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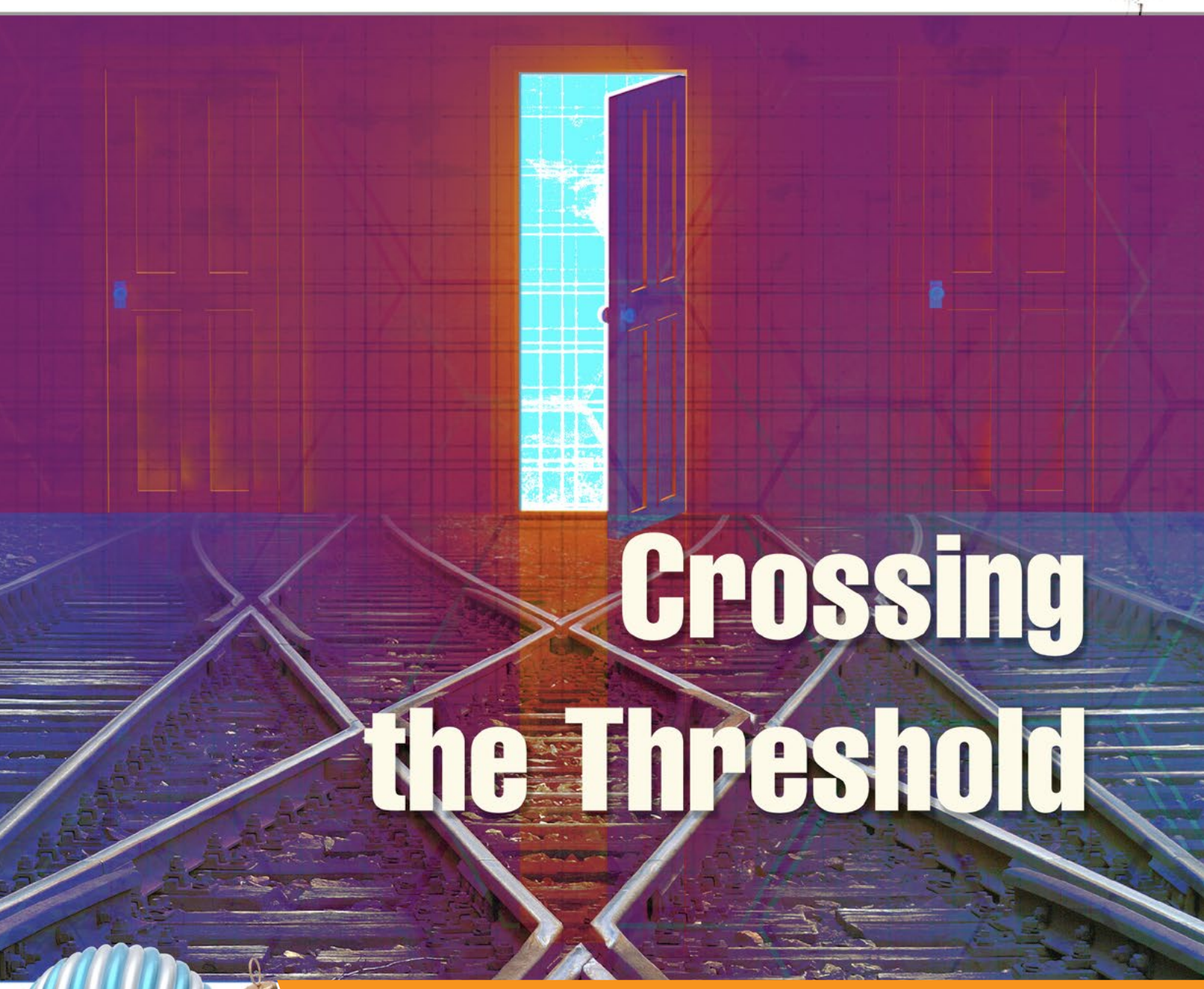

Crossing the Threshold

In this Issue

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

Contents

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EDITORIAL

How physicians can influence their “SCARF”

Johny Van Aerde, MD, PhD

How are the five elements of the “SCARF model” — status, certainty, autonomy, relatedness, fairness — affecting physicians’ responses to what is happening in the health system across Canada? How can physician leaders create conditions that keep threat and reward responses balanced?

Conversations with physicians during my travels across Canada, combined with daily health-related news, reports, and studies, show me first hand that many doctors have disengaged and can no longer be motivated to contribute to the much-needed health system reform. Although conversations between physicians and other stakeholders continue to be productive in a few pockets, in more cases, conflict has become overt, triggering incivility within and outside the profession.

Based on well-known survival-related brain reactions, the SCARF — status, certainty, autonomy, relatedness, fairness — model[1,2] offers, in part, an explanation for the increasing disengagement and change fatigue that can contribute to burnout. The model captures the common factors that can activate a reward or threat response in social situations, leading to positive or negative influences on an individual’s motivation. It draws our attention to the basic psychosocial aspects of human nature. Motivation that drives social behaviour is governed by an overarching, mainly subconscious, mechanism of avoiding danger and maximizing reward, using the same brain networks as our ancestors did to survive. A perceived threat to one’s status activates similar brain networks as danger to one’s life, and a perceived increase in fairness activates the same reward circuitry as receiving a monetary reward.

Status is about one’s importance relative to others. Over the ages, physicians have earned the trust and respect of society, and medicine remains one of the most respected professions.[3] However, the status of physicians is changing as knowledge, once exclusive to the profession, becomes shared with many through the Internet and other media. The increasing — reasonable and unreasonable — expectations of the public challenge the physician’s expertise and decision-making and trigger a threat response. Real or perceived attacks by some politicians further undermine the status of the profession. The increasing demands of performance reviews and outcome measures add to that status threat.

Status perception improves with public acknowledgement, particularly of efforts leading to improvements. Improvements often go unnoticed in Canada. For example, Canadians are unaware how much heart attack prevention and survival rates have increased in the last 50 years[4], and they know

even less about the many small, altruistic acts physicians perform for their communities. How can we as a society celebrate these improvements? Physician leaders, within their own groups and within their communities, can recognize and celebrate what doctors are contributing to our society. The perception of status can also be improved when physician leaders identify and draw on areas of expertise of physicians who then become engaged in health system change and receive recognition for their contributions.

Physicians have come to a point where they need to renegotiate their professional role, and the status that comes with it, as part of the social contract around stewardship.[5] It is up to physicians to choose whether they see that renegotiation as a danger or an opportunity.

Certainty deals with the ability to predict the future. The brain continuously looks for patterns and, if recognized, tries to predict the future based on which it can make decisions. Unfortunately, we live in a world that is volatile, uncertain, complex, and ambiguous. In it, physicians need to develop resilience and agility, including the capability to act both as disease experts for each patient and as stewards of the health care system.

Involving physicians in organizational strategies and planning or systemic redesign can help them regain certainty. How can physician leaders influence governments at all levels to engage doctors in the redesign of the various components of our health system, thereby decreasing the danger triggers around uncertainty? How can they influence their own colleagues to become engaged in the reform of the health care system? As the system will not change without physicians, they have to become engaged in innovation at all levels.

If physician knowledge and expertise are to be recognized, all physicians must take the initiative to reach out and engage on an interpersonal level and/or take a leadership role in an institution or community. Following several of the CSPL white paper’s[6] recommendations might also reduce the uncertainty threat for physicians, including becoming active champions for and partners in physician engagement and leadership development toward transforming the Canadian health system.

Autonomy provides a sense of control over events, a feeling

of having choices. A reduction in autonomy, or the perception thereof, can generate a strong danger response; however, it does not have to be like that.

For many years, physicians, because of their unique contractual relationship with the system, have reveled in their special status, which in many cases allows them to be independent business people and grants them significant freedom compared with other health care professionals. When reform happens, it inevitably alters the context in which physicians practise.

Physicians appear to have two choices: either become part of the process of reform in a manner that allows them to negotiate what the future system will look like or remain independent of it and accept whatever society negotiates for them. Taking the latter path is dangerous: in negotiation, if one side is not at the table, the other side will dictate the rules. Thus, physicians must challenge their own sense of independence and accept that how their time is allocated, how their work is defined, and how care is delivered will not be independently determined, but agreed on collectively.

Autonomy is part of stewardship, which is embedded in the social contract between society and physicians. Society provides physicians with autonomy, trust, self-regulation, monopoly, status, and rewards. In turn, physicians provide compassion, availability, and accountability, working for the public good with altruistic service.[5] If either society or physicians vary the terms in the contract, there is a corresponding, unavoidable variance by the other party.

