Medical Leadership:
Striving for Equity (Part 2 of 2)

CSPL
Canadian Society of
Physician Leaders

SCLM
Société canadienne
des leaders médicaux

EDITORIAL

Diversity and equity in the health care system

Johny Van Aerde, MD, PhD

Without pretending to cover every aspect of diversity, this issue of *CJPL* builds on the previous one by expanding the scope of equity and diversity in the health care system and medical leadership. Despite the wide variety in topics – gender, generations, races, roles in academic and health care organizations – the following five integrated items offer commonality and can help us with the changes needed to increase diversity and equity.

- Be aware of and manage fear
- Remain vigilant regarding mental models, assumptions, and beliefs
- Practise the skills of real dialogue
- Create psychological safety
- Make interactions relationship-centred

Be aware of and manage fear

A recent opinion paper in the *New England Journal of Medicine*[1] stated that, "We fear things that we perceive as unfamiliar, unexpected and uncontrollable." Any effort to change has always been met with resistance, because change brings uncertainty and anxiety and it disturbs the comfort of the status quo.[2] We often anticipate the worst possible outcome and perceive greater diversity and equity as a risk or a threat. For the groups that have been dominant for a long time – men over women, white over other races, doctors over patients, heterosexual over other gender orientations, trainers over trainees – change can trigger negative reactions including fear, when the advantaged position is threatened by redistribution of power.

For all parties "threatened" by increasing diversity and equity, it

is paramount to be aware of the feelings and emotions triggered by those changes and to reflect on where they might be coming from and why. Only after that reflection will we be able to move on to the following steps.

Remain vigilant regarding mental models, assumptions, and beliefs

Both dominant and non-dominant groups are likely to carry biases, consciously and subconsciously. Diversity and equity for all can only be achieved when we fight all stereotypes that hold us back. Self-awareness, reflection, and self-management will help us identify mental models, beliefs, and assumptions that might cloud our thinking and prevent us from reaching our common goal.

Practise the skills of real dialogue

David Bohm, a quantum physicist wrote, "As with electrons, we must look on thought as a systemic phenomenon arising from how we interact and discourse with one another."[3] Dialogue is about exploring possibilities, gaining insight, and reordering our knowledge.[4] In a world of aggressive debate and attention-seeking shouts on social media, our society has lost the art of true dialogue.

The six rules for real dialogue were detailed in one of our previous issues,[5] and some of these are important here: be open and curious about others' perspectives and willing to change your thinking; be respectful and supportive by suspending judgement and preconceived beliefs; share the reasons behind your questions and statements; listen to understand and be alert for what else is possible.

Create psychological safety

Dialogue cannot occur without psychological safety, which relates to a person's perspective on how threatening or rewarding it is to take personal risks. Will new ideas be welcomed and built on, or will they be criticized and ridiculed? Is it safe to admit that you do not understand something, or will this lead to embarrassment?

Psychologically safe environments help create a setting conducive to learning. Positive feelings, such as trust, curiosity, and confidence, broaden the mind to help us build psychological, social, and physical resources. We also become more open-minded, resilient, motivated, and persistent when we feel safe. Humour and joy in work increase, as does solution-finding and divergent thinking – the cognitive process underlying creativity.[6,7]

Seeing a problem as a learning opportunity, showing curiosity, and having the courage to acknowledge fallibility and vulnerability contribute to building psychological safety. Speak human-to-human, asking yourself why a reasonable person would say or do certain things, while remaining aware of your own biases. Promote the practice of gratitude, which contributes to psychological safety and joy in work.[7] Take an interest in other people and ask, "How are you, *really*?"

Make interactions relationship-centred

Many of our interactions, including clinical interactions, can be seen as complex adaptive systems.[8] In

the case of the clinical encounter, the focus has shifted from doctor to patient-centred care. Although the purpose of health care is to respond to the needs of the patient, the process toward equity can be understood neither from a doctor- nor a patient-centred perspective,[9] but rather the explicit focus should be on the relationship between partners.

Regardless of whether we are in a clinical setting, when we aim to reach equity within diversity, the same principles of relationship-centred interaction apply: the relationship ought to include the personhood of each participant with her/his values, experiences, and perspectives; empathy and kindness are fundamental pillars of those relationships; parties influence each other reciprocally, even though one partner's goal may take priority; there is a moral foundation to develop interest in the other and invest what is needed to serve others.[8,9]

Equity and diversity, inside and outside the health care system, are about true partnership. To paraphrase the LEADS framework, it is about distributed leadership to achieve common constructive goals in a caring environment.[10]

Clearly, we have a lot of work to do.

References

1. Soklaridis S, Zahn C, Kuper A, Gillis D, Taylor V, Whitehead C. Men's fear of mentoring in the #MeToo era – what's at stake for academic medicine? *N Engl J Med* 2018;3 Oct. doi: 10.1056/NEJMms1805743

2. Bridges W. *Managing transitions: making the most of change* (2nd ed.). Cambridge, Mass.: Da Capo Press; 2003.

3. Bohm D, Edwards M. *Changing consciousness: exploring the hidden source of the social, political and environmental crises facing our world*. San Francisco: Harper; 1991.

4. Isaacs W. *Dialogue and the art of thinking together*. New York: Currency Doubleday; 1999.

5. Van Aerde J. Real dialogue: six conditions, six ground rules, three barriers. *Can J Physician Leadersh* 2017;4(1):3-7.

6. Delizonna L. High-performing teams need psychological safety. Here's how to create it. *Harv Bus Rev* 2017. Available: https://bit.ly/2wCd0t9 (accessed 20 Nov. 2018).

7. Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. IHI framework for improving joy in work. Cambridge, Mass.: Institute for Healthcare Improvement; 2017. Available: https://tinyurl.com/jdkc999 (accessed 19 Nov. 2018).

8. Tresolini C, Pew-Fetzer Task Force. *Health professions education and relationship centered care*. San Francisco: Pew Health Professions Commission; 1994.

9. Van Aerde J. Relationship-centred care toward real health system reform. *Can J Physician Leadersh* 2015;1(3):3-8.

10. Dickson G, Tholl B. *Bringing leadership to life in health: LEADS in a caring environment*. London: Springer; 2014.

Author

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

Correspondence to:
johny.vanaerde@gmail.com

This article has been peer reviewed.

Mind the gap: thoughts on intergenerational relations in medical leadership

Glen Bandiera, MD, MEd

Numerous models categorize, characterize, and explain differences among generations in society. Currently, four distinct generations are engaged in the physician pipeline from early training to late career. The distinct differences in how they view the world, their self-perceptions, and how they conduct relationships create real and imagined tensions. However, the significance of these differences is debated, as variability among those within a generation is likely larger than that between generations. Nevertheless, medical leaders and educators will be wise to develop an appreciation for generational differences to ensure that everyone may live up to their full potential. Opportunities exist to gain greater appreciation for how generational differences manifest in day-to-day interactions, adopt new approaches to interacting with those of different generations, and identify points of leverage across generations to optimize relationships and outcomes. Seizing these opportunities will require tough introspection and effort by leaders to overcome stereotypes and adapt to the challenges presented by those of generations ahead and behind them. This article looks at generational differences from a medical leadership perspective, offering observations and suggestions to address tensions in four domains: feedback, communication, collaboration, and problem-solving and lifelong learning.

KEY WORDS: Boomers, Generation X, Generation Y, Millennials, physician leaders, intergenerational differences

Roughly four distinct generations are currently engaged in medical careers: Traditionalists (born roughly 1925–1945), Baby Boomers (1946–1964), Generation X (1965–1980), and Generation Y or the "Millennials" (1980–1996).[1-3] Howe and Strauss[4] argued to both popular acclaim and criticism that these are recent iterations of a repeating cycle of generational "archetypes" throughout the modern history of the developed world. The cycle starts with a high point after a crisis, creating an idealistic "prophet" generation adhering to an optimistic view of what the collective can accomplish with new opportunity, conformity, and dedication. These are the Boomers. Generation X comprises reactive "nomads" who begin to develop a consciousness about the implications of blind conformity and the importance of questioning societal directions. They seek increasing personal autonomy and the erosion of institutional authority. The archetype of the "hero" typifies Millennials, who are more civic-minded and adhere to a need for

security and belonging fed by their overprotected childhood and a sense of impending "social unraveling." Still to rise within the profession (and also represented by the departing Traditionalists) is the fourth archetype, the "artist." People in this generation also had overprotected childhoods during a crisis and seek security through due process, order, and fairness for all.

Millennials entered the workforce during a time of unraveling with serial financial downturns, the rise of terrorism, and rapid advancement of technology. They are products of overprotective home environments...

The experiences of each generation drive the archetypal characteristics. For example, the Boomers emerged after the crisis of two world wars. Their strong adherence to conformity and social change drove the expansion of corporate America, the sense of company loyalty, strong nuclear family values, and the expectation that hard work, calculated sacrifice, and dedication pay off in personal affluence and well-being.

Millennials entered the workforce during a time of unraveling with serial financial downturns, the rise of terrorism, and rapid advancement of technology. They are products of overprotective home environments, they seek a strong voice in matters related to them, believe strongly in their potential to influence

people and outcomes, and see the power of the generation in the ability to collectively self-determine, rather than conform to existing norms. They have a strong affinity for sharing and collaboration. Manifestations of these perspectives, enabled by modern technology include the #metoo movement, the Arab Spring, crowdsourcing, and the long overdue increased focus on gender-based and other forms of equity within institutions.

One can see potential sources of friction between the generations. These may be amplified by the belief that each has in its own validity: while each generation self-identifies unique characteristics, with the Millennials seeing themselves as most distinct, each generation notably feels they are smarter than the others.[5] Millennials, although junior, feel that others have much to learn from them.

Although this framework might seem like a convenient way to make sense of professional relationships and related observations, it is important to consider dissenting views. Davey[6] outlines some risks of over-reliance on these models and encourages consideration of the individual first: "It's time to stop thinking about problems as 'generational issues.' If you have a problem with an entire generation, that's your problem and your prejudice. If you have a problem with one employee who happens to be of a different generation than you, then you have a problem with one employee, period." These cautionary words notwithstanding,

there is some utility in exploring further the role of generational differences in leadership.

Implications for leadership

As Boomers make up the institutional senior ranks and early Generation X members the established mid-career cohort, most medical leaders arise from these groups. In contrast, those being taught, mentored, and overseen are predominantly late Generation X members and Millennials from Generation Y. If stereotypes are to be believed, current leaders are tenacious individualists with a high degree of practicality and a strong work ethic, who believe that resources are to be individually managed and you get what you earn. They are providing leadership and mentorship to a generation of overprotected, empowered collaborators, who believe that no individual has a lock on anything and that power exists in sharing and collective ownership. The tensions are obvious.

There is also a well-articulated leadership gap in medicine.[7] Current physician leaders often took on sequential leadership roles out of necessity, a sense of obligation, or personal interest in making a difference through administration. Many learned about leadership on the fly, some adding formal education later. The currency for effectiveness is often personal impact and just portfolio stewardship. The allure of administration became muted as Boomers tended to hold on to power and influence, while

Generation X exploited skepticism about organizational hierarchy and their need for autonomy and flexibility to avoid taking on leadership roles. The current health care climate and seemingly unending operational challenges do little to encourage mid-career individuals to step up.

Millennials, on the other hand, are connected and well-mentored. They have an invigorated energy to see a better future, one that depends on them. They formally prepare themselves for leadership roles and pursue opportunities to gain experience. They are motivated by social consciousness in leadership.[8] The typical Millennial would think nothing of jumping over a member of the preceding generation to take on a plum role, something that would be almost anathema to a Boomer. Again, more tension.

Finally, one need only look to medical leadership advertisements to identify one key desirable: the ability to influence others.

This may pertain to one's impact on a group, such as setting a direction and achieving goals within an institutional framework, both of which require the ability to influence others and create alignment to a vision. Leaders are also expected to attend to individual needs through provision of personal mentorship, support, and advice, as well as creating an environment in which each and all can reach their full potential. An appreciation of generational differences and adoption of mitigating strategies will be key for success in both areas. Leaders are also often involved in mediating conflict between others experiencing these same tensions. Finally, generating consensus and commitment to certain directions within an age-diverse group can present challenges when differing perspectives cannot be reconciled.

So what to do? The following sections provide some ideas for turning generational tensions into opportunities for success.

Mind the "feedback gap"

As Busari[2] outlines, "While members of the Greatest Generation [Boomers] revere the institution of education as the source of all knowledge, conform to rules and regulations and tend to experience having failed if and when feedback is offered, members of the Millennial generation, and to a lesser degree the Gen Xers, thrive on immediate and continuous feedback, feel insecure without it and expect to be acknowledged based on how big their social network followers are." Millennials are so used to explicit feedback that they find it hard to make inferences about their performance in its absence. Nuanced and implicit feedback, through such means as body language, is often lost on Millennials, frustrating teachers who may assume the learner didn't listen or didn't care.

Leaders should remember that Millennials welcome feedback, rather than seeing it as an imposition. Feedback should be both more frequent and more explicit to effect change in a Millennial. In education, this is a key feature of the new competency-based models, which involve frequent observation and feedback. For their part, Millennials, accustomed to constant validation, must be prepared for what they ask for: as one advances in a career, feedback is less uniformly positive.

Coaching frameworks have been championed as ways to make

feedback more palatable for both participants: "Exciting research in recent years has moved medical education closer to an enlightened perspective on assessment and feedback. Robust assessment of learner competence and coaching for learner development are increasingly recognized as necessary partners in effective clinical education."[9]

Frequent, explicit feedback and coaching in leadership relationships will help Millennials feel more welcome and support their development. Getting to know and understand their perspectives through focused questioning will also help to bridge the gap and may result in a more senior leader learning how to best optimize a Millennial's role in the organization.

Davey,[6] writing from a perspective outside medicine, offers suggestions: "Where have you seen great ideas that we could apply here?" "What can you teach me that would help me keep up with the digital age?" "Given what you've just told me... what advice would you give me to make this work?" "What do you see as the strengths you bring to the team?" She concludes, "For most people,

young or old, seeing their ideas in action will reduce their resistance and start to bridge the divide."

Embrace different communication styles

Bernard Shaw reputedly said, "The single biggest problem in communication is the illusion that it has taken place." This rings truer now than ever. Many emphasize the importance of not jumping to conclusions about motives or character based on one's manner of communication.

One obvious example is technology use. Millennials grew up connected and are accustomed to instantaneous, abbreviated conversation segments. Older folks, less so. Citing Erikson,[10] "The crux of most technology-based team misunderstandings is not the technology per se – it is how team members interpret each other's intentions based on communication approaches."

Ellaway[11] offers a label in her paper, "The informal and hidden curricula of mobile device use in medical education," emphasizing problems with misguided assumptions about mobile technology. One should avoid assuming Millennials are detached or pre-occupied when they focus on their device; they may be involved in problem-solving or bringing others into the conversation.

A barrage of emails with explicit demands and expectations of a rapid response can seem intrusive. This, however, is how Millennials communicate with each other.

More senior leaders should set an early pattern of when and with what urgency they will respond to emails, advise when a response will be delayed, follow-up with a verbal conversation at a next meeting, or send an auto-reply something akin to, "I check emails infrequently, if this is urgent please call or visit my office."

E-communication may also seem impersonal or distant to an older generation, sometimes to the point of offense or worry about the lack of interpersonal contact. Those afflicted should reassure themselves that this is a style issue rather than a personal slight.

