and also remunerate everyone fairly and equitably?

This paper addresses the various types of conversation and the advantage of dialogue to address complex issues in the Canadian health care system. It also includes simple guidelines for physician leaders who want to use dialogue.

Debate versus dialogue versus discussion

Conversation is the summation of all forms of oral communication. Debate, discussion, and dialogue are three very different types of conversation. The aim of debate is to argue and win, and the word comes from the Latin *dis* (expressing reversal) and *battere* (to fight). Its combative style, with winner and loser, has no place in health care.

"Discussion" comes from the Latin word *discutere* (to squash to pieces), with the same root as concussion and percussion.[2,3] Discussion promotes fragmentation, the topic is dissected into parts, different views or facts are presented, analyzed, and defended as one fundamentally wants one's view to prevail. Through discussion, experts find solutions to problems based on certain evidence, and they find agreement in the context of mechanistic systems thinking. It is a powerful mode of information

exchange and tends to force people into an either/or thinking mode. It tries to contain and guide separate parts into a coherent order, and it does not assume an existing or underlying wholeness.[2] It is about making a decision on one specific problem or element within a system and produces important and valuable results for the many situations we face. An example of appropriate use of discussion is when various experts get together to plan an integrated treatment approach for a patient with multiple chronic disease problems.

According to David Bohm, the great quantum physicist, thought is to a large degree a collective phenomenon: "As with electrons, we must look on thought as a systemic phenomenon arising from how we interact and discourse with one another."[3,4] Dialogue is about exploring possibilities, evolving insight, and reordering our knowledge.[2] It is a self-organizing system that evolves based on the principles of complexity. That is why, in dialogue, inclusive "and" statements trump "either/or" expressions. Because "dialogue is a conversation with a center, not sides,"[2] it lifts us out of polarization by accessing the combined intelligence of people.

The word "dialogue" comes from the Greek words *dia* (through) and *logos* (word or meaning). As participants become observers of their own and others' thinking through dialogue, they reach new understanding and meaning, forming a completely new basis from which to think and act, and creating context from which many new agreements might originate.[3] As a result, entering into true dialogue builds trust, as it is a forum for open and transparent communication.[5,6]

Table 1. Differences between dialogue and discussion

DIALOGUE	DISCUSSION
See the **whole** among the parts	Break issues and problems into **parts**
See the **connections** between the parts	See **distinctions** between parts
Use **AND, not BUT or EITHER/OR**	Use **EITHER/OR, not AND**
Inquire into assumptions	**Justify/defend** assumptions
Learn through listening, inquiry, and advocacy	**Persuade, sell, tell**
Create shared meaning among many	**Gain agreement** on one issue or meaning

Dialogue does not seek initial agreement, but rather promotes a rich grasp of complex issues for which there is no certainty and no clear agreement, as is the case in many issues related to health systems. In other words, dialogue is the type of conversation to be used around issues for which there is no clear answer. A successful example of such dialogue can be found in Brazil's approach to HIV, which was an intractable problem 20 years ago, yet was kept under control much more than in other developing countries.[7] Closer to home, examples of issues where real dialogue is needed are obesity in the western world, how to involve the elderly in a healthy community, and the sustainability of the Canadian health care system. Dialogue is not reserved only for large-scale systemic complexity; it is also helpful in addressing smaller complex issues for which there is no straightforward answer.

Leaders require not only good facilitating skills to guide dialogue successfully, but also the ability to move a group between dialogue and discussion, knowing that the rules and goals of both types of conversation are different (Table 1). Failing to distinguish between them results in non-productive discussions and a lack of true dialogue.[3] Once the wholeness of the dialogue topic has been addressed satisfactorily, specific parts and elements of that topic can then be solved using discussion.

Dialogue and deep listening are part of effective communication, one of the important capabilities needed by leaders to lead change[8,9] and build trust.[5] How can a physician leader facilitate true dialogue? Here are six basic conditions that must be fulfilled before initiating the dialogue, six ground rules to follow during the dialogue, and three barriers to watch out for as they could derail the purpose of the dialogue. They are a synthesis of various publications on the topic of dialogue, integrated with personal experience and practice.[2,3,10-14]

Six conditions for real dialogue

1. **Ensure that all the elements of the system you want to change are in the room**. Unless all stakeholders are part of the same dialogue, the system will not change.[3] Similarly, all parties must have equal opportunity to add meaning and content to the dialogue.[12]
2. **Create a safe environment** and encourage participants to raise the most difficult issues as needed.[13] A safe environment helps build relationships and trust and is created partly by agreeing on and respecting the ground rules (see ground rules below). In the presence of distrust and toxicity, dialogue on their causes and on trust rebuilding must occur before the topic at hand can be addressed.[5,6] Various tools for conflict resolution and reconciliation might be necessary, but are not part of this paper.
3. **Enforce the ground rules** by reminding people to suspend their assumptions and inquire into others' assumptions during the dialogue.[11] This also contributes to building safety and trust.
4. **See others as colleagues** in the quest for mutual insight and clarity.[12] Having courage and establishing positive tones are critical to overcome the vulnerability inherent to true dialogue.
5. **Appoint a leader or "facilitator,"** who has the skills to create the container within which dialogue can evolve and to differentiate between discussion and dialogue.[10]
6. **Set aside sufficient time for the dialogue, and allow space for silence and reflection.** Selective silence can be a powerful form of engaged listening. Listening is not the same as waiting to talk. We can offer nonverbal cues showing interest and focus without jumping in with an immediate response. If the group has no previous experience with dialogue, people are likely to interrupt each other. The use of a talking stick or rock may help initially, where the holder is allowed to speak or be silent while everyone else listens.[13]

Six ground rules

At the beginning of a dialogue, a few points can form the basis for agreement.

1. **We are open to and curious about others' perspectives and willing to change our thinking.** Be fascinated by what others say; have an open mind willing to explore the possibilities. Dialogue is a process that can help us realize more of our human potential by learning how to embrace the qualities of cooperation and balance them with our natural urge to compete.
2. **We are respectful and supportive; we suspend judgement and preconceived beliefs.** Suspension of judgement is about developing the ability to observe our own and others' views from a neutral position. Our judging process occurs subconsciously, very quickly – faster than our conscious decisions. It is based on our upbringing, previous experiences, beliefs, and values. Although those automatic judgements will still come up during the dialogue, establishing this ground rule helps us choose not to act on them in a reflex mode.
3. **We share the reasons behind our questions and statements (advocacy)**. The two most important parts of dialogue are advocacy and inquiry, which have to be balanced skillfully.[14] Advocacy refers to explicitly asserting an opinion, perception, feeling, or proposal for action. As people cannot read someone else's mind or know the assumptions behind a statement or a question, it is important that speakers make their thinking process visible. This contributes to the building of safety, relationships, and trust. Example statements: "The reason I say (or ask) this…," "I came to this conclusion because…," "My assumption is…," or "The story I told myself is…"

Such clarification helps people understand how and why we said what we said. One could add, "Do you see it differently?" or "What can you add?" to elicit a response to such statements.

4. **We listen to understand and inquire into others' perspectives**. Listening to understand is difficult; even if we don't interrupt, we are often just waiting to talk. Skillful inquiry is as important as advocacy. It explores the assumptions and thinking underlying others' statements. Examples of exploratory questions include, "What causes you to say that?" or "What led you to that conclusion?" Be careful to use non-aggressive language and say, "Can you help me understand your thinking?" or "Can you give me an example?" rather than, "What do you mean?" or "Where is the evidence?" If you are uncertain or unclear, paraphrase by saying, "Am I correct that you are saying…?", or "Did I understand you correctly when I say…?"
5. **What we say here, stays here** (Chatham House Rule[15]). Participants are free to use the information from the meeting, but neither identity nor affiliation of the speaker or other participant may be revealed.
6. **Anything else we want to add** to make this a safe and successful dialogue? Offer people the chance to clarify the ground rules and add to or change the dialogue agreement.

Three potential barriers to watch out for

(Based on Stoner and Stoner.[12])

1. **Groupthink** is common and occurs in groups when members' quest for unanimity overrides their motivation to realistically appraise alternative courses of thinking or action. When groupthink occurs, leadership is paramount in encouraging dissenting views and unleashing the devil's advocate. Be acutely aware of individual or group tactics to squelch dissenting views. Sincerity and authenticity on the part of the leader are important here.
2. **Commitment bias** happens when people enter a dialogue with preconceived beliefs and assumptions. The leader will respect offbeat perspectives and ensure that they receive a fair hearing and consideration. This is where good inquiry skills come in handy.
3. **Power bias** might occur because some individuals are accorded a higher status than others in the dialogue, because of their knowledge, reputation, or position. In cross-disciplinary teams, by virtue of their specialized expertise and social status, some participants often carry differential power. It is the leader's responsibility to minimize the coercive nature of these power differentials by reinforcing the ground rules.