Is physicians’ sense of change in autonomy affecting the way they see the social contract? Every time a patient is seen, an opportunity can be created to reshape the health care system. Physicians can do this by shifting the social contract equation in a positive direction to improve the relationship, not only with that patient, but also with society in general. Ultimately, this will create a positive patient experience, happiness, and system success. Physicians can do this only through the individual choices each doctor makes, every time they interact with a patient. It is up to physicians to renegotiate their role within a social contract and, in so doing, renew or redefine the autonomy of their profession.

Relatedness is a sense of safety with others and knowing that others are “alike” enough to be part of a social group. That relatedness is threatened from inside and outside the profession. On the inside, incivility is occurring, as described by Kaufman in this issue.[7] Opportunities for conversation among peers have also been diminished: attendance at medical staff meetings has been dwindling in many parts of the country; emails are the preferred mode of communication rather than a phone call or face-to-face conversation; and doctors’ lounges are virtually extinct.

How can physicians relate more frequently and in meaningful ways with each other, converse in person, have a cup of coffee together or a meal? How can physicians and physician leaders help each other as mentors or coaches or by creating support groups?[8] Working toward each other’s wellness and developing the skills to offer that support will contribute to less fatigue and, hopefully, reduce progression to burnout.

From the outside, physicians are pressured to work in multidisciplinary teams. By creating projects requiring collaboration, physician leaders can help all physicians develop skills to

engage others, be part of team building, and create a sense of belonging. Feelings of belonging and trust building can only occur in an environment of psychological safety.[9]

Fairness is a perception of equitable exchanges between people. Unfair exchanges generate a strong response in the part of the brain that deals with intense emotions, such as disgust.[10] Recent national events around tax unfairness and breaches of agreement in some provinces have increased the fairness threat among many physicians. Because the scope of involvement of doctors in areas affecting patient care and their own practice is much broader today than in the past, the boundaries of where and when physicians speak out about real and perceived threats to fairness have increased.

Physicians need to increase their level of involvement, starting with conversations on the purpose of our health care system and where physicians’ responsibilities start and stop. Without clear definition of roles and responsibilities, fair judgement on accountability is impossible, which, in turn, makes it difficult to build trust within the system.[11] This vagueness can add to the sense of unfairness, which can be attenuated by clarity about the responsibilities of all stakeholders.

In conclusion, as physicians have a unique position and responsibility in the delivery of our universal health care, efficient and effective reform cannot happen without their active participation. Physician leaders are well positioned to be “interface professionals,” who bridge the disciplines of medicine, administration, management, and leadership to fulfill the systemic fiduciary responsibilities to Canadians. Paying attention to the domains of SCARF might help physicians find balance between psychosocial reward and danger responses while redefining and renegotiating their professional roles within the social contract of the Canadian health care system.

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Five fundamentals of civility for physicians

Michael Kaufmann, MD

This is the first of two articles introducing five fundamentals of civility for physicians. Incivility in the health care system can have an enormous negative impact and consequences. In contrast, civil behaviour promotes positive social interactions and effective workplace functioning. This article focuses on the first two fundamentals: respect and self-awareness.

KEY WORDS: civility, definitions, awareness, respect, humility, CanMEDS roles

A medical student on a surgical rotation walks into the emergency department of a teaching hospital in response to a page for a consult from the attending ER physician. Seeing the student approach, the ER doc rolls his eyes and says, "If your resident isn't right behind you, turn around and leave now."

A busy surgeon, intent on his case in the OR, is frustrated when the nurse hands him the wrong instrument. He reaches across and snatches the correct instrument off the tray, pushing the nurse back as he does so.

A senior physician, convinced of his own good ideas and certainty of perspective, talks over his colleagues at a departmental meeting, diminishing their contributions.

Are these examples of disruptive behaviour? Possibly. Unprofessional behaviour? That might be a stretch, but it's easy to identify these behaviours as lacking in civility.

...an uncivil behaviour is one that lacks the attributes of civility, and incivility refers to a condition characterized by the absence of civility in social interactions.

Definitions of civility

The dictionary defines civility simply as polite or courteous behaviour. However, civility is more than that. Perhaps civility is most easily recognized by its absence. Everyday incivility has been described as seemingly insignificant behaviour that is rude, disrespectful, discourteous, or insensitive, where the intent to harm is ambiguous or unclear.[1,2] An interaction characterized by uncivil behaviour leaves one feeling uncomfortable, fundamentally disrespected, diminished, and ostracized. Civility, then, achieves the opposite effect.

Civility has many dimensions that involve the individual, as well as the communities and culture we share. According to Forni[3]: "Although we can describe the civil as courteous, polite and well-mannered, etymology reminds us that they are also supposed to be good citizens and good neighbors."

Davetian[4] says that civility is characterized by: "The extent to which citizens of a given culture speak and act in ways that demonstrate a caring for the welfare of others as well as the welfare of the culture they share in common."

A robust and useful definition of civility comes from the United States' Institute for Civility in Government[5]:

> Civility is about more than just politeness, although politeness is a necessary first step. It is about disagreeing without disrespect, seeking common ground as a starting point for dialogue about differences, listening past one's preconceptions, and teaching others to do the same. Civility is the hard work of staying present even with those with whom we have deep-rooted and fierce disagreements. It is political in the sense that it is a necessary prerequisite for civic action. But

it is political, too, in the sense that it is about negotiating interpersonal power such that everyone's voice is heard, and nobody's is ignored.

From the same source comes a reminder that civility is about respect and self-care as well: "Civility is claiming and caring for one's identity, needs and beliefs without degrading someone else's in the process."[5]
For the purpose of discussion in this and a subsequent article, an uncivil behaviour is one that lacks the attributes of civility, and incivility refers to a condition characterized by the absence of civility in social interactions.

The consequences of incivility

Incivility has a negative impact on the delivery of health care services at all levels: the worker, the health care team, organizations, and even patients and their families.[6,7] Individuals experience incivility as personal stress, distress, anxiety, depression, psychosomatic disorders, and burnout. Naturally, these people are hard pressed to live up to their productivity potential. Some people experiencing uncivil behaviour may, in turn, retaliate by directing unwanted and unhelpful behaviour toward co-workers and the organization itself.

Organizations pay a price for incivility, too. Persistent incivility in the workplace creates an environment that is psychologically unsafe and difficult to endure – one that creates worker unhappiness and under-performance, at the least, and drives people away, at the worst. Along with the psychological costs, incivility can also inflict striking fiscal costs on the organization, although precise calculations can be difficult to obtain.

Even small acts of everyday incivility can contaminate the culture of a workplace. Unaddressed and uncorrected, this can lead to an insidious infusion of risk and insecurity into the social environment at work creating a spiral of uncivil behaviours, reactions, and retaliations. The unstated, but actual, code of conduct becomes a code of incivility. If this condition is repeated in a sufficient number of related workplaces, such as health care institutions, entire professions can be culturally "tarred" as uncivil.

The impact of civility

Positive social interactions allow the development of strong and effective connections with others. Civil interactions at work identify co-workers and leaders as supportive and are, therefore, associated with enhanced seeking and exchanging of advice, increased professional efficacy, and effort.[8] Civility among colleagues is associated with lower rates of professional burnout.[6] Civil collegial relationships foster inclusivity and cooperation and can be energizing and empowering. Health care workers and patients alike perceive a higher quality of care in a climate of civility.[9]

One might argue that there is no need to discuss the benefits of civil behaviour in the workplace, or anywhere, for that matter. Everyone wants to be treated well. No one wants to feel hurt by an interaction with a friend, colleague, or co-worker. We all appreciate a workplace that is comfortable and supportive. Yet many, if not

most, medical workplaces include doctors whose behaviour has been identified as uncivil and labeled as "disruptive." These cases occupy a disproportionate amount of time for physician leaders and often result in referrals to physician health programs and regulatory colleges.

Embracing civility

It appears, then, that a civil approach to relationships in the workplace has merit, but there are many questions to explore. Is there something different about the culture of medicine – something that justifies incivility? Should all doctors be expected to behave in a civil fashion all the time, even in tense situations or difficult work environments? Is civility being sufficiently modeled and taught in medical training programs and beyond, if it can be taught at all?

Most doctors interact with others in a civil manner most of the time. Does this come naturally to them, or have they been trained in civil conduct? It is no longer enough for doctors to have the clinical knowledge and skills once thought to be sufficient for the complete medical practitioner. The kind of person the doctor is, how he or she interacts with co-workers, and how, together, they bring their technical knowledge and skill to the patient matter equally.