Explicitly stating one's communication preference may help, as Millennials may not realize they have "permission" to approach superiors directly rather than digitally. Conversely, Millennials would do well to understand that tardy delays are not dismissive, as others are not tied to devices as they are. They should try to avoid feeling frustrated or rejected by a delayed response. Everyone in the modern workplace should develop multi-modal communication strategies suited to purpose.

Accept greater collaboration but proceed with caution

Millennials were told their opinions matter, they should express them freely and they would be listened to. This generation is, thus, very collaborative and open with their opinions. They see knowledge as available for everyone, not something to be hoarded. Their

view is that real power lies in the collective and the ability to consult, engage, and involve others quickly and liberally.

In medical circles, these propensities play out in several ways. Millennials prefer to collaborate widely rather than take a sole role in academic endeavours, a practice that may make their CVs hard to interpret for more senior academics.[7] In a clinical teaching session such as questioning on ward rounds, seeking out information "on the fly" is smart to a Millennial but may be seen by their teachers as "cheating" or being underprepared.

Similarly, sharing information may have different meanings; Hopkins et al.[12] provide an excellent example of the tensions that may arise when Millennials liberally share information that their supervisor took to be protected. A key principle seems to be: encourage collaboration to maximize input and impact, but be sure everybody is comfortable with it.

Boomers and Generation X members would do well to become comfortable with embracing the democratization of information and increased open collaboration. Encouraging Millennials to share their strategies or to explain where and how they got information can have a positive effect on a relationship. Millennials should use caution when sharing information provided by their teachers and leaders and ask for permission or guidelines.

Think about problem-solving and lifelong learning differently

When problem-solving, the Boomer perspective would bring a small group of key individuals together in a formal, scheduled meeting to talk things through, whereas the Millennial perspective would involve more people accessed asynchronously and quickly via electronic means. Erikson[10] frames this dichotomy as such: "[Millennials may view] work as 'what you do' vs. 'where you go'" and asks some challenging questions: "Is someone who arrives at 9:30 necessarily working less hard than other team members who are there at 8:30? Is it okay for some members to work from alternate locations? Is adherence to time and place norms important for the team to accomplish its task? Is it viewed by some as an important sign of team commitment?"

Boomers should recognize that Millennials' reluctance to commit to structured meetings is not reflective of detachment or lack of commitment, rather it represents a different manner of engagement in which as many opinions as possible are valued and meetings are unnecessarily rigid in terms of both scheduling and structure. Leaders should consider creating some space for Millennials to collaborate in this way, perhaps between formal meetings scheduled less frequently. Millennials, in turn, should recognize that some initiatives must be contained to fewer individuals and check on the appropriateness of more general

consultation before engaging in it. They may also consider embracing the structure of meetings as a way to engage in the details of a topic and more fully appreciate the perspectives of others.

Boomers and Generation X

Given Millennials' expectations of rapid responses and direct interaction with their leaders, it might be advisable for leaders to create a forum for such interchange.

members are more likely to accept "packaged" education products with a firm plan and structure, and the focus is likely to be on learning facts and skills. Classrooms, lectures, traditional conferences, and reading papers and chapters resonate with them. Millennials typically do not respond well to some traditional instructional methods, such as public inquisition (being put on the spot in ward rounds), single-moded information sources (listen to the expert), and large group lectures with one-way communication. This has implications for faculty and organizational development.

Those looking to reach early-career learners should consider newer educational models, such as e-modules, flipped classrooms, and gamification.[3] Flipped classrooms involve providing learners with materials in advance and using an in-person environment to discuss issues, answer questions, and interact with the materials through such things as case studies, simulation,

and Q&A sessions. This may prove uncomfortable with previous generations who may be reluctant to "leak" the content and risk reducing the value-added of the session. Millennials can help by providing input into the design of interactive sessions, preparing as required in advance, and demonstrating appreciation for the perspectives of more experienced individuals.

Millennials are highly skilled at accessing information. So much so, that they fuss far less about remembering vast amounts of information than their predecessors did.[10,12] Erikson[10] refers to this generation as "largely 'on demand' learners" who "figure things out as they go." They will take advantage of their networks and electronic information sources to figure out a course of action and expect others to do the same.

Again, tolerance is foundational to creating a way forward. Older generations have had to face the reality that they cannot know or remember everything and should accept that Millennials are demonstrating how to manage information in a different way. The value-added by older generations may be to demonstrate how to be better curators or brokers of information, how to be appropriately critical of information, and how to use information to eventually make wise decisions.

Given Millennials' expectations of rapid responses and direct interaction with their leaders, it might be advisable for leaders to create a forum for such

interchange. Certainly having individual simultaneous email conversations with each member of a large group is not a palatable endeavour, nor are group email discussions that serve only to clog inboxes. Setting up a discussion forum or blog or setting aside time for open web-based sessions to discuss topics may be helpful strategies that allow leaders to manage their time while also providing frequent access to those they are leading.

Summary

Intergenerational differences are well described and, to a degree, real. Recognizing that interpersonal differences are still paramount and can be larger than group differences, leaders should consider how to use the described generational differences to advantage as they develop as leaders. The key principles for success seem to converge on the following: strive to understand, be slow to assume, validate perceptions, and look for common ground. These, along with some of the more specific strategies outlined in this paper, may be helpful to all within the profession as they struggle with how to best seek synergy among generations.

References

1.Boysen P, Daste L, Northern T. Multigenerational challenges and the future of graduate medical education. *Ochsner J* 2016;16:101-7.
2.Busari JO. The discourse of generational segmentation and the implications for postgraduate medical education. *Perspect Med Educ* 2013;2(5–6):340-8.
3.Evans KH, Ozdalga E, Ahuja N. The medical education of Generation Y. *Acad Psychiatry* 2016;40:382-5.
4.Howe N, Strauss W. Generations: the history of America's future, 1584 to 2069. New York: William Morrow & Company; 1991:538.
5.Taylor P. T*he next America: Boomers, Millennials, and the looming generational showdown*. New York: PublicAffairs; 2014.
6.Davey L. The key to preventing generational tension is remembering that everyone wants to feel valued. *Harv Bus Rev* 2018;16 July. Available: https://tinyurl.com/y8jwpmct
7.Blumenthal DM, Bernard K, Bohnen J, Bohmer R. Addressing the leadership gap in medicine: residents' need for systematic leadership development training. *Acad Med* 2012;87(4):513-22.
8.Waddell J, Patterson K. The servant leadership pin: bursting the generational bubble. In: van Dierendonck D, Patterson K (editors). *Practicing servant leadership: developments in implementation*. Basingstoke, UK: Palgrave Macmillan; 2018:211-30.
9.Watling CJ, Ginsburg S. Assessment, feedback and the alchemy of learning. *Med Educ* 2018;2 Aug. doi: 10.1111/medu.13645
10.Erikson T. The four biggest reasons for intergenerational conflict in teams. *Harv Bus Rev* 2009;26 Feb. Available: https://tinyurl.com/yb66fxc9
11.Ellaway R. The informal and hidden curricula of mobile device use in medical education. *Med Teach* 2014;36(1):89-91. doi: 10.3109/0142159X.2014.862426
12.Hopkins L, Hampton BS, Abbott JF, Buery-Joyner SD, Craig LB, Dalrymple JL, et al. To the point: medical education, technology and the millennial learner. *Am J Obstet Gynecol* 2018;218(2):188-92.

Author

Glen Bandiera, MD, MEd, FRCPC, is associate dean for postgraduate medical education at the University of Toronto. He was born on the watershed between Boomers and Generation X and adopts the perspective of either, depending on the day.

Correspondence to:
bandierag@smh.ca

This article has been peer reviewed.

PERSPECTIVE

What patients want: care that is humane as well as advanced

Judith John

In my long health care journey, I had outstanding care from knowledgeable clinicians with experience and skill. But I wanted to be treated like a person, not an array of symptoms, a problem to be solved, a case number on a chart.

It was a surreal moment. I was listening to my doctor explain that the Gamma Knife was no longer an option for my stubborn, dangerously located, and growing pituitary adenoma. That option, which we had talked about for more than four years, was not viable because the tumour had expanded so much that it was now located too close to cranial nerves, wrapped around my carotid artery, which would make the procedure dangerous. Instead, I was to have weeks of fractionated radiation

(another term to research and literally wrap my head around). Before I could even ask what that meant, he said we would need to start immediately.

I was surprised to discover that "immediately" didn't mean tomorrow. It meant 15 days later. And not because of availability or higher priority patients, but because it would take the radiologist and his team that amount of time to determine the appropriate course of treatment: dosage, location, patterning.

That was three years ago. Today, that hospital has an advanced computer that determines the correct radiation therapy with the same data input – but it takes 15 minutes instead of 15 days.

That's the power, and the thrill, of astounding scientific advances in health care – and all the extraordinary progress it can, and will, make. The frontiers are being advanced at a dazzling pace. Now surgeries can be less invasive, diagnosis can be remote, new drugs can impact results, robots can perform operations, treatment plans can be personalized, health apps can share information with a swipe.

The delivery of medicine and health care are definitely in the midst of a technological revolution. I'm not a scientist. I am a former hospital executive, a grateful patient with an inoperable benign tumour and a chronic condition, an advocate, and a storyteller. In my journey, I saw and experienced many examples of how all these sophisticated

tools to ease workflow, ensure patient safety, expedite treatment, and obtain better outcomes – successful as they are – often made clinicians feel robotic and dehumanized, distant, using technology as a shield, not a bridge.

Because although technological advances can *em*power, they can also *over*power. That's a real risk to compassionate patient care and a real factor in physician burnout.

I was struck by this recently when I was invited to give the keynote address – The Patient is a Person – at the Canadian Medical Association Health Summit in Winnipeg. It was an honour, especially as I was probably the only speaker without initials after my name. I was admittedly quite nervous, sharing the stage with and talking to people of great achievement.

However, I consider that the CMA is not actually about doctors. It's about doctors *and* patients. So my voice would be about experience, not accomplishment. And I'd tell my story to the group, just as patients tell their stories to their clinicians.

With jitters in my stomach and a sheaf of notes in hand, I watched the beautiful video produced to introduce the conference themes, and me. The conference focus was the dazzling future that technology would bring to medicine, so powerful words appeared onscreen: innovation, problem solving, exploration, artificial intelligence, hi-tech, investigation, solution, cure.

I remember a talented doctor, who was so absorbed in my MRI image on the computer screen that he never even acknowledged or glanced at me until I asked if he might want to take a look at me, the "packaging."

Then it was my turn to speak. I noted in my opening comments that although considerable time and effort created the handsome production, I was disappointed (but not actually surprised) that the video did not include a single word about patients: compassion, person, care, empathy. It was the perfect segue to the core of my message: that despite transformational technology, patients crave the humanity that comes from an empathetic caregiver.

Clinicians and professionals must bring knowledge, technical skill, *and* compassion to their patients. Because without compassion, there is no *care* in health care.

Our world is increasingly evidence-based and focused on the latest technology. Our system is overloaded and fragmented, obsessed with progress, process, data, and measurement. The value of relationships and communications has been diminished. Access from person to person can seem impossible. Clinicians can be MDeities, dismissive impatient explainaholics, who don't actively listen and are absorbed in technology rather than engagement.

And that's why concentrating on the person in the centre has never been more important. Because patients crave care that is humane as well as advanced.

In my long health care journey, I had outstanding care from knowledgeable clinicians with experience and skill. But I wanted to be treated like a person, not an array of symptoms, a problem to be solved, a case number on a chart. To be treated like a person with a disease, not labeled only by the disease. I often felt I was on a conveyor belt of excellent, pressured, and busy specialists. The system feels as if it has been developed around process, not people, and geared to getting patients in and out as fast as possible. Access to treatment was possible; access to humane care too often was not.
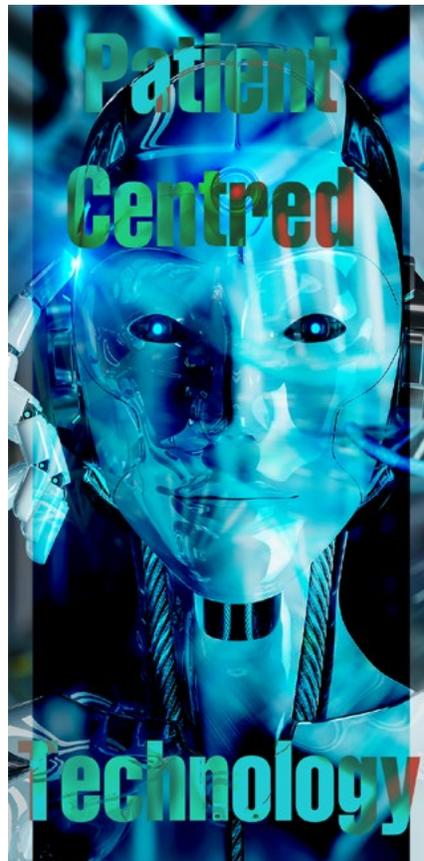
"Patient-centred" is a mantra in every clinical practice, in every health care organizational strategic plan, a plaque on countless hospital walls. Hecrteningly, glacial progress is being made, but the rhetoric still does not match the reality.

Getting to that reality relies on very basic steps. It starts by remembering what our parents taught us: treat others as you would have them treat you. Attend to all the small gestures that actually create our relationships and experience. Acknowledge the individual inside that blue hospital gown. Make every human interaction count, pay real attention, and offer genuine clinical empathy. Encourage and answer questions. Recognize that curing and healing are not the same thing, but that true caring will sustain the journey. Be kind, build trust, provide access, create bonds.

It also means moving away from high-tech, low-touch practice, which is so completely dispiriting and distancing. Eighty per cent of care is personal. I remember a talented doctor, who was so absorbed in my MRI image on the computer screen that he never even acknowledged or glanced at me until I asked if he might want to take a look at me, the "packaging."

We all crave care that is humane as well as advanced. And connection is important in both directions: for patients to feel there's a human not just a machine looking after them. And for doctors to be more engaged and fulfilled, less detached from the very reason they went into medicine: helping

people. This will restore that sense of purpose and passion for demanding, complex work in a relentless, challenging environment.

The massive power of technology is literally transforming every element of our world. What this advance will be able to achieve in the future is breathtaking and unimaginable. I also believe it needs to be harnessed with compassion. As Kai-Fu Lee[1] wrote, technology is "here to liberate us from routine jobs, and it is here to remind us what it is that makes us human."

No matter how extraordinary our tools, thrilling our knowledge, and dazzling our progress, the human relationship is the very heart of healing. The secret of care of the patient is caring for the patient.

Reference
1. Lee KF. How AI can save our humanity. New York: TED Conferences; 2018. Available: https://tinyurl.com/y75q65rf

Author
Judith John's career spans all aspects of communications, marketing, and public affairs. In the health care sector, she has served as vice-president communications and public affairs at the Hospital for Sick Children and as vice-president communications and marketing at Mount Sinai Hospital and Foundation. She is currently a patient advisor for the University Health Network's Partners in Care program.

Correspondence to:
judith.h.john@gmail.com

This article has been peer reviewed..

CSPL bi-weekly e-newsletter

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

Our e-newsletter reaches over 700 CEOs, department heads, chiefs of staff, and other health care decision-makers. Our "open" rate is almost 3 times the industry average and our "click" rate over 7 times the industry average.

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

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

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

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

Payment
Payment must be made by cheque payable to the Canadian Society of Physician Leaders or by credit card (please contact the office to process). Taxes not included in the prices listed.

INTERVIEW

Women leading change: perspectives on the Saskatchewan experience

Maria Ryhorski

A sea change is happening in Saskatchewan. Health regions have consolidated into a single authority, and the entire health system is undergoing a complete redesign informed by the people who provide care and the patients who receive it.