In short, through dialogue, people learn how to think together, not just in the sense of analyzing a shared problem or creating new pieces of shared knowledge, but in the sense of occupying a collective sensibility in which the thoughts, emotions, and resulting actions belong to all stakeholders. Whether it is used for large or small complex systems, the outcome is often unexpected, innovative, and transformational.

Let's consider where and when physician leaders can use dialogue as a conversation tool across Canada, not only for the large-scale issues in our health care system, but also for the local, often seemingly intractable questions and problems.

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Population health management

Coming soon to a province near you?

Brian N. Jobse, PhD, Isra Levy, MBBCh, MSc, and Owen Adams, PhD

Internationally, two trends in health care are becoming increasingly well established. One is the growing recognition that health care is just one determinant of health status. Prevention and health promotion have a large role to play by affecting the social determinants of health and the sectors that represent them. The second trend is experimentation with approaches to systems funding that aim, increasingly, to share risk and benefits between funders and providers. Together, these trends form the impetus for what is becoming known as population health management (PHM). Canada has been a pioneer in developing the concepts, but international experience suggests that it has been a laggard in implementing them. In moving forward, critical success factors for Canada include health information management, multisectoral collaboration, and clinical leadership.

KEY WORDS: determinants of health, health care system funding, health information management, multisectoral collaboration, clinical leadership, system integration

A Canadian perspective

A large majority of Canadians continue to see health care improvement as a primary concern for government.[1] Escalating costs, at least partly attributable to an aging population and a greater burden of chronic disease,[2,3] demonstrate the need for change, but policymakers struggle to introduce effective innovation. Where should we turn for inspiration? The health system is obviously an important input with regard to individual health, but the 2009 Canadian Senate Subcommittee on Population Health Final Report highlights that 75% of health is attributable to other determinants.[4] Long before this report, Canadians were playing a large role in the development of this line of social inquiry,[5] but the implementation of public health measures and the integration of these concepts into health care have been limited.

Understanding and accepting the social determinants of health in a society is an area in which Canadians have had important impacts on the development of population health models. Key to this work is acceptance of the 1946 World Health Organization constitutional statement that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[6]

The record of the Canadian perspective and input begins with the Lalonde Report of 1974 entitled "A new perspective on the health of Canadians,"[5] which described the factors of health as human biology, lifestyle, the organization of health care, and the social and physical environments in which people live. The upstream determinants of health, and health promotion as a tool to impact these determinants, were central themes.

The Epp Report of 1986, entitled "Achieving health for all,"[7] continued in this vein by highlighting preventable disease, stress, and chronic conditions as major challenges to health. Of importance, this report also emphasized the social support, from both government and community, needed to facilitate healthy outcomes.
Further elaboration on the Lalonde

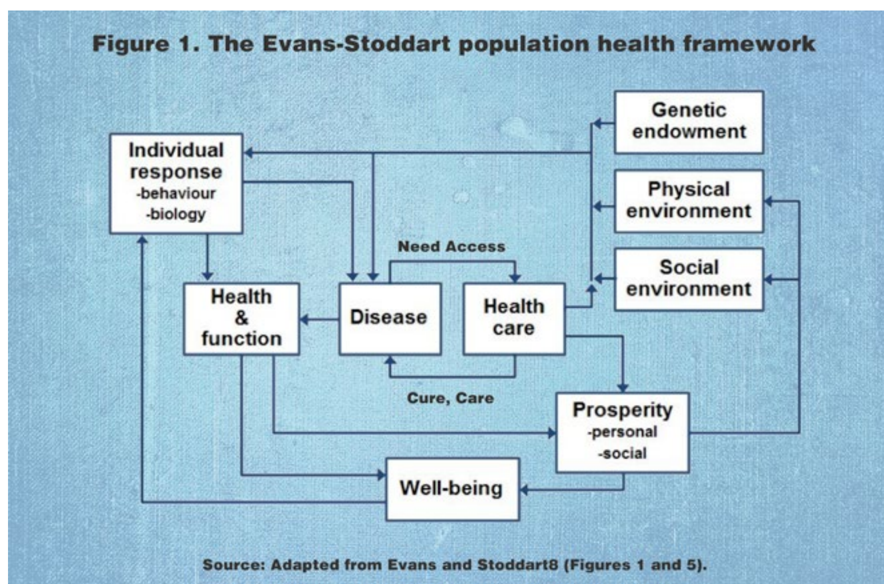

Figure 1. The Evans-Stoddart population health framework

Source: Adapted from Evans and Stoddart8 (Figures 1 and 5).

framework was provided in 1990. In "Producing health, consuming health care," Evans and Stoddart[8] advanced the Lalonde model to describe the interaction between social, environmental, and biological elements of health, their relation to general health and, ultimately, the overall well-being of an individual. Effectively, the authors position health care, and the associated costs, within the social feedback cycles that describe our society.

If Canadians were at the forefront in building these foundational ideas, why haven't they been more effectively implemented in the decades since? Although the Public Health Agency of Canada currently provides a framework for a population health management (PHM)-style approach, there is little evidence of an implementation strategy. Increased provincial reliance on regional health authorities is an example of the shift toward management of geographically defined populations, a stance that reflects a core consideration of PHM approaches. However, there seems to be little acknowledgement of PHM as an option in Canadian health systems. A universal access-based system should surely favour adopting methods to impact the social determinants of health; so, why then, is PHM currently a foreign concept best exemplified south of the border?

Defining population health management

PHM can be narrowly interpreted as the use of patient-level socioeconomic and geographic data to direct health resources and assess key population-level outcome indicators, such as life expectancy. Ideally, PHM is a strategy whereby population health status is improved by accounting for multiple determinants. Again, the current health care system is an important but relatively small contributor to life-long health.

As an approach to health system integration and improvement, PHM is arguably the contemporary extension of population health concepts that were shaped in Canada,[5,7,8] but are rapidly being adopted elsewhere, especially in the United States. For example, a PubMed search for "population health management" at the time of the writing of this article yielded 130 results, of which only 11 date before 2010 and only two have a Canadian connection. Although publications on this subject are described in various ways, the message remains that PHM is taking off in the United States while it seems there is little momentum in Canada.

Risk sharing

There are two dimensions to provider risk sharing. The first is managing risk by contracting to provide all necessary care for an individual for a fixed rate of payment for a specified time. The second is sharing risk between the funder and provider by agreeing to share in savings or losses if care is provided at a return either less or more costly compared to some predetermined benchmark (e.g., growth rate in the previous year's costs).

Integrated delivery systems

Integrated delivery systems typify risk-sharing behaviour and have been evolving over the last several decades. A number of US health care providers neatly illustrate this model; perhaps the best example is Kaiser Permanente, which boasts operating revenues and population served not dissimilar to those of the Ontario Ministry of Health and Long-Term Care.[9] This health care provider was founded

on the experience that charging individuals a flat yearly rate for health care services reduces financial barriers to care and leads to increased use of health interventions, limiting the scope and cost of long-term morbidities. Population health information, then, became a great commodity in a competitive market, as resource development could be directed toward limiting upstream negative determinants.

Associated providers, generally led by physicians, are incentivized by capitated budgets and shared savings arrangements to create efficiency and reinforce population well-being.[9] This, in turn, encourages continued service use as a result of greater user satisfaction. This model also encourages fast integration of new technologies and concepts to improve efficiency and user experience. Today, the assorted entities that make up the Kaiser Permanente (working cooperatively) have created a single integrated electronic record system with online access for users.[9] As such, population health data are readily available to inform best practices, identify problems, and lead to tailored solutions.

In brief, Kaiser Permanente represents the most established case of a large-scale PHM approach, demonstrating the potential for application elsewhere. It is important to note, however, that Kaiser had the opportunity to develop slowly and represents a model of efficiency in a competitive market more so than it does a model dedicated to the social determinants of health. That said, the example stands as evidence for the success of preventative PHM.

Emergence of accountable care organizations

The Triple Aim framework, developed by Berwick, Nolan, and Whittington with the Institute for Healthcare Improvement (IHI) in 2008,[15] succinctly describes the core concepts of PHM as they relate to service providers: improving the experience and quality of care, improving the health of populations, and reducing the per capita cost of health care. Since 2010, Whittington and colleagues[16] have provided an update of Triple Aim framework practices based on experience from IHI collaborations aiming to reorient health care delivery systems toward PHM approaches.

The proliferation of accountable care organizations (ACOs) in the US also falls into this time frame, following the *Patient Protection and Affordable Care Act* of 2010, which proved to be a major driver for PHM implementation. Within this legislation, a shared savings plan for the Medicare program was established that rewards ACOs that are able to lower their growth in health care costs while meeting specified quality standards. ACOs can accept either one-sided (shared savings) or two-sided (shared savings or losses) risk-sharing models.[17]

Overall, ACOs have experienced fairly profound success in improving quality of care and most of the original participant organizations have opted to continue on under ACO frameworks.[18] It should also be noted that the track record for cost savings is much less conclusive.[18,19] Several of the obvious issues may not apply to the Canadian context, but it is becoming clear that appropriate incentivization across the various aspects of health

Glossary

Public health – "Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society."[10]

Population health – "The health outcomes of a group of individuals, including the distribution of such outcomes within the group."[11] (Generally taken to refer to a geographic population.)