The CanMEDS framework[10] highlights a number of competencies required of the complete medical practitioner, including those of Communicator, Collaborator, Manager, Advocate, and Professional. Thus, when the many dimensions of civility are considered more closely, it appears that there are key competencies that can be learned and adopted to foster civil behaviour, even at times of risk. As such, the following are offered as "Five fundamentals of civility for physicians": respect others, be aware, communicate effectively, take good care of yourself, be responsible.

Respect

Respect can mean many things, but here, respect is a consideration of the way we regard others and ourselves. To respect is to recognize a sense of worth, to hold in esteem desired or admired qualities, to accept and acknowledge the intrinsic value of oneself and others.

Respect and civility are intertwined. It's easier to interact with others in a civil fashion when we view them with respect. And civil behaviour conveys our respect while fostering the same in those with whom we live and work. Civility, as a means of demonstrating respect, engages people in their work.[6]

Respectful relationships are fundamental to worker engagement, high-quality job performance, and, therefore, in the health care sector, the highest quality of patient care.[6,11] Thus, if respect is fundamental to civility, how can respect be kept foremost in our thinking? Is it possible to respect everyone, without exception? What is the role of self-respect?

In a good number of its practitioners, the culture of medicine has bred a style of aggressive self-assurance that can be interpreted as arrogance. Such doctors see themselves as heroic champions for patients and health care improvement. They launch themselves vociferously and belligerently against individuals and systems, speaking their "truth," heedless of those they trample in the process. Convinced that their own system of values is unassailable, they judge the motives of others at suspect. Despite the positive intent of these usually amazing and accomplished individuals, their approach is seldom respectful of the needs, status, and opinions of others. Arrogance does not convey respect and is not civil.

Humility: Respect and humility are also intertwined. A humble person has an open mind, recognizes his or her own limitations and is willing to consider other ways of being, thinking, and behaving. A leader who is humble will understand the appropriate use of the power their status confers. Humility allows for apology when needed. Even a modicum of humility in our manner can convey respect for others, engage cooperation, and help us effectively reach the same goals that a more forceful approach demands but fails to achieve.

It's easy to respect friends and colleagues we know well and, perhaps, admire. Still, a vigilant

approach that considers etiquette and healthy interpersonal boundaries will promote acts of everyday civility. Here are some examples:

- Be present. When in conversation with others, pay attention. Consider putting the smart phone aside whenever possible.
- Everyone needs personal space, both physical and psychological. Keep an appropriate distance in conversation, and don't pry or divulge too much about yourself uninvited. Make space for others to speak and contribute.
- Maintain professional dress and grooming.
- Be mindful of timeliness. Arriving and leaving meetings on time tells others that their time is as important as your own.

Showing respect toward colleagues we don't know well offers them inclusivity – a civil thing to do:

- Acknowledge them. Make eye contact. Smile.
- Learn their names, and address them by name.
- Engage in friendly conversation from time to time.
- Learn more about their role and duties within the organization.
- Invite their opinions when appropriate, listen carefully, and express appreciation toward them.

Special mention needs to be made of power imbalances and workplace relationships. Uncivil behaviour by those with higher status directed toward subordinates has a greater negative impact compared with such behaviour between peers.[6] Even unintended slights can convey disrespect and cause harm. And if intended? There is no valid pedagogy that supports shaming as an effective teaching or workplace engagement strategy.

A further complexity arises when it comes to people with whom we don't agree, or perhaps those whose opinions or values we don't share. However, there are still ways to show respect. Here are some suggestions:

- Assume positive intent. Generally, in any medical workplace everyone is working toward the same goal: positive outcomes for patients and their families.
- Seek to understand other perspectives by finding common ground and identify with that. Remember that colleagues and co-workers from other cultures, generations, and even gender are inclined to see things differently.
- Value the fundamental humanity and worth these colleagues and co-workers possess as members of our community.
- Respect the established systems and roles that govern and guide our work and our profession. Disdain for health care administration or regulations and scorn for its leaders is uncivil and unhelpful. If change is the goal, healthy participation, strategic advocacy, and sound leadership are the routes to take.

Perhaps the greatest challenge arises when dealing with someone who has bullied us or hurt us in some way. Even in this situation, civility is preferred over incivility – even if not everyone agrees. Self-respect is an important component of civil interactions with others in all circumstances, but in this instance, it is key.

- At the end of the day, reflecting on your behaviour when interacting with these individuals, think about how you feel about yourself – especially if you chose incivility.
- Understand the useful steps that can be taken from a procedural perspective in dealing with someone whose behaviour toward you in the workplace is hurtful. Gossip, disparaging remarks in clinical notes, email, or the press, and threats of retribution are not among them.
- Show leadership by demonstrating the kind of assertive communication and regard for others that you wish to be modeled in your medical community and culture. Others will respect and emulate that.
- Demonstrate self-respect and compassion by seeking advice

and personal support should you find yourself feeling distressed or victimized by the behaviour of others in the workplace.

Can respect and humility be taught and learned? That is a good question for discussion, but it is certain that the opportunities will keep on presenting themselves.

Awareness

A myriad of influences inform and shape our every thought, choice, and deed. Most are beyond our awareness, therefore, unconscious. They include our physical and emotional states, temperament, values, assumptions, beliefs, past experiences, attitudes, biases, cultural practices and prejudices, knowledge content and gaps, and much more.

Reflection and self-awareness help doctors examine many aspects of themselves that contribute to their thoughts, moods, and actions. Without this awareness, we function "mindlessly," and mindless interactions with colleagues and co-workers can sometimes lead to uncivil behaviour. In fact, mindlessness accounts for many deviations from professionalism that seem to occur more often when doctors find themselves in pressured, emotionally charged situations.[12]

Mindlessness can catch us up into negative emotional, cognitive, and behavioural patterns without our being able to intervene. Mindlessness also prompts shifting of blame and avoidance of personal responsibility. In short, when we are not sufficiently self-aware, choosing civil behaviour can be difficult; we might even do harm to ourselves and others.[13]

Mindful self-awareness: Hence, we see the connection to civility. Mindful self-awareness leads to accepting, non-striving, contented well-being – a "being mode" rather than a "doing mode."[13] Another description of mindfulness is a state of "could be," welcoming uncertainty rather than trying to avoid it.[12] Self-awareness is the moment-to-moment, non-judgemental recognition of what's happening within us. The goals of mindful self-awareness include enhanced expression of core values, such as empathy and compassion; the courage and ability to see the world more as it is rather than as one would have it; and the humility to recognize, tolerate, and embrace our "blind spots," or areas of weakness, while leveraging our strengths.[6,12] Awareness practices also open the door on sensitivity to others. We might wonder about how they are interpreting their circumstances and understand that they might not react in the same way as us, even in the same situation. We can respect others' feelings without taking them on to ourselves or automatically reacting emotionally to them. It is easier to understand how another might be challenged to behave in a civil manner if we accept that the same is often true of ourselves.

Cultural awareness: If the simple definition of culture is "the way things are done around here," then we need to pay attention to that as well. Our behavioural choices are influenced broadly by external norms and expectations, just as they are by our internal status and the behaviours of others. Civility is easier to choose if one is aware of the cultural influences, positive and negative, all around us. Kindness is good, meanness is not. Directive communication is acceptable under certain circumstances, profanity is not. Teaching by asking tough questions is fine, shaming is not. Humour is fun, sexist jokes and other forms of harassment are not.

Barriers to awareness: Barriers to self-awareness are numerous in medical training and practice.[12] Fatigue, dogmatism, emphasis on an overly "algorithmic" and literal-minded approach to clinical choices and behaviours (rather than on conscious, non-judgemental awareness and reflection) close the mind to relevant feelings and options. These practices in senior

physicians may be emulated by learners and junior colleagues, who then become unconsciously incompetent with respect to self-awareness, even as they develop exquisite competencies with respect to the clinical knowledge and skills of their specialties. In essence, learners are trained to behave in an uncivil manner.