Helping lead this change is a group of dynamic women, mostly physicians, who fill key roles at health care organizations in the province: Dr. Susan Shaw, chief medical officer, Saskatchewan Health Authority (SHA); Dr. Janet Tootoosis, board member, SHA; Dr. Karen Shaw, registrar and CEO, College of Physicians and

Surgeons of Saskatchewan; Dr. Joanne Sivertson, immediate past-president, Saskatchewan Medical Association (SMA); Dr. Susan Hayton, director of physician advocacy and leadership, SMA; and Bonnie Brossart, CEO, SMA.

I had the privilege of sitting down with these health care leaders as they shared their experiences in rising to the top, discussed what contributed to their success, what they still struggle with, what excites them, and what they've learned.

Maria: *In this province, we have a particularly strong complement of women leaders. How do you think that compares to what you've seen in other sectors and other parts of the country?*

Dr. Joanne Sivertson: Honestly, for me it's never been about gender. It is far less important to me whether I am male or female

> **We're finally getting a chance to see women and their strengths. I also think women sometimes tend to be more collaborative.**

— and I was raised in that vein — it just matters if you're competent and interested and passionate and you do what you do.

Dr. Karen Shaw: I would echo what Joanne says. I never thought much about gender per se. I've always looked at the individual for the competencies they have and the passion that they've had to go forward. But, I think that we're doing well; for example, there are

six male and 12 female presidents and six male and 20 female registrars of the organizations that make up the Network of Inter-Professional Regulatory Organizations.

Maria: *It sounds like there's been a shift. What do you think has contributed to that?*

Dr. Janet Tootoosis: Things have become much more competitive in the sense that companies and organizations need to have the best person in the position; so, it really became about skill set and having the best person for the job. Gender, belief systems, your abilities, and your skill set have had to come to the forefront because it's a big market out there.

Dr. Susan Hayton: We're finally getting a chance to see women and their strengths. I also think women sometimes tend to be more collaborative. We have often played multiple roles over the centuries so maybe we have that opportunity to see ourselves and imagine ourselves in different roles and play supporting roles, collegial roles, maybe more so than men have been able to do.

Maria: *Has the environment in Saskatchewan been supportive for women or do we still have a long way to go?*

Dr. Susan Shaw: It's been crazy, crazy supportive. I'm not sure that it is different in Saskatchewan, but it feels like it is. We're small, we're relationship-based, and we have a history of supporting each other. We still have egos and all these other things, but I think we're

(top row) Dr. Susan Hayton, Dr. Karen Shaw, Dr. Susan Shaw; (bottom row) Bonnie Brossart, Dr. Janet Tootoosis, Dr. Joanne Sivertson.

able to find common ground – to get into a room together, have a meal together, solve a problem together, allow strengths to rise and give people opportunities. But I know that isn't everyone's experience.

Dr. Susan Hayton: Yes, it was quite different for me. I was the first woman general surgeon practising in Saskatoon, and at times it was difficult. I finished medicine in '85 and I did my residency in Calgary, and at that time no women could wear "greens." You had to wear a dress. If you wanted to wear scrubs, which some women were trying to do, you had to go around to the men's change room on the

other side of the OR. That didn't change until a woman walked into the change room and a man was standing there: a 65-year-old in his underwear. All of a sudden, that same day, greens appeared in the women's change room.

Now, it's much better than it was, but I think it's still harder for women. Things have changed a lot because men have changed, thank goodness. My spouse has been extremely supportive: we're equal partners and if I'm not there, he makes dinner, cleans up, and gets the kids organized.

Dr. Susan Shaw: I think about this all the time. Who here has not felt

guilt about whether you're in the right place at the right time? If you're at work, you're not at home, and if you're home, then you're not at work. If you love both – and it's ok to love both – then there's a conflict.

Dr. Karen Shaw: One of the biggest challenges for me, and most women in medicine, is getting that work–life harmony. I don't truly believe there's a balance, and if that's your goal, you're kidding yourself. But you have to be able to get a harmony that fits so that you don't feel like you're in the wrong place at the wrong time as Susan alluded to.

Dr. Janet Tootoosis: That reminds

me of a discussion I had with Bonnie at the CMA General Council around disruptive

Maybe disruptive innovation means changing the way we do things. For example, how do you meet your responsibilities as a leader?

innovation. Maybe disruptive innovation means changing the way we do things. For example, how do you meet your responsibilities as a leader? I'm talking about changing the way in which we do that so that it's amenable to someone who wants a family, to a woman who wants to have it all. Changing the process. Changing the travel. Changing the paradigm. There are ways that we can run companies, there are ways that we can see patients, and make an impact, and do all kinds of things without following the traditional paths in what was, before us, a male-dominated profession.

Maria: *What are some of the other challenges you have faced?*

Dr. Janet Tootoosis: I think I was the biggest challenge: wrapping my head around who I was, what I was going to do, where I wanted to go, and whether I could match that in real life. I would sometimes feel like somebody was faking my grades. Then I'd get a really bad grade and say, "Oh it's all good!" Whether you want to call it imposter syndrome or just building confidence – to be who you truly are, to be unapologetic, and to pursue your truth – and silence all those negative ideas or thoughts,

the self-doubt, and things that take you down rather than build you up.

Bonnie Brossart: I found that compounded when I took on my role as CEO at the Saskatchewan Medical Association, because now I was arrogant enough to think that I could lead an organization of one of the highest calling professions. When I thought of the community of physicians and their ability and their contributions to society, I wondered, 'What can I, as a non-physician, possibly give to this esteemed group of people?'

Maria: *I'm seeing a lot of nods around the table. Yet, in defiance of self-doubt, you've each risen in your careers. What do you think contributed to your success?*

Dr. Susan Hayton: It helps to have people support you. My dad did everything with me that he did with my brother. It was always assumed that there was no distinction between us. I think that's a great thing as a parent to let your child know that you back them. And later with your partner in life.

Dr. Karen Shaw: If you have a good, well-rounded upbringing – and I had exactly the same experience as Susan – I never doubted that I could do anything. If you have a sense that it's okay to experiment and try things, you get a lot of practice before you get into a real leadership position. By then you've had failures and you've had successes, and you've coped; the value of these things can't be underestimated.
Maria: *You need to be strong to tackle the challenges that come with your roles. Are there any other challenges that come to mind?*

Dr. Joanne Sivertson: I'm going to put something out there: I think a challenge is working with other women. I was a subtle leader early in my career, and my department, which was made up of women and one man, were happy to have me take that role. But once I became SMA president, there was certainly a lot more friction and more discontent.

Dr. Karen Shaw: There is the sign in the gym downstairs that says "Girls compete, women empower." There is that competition sometimes, for whatever reason, and you have to develop a thick skin early on. You have to feel confident in wanting to do something for the right reasons and not get distracted. You receive criticism sometimes, but if you learn to manage that criticism and look at it as feedback to try to improve things, oftentimes you can break down those barriers.

Dr. Janet Tootoosis: When you put yourself out there, you put yourself in a position for criticism, for people to lash out, perhaps unjustifiably. That risk is part of the leadership package. You need a thick skin and you need to understand that humans are humans. I think this happens to both genders. But I fully agree – when you put yourself out there, be ready to dodge!

Maria: *Janet, you're a physician of Indigenous heritage. Are there any additional challenges you would like to speak to?*
Dr. Janet Tootoosis: As we've already discussed, we don't put a lot of thought into being women, and so the idea of being a group

of women leaders stings a little bit. Why does there have to be that distinction? In my case, I never get introduced as a physician; I'm introduced as an Indigenous physician. And there's a lot of weight with that. That "label" is a big challenge because the expectation that I'm going to somehow contribute in a much bigger way for a large population that I have no real authority over, or even knowledge of for that matter, is unrealistic. I have my circle, my knowledge, my upbringing, my tribe, my spirituality, but why is that always on the table?

Maria: *This isn't the first time we've talked about labels, whether it's being labeled a woman leader*

instead of a leader or, taking it a step further, an Indigenous woman leader. It sounds like this issue has been a challenge for many of you.

Dr. Joanne Sivertson: My speech at the end of my presidency was about coming to terms with the fact that, even though I don't identify as a "female leader," people see me as that, and some people need to see me as that. They need women in these roles to feel like they can aspire to them. So, if I have to wear a mantle of "female-ship," I can do that. If you don't see me as a woman, but just as a competent leader, that's fantastic. But if you need to see me as a woman, then I'm the

"president in heels," as the medical students named me.

Dr. Susan Hayton: For my kids, and probably for anybody who has daughters, seeing you in that role makes a difference. Maybe they already think, "Of course I could do that." But when they see a woman like you in that role, it helps. That's why we want people of different ethnicities and races in these leadership roles, because people tend to think, "That could be me."

Maria: *You're each an inspiration – you have accomplished so much and are making real change for the people of Saskatchewan. What are some of the things you're working*

on now that excite you?

Dr. Susan Shaw: Well this health authority is pretty exciting! That's what I am spending most of my waking and thinking, and, actually, dreaming time on. How many people get to be part of redesigning a health care system? We have a long history, all around the world, of tweaking and testing but here we – everyone around this table – have been given the opportunity to make a difference in how patients have a voice and how physicians and patients partner together.

Dr. Janet Tootoosis: My focus has shifted to how I can support improvements in Indigenous health. From this privileged vantage point – in my work with the board and with all of you – and as a physician, I understand that the contribution health care makes to our overall health is maybe 20%. Your family physician and your access to acute care makes up that 20%, and there's all this other space that is really in your decisions, in your opportunities. How do we move this understanding upstream so that our Indigenous communities aren't overusing the system, so that the majority are not even in the system because they don't need it?

Maria: *The potential for positive change in Saskatchewan is staggering. Is there anything you've learned that you would like to share with the next generation of leaders?*

Dr. Karen Shaw: Often, when you first start out, you doubt yourself because you don't have all of the

competencies and you're trying desperately to gain them and become an expert in everything. So the lesson is, try your very best to gain all the competencies that you can, but the better solution is to surround yourself with good people. The more diverse the better.

Dr. Joanne Sivertson: I used to think that being a leader meant telling people what to do – you got out there and had your idea, so if you didn't have an idea then you shouldn't be a leader. I've learned that leadership has nothing to do with that at all. You don't need the answers. You need the right questions and to be able to amplify the voices of the people who have good suggestions. It's truly a huge privilege when people let you be their voice.

Maria: *How can we foster more leaders like you?*

Dr. Susan Hayton: One thing we have to do is not just encourage but reach out and try and pull people in.

Bonnie Brossart: We need more intentionality. All of us came from supportive families that said, "I believe in you." There were also moments in our careers where somebody said, "Hey, have you thought about this? I think you'd be good at it." That's what I think we have to do for others.

Maria: *Any parting words for the leaders who will come after you?*

Joanne Sivertson: Don't wait until you're ready. You'll never be ready. Just do it.
Dr. Karen Shaw: Prepare for

what the changing role will be for physicians. The advent of artificial intelligence and all these technologies that are coming at us are going to require a different role for physicians and a different leadership role. Get prepared to take on some of the things that women aren't usually involved in. The IT world is male-dominated, and yet that's where we will be getting a lot of the things that are going to change how we do medicine.

Dr. Susan Shaw: Work to your strengths. A strengths-based approach is so much better than any other way. Work to your strengths and learn where you need to grow. I think I was lucky to have had the opportunity early on to be able to do that.

When people give you a tap or a push, listen to them. Believe in them more than you would believe in yourself, because they can't all be wrong. If you're getting a message that you should give something a try, do it. Don't wait until you feel ready. You'll never be ready. If other people are giving you that message, maybe you should go, because who knows where you'll end up.

Author
Maria Ryhorski is a communications advisor with the Saskatchewan Medical Association.

Correspondence to:
maria.ryhorski@sma.sk.ca

This article has been peer reviewed.

LGBTQ2S+ diversity: leading and celebrating pride

Derek Puddester, MD

Organizations that actively promote diversity tend to be learning and practice environments of choice, excellence, and innovation. However, despite all our hard work and successful social equity efforts, discrimination still exists in Canadian health care and medical education. Leaders can influence diversity in their organization by taking four urgent actions.

KEY WORDS: diversity, LGBTQ2S+, health care, education, harassment, discrimination, leadership

Diversity promotes leadership success

The Harvard Business Review[1]

has identified diversity as a source of power, influence, and success that organizations ought to nurture and support. In particular, organizations that actively promote LGBTQ2s+ (lesbian, gay, bisexual, trans, queer, two-spirited, and other) diversity tend to be learning and practice environments of choice, excellence, and innovation. Promoting and enhancing LGBTQ2S+ environments are associated with three practical outcomes: recruitment and retention of top talent, improved quality of service and engagement with critical stakeholders, and enhanced creativity and innovation.

It simply makes good sense for Canada's health care and education sectors to develop best practices that leverage diversity and inclusion to promote excellent clinical outcomes and outstanding workplace health and wellness. Fostering pride serves all members of the health care sector well and sends a powerful message of inclusion to the communities they serve.

Canadians are rightfully proud: a brief primer on LGBTQ2S+ history

Canada is among the most advanced nations of the world when it comes to human rights. Indigenous peoples held cultural norms and descriptors long before that; the land on which we live, work, and practise is rich in respect for diversity, inclusion, and equity. Canada's post-colonial population declared same-sex sexual activity

legal since 1969 when then Justice Minister Pierre Trudeau declared: "There's no place for the state in the bedrooms of the nation." In 1985, section 15 of the *Canadian Charter of Rights and Freedoms*[2] came into effect, protecting sexual minorities from discrimination and, in the same year, the *Canadian Criminal Code* began to forbid hate-crimes against homosexuals. In 2005, Canada became the fourth nation on earth to allow same-sex marriage with equal rights for adoption quickly following.

Last year, Prime Minister Justin Trudeau, on behalf of the nation, formally apologized to the LGBTQ2S+ community, an apology worth considering carefully:

It is with shame and sorrow and deep regret for the things we have done that I stand here today and say: We were wrong. We apologize. I am sorry. We are sorry... To members of the LGBTQ2 communities, young and old, here in Canada and around the world: You are loved. And we support you. To the trailblazers who have lived and struggled, and to those who have fought so hard to get us to this place: thank you for your courage, and thank you for lending your voices. I hope you look back on all you have done with pride. It is because of your courage that we're here today, together, and reminding ourselves that we can, and must, do better. For the oppression of the lesbian, gay, bisexual, transgender, queer, and two-spirit communities, we apologize. On behalf of the

government, Parliament, and the people of Canada: We were wrong. We are sorry. And we will never let this happen again.[3]

Canada is, without doubt, a global leader when it comes to human rights and freedoms. But there is much more for us to consider, particularly in health leadership

Contemporary opportunities and challenges for the LGBTQ2S+ community

Last year, the Fondation Jasmin Roy commissioned a report[4] on the values, needs, and realities of LGBTQ2S+ people in Canada. One of the first contemporary studies of sexual minorities in the country, the foundation reported many critical findings, including:

- Generation and gender matter; there are more self-reported pansexual, asexual, and non-binary people among 15–24-year-olds, particularly women, than any other age group.
- Having safe spaces and assertive positive role models is associated with more positive mental and physical health outcomes.
- 45% of respondents viewed Canadian society as still not open to sexual diversity, particularly in schools and workplaces.
- 75% of respondents reported bullying in the workplace or educational setting (compared with 45% of members of sexual majorities); sadly, this seems to increase the more open a person chooses to be,

suggesting that tolerance, not acceptance, is a strong Canadian value.
- A vast majority of respondents identified the health and education sectors as having the greatest capacity to influence ongoing integration, equity, and fairness.