Population health management – The application of population health concepts and measurements in reference to specific patient populations.[12]

Population health approach – An approach "that aims to improve the health of the entire population and to reduce health inequities among population groups."[13]

Social determinants of health – The conditions in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness.[14]

care provision are necessary to engender success.[18]

It is also becoming apparent that physician and clinical leadership have a very large role to play in the success of PHM approaches to health care.[20] Physician involvement in redesigning health systems and overcoming resistance to change, both financial and procedural, is undoubtedly an important facet of the successful transition to a new paradigm. As evidenced by ACOs, the growing trend to share risks between funders and care providers is likely key to creating momentum toward the goal of health care improvement.

Limited Canadian exploration

Of relevance to this discussion are the projects supported by the Canadian Foundation for Healthcare Improvement,[21] indicating, in similar fashion to the comparable examples south of the border, that the change to PHM is a complex realignment that requires concerted and sustained efforts along multiple social trajectories.[22] Various other Canadian ventures into PHM approaches to solving various pressing societal health concerns are detailed in a 2014 report from the Canadian Institute for Health Information.[23] A further article from this organization describes the options, benefits, misconceptions, and pitfalls of implementing ACO-style health system management in Canada, using Ontario as a case study.[19] Ontario is also currently working toward reducing expenditures by increasing service integration through community "health links," an emulation of the PHM paradigm without the population health feedback to truly assess impact. Despite these examples and some positive momentum toward PHM ideologies, there is currently no large-scale (provincial) example of a fully integrated PHM-oriented health care network in Canada.

Critical factors for implementation

Instead of the generally accepted view that the health care system is the main mode of disease and illness treatment, the PHM paradigm integrates health care as only one (albeit a pivotal) determinant of individual well-being and population health outcomes. As such, PHM frameworks require health care systems to engage with individuals and their communities, work with governments and population health agencies to intersect emerging issues, and develop multidisciplinary and inter-sectoral collaborations to provide a higher standard of care. The PHM approach acknowledges that relevant and timely information is critical to decision-making and, therefore, requires measurement of outcomes at the population level, whether that population is large or small.

Interest in PHM continues to develop, as evidenced by a broadening body of Canadian academic literature revolving around the social determinants of health and aimed at policymakers.[24] The chaotic state of the diverse terminology and confusion regarding roles and responsibilities[25] requires delineation of what is likely necessary to achieve success of implementation in a large-scale context, such as an entire provincial health care system. The three following concepts, therefore, are critical to the successful establishment of PHM in Canada. Similar to the IHI's Triple Aim, all three facets are contingent on one another, helping to explain why progress in this area has been slow without a concerted effort by policymakers, population health agencies, and the medical community.

Information management

Health data are integral to care delivery, research, and policymaking. Electronic health records are currently in varying states of implementation across Canada, but, although progress in adoption has been steady,[26] integration of records across health care environments is limited.[27]

A single, compulsory set of standards for all health-related services allows any provider to quickly understand the history and needs of a patient and to better communicate treatment options and other lifestyle recommendations. With regard to population health, an integrated health records system allows for the necessary research to assess population outcomes, appropriately use limited resources, and mobilize stakeholders.[23]
Patient engagement is also

served by the accessibility of a system-wide electronic platform. Not only can this platform serve as an educational repository and a source of public health information, but it can also enable online provision of services, especially where access to appropriate expertise is an issue.[9] Citizen engagement in the health care system should not be underestimated, as it has the potential to effect change in a broader, societal sense. Information management is a key to this endeavour, empowering patients by allowing greater access to the tools and understanding required to impact their health.

Multisectoral collaboration

In the wider societal sense, cooperation between governments, public health agencies, the health system, and many other stakeholders is necessary to facilitate any PHM-style approach. Collaboration with social services and education sectors are evident connections, but other sectors that could affect long-term health trends include agriculture, transportation, and land use, just to name a few. Governments should aim to facilitate knowledge-sharing among all levels and districts, but especially between public health and health sectors.[28]

The 2009 final report of the Senate Subcommittee on Population Health[4] positions the necessary outlook as a "whole-of-government" approach, with direct involvement of the Prime Minister in a Cabinet committee overseeing participation of various departments and agencies encompassing education, finance, employment, health, and the environment. A health lens in all policies, and across all departments, is seen as a necessary point of view to facilitate the transition to a population health model. Because health and the economy are inextricably linked,[4,8] the role of politicians in adopting this model is clear; investment and advocacy for population health must become the norm to increase well-being and enhance economic productivity in the long term.

The framework for incentivization of PHM approaches will also be an evolving issue to be negotiated among health care professionals, stakeholders, and policymakers; medical leadership will be vital to this process, as the funding formulas for various services

and regions will require different solutions that speak to both the professional performance of health care providers and the implementation of public-health-derived measures of success.

From the standpoint of cooperation within and between health sectors, PHM methodology requires an individualized, patient-focused standard that aims to address health concerns through integrative needs assessment and delivery. As such, the onus is on primary care to ensure that individuals receive support, resources, and referrals to a broader range of services than is traditionally available.

This, in turn, relies on cooperation outside the primary care setting to ensure integrated delivery. Further, outreach and collaboration require local relationship building to successfully affect upstream determinants of health, thereby reducing costs related to chronic and complex diseases.

Examples of this kind of outreach are becoming more common, with work by HealthPartners standing out as an early effort to create sustained partnerships between health, education, non-profits, and government by adopting a community business model.[29] The organizational shift by this non-profit health insurance/integrated delivery provider has provided the means and motivation for a health system to influence upstream determinants in the local community. It is clear from this example, and others, that a positive impact is possible, but questions around incentives and a continuing policy-driven effort remain.

Clinical leadership

A critical point in the development of PHM is that medical practitioners need a greater voice in their areas of expertise and that those areas represent a dynamic, shifting landscape of problems, needs, and solutions.[30] "Chief population health officer" is an emerging role in the US, speaking to the expertise needed to design and implement population health strategies. This position is often integrated into clinical executive bodies and is likely vital to creating an environment that facilitates sustained progress.[31]

From a ground-level standpoint, however, clinicians are ultimately in the best position to make changes reflecting both increased quality of patient care and efficiency within their practices. The current CanMEDS framework from the Royal College of Physicians and Surgeons of Canada addresses many concepts needed in this endeavour.[32] Within the Leader role, a key competency is to engage in the stewardship of health care resources. Within the Health Advocate role, an enabling competency indicates that physicians should improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities.[32]

Successful implementation must also look to enable the diversification of systems to better empower service providers given their particular populations, environments, and challenges.[23] It follows that, given the latitude to problem-solve, the appropriate leadership structure, and the incentive to produce greater population health (not just the absence of disease), health care systems will adapt to better account for the well-being of the individuals with whom they interact. The strength of US examples provides some validation of this stance, although an emphasis on funder–provider agreement to public betterment seems an implicit warning if the long-term success of such a paradigm shift is the goal.

The need for clinical leadership also extends beyond particular areas of expertise and into the broader policymaking environment. There is no doubt that the experience and drive exists for this venture in the Canadian context; thus, enabling leadership on both provincial and national stages is primarily an issue of building appropriate venues and opportunities to allow the medical community to truly take part in the restructuring of health systems.[30] Unifying the profession behind shared values of conduct as well as a modern ethical framework is a first step toward providing the landscape for clinical leadership.[33] As medical associations, both new and old,

take on greater roles in health advocacy, members will need to be more willing to participate in forums establishing direction and policy positions.

Implications for physicians

Without the ability to prioritize patient health and population health concurrently, real positive progress within the Canadian health system will continue to be elusive. Dynamic situations, such as the modern health system, require communication, willingness to implement new ideas, disruptive innovation, and the perspective that no one framework is infinitely applicable. Above this, consensus and commitment to a strategic direction will shape the effectuality of implementation.

The foregoing suggests three key implications for physicians and medical organizations in engaging in PHM approaches. First, physicians can get involved in reform and transformation initiatives. If nothing else, physicians should realize their potential for leadership, as they can both champion efforts towards reform and impact the transformation of patient care. Second, physicians can play a key role in establishing intersectoral collaboration and partnerships, both through their workplaces and through the medical associations to which they belong. Finally, physicians need to facilitate the development of timely, population-based data systems integrating individual clinical records, indicators of the social determinants of health, and information from other parts of the health and social services delivery system.