Self-awareness strategies: Here are a few recommendations designed to help improve self-awareness:

- Keep a journal of reflective writing. Record thoughts and ideas, without censorship or judgement, about your reactions to events of the day, reflecting on what went well, or not, and how your personal realities influenced your choices.
- Learn and practise meditative techniques.
- Seek out trusted friends and peers with whom you can discuss your thoughts, feelings, behavioural choices, and reactions. Invite their honest feedback.
- Seek behavioural feedback at work in the form of regular supervision (from a department chief or other physician leader) or by using a 360° multi-rater survey tool specifically designed for this purpose.
- Seek out opportunities for group education and discussion that focus on relevant leadership, problem solving, and ethical practice.
- Mentor and be mentored by others who value self-awareness practices.
- Employ the services of a suitable professional coach. Coaching is an increasingly available tool to help define one's personal and professional goals, enhance motivation, and reinforce positive choices to attain those goals.
- Sometimes professional counseling is a good way to enhance self-awareness in a more clinical and in-depth way.

In the heat of the moment: Is it ever acceptable, as a physician, to be uncivil toward colleagues or co-workers? Some say it is, especially when the physician is in charge of a patient's care in a life-and-death situation. They are usually referring to a communication style that is firm, even forceful — not necessarily a bad thing. However, few condone the use of profanity in that situation. Moments of high tension can generate feelings of frustration, anger, or fear that can place civility at risk. Once aware of these reactions, the doctor can pause, then choose an assertive, directive, yet respectful, stance designed to bring out the best action from others on behalf of a patient in dire need and still leave co-workers feeling intact.

The goal of awareness, as it pertains to civility, is to render informed and conscious behavioural choice readily available. Then, an interesting thing can happen: when any one of us accesses civility, others seem to do the same!

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Crossing the threshold: physician leadership and liminality

Lara Hazelton, MD, MEd

In becoming leaders, physicians leave the familiar world of clinical medicine and assume new identities. Providing education and training in leadership may not address their reluctance to take on leadership positions if we do not also acknowledge the psychological processes involved in becoming a formal leader and the psychosocial phenomenon of liminality.

KEY WORDS: leadership training, leadership development, transition, liminal state

How often have you heard a physician colleague protest that he or she cannot assume a formal leadership role because of lack of training? It is a common justification for the discomfort many feel when contemplating a new position. In focus groups conducted by the Canadian Medical Association (CMA), participants spoke of feeling unprepared to assume leadership roles as they lack education in leadership.[1]

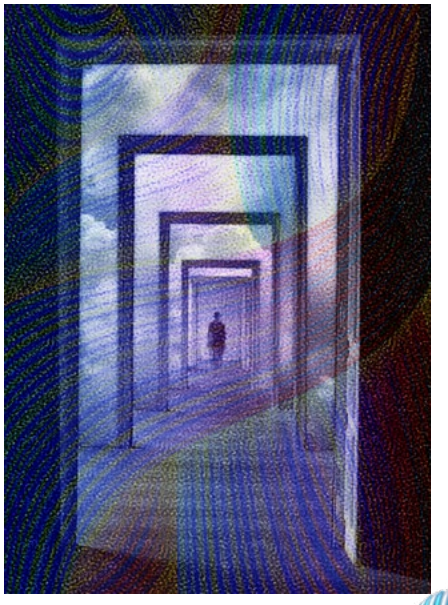
In response to this perceived need for more education, numerous programs have been created for physicians, and there is increasing emphasis on leadership education for residents[2] and medical students.[3] Yet, providing education and training may not address the reluctance of physicians to take on leadership positions if we do not also acknowledge the psychological processes involved in becoming a formal leader and the psychosocial phenomenon of liminality.

The meaning and impact of liminality

The term "liminality" comes from the field of anthropology where it has been used to describe the status of community members undergoing a rite of passage. It derives from the Latin word for threshold, the structure that is crossed when passing through a doorway from one place to another. In his 1964 article, "Betwixt and between: the liminal period in rites de passage," sociologist Victor Turner[4] wrote of liminality as both a state and a process of transformation. The concept has been extended beyond its original use in anthropology to describe the transitions between states experienced by individuals and societies across a broad range of settings. In their book, *Managing Transitions*, Bridges and Bridges distinguish between change and transition, the former being situational and the latter psychological.[5] Both pose challenges to organizations and individuals.

The term "liminality" comes from the field of anthropology where it has been used to describe the status of community members undergoing a rite of passage.

Understanding how liminality, identity, and role transition have an impact on new and aspiring leaders can help to account for challenges in engaging and retaining physician leaders. In becoming leaders, physicians may enter a liminal space, leaving the familiar world of clinical medicine and assuming new identities. As Skinner[6] writes, "Identifying oneself as a leader is another social role



that individuals can adopt, and one that is open to the personalized meanings that they ascribe to it" (p. 40).

Becoming a leader can resemble the transformations of identity that take place when medical students become residents or residents become independent practitioners. Although the imparting of medical knowledge and the development of procedural skills are obvious components of medical education, there is increasing recognition of the importance of professional identity formation during medical school and residency.[7] This process, which takes time to occur, is not easily quantified or incorporated into competency-based systems that rely on observation of behaviours to assess readiness to practise.

The transition to leader

What is different about becoming a leader is the lack of a mandatory process of training and licensing that legitimizes the new identity. Professional practice in medicine is regulated by colleges and legislation that determine who is qualified to call him or herself a physician. Although they do not entirely assuage the anxiety associated with transitions in practice, clerkship and residency serve psychological and social functions, with credentialing examinations acting as a "rite of passage," a common means by which cultural entities can integrate newcomers. Learners gradually gain both expertise and status through a process of legitimate peripheral participation that involves ever-increasing levels of responsibility and moves them from the edges of the community toward full participation.[8]

In general, leadership, whether formal or informal, does not have defined qualifications, processes of becoming, or codified certification. Whereas examinations and licensing provide a sense of having successfully completed a transition to full participation in the medical community, becoming a leader is more nebulous.

The liminal state has also been used to characterize those who exist between or on the margins of social groups or who inhabit multiple roles.[9] Often, the identity of leader coexists with that of physician in an uneasy and often contradictory manner, and, for those who continue clinical practice, there may be conflicted allegiances. These factors may explain why even those physicians who have undertaken positions of formal leadership still sometimes resist applying the term "leader" to themselves.

Embracing the discomfort

In our online Emerging Leaders in Academic Medicine (ELAM) program at Dalhousie Faculty of Medicine, we encourage participants to see the liminal discomfort associated with becoming leaders as something to be embraced rather than avoided. Through moderated discussion boards and webinars, participants are introduced to the idea that the liminal period presents an opportunity and space for the individual to undergo a transition of role and identity. Because the individual is between realities, there are psychological and social uncertainties that can be marginalizing and distressing, but they can also open up possibilities for personal innovation and growth. Uncertainty and insecurity are part of the educative process and are to be welcomed rather than avoided. Bridges and Bridges[5] write about the "emotional wilderness" of the transitional state, and caution: "You may be anxious in this no-man's land and try to escape… To abandon the situation, however, is to abort the transition… and to jeopardize the change"(p. 9).

Because transitions can be stressful, many societies have structures and rituals to bring together people who are undergoing a liminal phase.[8] In designing and implementing leadership development programs for physicians at our medical school, we have been deliberate in our attempts to create an online community of learners who are undergoing a similar process of leadership development. We also provide opportunities for new leaders to connect with more experienced physicians. Participants who complete our online program are invited to attend a leadership forum with senior leaders where opportunities for connection, such as "speed-networking," are an important component of the face-to-face programming.

Organizations, such as the World Federation of Medical Managers (WFMM) and its member

organizations (including the Canadian Society of Physician Leaders), provide worthwhile venues for recognition of training and credentials in leadership. There may be psychological as well as practical benefits for those who complete leadership programs and attain various forms of certification. Yet, although leadership education should seek to equip physician leaders, we should not judge the effectiveness of programming solely on satisfaction ratings that ask participants how prepared or confident they feel at the end of the course. For many participants, an awareness of feeling unprepared, while disconcerting, may not only be appropriate but also constructive. Leadership educators also need to be reflective when responding to the uncertainty and anxiety expressed by participants and remember that sometimes it will be helpful to thoughtfully explore the (expected) doubts and insecurities associated with taking on a new role rather than rushing in with reassurances or "tips and tricks" that do not promote deep learning.