The report also concluded that members of Canada's LGBTQ2S+ community hold several core values in levels that distinguish them from the greater population: a great desire for fulfilment and authenticity and intentioned practice to find ways to express their true selves, a more developed creativity, which makes them more apt to think outside the box and adapt more easily, and heightened social and environmental awareness. This unique blend of authenticity, adaptivity, and social consciousness suggests that many members of the LGBTQ2S+ medical community have naturally developed leadership skills that can serve the greater good of the profession in Canada.

Opening medicine's closet door

A recent study[5] looked at sexual disclosure among sexual and gender minority students in the United States and Canada. Almost a third of them reported choosing to conceal their identity in medical school, with a marked difference between sexual minorities (67.5% out) and gender minorities (34.3% out). On the positive side, the rate of being "out" in medical school appears to have doubled in the past two decades.[6] However, much

work needs to be done to promote safety, respect, and inclusion for gender minorities. Indeed, almost half of respondents reported a strong fear of discrimination and lack of support, particularly during the matching process and in accessing mentorship and career advice.

In 2016, the British Medical Association[7] looked at the experience of lesbian, gay, and bisexual doctors in the National Health Service in detail: 70% of respondents reported being subject to homophobic or biphobic abuse, more than 12% reported at least one form of harassment or abuse and more than 12% suffered some form of discrimination. Only 25% of victims reported maltreatment to their senior leadership, and only 20% chose to seek resolution. This study also found that fewer than 40% described their place of study or practice as encouraging of openness, and 33% chose their specialty based on their belief that it would be LGBTQ2S+ friendly. Finally, respondents identified senior medical or clinical colleagues as the most likely people to initiate harassment or abuse, with the next most likely sources peers, non-clinical managers, patients' families, and fellow learners.

Tackling such complex issues will require more than legislation, policies and procedures, and codes of conduct. Developing and implementing named, staffed, and funded LGBTQ2S+ inclusion programs is a practical strategy used by many of North America's largest and most successful

enterprises.[8] These programs typically advise leadership teams regarding recruitment, professional development, network building, and succession planning. Not only do such programs promote diversity across organizations, they are also associated with improved problem solving, enhanced sustainability and collaboration, and establishment of the organization as an employer of choice. The BMA study[7] identified a number of practical action strategies for leaders to consider, such as ensuring that sexual-minority-themed diversity training is mandatory in all training programs, hospitals, and clinics; addressing bullying and intimidation of sexual minorities studying and practising medicine; and taking active part in pride celebrations in their communities.

Leaders may be well-advised to familiarize themselves with emerging best-practices in health care for the LGBTQ2S+ community. Rainbow Health Ontario (www.rainbowhealthontario.ca)

is a province-wide program of Sherbourne Health that creates and disseminates clinical and educational resources, conducts research, and informs health policy. Its "safe-space" symbols are exemplars worth posting in any clinical or medical education setting in Canada.

Valuable work has also been done by the Canadian Federation of Medical Students[9] on improving health care for LGBTQ2S+ populations. This study offers several practical suggestions to medical schools and teaching centres on promoting collaboration with LGBTQ2S+ peers and professionals, promoting excellence in the care of patients identified as sexual minorities, and ensuring a hate-free practice and learning space. The Royal College of Physicians and Surgeons of Canada[10] has an excellent bioethics case module on sexual minorities that leaders and leadership teams may find helpful. Canadian leaders may also find it useful to attend the Gay and Lesbian Medical

Association Annual Conference on LGBTQ2S+ Health at some point in their tenure; its focus on professionalism, system-based practice, leadership, and quality improvement may trigger useful insights and generate ideas for implementation at their home sites.

What will you do in your leadership practice?

I have served hundreds, perhaps thousands, of children and youth presenting with suicidal ideation, depression, anxiety, substance use, and trauma-related suffering. A disproportionate number of these patients are either questioning their sexual or gender orientation or have already identified as sexual minorities.[11] Even in Canada, with all our hard work and successful social equity efforts, children and youth suffer, some fatally, from homophobia. We must continue to make all sectors of our health care system sensitive, respectful, and welcoming to sexual minorities across the lifespan. This demands ongoing diversity training, monitoring, and quality improvement efforts.

I have also cared for many medical students and physicians over the past 20 years. Every year, I am asked by medical students about how "out" they should be during the CaRMS match. Physician-patients have shared stories about their experiences with discrimination, stereotypes, and lack of positive role models. Many disclose how their careers were curtailed or derailed in the absence of any clear feedback

about their performance or productivity, raising the possibility of active discrimination. Several felt forced, often under duress, to participate in "conversion therapy," i.e., an unscientific and unethical psychological and pharmacological "treatment" designed to reprogram their orientation to heterosexual and/or cis-gendered — a form of medical abuse that has been banned by many provinces and all major medical organizations.[12] These are but a few of the tragic stories that our learners and colleagues struggle with in contemporary Canadian medicine.

In that spirit, I encourage leaders to consider taking four urgent and important actions:

- Acknowledge that it is shameful that conversion or reparative therapy hasn't been banned in each province and territory and do everything possible to ensure that it is banned at your clinic, hospital, and university.
- Host a lunch-and-learn session for your leadership team to review Rainbow Health Ontario's fact sheets on bisexual, gay, lesbian, and trans health needs, and deeply reflect on your organization's capacity to meet and exceed them.
- Identify, appoint, and appropriately resource an LGBTQ2S+ senior leader in your facility and seek their advice on recruitment, retention, and celebration.
- Ensure that your organization promotes and participates in your local LGBTQ2S+ pride

celebrations: your community will be delighted with your presence and develop a deeper sense of commitment and connection to your mission.

Canada is, without doubt, a world leader in LGBTQ2S+ diversity. However, there must also be no doubt that hate, both conscious and subconscious, is very much alive. What are you doing to influence diversity in your institution?

References

1. Hewlett S, Yoshino K. LGBT-inclusive companies are better at 3 big things. *Harv Bus Rev* 2016;2 Feb. Available: https://tinyurl.com/hp46b9d
2. Equality rights. In *Constitution Act, 1982*, Part 1: Canadian Charter of Rights and Freedoms, section 15. Ottawa: Government of Canada; 1982. Available: https://tinyurl.com/y8uohkm2
3. Rights of LGBTI persons. Ottawa: Government of Canada; 2018. Available: https://tinyurl.com/yahaa6lh
4. LGBT+ realities survey: the values, needs and realities of LGBT people in Canada in 2017. Montréal: Fondation Jasmin Roy; 2017. Available: https://tinyurl.com/y876bxde
5. Mansh M, White W, Gee-Tong L, Lunn MR, Obedin-Maliver J, Stewart L, et al. Sexual and gender minority identity disclosure during undergraduate medical education: "in the closet" in medical school. *Acad Med* 2015;90(5):634-44. Available: https://tinyurl.com/y9cztpm8
6. Townsend M, Wallick M, Cambre K. Follow-up survey of support services for lesbian, gay, and bisexual medical students. *Acad Med* 1996;71:1012-4. DOI: 10.1097/00001888-199609000-00018
7. Experience of lesbian, gay and bisexual doctors in the NHS. London: British Medical Association; 2016. Available: https://tinyurl.com/ycg9cprm
8. Silva C, Warren AK. Building LGBT-inclusive workplaces: engaging organizations and individuals in change. Toronto: Catalyst; 2009.
9. Charles C, Haaland M, Kulkarni A, Webber J. Improving healthcare for LGBTQ populations. Ottawa: Canadian Federation of Medical Students; 2015. Available: https://tinyurl.com/y8r3m59h
10. Murphy TF. 2.4.5. Respect for difference – sexual orientation. Ottawa: Royal College of Physicians and Surgeons of Canada; 2013. Available: https://tinyurl.com/ycbargxf
11. Lesbian, gay, bisexual, trans & queer identified people and mental health. Toronto: Canadian Mental Health Association; 2018. Available: https://tinyurl.com/y94rg9yt
12. Gajdics P. I experienced 'conversion therapy' - and it's time to ban it across Canada. *Macleans* 2018;6 June. Available: https://tinyurl.com/yarcwllw

Author

Derek Puddester, MD, MEd, FRCPC, PCC, is an associate professor of psychiatry at the University of Ottawa. He is proud partner to his husband and father to their adopted son. He is very grateful to live in a democratic, inclusive, and innovative country that has been incredibly supportive. That said, he won't quite forget being called a faggot in medical school, listening to homophobic jokes in residency, fabulously checking off the box on a marriage license form as a bride and on a birth certificate as a mother (the other guy checked the only groom and father boxes). He is incredibly proud of his son, who sees his family as no different from any other.

Correspondence to:
drpuddester@me.com

This article has been peer reviewed.

Web-based resources for Canadian Leaders
Gay and Lesbian Medical Association: www.glaad.org
Association of LGBTQ Psychiatrists: www.aglp.org
Gay and Lesbian Association of Doctors and Dentists: www.gladd.co.uk
Rainbow Health Ontario: www.rainbowhealthontario.ca
Royal College of Physicians and Surgeons of Canada, 2.4.5. Respect for difference – sexual orientation: https://tinyurl.com/ycbargxf
College of Family Physicians of Canada, Resources: Gay and lesbian health: https://tinyurl.com/yayct7u2

Empowering women leaders in health: a gap analysis of the state of knowledge

Ivy Lynn Bourgeault, PhD, Yvonne James, MA, Karen Lawford, PhD, Jamie Lundine, MSc

We know that the road to leadership for women is arduous and the pace is slower than anticipated, despite their increasing representation in the labour force. In Canadian health care, where women constitute over 80% of the workforce, their representation in leadership positions is low. In our project, Empowering Women Leaders in Health, we apply a gender lens to achieve transformative systemic gender equity change in these contexts through the increased participation, visibility, and advancement of women in leadership positions. In this paper, we provide an overview of the needs assessment we conducted, which forms the basis for the larger project. Across the health care, health sciences, and Indigenous health literatures, we know more about the barriers to than facilitators of women's leadership. Where the literature describes an intervention, it is seldom evaluated. There is also a notable absence of information on how we can and need to engage men to be part of the solution and facilitate the inclusion of women leaders. The literature on women and Two Spirit leadership in Indigenous health is particularly sparse, which has produced an extensive knowledge gap in this sector.

KEY WORDS: women leaders, health care, health sciences, Indigenous health, Two Spirit, barriers, facilitators

Women hold a unique position in health care as they constitute over 80% of the health workforce, and their predominance in the field in Canada has been growing.[1] Yet women attain disproportionately fewer leadership positions in hospitals and other health care organizations. In the prestigious teaching and research hospitals in Ontario, for example, only five of 23 CEOs are women.

Women's leadership in health sciences is also critical to advancing scientific inquiry fostering the generation of new knowledge of unique interest to women. Here, too, women are less likely to be in academic leadership positions – deans, associate deans, and directors – and they are less likely to hold prestigious Canada research chairs.[2] Beyond these leadership roles, women are less likely to receive competitive Canadian Institutes of Health Research (CIHR) funding, and when funded they receive significantly less.[3,4] Women are also less likely to be first author, senior author, or authors of guest editorials in key medical journals,[5,6] which affects the translation of knowledge that women scientists generate.

Indigenous women and Two Spirit leadership in health care and health science reveals a similar gap contrary to pre-contact leadership roles. (Note: Two Spirit is a term used by some Indigenous communities to describe people who identify as having both a feminine and masculine spirit.) Since confederation, gender inequity has been enshrined in the explicitly patriarchal elements of the *Indian Act*.[7] We must design and support leadership

programs for Indigenous women and Two Spirit to respond to the calls to action of the Truth and Reconciliation Commission[8] to increase the complement of Indigenous health workers, who currently make up a mere 2.2% of the Canadian health workforce, in contrast to 4.9% according to the 2016 census. This increase will positively affect the provision of culturally competent and appropriate care to their communities and be a source of high-quality employment.

Goals

The overall goal of our project – Empowering Women Leaders in Health (EWoLiH) – is to achieve transformative systemic gender equity change in the health care, health sciences, and Indigenous health contexts through the increased participation, visibility, and advancement of women and Two Spirit leaders. We draw inspiration from the second recommendation of the United Nations High-Level Commission on Health Employment and Economic Growth,[9] which stresses that we need to "maximize women's economic participation and foster their empowerment through institutionalizing their leadership."

EWoLiH aims to build and sustain their leadership capacity through two interrelated objectives:

- Develop a strong and supportive network and community of practice among established and emerging women leaders, enhancing their capacity to make transformative systemic change
- Develop and implement evidence-informed tools for transformative systemic change through our network

In this paper, we provide an overview of a knowledge gap analysis, which forms the foundational basis of the larger project.

Methods

Three key sources inform this gap analysis. The first was a targeted search and review of the

published and grey literatures. The sources selected include 111 published articles and 48 grey literature sources. Although we take an intersectional approach in our project, focusing not only on women in general, but also Indigenous women, Two Spirit, women from visible minority backgrounds, and women with disabilities. The literature describing Indigenous women leaders, for example, is extremely limited; a review did not locate any articles specific to Canada and only three from outside Canada. One edited book, *Living Indigenous Leadership*,[10] was reviewed; however, it was not specific to leadership in health. As well, we were unable to locate any literature relating to Two Spirit leadership in health care and health sciences. As such, most – if not all – of our findings refer to only non-Indigenous women, unless otherwise stated.

Extraction of the key themes from the literature followed an initial framework that delineated the barriers and facilitators to women's leadership. This was more fully fleshed out into the framework described below, with input from our three project leaders in the domains of health care (Dr. Gillian Kernaghan), health sciences (Dr. Nancy Edwards), and Indigenous health (Dr. Lisa Richardson) and our Interdisciplinary and Intersectoral Women's Leadership Project Advisory Group, our second and third sources. We met with our three women leaders on three occasions during the fall and winter of the first year of our project (2017–2018) and with our advisory group twice since the inception of the project. We shared our findings from the scoping review of the literature and promising practices enhancing women's leadership.

Key findings

Emerging conceptual framework
The conceptual framework that informs our project delineates three levels of barriers and facilitators (Figure 1). The first, and most prominent in the women's leadership literature, is at the *individual level*. Here, a number of barriers are noted: from one's leadership style to a lower sense of control/self-esteem and internalized sexism/gender bias and colonialism. The typical facilitators discussed in the literature are for the individual to somehow develop resilience and resistance to these barriers and to adopt an assertive lean in attitude. This individual level, however, is not the primary focus of our conceptual framework.

Our project encourages a more *organizational level* approach. Here, the barriers include unconsciously gender and racially biased recruitment and promotion, sometimes conceptualized as a "glass ceiling."[11] Others include gender and racial discrimination, which can be overt. Women's lack of mentors and their experience of exclusion from influential

BARRIERS

FACILITATORS

Patriarchal culture
Gender "blind" policies

Culture of representation
Gender equity initiatives

Recruitment/glass ceiling
Discrimination (gender, ethnicity)
Lack of mentors
Exclusionary networks
Poor retention (glass cliff)
Sexual harassment
Caring dilemmas

SOCIETAL/POLICY

ORGANIZATIONAL/ TEAM

INDIVIDUAL

Policies based on sex/gender-based analysis (target/quota)
Gender-sensitive mentoring & networking
Gender-focused leadership opportunities
Gender-based organizational practices

Leadership style
Sense of control/self-esteem
Internalized sexism & colonialism

"Lean in" attitude
Assertiveness
Resilience/resistance

social networks is another barrier. Challenges with retention, sometimes as a result of sexual harassment or when women are only recruited to positions doomed to fail (i.e., a "glass cliff") is another.[12] The caring dilemmas[13] that women experience when managing work and home life result in a disproportionately heavier load of care, which is another substantial barrier to leadership advancement.