The health system, as a whole, stands at an important crossroads between the status quo and a fundamental shift in societal impact. Physicians can ensure that they, and patients, are best represented by becoming informed and active in the restructuring process, wherever opportunities arise and at all levels of governance.[30] Provinces are moving ahead with health system reforms, but many physicians do not seem to be engaged in the process and, instead, are only reacting to policy decisions.

In realigning the delivery of health care, emphasis on improvement in health outcomes may be what is needed in Canada as both the driving impetus for change and the evaluation tool to make change possible.[3]

Establishing leadership goes hand in hand with determining direction. It may be of import to the discussion to consider that medical ethics is generally concerned not only with the well-being of any patient in their role within the health care system, but also in their well-being in a broader societal context. Physicians who hold to this view should consider the ramifications of any particular style of delivery. Although PHM appears to promise greater financial sustainability for the health care system, it also speaks to the ethical values rooted in medical practice and the societal values that led to the creation of a universal access system in Canada.

Canada has been a leader in the development of the population health perspective, the impact of lifestyle on well-being, and the multiple determinants of health. There is a growing interest in PHM for all of the reasons already described, the examples and comparisons necessary to conceptualize an approach of this style in the Canadian context have been detailed,[9] and the framework for application to the Canadian health system continues to develop.[19] It is also noteworthy that Accreditation Canada has introduced standards for population health and wellness.[34]

In realigning the delivery of health care, emphasis on improvement in health outcomes may be what is needed in Canada as both the driving impetus for change and the evaluation tool to make change possible.[35] However incentivization is conceived, the US experience would suggest that a focus on outcomes, with risk–benefit sharing of costs, will be necessary to decrease the rates of preventable disease and health system use, ultimately reducing costs and increasing prosperity.[8] Health really does matter for the well-being of society and the economic outlook of the future, but, to improve the health of Canadians beyond what has been achieved to date, there is a need to look past today's work in managing costs toward the long-term benefits of understanding true population health status outcomes.

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PERSPECTIVE

The way to get there

Working toward balance in Quebec's health care system

Ruth Vander Stelt, MD

We are closer than we think to achieving success in repairing Quebec's health care system. In this third and final article in a series on its issues, I focus on how to achieve a system that would be balanced with respect to quality, accessibility, safety, and affordability.

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

The goal of any health care system is to provide high-quality, accessible, safe, and affordable health care. Given that health care is a basic necessity in any society, stakeholders must find sustainable solutions for the populations under their care. As seen in the first two articles in this series,[1,2] the solution to the problems currently experienced in Quebec must be based on four principles:

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

The chosen solution should simultaneously:

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

Based on these principles and the direction of the solution, I suggested in the second article of this series[2] that Quebec rally its clinicians and managers around a robust mechanism of resource synchronization that allows for an ongoing response to the question: "Of all the things we could try to improve, which should we improve first?"[3] Using this method, we will be able to remain focused on what impedes patient flow. At the same time, it will become perfectly clear that some of our activities – carried out with great effort and, at times, significant cost – do nothing to improve either patient or system outcomes. We will thus abandon these efforts in favour of avenues that reap obvious results.

Why delve into this question of improving health care? In fact, we have no choice but to address the issue, as our health care system cannot continue on its current path. Health care workers are often exhausted, which compromises the quality and safety of care. Costs continue to escalate, and society will soon be unable to afford the advances of modern science. Physicians and managers work in conditions that are far too "siloed" to be able to make the improvements needed to cure the ills of the system. At the end of the day, patients still suffer, and society does not get its money's worth.

The assumptions

The biggest error we can make in the current context is to assume that the pressure we are experiencing is normal, that there is nothing we can do, that the pace of cost increase is impossible to catch up with, that success would be too complicated or require too much effort – in short, that costs or collective fatigue will break the system before we are able to fix it. The reality is quite the contrary.

In fact, it is by challenging these assumptions that we will be able to identify the key element at the heart of the solution, i.e., the patient–clinician relationship. In doing what is best for patients and making all health care workers accountable to them, we will build a system that not only honours the needs of individuals, but also

respects the community through the compilation and management of individuals' information. This notion of accountability to patients is not controversial for physicians, managers, or policymakers. We, thus, need to shift our thought process toward the growing notion that we are all accountable to patients for the results of our actions.

The method to use

The second article in this series[2] laid the foundation for a desired future for our health care system, namely a state of balance where clinicians and managers work together, relying on dynamic and powerful information technology that sheds light on the constraints that prolong trajectories of care. In reality, patients should only find themselves in the health care system for clinical reasons, not organizational or administrative ones. By consecrating their collective efforts within the same continuous improvement process, clinicians and managers would find solutions for each problem, while constantly reevaluating the impact of each measure undertaken on the lives of patients and the experience of employees. These solutions would, therefore, be tailored to each clinical and geographic reality, while providing ongoing information to policymakers at every level of the system.

The road ahead

For this new system to become established, a series of necessary and sufficient steps must be

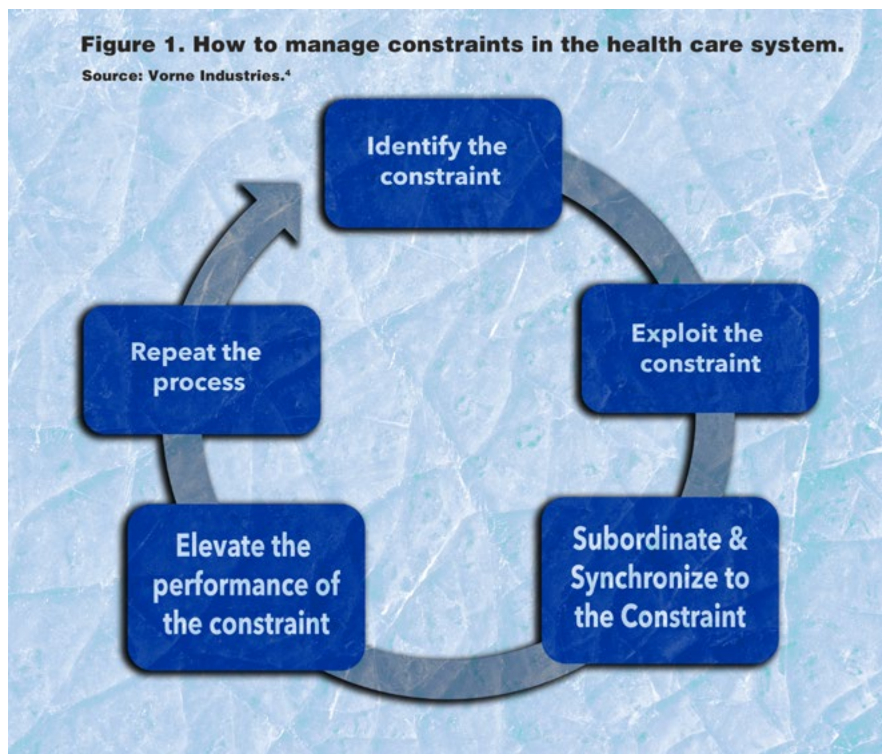


Figure 1. How to manage constraints in the health care system.
Source: Vorne Industries.[4]

followed. Necessary, because each step must be carefully and methodically completed to achieve the desired result; sufficient, because, as a whole, these steps will be enough to produce the desired effect. When these crucial steps are completed, the desired future will inevitably fall into place.

Above all, it is important to achieve enough of a consensus to establish a medium-scale arena to test the constraints management method in Quebec (see Figure 1). At the same time, ongoing training must take place, progressive support must be obtained from the professional community, and results must be made available for external review and critique. This will lay the foundation for an expansion phase with the method deployed throughout the province.

To establish this testing ground, a sufficient number of stakeholders will have to agree with the principles listed above and believe in the criteria against which any solution must be judged. In addition, a minimum level of knowledge and skills is necessary to deploy the approach, as is the case in western Quebec, where it has already been attempted on a small scale with very promising results.

Thankfully, there are sufficient medical and administrative structures in place in Quebec to begin the methodical management of constraints. To the extent that administrative structures can, at times, constrain the free flow of patients within the system, the larger administrative districts created by Bill 10 provide new opportunities to dynamically manage patient flow, as well as for enhanced communication between health care professionals. Furthermore, regional institutions now have a certain population-based mandate both inside

and outside the traditional care framework. This will help them address entire patient trajectories, including keeping them from entering the system and helping them exit establishments when care is no longer required.

As part of the testing ground, physicians and managers will attend meetings focused on patient flow. They will contribute to the continuous elimination of constraints, which will be brought to light with the help of robust and dynamic software. They will develop policies and procedures that will be constantly reassessed to ensure that they themselves do not become constraints. Physicians and managers will remain attentive to each other with the goal of maximizing their professional performance. If any professional lacks the tools needed to perform to the best of their ability, the reasons will be sought out to remedy the problems and eliminate any constraints involved. In the case of both physicians and managers, constraints will be directed to higher levels when needed and, if necessary, to the institution's governing authorities.