For some, the desire to complete a program of training in leadership may be as much a means of gaining legitimacy and identity as it is an opportunity to acquire applicable knowledge and skills. Certainly, it is much easier to be engaged and effective in a role for which one has been prepared and gained a sense of mastery. Nonetheless, participants in any professional course should be encouraged to reflect on the possibility that after leaving the liminal space, the troubling uncertainties and questions that exist there may diminish and with them the opportunities for new insights.[5] As Alexander Pope has said, "Some people will never learn anything... because they understand everything too soon."[10]

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CASE STUDY

Engaging physician leadership in multi-hospital clinical information technology transformation

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Ten hospitals in southwestern Ontario, already sharing a common EHR platform, implemented computerized provider order entry, an electronic medication record, electronic medication reconciliation, and closed-loop medication administration including bar codes. The project leaders included many physicians and considerable effort was made to engage as many physicians as possible in every stage of the project. Adoption was excellent and, 3 years after implementation, data show significant patient benefits. Much of this success relates to strong physician engagement and leadership. However, even stronger physician leadership and more consistent engagement would have eased the transition for many physician users and might have resulted in even faster adoption. This article presents an outline of physician involvement during the project and lessons that may help others engaging in large-scale clinical transformations better plan their physician partnership strategy.

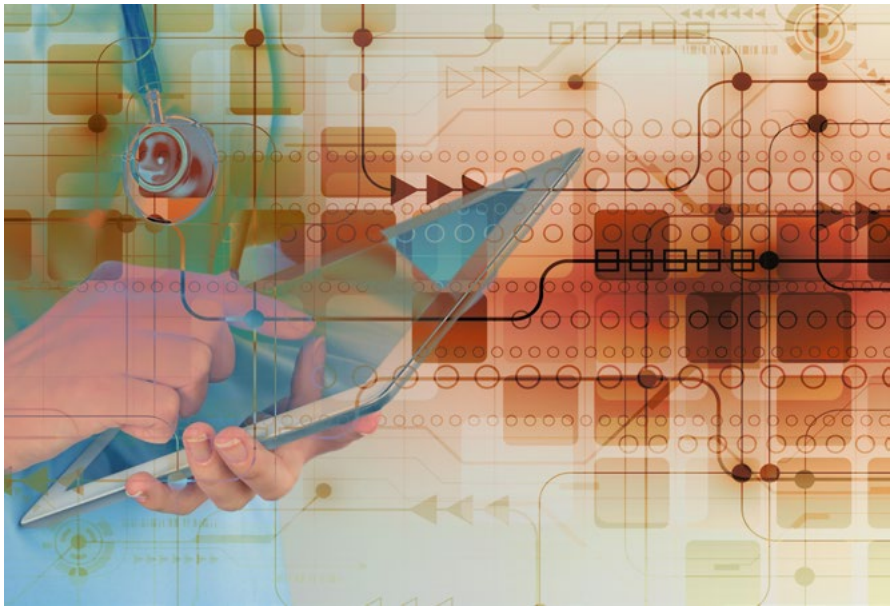
KEYWORDS: electronic health record, electronic medical record, physician leadership, physician engagement, clinical transformation

In the United States, the adoption of electronic health/medical records (EHR/EMRs) by hospitals has increased rapidly in the last 8 years. According to the Office of the National Coordinator for Health Information Technology, by 2015, 96% of non-federal acute care hospitals possessed a certified EHR system (i.e., had a legal agreement with an EHR vendor), representing a nine-fold increase from 2008 when that number was only 9.8%. Fully 83.8% of acute care hospitals had actually adopted a basic EHR system (i.e., a system meeting ten "essential" core functionalities, including clinician notes).[1]

In Canada, adoption of EHRs has been much slower. The Health Information Management Systems Society (HIMSS) scores the level of adoption of hospitals on a seven-point scale. Their EMR adoption data for Canadian and US hospitals show that 4.3% of the 5456 US hospitals in their database have already achieved stage 7, compared with only 0.2% of 641 Canadian hospitals. Even at lesser stages, Canadian adoption levels are much lower than in the US: 29.1% of US hospitals have achieved stage 6 compared with 0.9% in Canada; and 34.4% US hospitals are at stage 5 compared with only 3.6% in Canada.[2] Given the well-established safety and quality benefits of EHRs, the slow rate of implementation of these systems represents significant opportunity lost for our patients.

The HUGO project in southwestern Ontario

In southwestern Ontario, 11 hospital organizations had



previously formed a voluntary coalition based on a common EHR platform. In 2011, ten of those hospitals agreed to move their EHR adoption forward with a project to implement computerized provider order entry (CPOE), an electronic medication administration record, electronic medication reconciliation, and closed-loop medication administration including bar codes. The project, named HUGO (Healthcare UnderGoing Optimization), took place over 3 years, from 2011 to 2014, and cost $32 million (< 1% of a single year's budget for these hospitals). Over 6000 users had to be trained in the expanded EHR, including over 2000 physicians. Three years from the last hospital's "go-live," it is now possible to assess the outcomes of this significant expansion in the region's EHR.

From the beginning, the project leaders recognized that physician leadership and engagement would be one of the most important factors in the project's success or failure. A readiness assessment, undertaken at the largest hospital in the region, suggested that the "burning platform" for the change (i.e., improving quality of patient care) was well understood, including by physicians. However, expectations of success were not high, and there was evidence of change fatigue among many physicians and other professionals. Therefore, a decision was made to appoint a physician to act as executive sponsor for HUGO to clearly establish that this was a clinical project, owned and led by clinicians, and carried out to ensure clinical benefits for our patients.

The governance structure for the project included both clinician (non-physician) and physician advisory committees reporting to the Steering Committee. These committees frequently met together and provided leadership and advice on every aspect of the project from the point of view of the various health professions involved. The leadership team included physicians from several departments, who were funded to assist in implementation of every aspect from order set development to program build and through the implementation. Physician champions were identified in every department/division of each hospital and worked with their colleagues to promote the need for the change and to support physician involvement at every stage of the project.

Although all physicians involved in the project had to demonstrate Leadership, Communication, and Collaboration competencies, as described in the CanMEDS 2015 framework,[3] these competencies were particularly important for those providing project leadership. Using the LEADS framework,[4] the role of the physician project leaders was principally to "achieve results," whereas the physician champions endeavoured to "engage others." Every physician was invited to participate in critical stages of development, such as workflow analysis and design and order set development, thus fulfilling the CanMEDS Collaborator role.[3]

By the time the project was implemented, about 50% of full-time hospital physicians had been involved in it, in one way or another. Throughout the project, a full-time communications consultant ensured the dissemination of frequent region-wide and hospital-specific bulletins, web sites, and messages, including physician-specific strategies. Project physician leaders, including the executive sponsor, traveled the region to ensure that physicians at every site

had opportunities to meet with them frequently, as they presented progress, answered questions, and attempted to allay concerns.

As issues arose among specific groups, project and physician leaders met with those concerned to listen, provide data and literature, and, in several cases, arrange visits to US centres with a similar system already implemented, so that our local users could assess for themselves the impact and outcome of the proposed changes. At the same time, the Medical Advisory Committees (MACs) of all ten hospitals agreed that use of the system would be mandatory for all physicians and amended their policies to ensure compliance after implementation.

Acceptance of the system was high from the beginning for nurses and allied health professionals, but slower for physicians.

The go-lives at the ten hospitals (14 sites) were staged over 6 months with short gaps of 2–3 weeks between each to allow the implementing team time to resolve issues and prepare for the next launch. In the weeks immediately preceding each go-live, nurses, physicians, and other professionals received profession-specific training on the new system. "Super users," including many physicians and residents as well as nurses, allied health professionals, and students, were chosen from as many departments as possible and received additional training, so that they would be able to support other users in their department and others. In addition, a large group of nursing students was trained on the system as super users.

At each go-live and for some weeks following, the super users provided "at the elbow" support to users to assist their transition to the new functionalities. The nursing students proved so effective in this role – and the need for ongoing support, particularly for physicians, so great – that their engagement was extended well beyond the original intent. Every user was able to signal a problem via a dedicated HUGO "hot line," and help could usually be dispatched within minutes. All reported system problems were logged, triaged, and addressed in order of severity and urgency. Any reported system errors were tracked and subsequently analyzed to identify whether the system was at fault versus workflow or user issues.

Outcomes

Three years after the last go-live, medication error rates for almost all ten hospitals have substantially decreased. At the two largest institutions, the decrease is 35–40% in overall errors, with wrong patient/wrong drug errors decreased by 85–90%. Turnaround times for medication and laboratory orders have been substantially reduced. Although there was an initial negative impact on productivity, particularly for providers such as physicians, all measures of productivity have returned to at least their levels immediately before implementation, and patient flow in a few ambulatory areas may have improved.

Adoption rates are excellent. In our largest hospitals, about 85% of all orders are processed via CPOE, and successful scanning rates for both medications and patients are 85–90%.