Women in typically female health professions and in the professions of medicine and dentistry are underrepresented at the top levels of both clinical leadership and the most prestigious subspecialties.

Sex/gender-based policies that operate as targets or quotas are a facilitator at the organizational level. Another gender-responsive mentoring and networking programs is where women are matched within and across organizations, and time is made during work hours to allow for mentoring and networking activities. Such initiatives can level the playing field in terms of access and participation. Gender-focused leadership opportunities that explicitly encourage and foster women's equal participation and promising gender-based organizational policies, such as setting meeting times around caring responsibilities and providing parental leave and childcare support (both maternal and paternal), are additional facilitators.

At the *systems level*, policies that do not consider sex/gender serve to obfuscate their differential impact on women, thus reflecting a broader patriarchal culture that privileges men's leadership participation. To counteract these gender-blind policies, we are encouraged by a growing culture of representation and gender equity initiatives at the policy level. We applied this conceptual framework to a needs assessment of women and Two Spirit leaders in health care, health sciences, and Indigenous health.

Barriers to women's leadership in health care roles
Women in health care face significant barriers when pursuing leadership positions. Bell[14] argued that the hierarchical organization of health care also conforms to a gender hierarchy. Women's predominant role has been that of a support worker to primary health care providers, such as nurses, dental hygienists, and dental assistants, although women are increasingly entering medicine and dentistry to the point that these professions are said to be feminizing.[15-17]

Women in typically female health professions and in the professions of medicine and dentistry are underrepresented at the top levels of both clinical leadership and the most prestigious subspecialties.[15,17,18] Riska[17] argued that the "persistence of gender segregation in the practice of medicine and the existence of a glass ceiling in the careers of women doctors" (p. 389) have become markers of gender inequality in the health care

workforce. She further noted that women doctors were relatively well represented in specialities that confirm gender-essentialist notions of women's work, such as pediatrics, psychiatry, geriatrics, and obstetrics and gynecology. Subsequently, women's work in health care has been more typically positioned within the caring aspects rather than the curing aspects of health care, which has important implications for gender equity.

In addition to the gender gap in clinical leadership, there is also a gender gap in leadership in health care management. Gumus and colleagues,[19] for example, found that women health care managers are less likely to pursue professional development activities compared with their male counterparts, even when the outcome (i.e., obtaining professional certification) is associated with career advancement and salary increases. Simply offering professional development activities for men and women is not sufficient to address the gender gap in leadership. Facilitators are professional development opportunities that explicitly consider the implications of gender in their organization and implementation.

Whether in clinical and health care management roles, women are disproportionally burdened with unrecognized and unpaid care work in their professional and personal lives, sometimes to the detriment of their career advancement.[20] In a qualitative study of male and female health

care middle managers and executives, Boucher[20] found that women described their office role as "unofficial counsellor" for both their peers and colleagues, and often experienced stress and burnout as a result. In this regard, facilitators include organizational awareness to ensure that women leaders are not being used as captive counsellors.

Kuhlmann et al.[21] also explored the gender gap in leadership and management positions in largely publicly funded academic health centres, taking four centres in European Union countries as case studies: Germany, Sweden, Austria, and the United Kingdom. They found that women were underrepresented in prestigious specialties and as senior doctors and full professors. Gender inequality was stronger in academic enterprises than in hospital organizations and stronger in middle management than at the top level. These novel findings reveal fissures in the glass ceiling effects at top-level management, while barriers for women shift to middle-level management and remain strong in academic positions. Kuhlmann et al.[21] argued that setting gender-balance objectives exclusively for top-level decision-making may not promote a wider goal of gender equality.

Barriers to women's leadership in health science roles

Women experience similar social and institutional barriers as they do in health care, which is reflected in numerical underrepresentation. In contrast to Kuhlmann et al.'s[21] findings of greater female leadership in top than mid-level positions, academic medicine in Canada boasts a total of only five female deans ever; currently, there are only two.[22] We know less about their numbers in the mid-level academic roles of associate and assistant deans and directors, as these data are not broken down by gender in Canada (nor by minority, disability, or Indigenous status). Reasons cited for underrepresentation of women in academic health sciences leadership positions are gendered stereotypes that define roles and expectations,[23,24] differential responsibility for caregiving,[25,26] lack of role models and mentors,[27] and women's dedication of more time to teaching and care of patients than research.[28,29] A hostile organizational climate, isolation, bullying, harassment, and sexual harassment were all described as elements that influence a woman's likelihood of achieving success in academic leadership.[30-32] A number of these overlap with health care.

At an organizational level, measures of academic job performance privilege quantity over quality and research over other university functions, such as teaching, academic service, support, and broader community service. Unfortunately, as women continue to conduct more academic care work, their ability to advance into leadership positions continues to be hampered[33-35]; this workload is compounded for Indigenous and racialized faculty, who are often expected to sit on diversity committees and mentor and support Indigenous or racialized students in addition to other care work mentioned above.[34,36]

Research funding criteria also put women at a disadvantage. A recent analysis of the prestigious CIHR foundation grant program revealed that female applicants are 1.6 times *less* likely than male applicants to receive funding.[3] Gender also influences authorship of research publications, another measure of impact. In leading United States medical journals, only 29% of first authors and 19% of senior authors were women, and women contributed only 11% of guest editorials.[5] Women are also less likely to act as peer reviewers and editors at academic journals, which entails a scientific gatekeeping function.[6]

Barriers to Indigenous women and Two Spirit leaders in health care and health sciences

Indigenous women and Two Spirit leaders are significantly and negatively affected by systemic exclusion. Federal legislation purposefully undermines the roles of women and Two Spirit people, so as to advance nation building.[7] *The, Indian Act,*[37] for example, purposefully excluded women and Two Spirit leaders and replaced them with men, reinforcing patriarchal and colonial governance systems. Unfortunately, the Government of Canada has yet to demonstrate meaningful and systemic commitments to redress this significant loss of leadership. It is only through the resilience and resistance of Indigenous women and those who are Two Spirit that elements of their leadership in health have been maintained.

We learned from our project

leaders and Indigenous members of our Advisory Group that the few women and Two Spirit leaders in health are actively engaged in their employment and community responsibilities. Many Indigenous leaders are often asked to take on leadership roles in early career, thus making them susceptible to overload and burnout. They are often unavailable to take on additional mentorship roles or the dissemination of leadership tools within their own professions or broader community. Further, their workload often far exceeds full time hours, so that they can properly engage with the communities they serve. As a result, there is simply not enough time and support to effectively engage with this vital community of leaders.

Facilitators of women's leadership roles

Designing, adopting, and implementing gender-responsive organizational policies are important tools for women and Two Spirit leadership in health care, health sciences, and Indigenous health. Networks and mentorship among peers as well as senior colleagues are identified as facilitators for women's career advancement. Interventions that focus on reducing isolation through networking, providing role models, and mentoring can support the advancement of women and Two Spirit people into leadership positions.[24,30,34,35] Department-level bias-reducing workshops were shown to be effective in a post-intervention evaluation.[38]

By recognizing the on-going implications of the gendered hierarchy in health care, Bell,[14] for example, recommended three steps for health care planners and policymakers to address inequity: reduce beliefs about general competence that privilege men over women; increase the number of women in leadership roles in medicine; and address the institutional connection of gender and medicine, which includes evaluating hiring practices,

workloads, and educational requirements. Although these recommendations focus on leadership in medicine, they could be applied to increase women and Two Spirit leaders in other professions and in health care management as well.

There is also a notable absence of information that describes how we can engage men to be part of the solution to facilitate the inclusion of women and Two Spirt leaders.

To address the slow pace of institutional change in health sciences and across disciplines in the United Kingdom, the Athena SWAN Charter was adopted as a mandatory criterion for receiving federal funding for health science research.[39] Currently, the Canadian Tri-Councils are undertaking a five-year pilot project to adapt the Athena SWAN program, and consultations are underway for a made-in-Canada Athena SWAN initiative.[40] The initiative, by design, is to pay particular attention to the four protected groups – women, people with disabilities, Indigenous peoples, and people from visible minority groups – and how the intersections of these identities are considered in the Canadian context.

Another example is the ADVANCE program in the United States, which provides support to university-based organizational gender equity change initiatives.[41] This program has supported the University of Michigan, for example, in creating resources,

such as Creating a Positive Departmental Climate: Principles for Best Practices[42] and Developing Anti-Harassment Programs in Academic Societies and Meetings: A Resource Guide[43] to address gender inequity in their organization.

Conclusion

Our review of the literature, with input from project leaders and advisors, demonstrates that to advance women and Two Spirit leadership in health care, health sciences, and Indigenous health, we must address a number of critical gaps in our knowledge. From the health care, health sciences, and Indigenous health literatures, we know more about the barriers than facilitators or interventions that foster women's leadership. Where the literature includes an intervention, it is most often only described and not evaluated. This is an important gap to address.

Because of the dearth of literature, a number of unknowns exist in the area of health leadership by Indigenous women and Two Spirit people. We do not know the specific facilitators and barriers that affect their participation in leadership roles in health; the mechanisms that facilitate knowledge transfer between established and emerging Indigenous and Two Spirt leaders; nor how non-Indigenous leaders in health care support and promote Indigenous women and Two Spirt leaders.

There is also a notable absence of information that describes how we

can engage men to be part of the solution to facilitate the inclusion of women and Two Spirit leaders. The next step of our project will be to gather key lessons learned into a tool kit of promising practices to support women and Two Spirt leaders.

References

1.Porter A, Bourgeault I. Gender, workforce and health system change in Canada. Presented at the Fourth Global Forum on Human Resources for Health, Dublin Ireland, November 2017.
2.Side K, Robbins W. Institutionalizing inequalities in Canadian universities: the Canada research chairs program. *NWSA J* 2007;19(3):163-81. doi: 10.1353/nwsa.2007.0046
3.Witteman HO, Hendricks M, Straus S, Tannenbaum C. Female grant applicants are equally successful when peer reviewers assess the science, but not when they assess the scientist. *bioRxiv* 2017;232868. doi: 10.1101/232868
4.Tamblyn R, Girard N, Qian CJ, Hanley J. Assessment of potential bias in research grant peer review in Canada. *CMAJ* 2018;190(16):E489-99. doi: 10.1503/cmaj.170901
5.Jagsi R, Guancial EA, Worobey CC, Henault LE, Chang YC, Starr R, et al. The "gender gap" in authorship of academic medical literature – a 35-year perspective. *N Engl J Med* 2006;355(3):281-7.
6.Lundine J, Bourgeault IL, Clark J, Heidari S, Balabanova D. The gendered system of academic publishing. *Lancet* 2018;391:1754-6.
7.Green J. Canaries in the mines of citizenship: Indian women in Canada. *Can J Political Sci* 2001;34(4):715-38.
8.Truth and Reconciliation Commission of Canada: calls to action. Winnipeg: Truth and Reconciliation of Canada; 2015. Available: https://tinyurl.com/phhrhf8
9.High Level Commission on Health Employment and Economic Growth. Working for health and growth: investing in the health workforce. Geneva: World Health Organization; 2016.
10.Kenny C, Fraser TN. *Living Indigenous leadership: native narratives on building strong communities.* Vanvouver: UBC Press; 2013.
11.Vaderbroeck P, Wasserfallen JB. Managing gender diversity in

healthcare: getting it right. *Leadersh Health Serv (Bradf Engl)* 2017;30(1):92-100. doi: 10.1108/LHS-01-2016-0002

12. Ryan MK, Haslam SA, Postmes T. Reactions to the glass cliff: gender differences in the explanations for the precariousness of women's leadership positions. *J Organ Change Manag* 2007;20(2):182-97. doi: 10.1108/09534810710724748

13. Hill MS, Nash A, Citera M. Parenthood in academia: what happens when there is no policy? *Wagadu* 2011;9:113.

14. Bell AV, Michalec B, Arenson C. The (stalled) progress of interprofessional collaboration: the role of gender. *J Interprof Care* 2014;28(2):98-102.

15. Adams TL. Gender and feminization in health care professions. *Sociol Compass* 2010;4(7):454-65.

16. Adams T, Bourgeault IL. Feminism and women's health professions in Ontario. *Women Health* 2003;38(4):73-90.

17. Riska E. Women in the medical profession: international trends. In Kuhlmann E, Annandale E (editors). *The Palgrave handbook of gender and healthcare*. London: Palgrave Macmillan; 2010: 389-404.

18. Bourgeault IL. Gendered professionalization strategies and the rationalization of health care: Midwifery, nurse practitioners, and hospital nurse staffing in Ontario, Canada. *Knowl Work Society* 2005;3(1):25-52.

19. Gumus G, Borkowski N, Deckard GJ, Martel KJ. Gender differences in professional development of healthcare managers. *Leadersh Health Serv* 2009;22(4):329-39.

20. Boucher C. A qualitative study of the impact of emotional labour on health managers. *Qual Rep* 2016;21(11):2148-60.

21. Kuhlmann E, Ovseiko PV, Kurmeyer C, Gutiérrez-Lobos K, Steinböck S, von Knorring M, et al. Closing the gender leadership gap: a multi-centre cross-country comparison of women in management and leadership in academic health centres in the European Union. *Hum Resour Health* 2017;15(2). doi: 10.1186/s12960-016-0175-y

22. Rush J. Dentistry has a far larger 'boys' club' problem. *Globe and Mail* 2014;24 Dec. Available: https://tinyurl.com/y9os58b6

23. Burgess DJ, Joseph A, van Ryn M, Carnes M. Does stereotype threat affect women in academic medicine? *Acad Med* 2012;87(4):506-12. doi: 10.1097/ACM.0b013e318248f718

24. Carnes M, Morrissey C, Geller SE. Women's health and women's leadership in academic medicine: hitting the same glass ceiling? *J Women's Health* 2010;17(9):1453-62. doi: 10.1089/jwh.2007.0688

25. Carr PL, Ash AS, Friedman RH, Scaramucci A, Barnett RC, Szalacha L, et al. Relation of family responsibilities and gender to the productivity and career satisfaction of medical faculty. *Ann Intern Med* 1998;29(7):532-8.

26. Schueller-Weidekamm C, Kautzky-Willer A. Challenges of work–life balance for women physicians/mothers working in leadership positions. *Gend Med* 2012;9(4):244-50. doi: 10.1016/j.genm.2012.04.002

27. Mayer AP, Files JA, Ko MG, Blair JE. Academic advancement of women in medicine: do socialized gender differences have a role in mentoring? *Mayo Clin Proc* 2008;83:204-7.

28. Buckley LM, Sanders K, Shih M, Kallar S, Hampton C. Obstacles to promotion? Values of women faculty about career success and recognition. Committee on the Status of Women and Minorities, Virginia Commonwealth University, Medical College of Virginia Campus. *Acad Med* 2000;75(3):283-8.

29. Expert Panel on Women in University Research. Strengthening Canada's research capacity: the gender dimension. Ottawa: Council of Canadian Academies; 2012.

30. Airini CS, Conner L, McPherson K, Midson B, Wilson C. Learning to be leaders in higher education: What helps or hinders women's advancement as leaders in universities. *Educ Manag Adm Lead* 2011;39(1):44-62. doi: 10.1177/1741143210383896

31. Ford LE. Two steps forward, one step back? Strengthening the foundations of women's leadership in higher education. *Polit Groups Identities* 2016;1-14. doi: 10.1080/21565503.2016.1170705

32. Van den Brink M. Scouting for talent: appointment practices of women professors in academic medicine. *Soc Sci Med* 2011;72(12):2033-40. doi: 10.1016/j.socscimed.2011.04.016

33. Cummins HA. Mommy tracking single women in academia when they are not mommies. *Women Stud Int Forum* 2005;28(2):222-31.