Physicians will become accustomed to airing their clinical opinions across the system in a methodical fashion. To do this, they will rapidly learn to communicate to the system what they already tell patients. For instance, "Sir, we expect you'll be in hospital for four days based on your condition" will translate into a prescription placed on file for an expected discharge date in four days time. If the preliminary diagnosis of the illness becomes more complex and the expected discharge date is postponed, the physician will immediately update the situation in the file. For the statement, "Your case requires that you undergo surgery in the next month," the surgeon will write a maximum time limit of one month on the admission forms. For this example, "Your baseline abdominal ultrasound must be done in six months," the exact date will be indicated on the requisition.

Using this method, patients become the pivot point in the system; they are located at the centre of all decision-making. Clinicians serve as antennas surrounding their patients, listening attentively to their needs and providing the driving force with regard to their health requirements (Figure 2). In terms of the greater health care system, it receives the information signals provided by clinicians. Its role is to uncover and eliminate any constraints to the clinically determined flow of patients.

Managers will, therefore, be specifically tasked with continually identifying any obstruction to the flow of patients as indicated by clinicians. They will distribute the management of flow throughout the institution based on established levels of constraint. When an obstruction is identified, it will be added to the agenda for joint meetings that address patient flow.

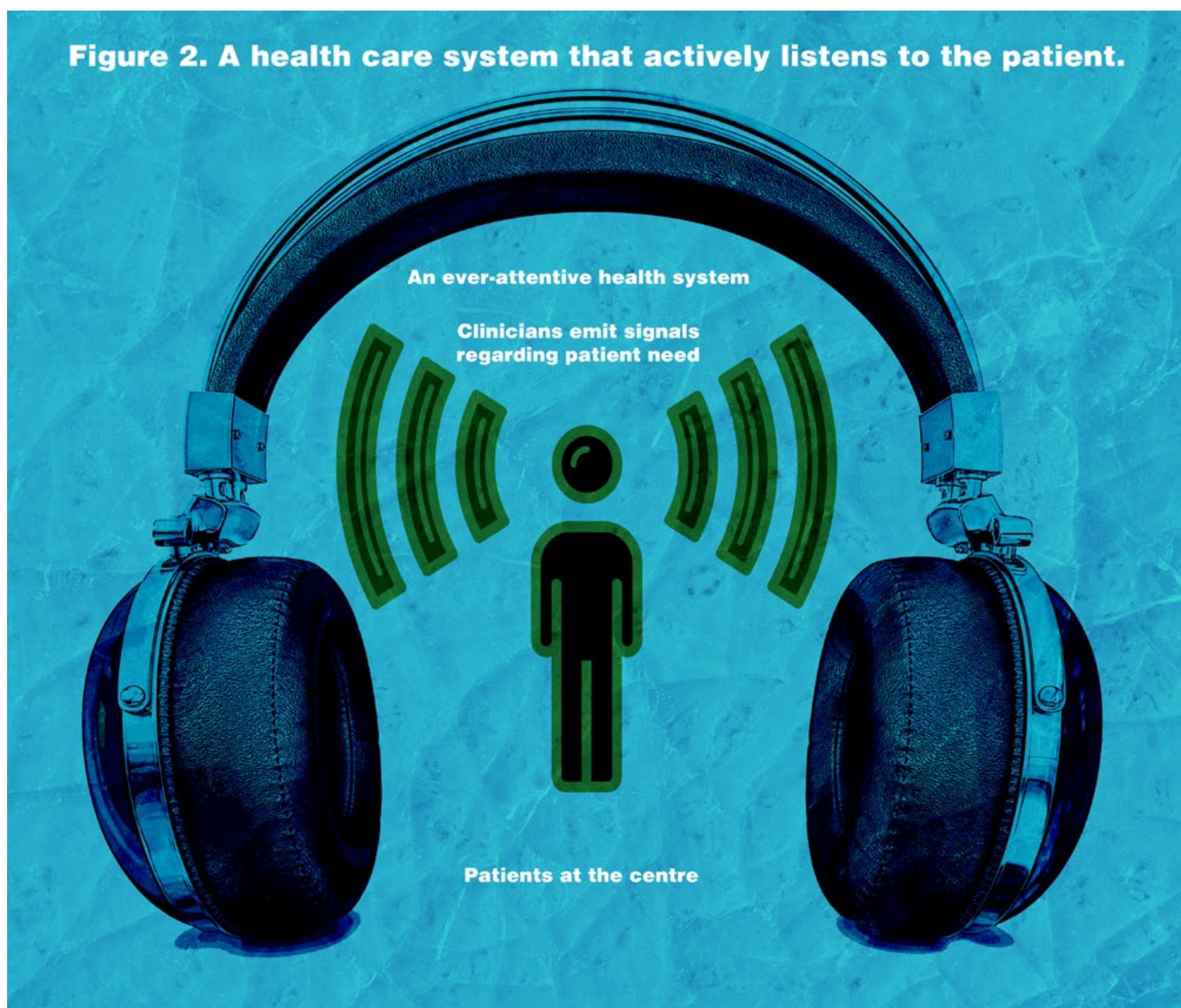
In short, the only way to increase the overall flow rate of the system is to increase patient flow through the constraints of all health care trajectories. To do this, physicians and managers must:

- Identify the current constraint(s) to patient flow
- Decide how to exploit the constraint(s), i.e., make quick improvements using existing resources
- Subordinate everything else to the above decision(s)
- Make the constraint the highest priority, if necessary
- If a constraint is eliminated by taking these steps, return to step 1, but never allow inertia to become a constraint

Using this method, it will be clear at any particular time where the constraints are, where patients are accumulating in the system, in short, where the price is being paid – from all standpoints – for administrative delays and where, in contrast, patients' clinical needs are being met.

With regard to education, basic training in constraints management is required. In addition, opportunities should be created for dynamic and ongoing feedback on the results of any change of practice, any new policy or procedure being tested, or any new objective set in place. Progressive training aimed at generalizing the approach at the provincial level will then be needed.

Finally, it is of utmost importance to pursue open and ongoing reflection so that everyone understands exactly why the successes occurred. This step is crucial, because solutions for Sainte-Justine Children's Hospital



in Montréal, for example, could prove to be a total disaster at the health centre in the northern Quebec village of Kuujjuaq, and constraints at the Gaspé Hospital in Chandler could be quite different from those of the McGill University Health Centre.

In reality, it is the method that is used and the achievement of tangible results that will unite the troops, rather than supposed solutions applied in areas where problems do not exist. It should also be noted that today's constraints in all these places will not necessarily be the same tomorrow and that there will be no one-size-fits-all solution to the difficulties that plague us, even in the absence of dynamic information management by competent professionals, i.e., physicians and managers.

Finally, Quebec must make its successes known; making the results of each location available for external assessment and critique is essential. The constraints management method must be applied rigorously and scientifically to learn, not only from successes, but also from failures experienced elsewhere in the province. We will, thus, be able to discover regions with similarities in terms of particular pathologies or trajectories and other regions that are unique, where innovative research can be conducted.

Continuous and dynamic information sharing will allow us to uncover unique solutions that, up until now, may have been suspected to be possible, but were not implemented. We will witness growing and self-sustaining feedback loops that increase

patient flow as we implement the steps outlined above, specifically:

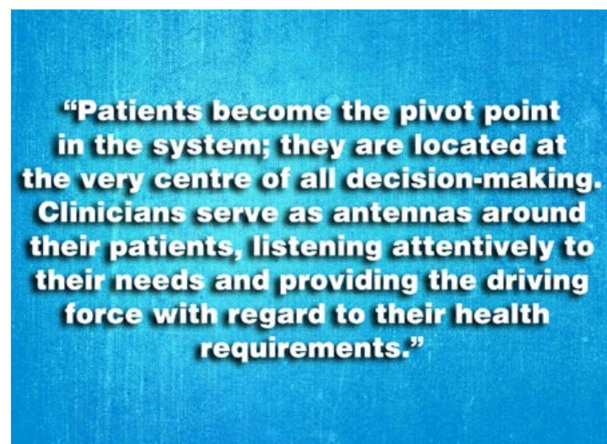
1. An initial medium-scale testing ground
2. Progressive support from the professional community
3. Training in constraints management at all levels
4. The availability of results for external assessment and critique

Expertise in managing constraints will increase and there will be a ripple effect from one end of the health care system to the other. Regional institutions will be able to provide robust recommendations to policymakers with regard to population-based health. Together, regional institutions will be able to integrate elements of learning into a provincial collaboration guide. They will also be able to provide ongoing dynamic information to the Ministry of Health and Social Services that will favour decision-making that is increasingly aligned with the needs of local populations.