Acceptance of the system was high from the beginning for nurses and allied health professionals, but slower for physicians. In a few departments, serious concerns were expressed initially about the intuitiveness of the system and its impact on productivity. The most serious concerns were expressed in our largest emergency departments (EDs). There, it was necessary to implement a 30/60/90-day program of rapid optimization to prevent a return to paper orders (which was, briefly, requested by physicians). Following success of that rapid improvement plan, the system has continued to be used in the EDs, and many of those physicians are now champions of further expanding the EHR to include even broader functionality (e.g., electronic clinical documentation).

A survey of users 1 year after implementation showed that nurses were generally very satisfied with the system. About 75% scored it as meeting their expectations for ease of use and functionality. In the same survey, physicians were less satisfied, with a substantial minority still finding the system not fully meeting their expectations. Nevertheless, none of the MACs in the ten hospital organizations has found it

necessary to use any sanctions to ensure compliance of physicians in using the system.

Lessons in physician leadership and engagement

The clarity of purpose achieved by having an executive sponsor who was a physician helped reassure physicians in the hospitals that this project and the resulting huge change to their practice were based on important clinical imperatives to improve patient safety and quality of care. Accordingly, although the executive sponsor was clearly functioning in the Leader role (CanMEDS[3]), attempting to ensure "systems transformation" (LEADS[4]) through this major change in health care practice, his most important function was arguably as a Communicator (CanMEDS[3]) who worked to "engage others" and "develop coalitions" (LEADS[4]) among physicians, between their leaders, and with other professional groups.

In hospitals where the Medical Advisory Committee was fully engaged and supportive, its chair played the same roles locally as the executive sponsor did regionally, further strengthening the clinical leadership of the project. The multiple physician leaders in the project structure, together with a strong physician advisory committee, provided further clarity and reassurance that physician input into designing and building the system was important. The uniform and consistent approach of the region's MACs ensured that all physicians would be held to the same standards of accountability wherever they worked in the region.

However, there was still some variation from hospital to hospital in engagement of medical and nursing leaders before and during implementation. As a result, transition to the new system was more difficult at sites where engagement had been weaker. Team culture also appeared to play a role. In cases where interprofessional relationships were strong, physicians received significant support from their nursing colleagues. In larger hospitals, there was also variation in engagement between departments or divisions, which again translated into more difficulty in adoption where fewer physicians had been engaged in building the new system.

For future projects, therefore, we plan to engage both medical and nursing leaders in our executive sponsor roles and support even more physician leaders within the project team. We will also more fully support physicians who help design and build the system as well as those who provide user support. This will include financial support, which was provided during the HUGO project only to physicians with the greatest time commitments. We will also better support physicians during their essential training.

Meanwhile, we have changed the governance of our e-practice committees to ensure that physicians become the main drivers of change and help lead all our planning for future EHR expansion. Finally, we will plan to have a part-time medical informatics lead in every large department in our academic centres during the pre- to post-implementation period. Training was another area where we learned much: generic training on system functionality is insufficient for physicians, whose practices vary significantly between specialties. Hands-on training using cases drawn from a physician's area of practice is much superior to generic training, and at-the-elbow support while the physician is actually using

the system is best of all. Our at-the-elbow super users were invaluable, but we learned that they are needed for far longer than we originally planned.

We also underestimated the importance of our trainees, both in pre-implementation engagement to ease their transition and in terms of their potential use as fast learners and super users. Our assumption that "tech-savvy" residents would transition easily was not completely true and resulted in difficulties in several areas of care. Moreover, we have subsequently realized that residents who are well trained and familiar with the system make excellent trainers for other physicians and we are now using this knowledge to facilitate our current training approaches for new users.

We also underestimated the impact of the change on medical students, both in terms of their role in electronic workflow and on the availability of residents and faculty as their teachers during implementation.

Conclusion

With strong physician leadership and engagement, ensuring use of important aspects of the CanMEDS 2015[3] and LEADS[4] frameworks, a major multi-hospital clinical transformation can be successfully accomplished with significant benefits to patients. However, our experience suggests that even stronger physician leadership and engagement, starting from the planning of projects through their implementation and beyond, would result in easier transition for physicians and other users and help ensure the most rapid adoption.

Multi-hospital EHRs with a full range of functionality promise real improvements in integration and quality of patient care. However, success in such projects depends on the breadth and depth of engagement of physicians. As described in the Institute for Health Improvement's "Framework for engaging physicians in quality and safety," this requires the discovery of a common purpose to improve patient outcomes, courage in leadership at all levels, and the involvement of physicians from the beginning.[5] Successful transformation can only be achieved if physicians are fully engaged in leading the development and implementation of these systems.

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STORIES FROM OUR CCPES

Effective communication is key

Rashmi Koul, MD

Editor's note: We asked CSPL members who have qualified as Canadian Certified Physician Executives (CCPEs) 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.

I feel strongly that a key factor in the success of physician leadership is to create good relations between physicians and organizations, which can only be nurtured with open communication and a shared vision.

My story in the health care system goes back to 1990 when I completed medical school in India. Even then, I had a passion for health leadership, but in those days leaders in the health care system were mostly non-physicians. Doctors were taught to go to the hospital before dawn, focus on the needs of each patient, and not worry about anything else. It was someone else's job to look into our needs. I had no idea how complex the health care system was until I began my leadership journey.

I received my CCPE in summer 2013 when I was lead physician for thoracic and central nervous system malignancies in Saskatchewan. Later that year, I interviewed for the job of medical director for CancerCare Manitoba's radiation oncology program. The interview covered many components of physician leadership, and I quickly realized how difficult the job was. However, I am able to provide insight and useful perspectives that are valuable even outside the scope of medical practice. As both a respected member of the community and a key player in the health care system, I have the opportunity to get involved and make a difference at many levels: individual, community, and society.

My leadership role at CancerCare Manitoba, as well as health care in general, has grown in complexity. I act as a bridge, filling the gaps between clinicians, managers, and organizational leadership. This is a big challenge as well as an unprecedented opportunity for me. I use various tools that I learned during Physician Leadership Institute courses, and one that has come to my rescue often is physician engagement and effective communication.

Effective communication is a key interpersonal skill that has many benefits. Communication is a two-way process, involving both how we send and receive messages. I learned that it's sometimes better to say nothing until you're certain that your actions will ring true. I learned to adopt strategies that are simple and easy to implement. I learned to make time for myself despite my busy schedule. Although emails serve a valuable purpose, in no way are they a substitute for face-to-face communication.

However, there are days when things don't work the way you want them to. Sometimes barriers, such as holding on to preconceptions or making assumptions and ignoring details or circumstances, create a poor environment. No matter how genuine, open, and honest you are, there will always be colleagues who will never be "on same page."

I learned to focus on issues, not singling out a difficult colleague. Over time, I have improved in terms of various skill sets. Poor planning, inexperience, stubbornness, and lack of vision are the worst enemies of a leader. Even if you fail, always choose to respond well. Sometimes moving on is not a bad idea.

I feel strongly that a key factor in the success of physician leadership is to create good relations between physicians and organizations, which can only be nurtured with open communication and a shared vision. I felt very humbled when the physicians in my department

nominated me for an award of excellence, as they truly felt that I am their honest voice. They felt that I have good skills in directing and motivating people and that I know how to interact with staff in ways that motivate them. That meant a lot to me.

I feel that my challenges are similar to those of any other leader, whether he or she is working in an integrated hospital delivery system, a large multispecialty physician group, or a small physician practice. Although the tactics may vary from one setting to the next, I believe that the core and broad roles that physician leaders need to assume will not change.

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STORIES FROM OUR CCPES

Learning leadership from errors

James Stempien, MD

Editor's note: We asked CSPL members who have qualified as Canadian Certified Physician Executives 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.

Most of my lessons on leadership have been learned from errors that I have made along the way. At times I've felt like a pinball bouncing from crisis to crisis, doing most of what I'm supposed to do – just a bit past time. Most of my errors have been correctable and excellent exercises in humility and enlightenment.

Back in 1992, I was medical director of Ialibu District Hospital in the Southern Highlands Province of Papua New Guinea. "Director," of course, as I was the only physician, not only in the hospital but also in the entire district.

These were great times: the hospital had been without a physician for about 2 years. When I arrived, most of the wards were closed except for intensive care and obstetrics. No visits had been made to the surrounding clinics over the same period, and the dog associated with the doctor's house had been left to fend for himself.

So much to do – surrounded by quality issues, it was heaven for a young wanna-be medical leader. We fed the dog, he vomited. I tried to use the phone; the lines had been cut some time before. I ordered meds, and realized our pharmacy was almost bare. Much to do, much to do.