34. Gutiérrez y Muhs G. *Presumed incompetent: the intersections of race and class for women in academia*. Logan, Ut.: Utah State University Press; 2012.

35. Hart J. Dissecting a gendered organization: implications for career trajectories for mid-career faculty women in STEM. *J High Educ* 2016;87(5):605-34. doi:

36. Henry F, James C, Li PS, Kobayashi AL, Smith M, Ramos H, Enakshi D. *The equity myth: racialization and indigeneity at Canadian universities*. Vancouver: University of British Columbia Press; 2017.

37. *Indian Act*. Ottawa: Government of Canada; 1985. Available: https://tinyurl.com/ybyfnzmy

38. Devine PG, Forscher PS, Cox WTL, Kaatz A, Sheridan J, Carnes M. A gender bias habit-breaking intervention led to increased hiring of female faculty in STEMM departments. *J Exp Soc Psychol* 2017;73(Feb.):211-5. doi: 10.1016/j.jesp.2017.07.002

Attestation

All authors contributed equally to the paper. Dr. Bourgeault, as the lead of the project, took the lead in drafting the final version. All authors approved the final article.

Sponsorship and funding

Authors

Ivy Lynn Bourgeault, PhD, FCAHS, is a professor at the Telfer School of Management and the Canadian Institutes of Health Research chair in gender, work and health human resources. She leads the Canadian Health Workforce Network.

Yvonne James, MA, is a PhD candidate at the Institute of Feminist and Gender Studies, University of Ottawa, and a research associate at the Gender, Work and Health Research Lab at the Telfer School of Management.

Karen Lawford, PhD, RM, AM, is an assistant professor in the Department of Gender Studies at Queen's University.

Jamie Lundine, MSc, is a PhD student at the Institute of Feminist and Gender Studies, University of Ottawa, and a research associate in the Gender, Work and Health Research Lab at the Telfer School of Management.

Correspondence to:
ibourgea@uottawa.ca

This article has been peer reviewed.

Leaning further

Sharron Spicer, MD

Diversity is one factor that has a positive impact on organizational performance. Women remain underrepresented in leadership positions of medical organizations despite two decades of equal numbers of male and female medical school graduates. Using Sheryl Sandberg's well-known book *Lean In* as a springboard for addressing the gender gap, I propose opportunities for medical organizations to improve their gender diversity, a strategy that has potential to improve the workplace for women and men, as well as for the organizations in which they work.

KEY WORDS: women in leadership, diversity, gender gap, biological factors, psychological factors, social factors, recommendations

"Today in the… developed world, women are better off than ever. We stand on the shoulders of the women who came before us, women who had to fight for the rights that we now take for granted. Since [the 1980s], women have slowly and steadily advanced, earning more and more of the college degrees, taking more of the entry-level jobs, and entering more fields previously dominated by men. Despite these gains, the percentage of women at the top of corporate America has barely budged over the past decade. This means that when it comes to making the decisions that most affect our world, women's voices are not heard equally. If we can succeed in adding more female voices at the highest levels, we will expand opportunities and extend fairer treatment to all." [1]

Many are familiar with Sheryl Sandberg's inspirational book *Lean In* (2013)[1] in which the Facebook COO draws attention to the vast underrepresentation of women in leadership roles in government and industry. Sandberg demonstrates how biological, psychological, and sociological factors contribute to the gender gap, and, more important, how women and the organizations in which they work can change the milieu for the benefit of all. Sandberg draws particular focus to the ways that women sometimes unintentionally hold themselves back in their careers and encourages them to sit at the table and "lean in," seek challenges, take risks, and pursue their goals. In this article, I reflect on Sandberg's call to action and explore how it can be applied in health care to enhance the medical leadership roles of women.

The argument for diversity

It should hardly be necessary to justify the need for women to hold leadership positions, yet if any doubt remains, research shows that organizations with more diversity – whether in terms of gender, race, ethnicity, age, or global experience – demonstrate better financial performance, greater organizational collaboration, and more effective problem-solving. When organizations commit to diversified leadership, they also reap enhanced employee engagement and competitive advantage to attract and retain diverse talent.[2-4] Having women in leadership roles, therefore, is not just a moral imperative, but also a strategy that brings about performance benefits to the organization.

The increase in the number of women in entry-level positions does not by itself close the gender gap in leadership.[2] For two decades, women have outnumbered men in undergraduate medical school classes. That should mean that – all things being equal – women and men at mid-career levels should be represented in about equal numbers in leadership roles today. Yet, women are vastly underrepresented in medical leadership, holding only 13–15% of department chair positions in Canada and the United States.[5]

To be clear, I don't equate number of women in leadership roles as the measure of equality, nor leadership itself to be a marker of success; yet, there continue to be barriers to women achieving leadership roles. Blatant or subtle discrimination still occurs and must be recognized and called out. Lesser known is a subtle and often invisible gender bias that arises from cultural assumptions and organizational structures, patterns, and practices.[6] This so-called second-generation gender bias continues despite overt programs to attempt to fill the leadership gap.[6] Only after prevailing corporate norms change will there be a significant impact on women's representation.[7] Let us look at how certain factors adversely impact women's entry into and success in leadership roles and how they can be managed organizationally.

Factors impacting women's leadership roles

Biological

As career-building often coincides with prime childbearing and caregiving years for women, the struggle to balance both — if that is what a woman chooses — can be a difficult one. More female than male physicians have young children in the home, and women physicians report spending considerably more time than male colleagues taking primary responsibility for their children.[8] Women may need more flexibility to accommodate pregnancy, breastfeeding, and child care in the workplace. Often, women defer career advancement while their children are young. Not to be disheartened, though, women generally achieve leadership roles about seven years later than their male counterparts, according to

psychiatrist Dr. Mamta Gautam.[9] Much of our middle-aged working population contributes to care of parents or even disabled children or siblings. This role, too, falls more often to women.[10]

Psychological

There are psychological differences, notes Sandberg,[1] that influence women in advancing their career opportunities. Women are more critical in self-evaluation than men, both to themselves and in groups. Women have been shown to judge their own performance to be worse than it actually is, men view it as better. For example, in a group of surgical trainees, the women (who exhibited slightly greater technical skills) rated themselves lower than their male counterparts.

Women tend to attribute their successes to external factors, such

as good luck or help from others, whereas men tend to credit talent and skills. When women fail at a project, they are more likely to attribute the poor performance to lack of ability, whereas men point to a task that might need improvement. When receiving negative feedback, women's self-confidence decreases more than men's. This internalization of "failure" leads to a sense of insecurity, which, in turn, can impact future performance. Enter imposter syndrome: the self-doubt that creates the distorted view that one is about to be discovered as a fraud. Women tend to experience the imposter syndrome more intensely and be limited by it more than men.

Even Sandberg describes her dance with imposter syndrome this way: "The real issue was not that I felt like a fraud, but that I could feel something deeply and profoundly and be completely wrong." Ironically, however, receiving praise is not necessarily the antidote for imposter syndrome. Sandberg notes that girls and women may actually feel embarrassed or vulnerable when receiving public praise. She gives her own example of feeling extremely awkward being named to *Forbes*' World's 100 Most Powerful Women list in 2011.

Women are more cautious about changing roles and seeking new challenges, notes Sandberg. Men believe that they can do more than the status quo and reach for opportunities more quickly than women. Women may need more encouragement to consider new roles. "You have to

take opportunities and make an opportunity fit for you, rather than the other way around," Sandberg quotes Padmasree Warrior, chief technology officer of Cisco. Comfort with ambiguity of role is a feature that women leaders need to embrace.

Women are more cautious about changing roles and seeking new challenges, notes Sandberg. Men believe that they can do more than the status quo and reach for opportunities more quickly than women.

Social
In social relationships, women also differ from men. I have noticed that women tend to build horizontal relationships. Women's relationships often cross sectors and are more peer-to-peer, including friendships and volunteer commitments outside the workplace. Men, more often, have a narrower group from which they draw their social connections, and very often these groups include colleagues. Men are more likely to cultivate vertical relationships through formal or informal mentoring roles and perform voluntary activities within the workplace. These patterns may impact promotion and selection for leadership. Certainly, we would benefit from the diversity of leaders who have experience in organizations outside our health system as well as within.

There are gender differences in communication styles. Even in childhood, boys are more likely than girls to raise their hands to

give an answer in class, to keep their hand raised until they can speak, and to talk over girls. Women in the workplace tend to speak less than men, and men have consistently been shown to speak over women.[1]

Fewer women than men identify attaining leadership roles as a personal goal.[1,5] Women are more likely to cite compassion, improving the lives of others, personal fulfillment, and a favourable work–life balance as their personal goals.[1] Moreover, women tend to identify critical functions of leadership, such as nurturing, empowering and motivating others, as being "other-driven."[5]

Motivation to attain a medical leadership position – or for that to be deemed "success" – may be a stronger attraction for more men than women. Women may see the self-promotion required to attain leadership roles as a deterrant.[5] Roth et al.[5] noted a surprising theme: women physicians, who are not in leadership positions, hold an uninviting view of leadership as being burdensome, lonely, and costly in terms of personal sacrifices. Those in medical leadership, however, viewed leadership as positive and motivating. As the paradigm of medical culture is shifting from an autocratic framework to a more collaborative one, the collaborative leadership style, which is more characteristic of women, as well as the younger generation, will become more and more valuable.[5] Taken together, these observations suggest that women will be more drawn to leadership positions if

the roles can be seen to contribute positively to the vision of the organization or value to society.[5] Women may underestimate their capacities to fill posted roles. Sandberg[1] notes that women are more likely to take themselves out of the running if they don't fill all the criteria of a job description; men, on the other hand, are likely to apply if they meet even six or seven of ten criteria. Furthermore, notes Sandberg, if a woman applies and is not successful, she is more likely to see herself as a failure, but a man might simply see it as not being a good fit.

Many women describe coming into medical leadership activities accidentally, perhaps being asked to fill a role on a short-term basis and then finding themselves successful and enjoying the role.[5] This shows value in a process to identify potential leaders and suggesting suitable roles in recruitment and succession planning.

Many women describe coming into medical leadership activities accidentally, perhaps being asked to fill a role on a short-term basis and then finding themselves successful and enjoying the role.

Opportunities for organizational change

Closing the gender gap in medical leadership relies in creating more opportunities to attract, select, retain, and promote qualified women into these positions.[5] Practical measures can be implemented in health care organizations to enhance opportunities for women. The benefits of these measures extend not only to women, but also to all who choose a leadership journey, as well as to the organizations themselves. Some of these positive measures are listed below.

Attract women to medical leadership

- Make medical leadership attractive. Leaders who speak highly of their positive experiences in leadership roles, citing examples of professional development, personal fulfillment, and service opportunities, are likely to serve as inspiration to those who might consider such roles. On the contrary, referring to leadership as "crossing over to the dark side" or speaking disparagingly about their organization is not helpful.
- Allow opportunities to continue other gratifying professional activities. For many physicians, clinical work is their sweet spot for inspiration and fulfillment. Ensuring opportunities for leaders to continue clinical work not only helps to maintain their credibility among peers, but it also provides oft-needed respite from the unrelenting demands of leadership.

Select qualified candidates who show potential

- Approach and encourage potential leaders. Physicians, especially women, may not self-identify their own leadership skills and potential. They may wait for affirmation of their suitability for a particular role. They might be in the category of "accidental leaders" waiting to be discovered. Identifying a candidate suitable for a role could awaken a latent interest in leadership.
- Ensure reasonable working

hours. As women continue to take on the bulk of domestic and child care responsibilities, they may benefit from flexibility to work some of the time from home, have dial-in or virtual options to join meetings, and anticipate fewer early or late meetings. Providing flexibility might overcome real or perceived barriers to women (and men!) considering leadership roles.

Retain physicians in leadership roles

- Mentor leaders at all stages. Mentorship of physicians is helpful to identify opportunities for growth. Women, in particular, benefit from the individual feedback provided by seasoned mentors of either gender. Perceived lack of support in a leadership role is a major deterrent for many women. A supportive mentor can provide a channel for learning and growth.
- Provide leadership training. Leadership is not entirely innate; it employs skills that can be learned. Investing in leadership training pays dividends in creating more effective leaders. Interactive learning opportunities further develop the social networks so important to leaders.

Recognize contributions of leaders

- Demonstrate and celebrate successes of medical leaders. Showcase the efforts and successes of formal and informal leaders who have contributed to improvements in the organization. Use awards, publications, display boards, and other means to spread the news of successes. Examine the gender balance of leader profiles in your organization. For example, if your department or faculty has photos of predominantly male forefathers, counter the imbalance with photos of current leaders – assuming, of course, that the gender split will be more even.
- Recognize the importance of leadership through promotions. Reward leaders with tangible recognition such as titles, promotions and advancement in ways that research, innovation and medical education are recognized. While recognition for leadership is not usually the leaders' motive, it sends an important message throughout the organization that leaders are appreciated and supported.

I close with an encouragement from Sheryl Sandberg[1]: "I hope you find true meaning, contentment, and passion in your life. I hope you navigate the difficult times and come out with greater strength and resolve. I hope you find whatever balance you seek with your eyes wide open. And I hope that you – yes you – have the ambition to lean in to your career and run the world. Because the world needs you to change it."

References

1. Sandberg S. *Lean in: women, work, and the will to lead.* New York: Alfred A. Knopf; 2013.

2. Hunt V, Layton D, Prince S. Why diversity matters. New York: McKinsey & Co.; 2015. Available: https://tinyurl.com/y9rsnkfd (accessed 16 July 2018).

3. Noland M, Moran T. Study: firms with more women in the c-suite are more profitable. *Harv Bus Rev* 2016;8 Feb. Available: https://tinyurl.com/hne9emz (accessed 16 July 2018).

4. Why having more female leaders will benefit your business. Cape Town: GetSmarter; n.d. Available: https://tinyurl.com/yacd2equ (accessed 16 July 2018).

5. Roth VR, Theriault A, Clement C, Worthington J. Women physicians as healthcare leaders: a qualitative study. *J Health Organ Manag* 2016;30(4):648-66. DOI 10.1108/JHOM-09-2014-0164.

6. Ibarra H, Ely RJ, Kolb DM. Women rising: the unseen barriers. *Harv Bus Rev* 2013;Sept. available at: https://tinyurl.com/mucx4qs (accessed 16 July 2018).

7. Women at the top of corporations: making it happen. New York: McKinsey & Co.; 2010. Available: https://tinyurl.com/yc86etsa (accessed 16 July 2018).

8. National Physician Survey: 2010 survey results. Ottawa: College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada; 2010. Available: https://tinyurl.com/y9ls349y (accessed 16 July 2018).

9. Gautam M. Leadership for medical women. Ottawa: Physician Leadership Institute; May 2016)

10. Women and caregiving: facts and figures. San Francisco: Family Caregiver Alliance; 2003. Available: https://tinyurl.com/zq73oer (accessed 26 July 2018).

Author

Sharron Spicer, MD, FRCPC, CCPE is a physician leader in Calgary, Alberta. Her clinical work as a pediatrician has included pediatric palliative care, complex feeding and nutrition and medical ethics. She is proud to serve on many local, provincial and national medical organizations.

Correspondence to:
sharron.spicer@albertahealthservices.ca

This article has been peer reviewed.

PERSPECTIVE

The first, the few, the many: pathways to leadership

Nadine Caron, MD

"The president would like to speak with you," said the unfamiliar voice on the phone. She was referring to the president of the university which, just 18 hours earlier, had granted me a degree. Although I had never graduated from medical school before, I knew this call was unusual. Was the president calling every student in my class?