Taken together, these steps will lead to the solution to the problems in our health care system: focusing on patient flow to unite clinicians and managers around patient need. Patients will then benefit from seamless care pathways across all the diagnostic and therapeutic interventions they may require. In fact, they will remain in the health care system only for the time needed to treat their specific case – not for administrative or organizational reasons.

Conclusions

We are closer than we think to achieving success in repairing Quebec's health care system. We have health care workers driven to make a difference in patients' lives and managers who are motivated to increase the system's performance. We have stakeholders who defend the public and others who negotiate on behalf of their members; they all say that the system is broken and that they would like to help put it back together. We have professionals who seek, above all, to work to the best of their abilities in brilliant careers on the cutting edge of science and technology, wanting nothing more than to concentrate on the clinical aspects of care rather than on administrative and organizational delays. We have patients who rightly demand quality, affordable, safe, and sustainable health care services. And finally, we have a society that seeks to balance the quality and cost of the health care system by acting, not only on care as such, but also on prevention. Furthermore, the structures are in place to create the vision I have just described.



The criteria for success are clear. We must first focus on the patient by taking on the collective responsibility we have toward them. Next, to create a health and social services system that will be successful and sustainable, we need to rapidly improve the quality, safety, timeliness, and affordability of care without creating more complexity for staff. By rallying clinicians and managers around patient flow, we will create a system that better meets their needs as well as those of society.

In the first article in this series, I expressed an understanding of the current reality of Quebec's health care system. The second article proposed a solution that will lead to an ideal future for our citizens. This third article outlines the path to which we must commit if we wish to move from the current state of affairs to the desired future. As we have seen, we must establish an inexorable process that will produce an efficient system of which we can all be proud.

There is no doubt in my mind that we are constantly creating our own future. I wish to be part of a brilliant future in the society where I have chosen to live. That is why I suggest challenging the current assumptions in health care and innovating by configuring the entire system around patients'

clinical needs. To meet this goal, I suggest deploying constraints management in a medium-sized environment, thereby gaining expertise unique to Quebec. The desired harmonization between patient need and the system's response can then be spread across the entire province to create a high-quality, safe, accessible, and sustainable system for the residents of our province. The final question remains: when do we start?

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ADVICE

Thriving online when dealing with controversial topics and strong opinions

Shawn Whatley, MD

This article has been adapted from a blog post called "10 tips to survive online with strong opinions," 21 April 2017, **http://shawnwhatley.com/survive-online/**

In 2012, public affairs experts told doctors to go wild on social media. They said Twitter could beat government. I followed orders, opened social media accounts, and started shouting into space. In late 2013, I even started a blog. However, expressing strong views online can be risky as it may trigger controversy and conflict.

The following tips can help you be heard, stay out of trouble, and retain the respect of your opponent and the people reading your thinking.

Separate people from their issues

Separate the people from the issues they present. Think about having a heated argument with a friend: you might disagree completely on the issue, but s/he is still your friend. Online interactions are impersonal compared with face-to-face conversations. To bring the human face back into your mind, ask yourself why a reasonable human being might write what they wrote.

Be consistent, one issue at a time

Separate issues to avoid confusion, and don't argue more than one at a time. People cannot follow arguments on several issues simultaneously; it's not only puzzling, but it also weakens your argument. If you want to build a voice online – a platform – you need to ignore some of the other exciting topics you might want to talk about.

Meet people at their level of knowledge

Many people in the crowd might not understand either side of a debate. They listen to learn, or to be entertained. Your topic might feel easy to you, but not to your audience. Think like your audience. Give people time to catch up, and meet them where they are at. Explaining understandably takes more time than you might think.

Arouse curiosity

Speak in a way that makes people want to hear more. Use language that makes sense, and entice readers with ideas that are unfamiliar to them. Get people to think, not just react.

Agree with your opposition

Find something to like about your opponent, and state it. Make it genuine, especially on social media, or it will come across as petulant and sardonic. Find the bit of goodness you can support and state your agreement.

Punch back with kindness

On social media, people attempt sarcasm and come across as just plain mean. Let them own it. Even if you think you know what they meant, ask for clarification. Always assume they meant something good or nice. Give them a way out. Kindness removes the sting of dismissive, mocking humour or sarcasm.

Concede with humility and courage

Show that you want to learn. Change your mind when presented with accurate facts and better evidence. Humility and courage win respect.

Stay quiet

How can you voice disagreement if you don't speak up? Staying quiet works in two ways. First, if an entire online mob turns against you, it keeps you alive while the mob whips itself into a blind rage. No one can speak sense to a mob; do not engage unless you wish martyrdom. Instead, keep quiet to live another day and share your story.

Second, once people learn that you aren't afraid to say that the emperor has no clothes, they will become uncomfortable with your silence. Opponents will want to know what you think, even if it is only to have the opportunity to say why you are so wrong or dumb. So stay quiet now and then. It makes people squirm.

Ignore trolls

Like angry mobs, trolls hate discussion. They shout slogans over and over, long after everyone has become bored and left the conversation. Trolls cannot survive without someone responding to them. We enable their dysfunction by responding. Do not throw your pearls before trolls or they will turn and troll you forever.

Put relationships before issues
This is the most important survival tip. Find people who can form relationships, and let them influence you as you influence them. Leadership is influence through relationships.

Author

Shawn Whatley, MD, is president of the Ontario Medical Association. He has been writing about our health care system and medical issues in social media for five years.

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STORIES FROM OUR CCPES

Building blocks or connecting dots: steps toward physician leadership

Abraham (Rami) Rudnick, MD

Editor's note: We asked CCPL members who have qualified as Canadian Certified Physician Leaders to tell us something about their "path" to leadership: what inspired them, how they succeeded, what they've learned. We hope their thoughts help you in your similar journey.

The path to leadership may take a long-term planning approach or an opportunistic route, but I believe that it is often a combination in different proportions depending on the individual and the stage of their career. Effective physician leadership development may also benefit from an occasional look back at past choices to learn from the past, optimize the present, and prepare for the future.

Currently, the route to leadership for physicians is not based on evidence.[1] For this and other reasons, it is helpful to share our experience and relevant reflections, with the aim of informing the pathways to leadership of other physicians. My "critical rationalist" preference leads me to start with reflections.[2] The few references I cite are intended to illustrate my own physician leadership development to date.

Reflections

Like most trajectories in life, physician leadership development may be robustly planned in advance (the building block approach) or it may take advantage of unexpected – as well as expected – opportunities (the connecting dots approach). In practice, most if not all development combines these two routes in what I term the stepping stones approach. The proportions of building blocks and connected dots may vary among individuals and at different times along one's path.

It is not clear to what extent the choice of one approach over another is intentional or whether such choices depend on personal or other factors. What seems clear is that, in retrospect, one can be more or less satisfied with these choices and learn from them for the future, not only about particular stepping stones, but also about one's development trajectory more generally.

For example, if one's long-term planning has led to success and

satisfaction, it may make sense to continue with a building blocks weighted approach. Yet, some flexibility may still be needed if an unexpected opportunity arises that fits the general outline of the long-term plan. In this article, I share some of my experience in planning and flexibility, as from early on I focused on long-term general goals, such as developing creatively, intellectually, and interpersonally.

Experience

During my childhood and youth, I was focused on a career as a classical pianist; this training developed some of my cognitive skills, such as the ability to pay prolonged attention to detail, and expressive skills, such as balancing content and style to achieve successful communication, artistic, in this case, but transferable to other contexts. Immediately after medical school, I worked as a military general practitioner, and this training developed some of my crisis management skills, such as remaining calm in hostile territory, and administrative skills, such as organizing large sets of health data in a user-friendly way. During my military service and immediately after that during my residency in psychiatry, I started and completed a doctorate in philosophy; this training developed some of my intellectual skills, such as critical thinking, and creative skills, such putting together facts and arguments as a reasoned narrative.

From early on in my medical career, I chose to and learned to improve health care systems collaboratively (with service users and other stakeholders), using applied research, clinical leadership opportunities, and, later, also academic leadership opportunities. To guide myself and others in this work, I developed a principled leadership values-based approach, focused on being person-centred, evidence-informed, and socially responsible.[3] As part of that, I have involved service users, such as people with mental health challenges and other stakeholders, in health systems improvement and related research. I have also provided needed guidance in health research, for example by publishing a comprehensive collection of articles on social science methods in this field.[4]

Conclusions

In retrospect, I see a clear – if not straight – path in my development as a physician leader. It has combined, or rather integrated, creative expression with intellectual inquiry and human service, leading to a dynamic balance among physician leadership, clinical practice, health research, and medical education. It seems that I have mostly used, and still use, a building blocks approach, but when unexpected yet relevant opportunities, such as research administration, arise, I have been able to take advantage of them, satisfactorily and successfully.

Other physician leaders may have different paths and face different choices. It seems to me that effective physician leadership development, perhaps similar to effective physician leadership,[5] can benefit occasionally looking back and learning from past choices, to both optimize the present and prepare for the future (planned or not). Perhaps this life lesson can be structured and studied as a next step in my leadership development.