The staff were eager to get the hospital up and running; the nurses, lab, and grounds staff were proud of their home hospital, but the lack of funding was very apparent. To see such a large hospital – with a potential of around 200 beds – virtually closed was perplexing. The medical, surgical, tuberculosis, and leprosy wards had been closed over the past 2 years and the patients sent home to wait for further instructions.

The problem was the toilet. When the hospital was built about 30 years before, it had multiple wards and a massive pit toilet with a rainwater shower and privy built above it. As in many health care regions, infrastructure is one budget, ongoing maintenance another; there had been none for the latter for quite some time. The massive pit toilet was full and unusable. To open the other wards of the hospital would require a new big pit, and this would require a major infrastructure project and a new structure standing over it.

To me, the first step seemed simple enough: we needed stuff, so I would get stuff. I wrote the provincial deputy health minister, outlining the problem, asking for support in terms of a crew, tools, and building materials. But I was told money was tight; the deputy health minister seemed uninterested. I was advised it was best to wait for him to decide when to repair the toilet and open the hospital wards, but no timeline existed, and, to be honest, he hadn't even heard about the problem before I mentioned it.

Over the next few months, I worked with the local staff to develop a plan. We needed shovels and cement and would have to come up with the funds ourselves. In the local tradition, anyone requesting an x-ray without a clinical basis would have to pay for it. Our local radiology technicians kept the money in a locked box in a locked room. We kept close watch on the funds and, over the next few months, accumulated enough to buy the needed supplies from a cheap nongovernment source.

One of the nurses had done a course on the design and safe

placement of pit toilets in the local environment. Our carpenter could design the building, and almost everyone had some carpentry or building skills, as they would have built their own homes.

The large hole was going to be the main part of the project. It was going to be about 3 m across and deep enough to function for many years. Any digging would have to be done by the hospital staff. Although we had a groundskeeper/security/maintenance person, we were planning a very big hole and it would take a long time with one shovel.

After much discussion, we planned a full day off for all hospital staff, a general digging day. It would have to be a day when all the staff were in town, neither a Monday nor a Friday as stragglers from home and early leavers would be affected. A Wednesday was chosen, clinics were canceled, food was planned, teams were organized so the digging would be continuous. Extra dirt would be carried to the edge of the hospital property by people not adept at digging. Lots of discussion of which clothes to wear and whether we could use the hospital laundry to wash personal clothes dirtied doing hospital work. "Of course" was the answer.

The morning was set, the crowd was arranged. I lived about a kilometre from the hospital and walked over a little after 8 am. It was raining, but I didn't think much of it, as it often rained in Ialibu. When I arrived, all hospital staff members were assembled in our main meeting area. Lots of chatter was going on and lots of cups of hot beverages were being passed around. Tea, coffee, or Milo, a local favourite. The rain came down a bit harder, so I poured a cup for myself and chatted to the staff.

Not wanting to appear too obsessive, I figured I would let the local leaders be the first to start digging, but I astutely noted after a while that little was happening and second or third cups of hot beverages were being poured.

Rising up on my hind legs like a young Churchill, I mentioned that it was "time to start digging for the benefit of us all." The faces of the staff were incredulous. "Impossible, it was raining," "too hard to dig in the rain," "Doctor, we can wait until the rain stops."

I was irresolute. This was our one big day for the dig, it always rains in Ialibu, and I've seen people work out in the rain all the time. But the local staff didn't seem excited to go out and work in what was now a small downpour, and I didn't blame them. I'm a young doctor, not totally inexperienced, so I did the wise thing and had another cup of tea.

The rain continued, my mind fidgeted and so did my legs. It was decision time. I was the hospital CEO, chief of medical affairs, medical director, and the only physician, so I was allowed to make some decisions.

I grabbed a shovel and headed outside, a few of the local staff gently tried to stop me, "Doctor, maybe we can wait another day?" But after looking at the pluses and minuses of the local situation, dig now was the choice I made.

I headed out to the marked area and started to fill a wheelbarrow. I was wet; the rain was steady, but not hard, and a pleasant temperature. A few staff came out, initially with some minor protests but eventually grabbing tools and digging in. Soon all of us were digging, singing, working, and laughing; it was a hard day but at the end we created a big hole.

At the end of the day, we had a bit of a celebration with more cups of hot beverages out of the rain. We celebrated our hole and the teamwork that went into it.

A few months later the structure, showers, pipes, and toilets were all completed. At the official opening ceremony, speeches were made, a big meal was served, and some local dignitary who hadn't helped in any way showed up to receive accolades.

When you approach the hospital, it seems pretty normal: five cinder-block buildings surrounded by a fence with some barbed wire loosely arranged at the top. A few gardens exist on the grounds; the verdant mass of flowers in front of the obstetrics ward is fertilized by nurses burying placentas post-delivery. The four largest buildings are wards, all of which are now open, a small administrative building, and a beautiful new toilet and bathing structure.

What lessons did I learn? Successes and failures occur almost at the same time. The

progression to completion was similar to starting one of our older hospital vehicles: lots of noise and smoke, half starts, and eventually the engine turns over to a cheer and a round of applause.

Use your local expertise. Somewhere in that crowd there is someone with extra knowledge or some level of inspiration that will help us all to success.

Front-line workers know what is going on; trust them, talk to them. The people on the front line doing the job every day have a unique perspective, and their knowledge is vital to any success. Get their input, feedback, pissed-off ramblings, and respond and learn from them.

Have a plan B or C or at least be prepared to come up with one in a hurry. No matter how well you plan, there is no way to anticipate every eventuality. That's fine; a good leader takes that challenge and comes up with something.

Leaders lead from the front. World War I would have been a lot shorter if that was a military rule. It's too easy to put out our dictates or decisions and lie back in the glory of our own intelligence. It's much more satisfying to work with and learn from the people in your own organization.

Celebrate your success. Everyone needs a break and a pat on the back, especially me; take a few minutes and celebrate a small success. A meal, a few short speeches, and congratulations all around are a useful and meaningful thing.

It was a great toilet; I used it many times.

Author

James Stempien, MD, and his wife Heather spent a year in Papua New Guinea where their first child was born. Since that time, he has been able to learn by error in other leadership roles. He is currently the unified department head of Emergency Medicine for the College of Medicine at the University of Saskatchewan.

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BOOK REVIEW:

Mistreated

Why We Think We're Getting Good Health Care — And Why We're Usually Wrong

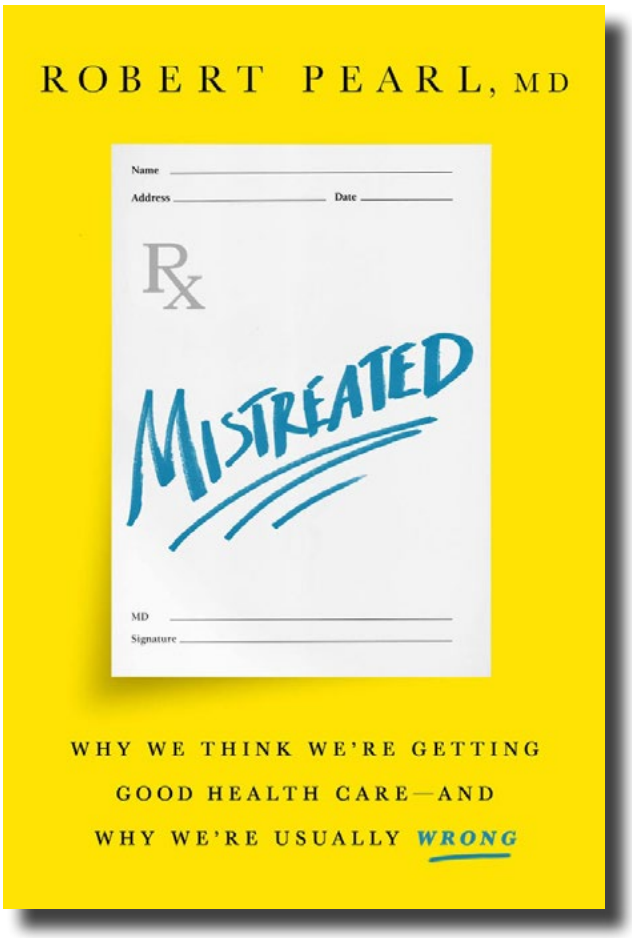
Robert Pearl, MD
Public Affairs, 2017

Reviewed by Johny Van Aerde

Robert Pearl is a reconstructive plastic surgeon at Kaiser Permanente, the CEO of the Permanente Medical Group, and a faculty member at the Stanford Medical and Business Schools. *Mistreated* is about our subconscious misperceptions of health and the health care system.