Moments later, the president's confident voice boomed through the receiver. "Congratulations," was his message. "Thank you, sir…" I responded as I gathered the wits to ask the question so obvious to me. "But do you mind if I ask… why are you calling *me*?"

Medical school was not a race that I set out to win. Every graduate had "won," as we all gained the initials MD after our names.

He hesitated ever so slightly, then happily explained, "Why, you are our *first* female First Nations

student to graduate from our university's school of medicine. We are so proud!"

The words "our" and "proud" sounded to me like the clash of cymbals in an elementary school band. Although the president had sounded sincere, I oscillated between the polite and likely expected "Canadian" thank you and the question I felt compelled to ask.

"Thank you, sir," I replied again, before taking a deep breath to ask what I would spend years contemplating. "But it's 1997 – is me being the 'first' really something we should be proud of?"

That morning, I realized that it can be quite odd what we, as a society, deem to be a success. Being first is often automatically considered something positive, something to cheer for. As if all firsts should lay claim to the classic spirit of "on your mark, get set, go" with the assumption that everyone starts the same race, at the same time, with the same rules. And that coming in first must be rewarded and celebrated as though it had always been the ultimate goal, the purpose of the effort.

Medical school was not a race that I set out to win. Every graduate had "won," as we all gained the initials MD after our names. That was the purpose of our journey. Surely my classmates and I felt as much of an accomplishment becoming doctors as the graduates in years before us? Medical students graduating these days seem just as thrilled at their

achievements as we did. Although the "first" our president had referred to was something that had never been done before at our university, this was not the achievement I was celebrating. The suggestion that we should applaud this landmark highlighted a vital lesson that was not part of our medical school curriculum: there are times when being first is more the result of filling a void than achieving a goal. To me, my being first did not reflect success; it shone a critical light on society's failures.

My conversation with our university president taught me that we do not all necessarily agree on the goalposts that define success. I learned that we must be careful when choosing what measuring stick to use when evaluating our progress or when setting goals, whether they be in the eyes of our profession, the public, or even our personal lens.

Back on that day, if we peeled away the layers that made "first" sound so positive, we would have seen elements in Canada's history that should have raised great concern. Not celebration. Nor pride. In this scenario, our country, academic institutions, and the medical profession at large should have been prompted to examine our past for injustices, misguided decisions, and indifference to see what kept the generations before me from even having this opportunity the university president was calling me about.

Indigenous communities face socioeconomic, political, and educational barriers – to name

a few – that my being first actually revealed. The impact of these factors may not have been obvious to some, but to those who have heard this music before, it continues to sound like a crescendo in a symphony. This unexpected telephone call created a watershed moment in my life: I could continue to celebrate the success of each individual in our graduating class or start to examine the failures of the country in which we had achieved it. I could ask, "Why was *my* graduation so significant?"

The fact that apparently no female First Nations student had previously completed medical school at that university had nothing to do with me. The paucity of Indigenous university students in our country, and the relative void of Indigenous health care professionals throughout Canada, was not my fault, but overnight it became a part of who I was. Even years later, when I am being introduced as a panelist at a national meeting or the keynote speaker at an international conference, I often hear a list of adjectives as I stand by the stage, waiting to speak. When I am described as the "first X doctor" to do this or the "first Y surgeon" to do that, I cannot help but recognize the role of history behind those descriptors. I aimed to achieve the nouns – I wanted to be a doctor, a surgeon – yet history assigned the adjectives, emphasizing words such as First Nations, Indigenous, female, and northern, while society added the five-letter word *first*. Together, these adjectives create the perfect

word storm that, on the surface, can sound like hallmarks of success.

Do you ever wonder, "Why was there no one before?"

We should redefine what we consider celebrating when we combine an individual's achievement with the history of our country or profession. While we should certainly continue to celebrate the individuals – the firsts – for achieving their personal goals, it should be because of their commitment, skill, and quality of their work, not just for the voids they fill. While we should acknowledge the potential impact when the first comes along and cheer for a long-awaited step in the right direction, it takes more than just one individual to bridge the chasm from "never before" to an endpoint that carries long-lasting effects. We must never risk confusing the "first" with the "only." Although anticlimactic, a fundamentally vital moment to celebrate as true success is when "the first" – in whatever field, for whatever void – becomes simply "one of many."

When the Truth and Reconciliation Commission (TRC) released its report in 2015[1] almost 20 years after my graduation from medical school, they clearly documented 94 calls to action. These calls to action were intended to move Canada in the direction of healing from our history of Indian residential schools, assimilation policies, and other attempts at cultural genocide that still plague our nation today.

Under the category of "health," TRC call to action number 23 includes the requirement to increase the number of Indigenous health care professionals. This was an identified need despite multiple Indigenous firsts, such as the first surgeon, the first obstetrician, and the first family physician, already marked off on the proverbial checklist. In this report, firsts have officially been discarded as a target endpoint for a profession, university, or country. An empowered workforce of Indigenous health care professionals working for and with Indigenous Peoples in Canada is needed and the TRC report clearly demands this.

To illustrate this difference between the first and the many, we can look briefly to the history of voting rights in Canada. Although our country values the principles of democracy, the battle for women's right to vote was long and passionate. Women first cast their votes in a Canadian federal election in 1917 (initially on behalf of their male family members in battle overseas) and those rights extended to most women by 1919 (presumably with the right to voice their own opinions at the ballot box).[2] Vital to this narrative is that First Nations Peoples were still waiting for this fundamental right, which came over four decades later, when they cast their first-ever votes in a federal election in 1960.[3]

We should know this history because it is as much a part of our country's fabric as gold medal hockey games, our universal health care system, or the maple leaf

itself. Although this history is not one we are proud of, it serves as an example of just how long sought-after change can take before it eventually becomes embedded in our society. This story highlights true success: since those first ballots were cast in 1960, the right to vote has become something that we as Canadians *expect*. During our most recent federal election, I heard no one protesting, saw no one cheering, read no storyline in the national media about the fact that women or Indigenous Peoples were voting. It is the norm. As a First Nations woman waiting in line to vote, I was one of many. No one even noticed me.

It should come as no surprise that as a female Indigenous health care provider in Canada, I believe that success within our profession and our society is not embodied by the next First Nations surgeon. It is not carried forward by the first Inuk dentist. Nor the next Métis doctor. Not the first Indigenous justice of the Supreme Court of Canada. Success is when we no longer pay attention to the adjectives but celebrate the talent, the commitment, the voices of those who dreamed of the nouns and took on these roles in society. Success is when our children and the generations that follow know that the goal they aspire to has been reached before – by people like them. It is possible. It will happen again. We hear examples of success by stories that begin with, "remember when…"

Where then does the concept of leadership apply in our profession when it comes to our firsts?

The day the university president singled me out also marked the moment when, seemingly overnight, I was conferred with a leadership role. I struggled for a long time to understand the difference between being first and being a leader, even though I had signed up for neither title. In September 2017, during a TEDx Talk entitled "The Other Side of Being First," I reflected on some of the leadership roles I have assumed over the years… and leadership roles people assumed that I have.[4] I shared how it sometimes feels to be the first to do something – especially when that something is far from innovative or ground-breaking in and of itself. Being first, I told the audience, is not always indicative of leadership. Leadership is an active role, not a passive descriptor. Leadership is an accepted responsibility, with the fundamental purpose being change.

Firsts within the medical profession are often leaders who accomplish something unique and innovative for the benefit of their patients. Their discoveries include new treatments, ground-breaking procedures, and diagnostic advances. Where would medicine be without the science, innovation, and the leaders to get us there? These historical icons led progress in our profession, not because of who they were but because of what they did. Some surgeons have procedures and surgical instruments named after them. Many physicians' names are the answers to questions medical students are asked on hospital rounds with their attending physician. Which surgeon completed the first liver transplant? Who discovered insulin? Who discovered penicillin? The history of medicine does not focus on individuals who were not followed by the many. Progress is filled with names of firsts who intentionally chose to do something never done before, shared their ideas, and inspired others to follow. They are leaders in their fields because the many who followed changed their clinical practices because of them. These leaders changed their profession.

Those who became firsts by filling in the gaps created by history, political agendas, and professional bias may also become leaders. With time, I realized being first was not a burden to carry by myself; one cannot lead if no one follows. If you are first, it is challenging to lead others to a place you have never been. There are the challenges of being a mentor while seeking a mentor and of saying, it is possible, when it has not been done. With momentum toward change, these firsts can also change our profession.

That telephone call, as challenging as it was, unknowingly set me on my career path. I had a president who respected my salient question, "Should we really be proud?" I stayed at that university, which has worked toward something

To me, leadership means encouragement

Aliah Turner

Leadership is often misunderstood. We often believe that being a leader means that you must be the first, the best, the most talented, or all of these. That is not always the case. Think about the next generation, my generation. What do you do to encourage, motivate, and inspire us, tomorrow's leaders?

I can relate to the example of being in a running race. When you race your teammates, you know everyone, their skill level, their endurance, and how you compare to them. Sometimes, you know that one runner is faster or has greater endurance than you. That is the one you expect to encourage you and others, the one you go to for advice, the one you want to learn from. Leaders should have the capacity to support others to improve, not just the ability to win.

Parents, grandparents, teachers, and coaches are my mentors. They encourage me to push past my perceived limits. They are the people who, no matter what, believe in me. Their experience and knowledge and their leadership capabilities help me reach beyond my goals. They help me get to a place and accomplish things that I may not have even known were possible.

When I was asked what leadership meant to me, the word "encouragement" was at the top of my list. I need encouragement from those whom I consider leaders. As someone who believes in the power of leadership, I need to encourage others.

How do you encourage the next generation? How are you our leaders? Leaders must recognize that it is not sufficient to show us how, they must also show us why. Someone who leads by being the first to do something shows everyone why, especially my generation, because we learn about the impact it has. These "firsts" show us that it can be done and that the possibilities are endless. They encourage us without words, in fact without ever meeting us. They show us the importance of knowing that being a first is not just filling the void of "never before" but teaching my generation why they did it.

I wonder what "first" I will be?

Author

Aliah Turner is 12 years old and goes to Lac des Bois Elementary school in Prince George, British Columbia. She enjoys trail running, cross-country skiing, biathlon, basketball, and soccer. She aspires to be someone to whom others turn for encouragement as she pursues her goals.

to be truly proud of. In 2014, the University of British Columbia opened the Centre for Excellence in Indigenous Health (health.aboriginal.ubc.ca) where the majority of the staff are Indigenous and work passionately in areas, such as student recruitment and retention into the health care fields, development of a curriculum that applies an Indigenous lens, and research in the areas most plagued by health disparities between Indigenous Peoples and the rest of Canada. Courageous, innovative, inspiring, passionate are just some of the adjectives that I would use to describe the people whose paths have merged to create and sustain this centre. The centre was created for the purpose of change. In the place of a first, there are now many. That is something to be celebrated.

I concluded my TEDx talk by asking the audience to imagine "the first" reaching his or her goal. To picture them walking through a grass field to reach their desired destination. After one person – the first – walks through, the grass easily springs back up. The impact that person leaves in the grass field lasts about as long as the media story of this single person's achievement (Figure 1). When a few people follow that path, their cumulative impact can create the suggestion of a trail, where the grass is partly compressed, hopefully long enough for the next person to find the path and know that what they pursue is indeed possible (Figure 2).

Now consider this subtle trail in

figure 1.

figure 2.

figure 3.

the transition from the only, then the few, to one of many. When this point is reached, the grass remains trampled into a permanent path (Figure 3). It becomes a blazed trail that those following can readily find. It is a clear path whose creation we can celebrate. It is a well-marked route whose barriers, both perceived and real, have been overcome. I suppose that when the first guides those who follow, when the path they leave is more inspiring and more permanent than a path they could have ever left by themselves, then they can be a leader after all.

References

1.Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada. Winnipeg: Truth and Reconciliation Commission of Canada; 2015. Available: https://tinyurl.com/njt3vd8
2.Strong-Boag V. Women's suffrage in Canada. In *The Canadian Encyclopedia*. Toronto: Historica Canada; 2016. Available : https://tinyurl.com/y7w5u4nm (accessed 7 Oct. 2018).
3.Leslie JF. Indigenous suffrage. In The Canadian Encyclopedia. 22 March 2018, Historica Canada. Available: https://tinyurl.com/ybdx7e59 (accessed 7 Oct. 2018).
4.Caron N. The other side of "being first." Presented at TEDx Conference, Prince George, BC; Sept. 2017. Available: https://tinyurl.com/ycnu6596

Author

Nadine R. Caron, MD, MPH, FRCSC, is a member of the Sagamok First Nation, an associate professor in UBC's Northern Medical Program, and co-director of the university's Centre for Excellence in Indigenous Health.

Correspondence to:
Nadine.Caron@ubc.ca

This article has been peer reviewed.

OPINION

Restoring joy in work

Gillian Kernaghan, MD

The headline in the *Canadian Medical Association Journal*, "Has suicide become an occupational hazard of practising medicine,"[1] needs to be a call to action for all leaders in health care. When burnout rates are 50% for physicians and nurses, we need to ask serious questions about the system, not the individuals.

Since the introduction of continuous quality improvement into health care in the 1990s, we have been focused on looking for system factors that result in errors in care rather than looking to blame individuals. We appreciate that well-intentioned individuals do not come to work to harm patients. We have focused on making it easier to do the right thing, with process redesign, standardization, controls, and alerts that reduce the risk of harm.

In 2013, the Mental Health Commission of Canada published the National Standard of Canada for Psychological Health and Safety in the Workplace,[2] the first of its kind in the world.

Similarly, as we approach the rates of burnout and suicide in health care providers, we are challenged in the *CMAJ* article to look at system solutions rather than seeing individuals as weak or non-resilient.

In 2013, the Mental Health Commission of Canada published the National Standard of Canada for Psychological Health and Safety in the Workplace,[2] the first of its kind in the world. It is a set of voluntary guidelines, tools, and resources intended to guide organizations in promoting mental health and preventing psychological harm at work. The standard is designed for all types of work environments and includes principles and implementation supports.

The For Health, By Health Collaborative is a group of health care leaders who, together, are committed to the application of this standard in health care organizations. The collaborative is providing leadership to develop implementation tools and processes that are sensitive to health care. Organizations will have components in place; however, the standard provides a framework with which to assess opportunities for improvement in a specific organization. Application of the standard takes a system approach that will benefit all who work in health care: staff, physicians, leaders, students, researches, and volunteers.

At St. Joseph's Health Care London, the use of the standard was identified as a strategic priority in the 2016 strategic plan. A steering committee of leaders and front-line staff was established to facilitate this initiative. A gap analysis was undertaken to look at what was in place and to set priorities for the work ahead.

In 2017, the Institute for Healthcare Improvement published a white paper: IHI Framework for Improving Joy in Work.[3] According to the authors, "Joy in work is more than just the absence of burnout or an issue of individual wellness; it is a system property. It is generated (or not) by the system and occurs (or not) organization-wide. Joy in work — or lack thereof — not only impacts individual staff
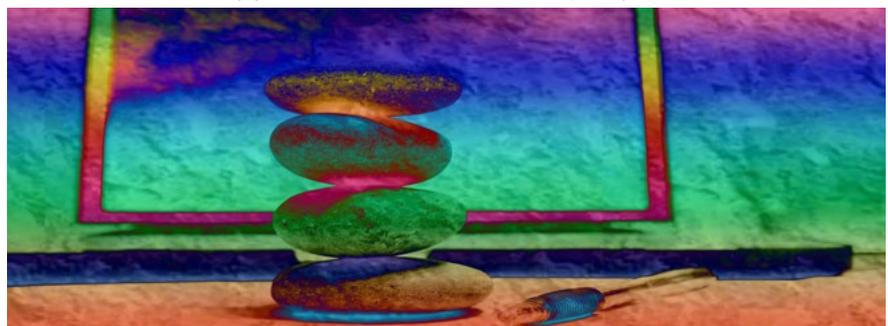
engagement and satisfaction, but also patient experience, quality of care, patient safety, and organizational performance."