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OPINION

Not personalized medicine, but personal medicine

André Picard, BCom, PhD

This spring André Picard received honorary doctorates from three universities: Carleton, University of British Columbia, and University of Toronto. The convocation speech that he delivered to medical graduates at the University of Toronto on 7 June 2017 is reprinted here, slightly abbreviated, with permission.

In my work, I meet many people, from those with acute illnesses through to those who live with rare and even fatal conditions, as well as their caregivers and care providers. I have the privilege of listening to, and learning from, their fears and frustrations, their hopes and their dreams, their wisdom and their rage, their intimacies.

My mom died a few years back of chronic obstructive pulmonary disease (COPD) – a cruel lung disease that slowly robs you of breath and makes you feel like you're drowning on dry land. She taught me more about medicine and health policy than any so-called expert ever did because she helped me understand what really matters to patients. She was one of those little old ladies you see at the mall, dragging an oxygen tank behind them. As she aged, she had an alphabet soup of conditions, arthritis, osteoporosis, a bout of breast cancer, and COPD leading to heart problems and mini-strokes, which in turn caused vascular dementia.

Try to remember that behind every one of those diagnoses, there is a complex story. My mother was a child of the Depression, and going hungry in childhood had life-long health impacts. She was also a smoker – COPD is principally a disease of smokers. That leads to a lot of judgement, and assumptions, but remember, people like my mom were products of their time, when smoking was the social norm. Her doctor encouraged her to keep smoking during pregnancy because the baby would be smaller, and the birth easier.

You see many patients like my mom, and sometimes we refer to these patients derisively as "frequent flyers." Try to remember that those frail, sick people sitting on your exam table had full, rich lives. Try, as best you can, to contextualize their illness.

The term "patient-centred care" gets bandied around a lot these days. What does it really mean? The United States Institute of Medicine defines patient-centred care as "care that is respectful of and responsive to individual patient preferences, needs, and values."[1] That's nice and inspiring, but it's also pretty vague. You've probably heard the expression: "I don't know anything about art, but I know what I like." Patient-centred care is a bit like that, you know when you experience it – and especially when you don't. The best definition I've heard is the simplest: giving a patient a better day.

When all is said and done, that's what health care is all about: making patients feel a little better. I don't want to downplay or dismiss your knowledge and your abilities, but simply remind you of the limitation of medicine. What really makes and keeps people healthy is their socioeconomic environment – their income, education, a roof over their head, access to decent food, and a sense of belonging. Medicine is there to patch things up when people are broken.

One of the greatest privileges in our society is to have the letters MD after your name. Those two letters confer great power. With that power comes great responsibility: sometimes you will literally hold a patient's life in your hands, but most of the time, you will have the power to make them

André Picard (right), health columnist with the Globe and Mail, receives an honorary doctorate degree at Carleton University, Ottawa. Also pictured (l to r): CSPL founder, Chris Carruthers, MD, Carleton chancellor, Charles Chi, and president and vice-chancellor, Roseann O'Reilly Runte.

feel just a little bit better. Your voice is also imbued with magical power because of those two letters, MD. Use it for good – not only for your individual patients, but also for society.

If there's one lesson I learned from my mom, time and time again, it's that the little gestures have the greatest impact. "Hello, my name is Jane. How can I help you?" Nothing mattered more to my mom than that simple introduction and question. In fact, one thing did matter more: that the doctor or other health care provider asking was actually willing to listen to the answer.

I want to read you a tweet from a physician who eloquently expresses this concept: "I had the chance to really talk with a patient today. When I say 'talk', I mean 'listen' and when I say 'a patient', I mean a person." It's something you should all strive for.

Modern medicine has become so specialized that many physicians treat specific syndromes and body parts, and the patient herself gets lost in the process. In our unrelenting quest for efficiency and measurement, we often lose sight of the person. We have filled our temples of medicine with such bedazzling high-tech tools that we've forgotten that we should treat people where they live.

In our desire to cure, we over-treat. We see death as a failure, but we can learn a lot about living from the actions of the dying. I speak to many people when they're sick and terminally ill. I've even been at the bedside when they take their last breath – and it's marvelous.

That may strike you as morose or odd, but I'm using the word "marvelous" here in its true sense – meaning "eye-opening" and "wondrous." When people are sick, when they know there is no cure, even when they're dying, what they care about is quality of life. They are not resigned, they are realistic. They don't expect miracles. They want respect.

We hear a lot these days about personalized medicine, about drugs and treatments that can be

tailored to specific genomic and epigenetic markers. What people really long for is not personalized medicine, but a personal touch. They crave a human connection. Not just care, but caring – a sense of belonging.

As a journalist, my job, ostensibly, is to write, to report, to summarize, to analyze, to inform, but my real job is to listen. Listening is a skill that will serve you all well – regardless of what program you have graduated from, but especially in medicine.

Listening is an art – and listeners are an endangered species. Listening well is more complex than it appears; it requires us to set aside our assumptions and prejudices. Above all, listening requires us to be quiet, to embrace silence. That's not easy in our fast-paced world. Like accomplished musicians, we need to recognize that the silence between the notes is as important as the notes themselves.

My mom was a woman of few words, but she would let her family and her health care providers know what she liked and didn't like – if they were willing to listen. What she hated the most was the blue hospital gown. To her it was a cloak of invisibility, a symbol of powerlessness.

My mom also balked at all the academic banter about privacy. She didn't care much about what health professional saw her medical records. To be honest, they weren't that interesting. To her, the privacy issue that mattered most was that she was too often left in the hallway of the emergency department for hours with, in her words, "my bony ass hanging out."

And she hated when she visited the doctor's office and he stared fixedly at the computer screen.

I once accompanied my mom on an appointment to her family physician and, after five minutes of him asking formulaic questions and tapping a keyboard, I interrupted and asked: "What colour are my mother's eyes?" For a second he was perplexed. But then he understood the gist of the question and turned beet-red with embarrassment, realizing that he never looked her in the face.

We hear a lot about personalized medicine these days, but what people really long for is not personalized medicine, it's personal medicine. They crave a human connection: not just care, but caring.

As you head out into the world to forge long, successful, and prosperous careers, remember that the best medicine you can offer your patients is a listening ear. The best treatment you can offer them is a compassionate heart.

I guess my take-home message is try to treat every patient as you would treat your mother, or your grandmother – with dignity and respect.

You leave here today with great knowledge; now go out there and learn some wisdom from your patients.

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BOOK REVIEW

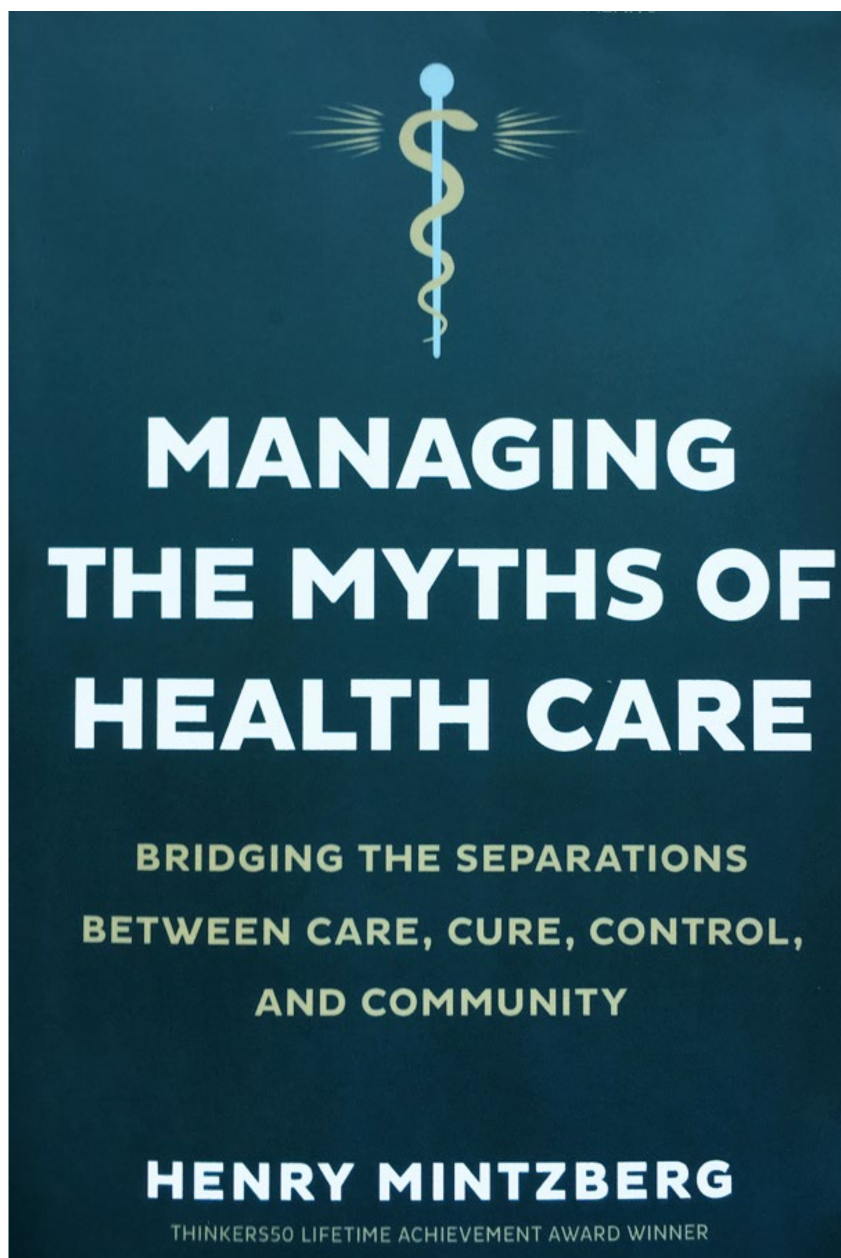
Managing the Myths of Health Care
Bridging the Separations between Care, Cure, Control, and Community