Although the book deals with the health care system in the United States, the issues also apply in Canada and to ailing systems in other countries. Canada and the US spend more on health care than any other nation in the world, yet, on almost every measure of quality, our outcomes rank in the bottom half among industrialized countries.

We know how to prevent tens of thousands of deaths every year from colon cancer, stroke, and heart disease, but we don't do it. And despite more than two decades of dialogue about patient safety, too many deaths continue to be a result of medical error, including hospital-acquired infections, medication mistakes, and poor communication among clinicians. Two decades into the 21st century, patients still cannot communicate with their physicians through secure email, make an appointment online, or receive medical care through a video visit within a comprehensive electronic health system. Until we turn our attention to addressing the way medical care is organized, reimbursed, technologically enabled, and led, today's problems will only become worse. Pearl uses many narratives and easy-to-understand research studies from psychology, neurobiology, and behavioural economics to support his points. He starts with the existing mental models and context perceptions of physicians and patients. He describes very well where some of these beliefs arose, what they are today, and what the barriers are to changing those models in the future.



He then describes legacy players, the industry and institutional leaders who use their position of dominance to serve their own interests, including maintaining the status quo or generating more of the same. The four major categories of legacy players that benefit from resisting major systemic changes are drug and device companies, physician medical associations, hospitals, and major insurers, which in Canada are represented by government and politicians.

Based on his experience at Kaiser Permanente, and having visited other international health systems extensively (he was also in Calgary for six months), Pearl comes up with four pillars of transformation:

1. Health care must be integrated horizontally within specialties and vertically across primary, specialty, and diagnostic care. This means that physicians will have to forego some of their independence. Striving for "operational excellence," the structure of integrated delivery systems would help maximize collaboration

and cooperation, making the provision of care more efficient and effective.

2. Health care must be prepaid, moving away from pay-for-volume toward paying for value and superior outcomes. Currently, physicians are paid mainly for dealing with the catastrophe of disease and little for preventing it.
3. Health care must be technologically enabled with comprehensive record systems, patient access to medical information, and the ability to obtain care using mobile and video technologies. Pearl sees comprehensive electronic health records (EHRs) as a flow of patient information in the entire system and across systems, not unlike the ATM system, which allows you to withdraw Euros in Madrid from your Canadian dollars account back home. The biggest resistance comes from EHR software companies, because ensuring compatibility and providing application interfaces are likely to eat into their bottom line. Pearl also proposes to reinvent the house call by electronic means, as it allows choice and is cost-effective and convenient. What about starting with patients booking their own doctor's appointments online?
4. Health care will have to be physician led, requiring more leadership training and development. Kaiser Permanente, a physician-led organization, is very strong in that domain: one of its slogans is "Every physician is a leader." Physician leadership development is expensive, takes time, and requires role models. Pearl adds that physician leadership also requires the skills to engage your heart, stimulate your brain, and trust your gut.

Pearl's four pillars complement Danielle Martin's six big ideas to improve health care.[1] Pearl talks about the need for a comprehensive EHR system and for physician leadership, two elements missing from Martin's book. Pearl doesn't address how to deal with the socioeconomic aspect of health care, while Martin covers the need for a basic income well. With only a small amount of overlap, Martin's six big ideas and Pearl's four pillars of transformation encompass the ten fundamental elements needed to achieve system transformation for better health and sustainability in Canada.

In summary, Pearl recommends integrating care so that it is coordinated and collaborative; requiring all information and data in patients' health records to be compiled into a single record as part of a comprehensive electronic system to prevent errors of omission; aligning incentives for doctors and patients through pay for value, not pay for volume or fee-for-service; and investing in physician leadership development. Change can happen, but it won't until all of us – doctors, patients, and citizens alike – demand it.

Reference

1.Martin D. *Better now: six big ideas to improve health care for all Canadians.* Toronto: Allen Lane; 2017.

Author

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BOOK REVIEW:

Medical Leadership

The Key to Medical Engagement and Effective Organizations

2nd edition

Peter Spurgeon and John Clark
CRC Press, 2017

Reviewed by Johny Van Aerde

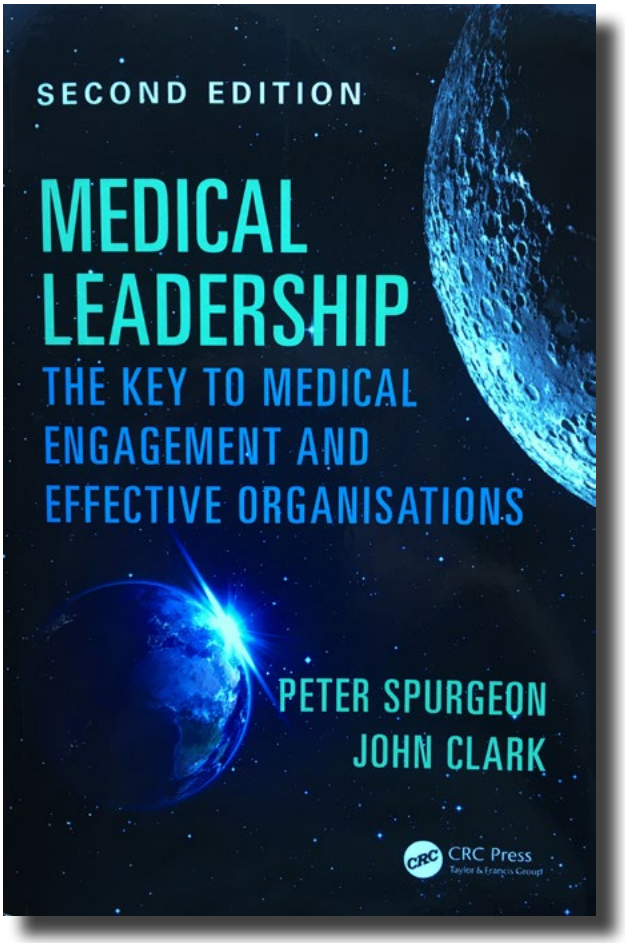
If you want to learn a lot about physician engagement, medical leadership and its competencies, and the effect of those factors on organizational performance and outcomes, then you have to read several outstanding chapters in this book. This second edition has changed considerably from its predecessor, *Medical Leadership: From the Dark side to Centre Stage*. Although two of the ten chapters pertain to the United Kingdom only, several of the remaining chapters are gems,

as they summarize extensive evidence from around the world, including research studies by the authors.

It is evident that fixing the health care system requires radical transformation, moving from a system organized around individual physicians to a team-based approach based on patients. Physicians must be central players in that transformation. After a few chapters covering content from the first edition, Spurgeon and Clark explain some of the root causes of the tension between physicians and managers and why performance management can be perceived as a threat to clinical autonomy.

Chapter 4 on roles and models of leadership is one of the best summaries on the topic available today. The description of shared or distributed leadership, essential for successful collaborative and multidisciplinary teams, adds two new dimensions to the construct: formality and leader–follower balance. Chapter 5 gives an outstanding overview of international competency frameworks for physician leadership development, and it is nice to see both Canadian models, CanMEDS 2015 and LEADS, included.

Chapter 6 provides solid evidence of the link between medical engagement and organizational performance. The authors go into detail on what engagement is and should be. They describe extensively how they developed and validated a medical engagement scale. From the literature and from their own studies, Spurgeon and Clark then provide plenty of evidence of how the level of physician engagement correlates with performance and innovation in health care. Briefly, working in an open culture, having purpose and direction, and feeling valued and empowered are, not surprisingly, characteristics of those in organizations with outstanding performance outcomes. Although our gut feeling would tell us that this is to be expected, Spurgeon and Clark provide the evidence to support it.



There is also a chapter on leadership in primary care. As in Canada, medical leadership development in the UK started among hospital-based physicians and later expanded to primary care physicians. Canada might learn from the good and bad lessons in the UK and choose a few elements for implementation here. The chapter on engaging residents in medical leadership is of less value for Canada, as the system of training and staff physicians in the UK is quite different from ours.

In summary, even though this book is not for everyone, the quality of the chapters highlighted above is outstanding. Many times, this reviewer paused to reflect on how some of the content could be applied to our health care system. It is clear that health system transformation and organizational performance are no longer about medical leadership alone. Physician engagement with the system is essential, and, without it, our health care system will have difficulty surviving.

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