Henry Mintzberg
Berrett-Koehler, 2017

Reviewed by Johny Van Aerde

Henry Mintzberg, McGill professor and world-renowned guru on organizational management, has divided his new book, Managing the Myths of Health Care into three parts: a description of the nine myths of health systems, an explanation of how health systems are currently organized, and his suggestions on how to reframe the health system and its organizations to function better. One anticipates that this will be a controversial book when reading in the introduction, "From a systems perspective, the narrow knowledge of self-serving professionals is hardly better than the broad ignorance of disconnected managers."

The nine myths about the Canadian (and other) health care systems that Mintzberg describes are mental models that form barriers to the appropriate functioning of those same systems and organizations for the benefit of citizens and communities. Myth 1: We believe that we have a system of health care when we actually have a set of disconnected parts of disease cures. Myth 2: People are convinced that our health care system is failing. Yet, Mintzberg argues, when we suffer a heart attack today, we are much better off than we were half a century ago when medicine did not have much to offer besides death or bed rest. As for failing from a sustainability point of view, he submits that, as taxpayers, it is our reluctance to pay for more and more increasingly expensive services within a universal health



system that is largely to blame. Myth 3: Some believe that our health care institutions need heroic leaders. Instead we need more communities with human beings leading from the ground and providing collective efforts toward great leadership. Myth 4: Administrative engineering can fix the health care system. Mintzberg makes a good argument that all the restructuring, reorganizations, and regionalizations have not provided the outcomes we had hoped for (assuming that we ever predetermined what those outcomes should have been). Although Mintzberg comes from a business world of categorizing, calculating, and competition, he rejects the notion that health care organizations can be fixed by managing them more like businesses (Myths 5, 6, and 7).

The last two myths, 8 and 9, should form a great topic for dialogue across Canada, with two opposing positions: for the sake of efficiency and choice, health care is best left to the private sector; for the sake of equality and economy, health care is best controlled by the public sector. For the sake of quality and engagement, Mintzberg adds the plural sector, arguing that community matters in health care and is largely ignored in economics. Plural sector organizations, i.e., NGOs such as Physicians without Borders and not-for-profit institutions, such as Kaiser Permanente and Intermountain Health, tend to exhibit characteristics of deep engagement, quality, commitment, and loyalty.

Part two deals with how our health care system is organized, what differentiates its elements, and what, as a consequence, separates those elements. Health care is structured around the professional organization model, and Mintzberg explains how such organization categorizes, commodificates, and calculates compared with other models.

Part three, "Reframing," deals with possibilities as reflected in one of the opening sentences, "Reorganize our head instead of our institutions." Indeed, systems transformation starts with self and with our mental models. In this section, Mintzberg helps us think differently about systems and strategies, sectors and scales, measurement and management, leadership and organization, competition and collaboration. He reframes management as "distributed beyond the top" and "human beyond economic," culture as "caring before curing," strategy as "venturing besides planning," organization as "collaboration and communityship," and ownership as "plural and common alongside public and private." The last chapter deals with the obvious: that the health care system needs to be seen as a system beyond its parts and how our mental and cultural models prevent us from doing so.

This book is based mostly on stories, personal opinion, and Mintzberg's vast experience in the world of human organizations and management, which make it a good read. The first part with its nine myths provides ample of food for reflection and conversations in our communities. Parts two and three sometimes state the obvious and provide little information on how to implement the suggestions. However, no matter how obvious, Canada still hasn't implemented what Mintzberg suggests.

It is good to read from someone in the business world that health care is not straightforward business, but a different beast altogether. At the end, the questions remain. Are we, as a wealthy, developed society, willing to invest in health outside curing acute disease? Are we, as individuals, willing to take some responsibility for our personal health? Are we, collectively, willing to take part in and pay for developing and maintaining healthy communities? As long as we are unwilling to have a dialogue around these questions and answer them in the affirmative, the nine myths of health care will continue to exist.

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BOOK REVIEW

Matters of Life and Death Public Health Issues in Canada

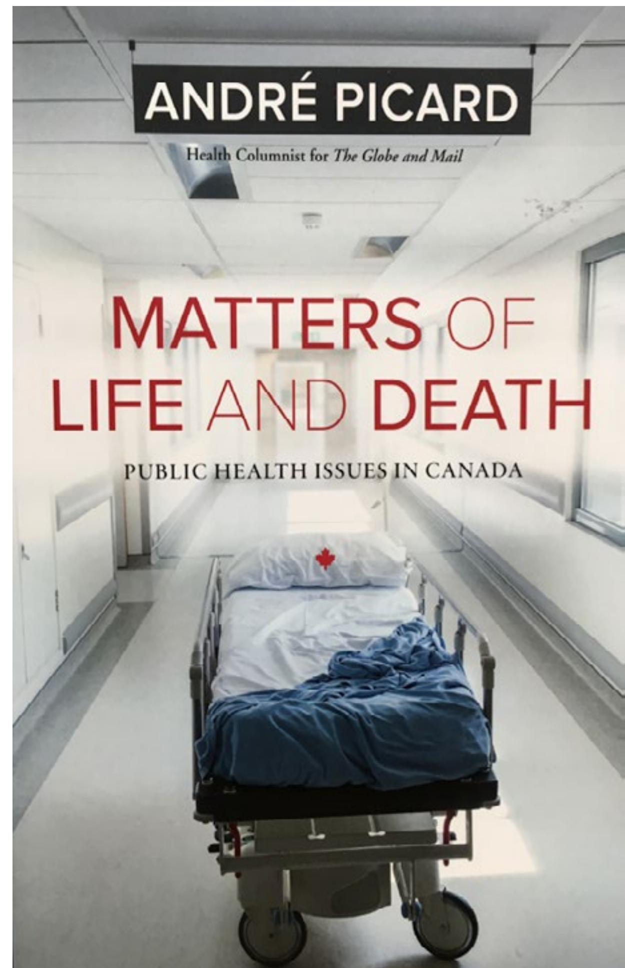
André Picard
Douglas and McIntyre, 2017

Reviewed by Johny Van Aerde

It was a mistake to finish reading André Picard's Matters of Life and Death in a few evenings, because each story should be read and reflected on slowly, one-by-one. The stories, which are slightly reworked versions of previously published columns, have been arranged into 14 chapters, each dealing with a different topic important to Canadians and their health.

Describing the topics of each chapter in this short review, or even focusing on a few favorite stories, would do disservice to the book. The first chapter on Canadian health care itself is, perhaps, the most interesting as it pertains to all of us.

Surprisingly, none of the tweets and reviews of the book have mentioned the introduction. In it, Picard highlights shortcomings in health reporting, and he warns us to be wary about interpreting health-related news stories and trying to distinguish between truth and half-truth or lies. He suggests that story selection, "black-and-white" reporting, and disproportionate attention influence patients' and consumers' perceptions.



He also points out the journalistic world's obsession with acute care and technology with little attention to low-key, long-term actions that have an effect on a much larger scale. He adds that the lack of critical thinking and content or source analysis further distorts our vision of reality. The warnings voiced in the intro contrast sharply with Picard's own style: he researches his topics thoroughly, reflects on them, adds his own lens, and then delivers stories in an understandable, non-partisan, and balanced fashion.

This is simply a must-read for everyone who is part of the Canadian health system. That means every Canadian. We believe that our health care system is part of our identity. We also know that it needs to change and improve, but many of us don't know what needs to change, and we end up arguing in opposite directions. That is why, as a start, we all need to read Matters of Life and Death, reflect on it, generate conversations, and take action for change. Without such conversations and changes, our health system is not sustainable. Thank you, André Picard, for giving us your columns to start these conversations.

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