These words speak to the importance of why, as leaders, we need to make this a system priority. If our ultimate goal is to provide exceptional patient experience and outcomes, this cannot be achieved in an environment where there is low staff and physician engagement.

The IHI Joy in Work framework, as with the Canadian standard, takes a systems approach, recognizing the responsibility of all in creating a work environment where people are valued and can contribute in meaningful ways.

The Mayo Clinic, when faced with physician burnout rates similar to the national average of close to 50%, took a systems approach to this challenge. Their framework[4]

speaks to the importance of individual, work unit, system, and national factors.

The alarming rate of suicide among physicians and medical trainees needs to be a burning platform for leaders in health care organizations and medical schools to take a systems approach, individually and collaboratively, to creating learning and work environments that promote psychological wellness and joy in work.

References

1.Vogel L. Has suicide become an occupational hazard of practising medicine? *CMAJ* 2018;190(24):E752-3. Available: http://www.cmaj.ca/content/190/24/E752
2.The national standard of Canada for psychological health and safety in the workplace. Ottawa: Mental Health Commission of Canada; 2013. Available: https://tinyurl.com/y775evp2
3.Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. IHI framework for improving joy in work. White paper. Cambridge, Mass.: Institute for Healthcare Improvement; 2017.
4.Shanfelt T, Noseworthy J. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Pro* 2017:92(1):129-46. doi: 10.1016/j.mayocp.2016.10.004

Author

Gillian Kernaghan, MD, is president and CEO of St. Joseph's Health Care in London, Ontario. She has been an active and vocal leader in health care and a champion of system leadership for many years.

Correspondence to:
Gillian.kernaghan@sjhc.london.on.ca

This article has been peer reviewed.

Invitation to submit articles

CJPL is inviting stories related to the CSPL white paper

A little over a year ago the CSPL produced a blueprint for transforming Canada's health care system, entitled "Accepting our responsibility." It included 20 recommendations aimed at physicians, health care organizations, provinces and medical associations, and Canada as a whole. Have those recommendations had an impact?

Are you aware of conversations or actions related to one or more of the recommendations? As a physician leader, what action have you taken or are planning to engage physicians in transforming Canada's health care system? Would you take the time to tell us about it in a short "story" of 800 words or less? Don't be shy – we provide strong editorial support.

The full white paper can be found on our web site: https://tinyurl.com/ht2ykoq.
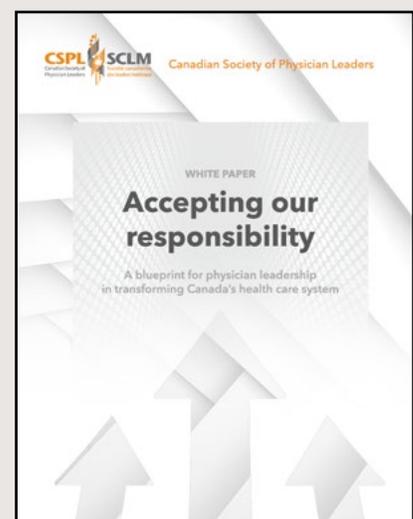
How to increase diversity: views from young physician leaders

Melanie Bechard, MD

Every physician leader has the power to increase the representation of early-career women physician leaders. Recommendations, based on interviews with young physician leaders – both women and men – as well as brief highlights from the literature, include dispelling myths such as women's "disinterest" in leadership roles, eliminating bias and exposing unconscious ones, avoiding discriminatory language, and accommodating family demands.

KEY WORDS: diversity, physician leaders, women physician, young physicians, myths, bias, discriminatory language

As leaders, we women physicians transform and contort ourselves in countless ways, impossibly balancing perceptions of likeability with competency, authenticity with self-preservation. The situation is particularly sensitive for learners and early-career women physician leaders. Without the security of an established career, advocating leadership diversity and promoting oneself may result in significant personal and professional consequences.

The intent of this article is not to invoke blame or guilt. All people, physicians included, have biases. Some are overt and easily demonstrable. Most are subconscious. Yet the collective subconscious bias of the culture of medicine has very apparent effects.

Women clinical department leaders in the United States are outnumbered not only by men, but even by men with moustaches.[1] It is a moral imperative that our medical leadership better reflect the general population. Gender is only one metric of diversity. Equally important is ensuring diversity in religion, racial background, socioeconomic background, sexual orientation and gender expression, family status, and appearance. These factors can interact to affect one's social standing – a phenomenon known as intersectionality. Only 25 of 166 internal medicine chairs in the United States are women, but only three are women of colour.[2] Although this article focuses on the experiences of residents and

new-in-practice women physician leaders, we cannot forget these other dimensions of diversity.

The problem is bleak, but our solutions are many. Every physician leader has the power to increase representation from early-career women physician leaders. The recommendations listed below were compiled based on interviews with young physician leaders – both women and men – as well as brief highlights from the literature.

Dispel myths

A new-in-practice physician, Dr. Natasha Snelgrove, mentioned that members of one of her organizations questioned efforts to increase women physicians in leadership positions, as women did not seem to be interested in these roles. A brief review of the literature reveals this to be patently untrue. Male and female faculty at USA medical colleges report similar leadership aspirations.[3] If these aspirations dissipate with time, we must question whether this is truly women's choice or whether repeated barriers to advancement dissuaded them from the leadership path. Hitting the glass ceiling too many times is sure to cause a headache.

The old adage, "men are from Mars, women are from Venus" deserves our skepticism. The differences between men and women are often exaggerated and ignore the wide inter-individual variation. Although men and women tend to use different

leadership styles, there is no evidence that women physician leaders are less effective than their male counterparts.[4] The colleagues I spoke with acknowledged that the individual personalities of their leaders, rather than gender, seemed to have the largest impact on leadership styles.

Seek and eliminate bias

All people have biases – even subconscious ones. These are necessary mental heuristics that allow us to rapidly appraise our world. Yet these cognitive shortcuts can lead to inequitable treatment of our colleagues.

Resident physician, Dr. Anthea Lafreniere, shared examples of her experiences. "There is the sexism at the board table. But there is all the subtle sexism that happens really regularly." Dr. Lafreniere

described a meet-and-greet event for a medical association board that she attended with her husband. Although she was the incoming board member, all of the current board members introduced themselves to her husband first, assuming he was the physician and board nominee.

Dr. Lafreniere also spoke about her experience attending a national medical organization meeting as a medical student. "I walk in, and I'm looking for my nametag and seat. I step up to the table and lean over to read the name labels. The man who was sitting nearby doesn't even look at me, whips his hand up with a piece of paper, and says 'I need a photocopy.' I just laughed and said that I'm a member of this committee. He didn't apologize. He seemed to still think I was a secretary. That was my first national meeting."

I spoke with several young women physician leaders who shared similar incidents: for example, a resident physician received an email addressed to her as "Ms. [surname]" while her male resident physician colleague was addressed as "Dr. [surname]" in the same message. Board chairs and presidents who were asked to take notes during meetings. These instances may seem trivial, but when they occur so frequently, it sends an unspoken but strong message that discredits the legitimacy of women physician leaders.

These situations create more than socially awkward encounters. Biases can impact the lives and careers of women physician leaders. Two thirds of women clinician-investigators in a survey felt that gender bias affected their academic advancement.[5]

Indeed, studies show female grant applicants of equivalent experience and prior success rates are given lower application scores than male applicants.[6]

Bias is a pervasive problem. Fortunately, there are mitigating strategies we can employ. Morgan and colleagues[7] produced recommendations for eliminating gender bias in academic medicine: acknowledge the systemic nature of bias, motivate those with influence to promote a culture of equity, implement evidence-based anti-sexism training, ensure transparent processes for career advancement and compensation, and research drivers of and solutions to gender bias within medicine.

Dr. Alim Pardhan, an early-career physician, further emphasized the importance of building diverse teams, "Diversity in leadership teams provides added context, a wealth of different opinions that ultimately make leadership teams stronger and more flexible. Fostering diverse teams should be one of the key performance indicators of leaders. Ensuring that women are encouraged and afforded the same opportunities to participate in leadership is a key part of that."

Acknowledge the blind spots

Dr. Thomas McLaughlin, an early career physician, informed me of when he was tasked with introducing fellows for grand rounds presentations as part of his chief resident responsibilities. After

the rounds presentations, a staff physician pointed out that he had introduced the male fellows as "Dr. [surname]" and the female fellows by their first names – a common phenomenon.[8] He admitted to initial surprise, but then reflected and apologized to both the staff physician and the female fellows. "I don't think people always notice their own internal biases… when you do get something pointed out, do be open to it."

Responding with grace to this type of feedback is unquestionably difficult. Although it takes great strength of character, an openness to these conversations is the only way we can mitigate our individual and systemic biases. Of note, women are not immune to gender bias. It is incumbent on all of us to pause, reflect, and respond with kindness if a colleague finds our blind spot.

Choose words carefully

One tangible action we can all take to advance women physician leaders is to consider nominating deserving candidates for awards or leadership positions. Many

of us may have experienced the challenge of trying to translate a candidate's ample qualifications into a letter of nomination. Little did we know that some of our laudatory comments might actually have harmed, rather than helped, our nominee's candidacy.

Words matter. Each word has particular connotations. The adjectives that we often use in letters of nomination can be categorized as "agentic" or "communal" traits. Agentic traits tend to be "competency-based" (e.g., strong, logical, decisive) and associated with masculinity, while communal traits are "warmth-based" (e.g., collaborative, kind, nurturing) and associated with femininity.[9] Word choice can affect medical students' perceived suitability for different specialties.[4] There is also evidence that including "leader" in the selection criteria for tenured medical faculty positions decreases the success rate of women applicants.[10] When preparing letters of nomination for our women physician colleagues, it is important to consider the connotations of the selection criteria and ensure that we

include relevant agentic traits as appropriate.

Family matters

During a coffee break at a national meeting of medical leaders, a student leader and her colleagues were admiring their friend's cooing infant. An older male physician passing by chuckled and exclaimed, "Typical women! Distracted by babies." Although the comment was likely intended to be good-natured, they were surprised (partly because two members of the group were men). It also seemed a very reductive label to apply to ambitious women leaders who had spent the conference engaging in difficult debates, ardently networking, and proposing creative solutions. The student described feeling as though her contributions to the meeting were discredited because of the momentary "distraction."

We have seen generational shifts in attitudes toward work–life balance; both male and female physicians are becoming more likely to prioritize family life. Resident physician, Dr. Ali Damji, expressed a need for the leadership community to embrace this mindset: "Generally, I think our leadership community needs to be more sensitive towards family needs. These are not female-specific. They need to be more responsive to having more familial responsibilities… We need to shift our mindset to people holding these multiple responsibilities as an asset and not a hurdle."

There is evidence that women physicians contribute

approximately eight additional hours a week to parenting and domestic responsibilities compared with male physicians.[11] For some, that represents an entire additional workday. I spoke with multiple young physician leaders, both men and women, who expressed a desire for childcare at meetings. It is a small but tangible step toward enabling women and family-focused physicians to adopt meaningful leadership roles.

Conclusion

Some of these experiences may seem trivial. They certainly pale in comparison to parts of the world with systemic violence and persecution of women, or the overt and widespread discrimination faced by our woman physician predecessors. Yet, it is a wonderful thing that there is not a finite amount of justice in the world. Every one of us can work toward improving the status of women in any corner of the world, while also promoting fairness and equity for women physician leaders within our hospitals and homes.

References

1. Wehner MR, Nead KT, Linos K, Linos E. Plenty of moustaches but not enough women: cross sectional study of medical leaders. *BMJ* 2015;351. doi: 10.1136/bmj.h6311
2. Albert MA. #Me_who: anatomy of scholastic, leadership, and social isolation of underrepresented minority women in academic medicine. *Circulation* 2018;22 May. doi: 10.1161/CIRCULATIONAHA.118.035057
3. Pololi LH, Civian JT, Brennan RT, Dottolo AL, Krupat E. Experiencing the culture of academic medicine: gender matters, a national study. *J Gen Intern Med* 2013;28(2):201-7. doi: 10.1007/s11606-012-2207-1
4. Carnes M, Bartels CM, Kaatz A, Kolehmainen C. Why is John more likely to become department chair than Jennifer? *Trans Am Clin Climatol Assoc* 2015;126:197-214.
5. Jagsi R, Griffirth KA, Jones R, Perumalswami CR, Ubel P, Stewart S. Sexual harassment and discrimination experiences of academic medical faculty. *JAMA* 315(19):2120-1. doi: 10.1001/jama.2016.2188
6. Morgan R, Hawkins K, Lundine J. The foundation and consequences of gender bias in grant peer review processes. *CMAJ* 2018;190(16):E487-8. doi: 10.1503/cmaj.180188
7. Morgan AU, Chaiyachati KH, Weissman GE, Liao JM. Eliminating gender-based bias in academic medicine: more than naming the "elephant in the room." *J Gen Intern Med* 2018;33(6):966-8. doi: 10.1007/s11606-018-4411-0
8. Files JA, Mayer AP, Ko MG, Friedrich P, Jenkins M, Bryan MJ, et al. Speaker introductions at internal medicine grand rounds: forms of address reveal gender bias. *J Womens Health (Larchmt)* 2017;26(5):413-9. doi: 10.1089/jwh.2016.6044
9. Heilman ME. Gender stereotypes and workplace bias. *Res Organ Behav* 2012;32:113-35.
10. Marchant A, Bhattacharya A, Carnes M. Can the language of tenure criteria influence women's academic advancement? *J Women Health* 2007;16(7):998-1003.
11. Jolly S, Griffith KA, DeCastro R, Stewart A, Ubel P, Jagsi R. Gender differences in time spent on parenting and domestic responsibilities by high-achieving young physician-researchers. *Ann Intern Med* 160(5):344-53. doi: 10.7326/M13-0974

Author
Melanie Bechard is a PGY4 student in pediatric emergency medicine at the University of Ottawa. She is past-president of Resident Doctors of Canada and has served on the board of Canadian Doctors for Medicare.

Correspondence to:
melanie.bechard@mail.utoronto.ca

This article has been peer reviewed.

STORIES FROM OUR CCPES

A Saskatchewan view on lessons learned and current trends

by Joy Dobson, MD, CCPE

Editor's note: We asked CSPL 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.

From 2008 to 2013, I served as the senior medical officer and VP medicine in the Regina Qu'Appelle health region. Almost 600 physicians, spread over a large geographic area, provided cradle-to grave tertiary care to 400,000 patients. My job was loosely described as "head coach of the medical staff."

Learning to manage difficult behaviour

We had many wonderful examples of superb care from caring, committed physicians, but, as in any workplace, we also had examples of challenging behaviours. Managing that small minority taught me much — and saw me spending far too much time with lawyers.

We learned that the old school "fireside chat" is a poor tool if your goal is to address negative behaviour. A better path is using the format from Crucial Conversations or Crucial Confrontations and ensuring that interactions are both witnessed and documented. If your fireside chat was meant to pass on praise, again not a good forum. Shout that message from the rooftops!

We never thought that verbal reprimands were an especially effective way of coaching. Through an appeals process, we learned that verbal reprimands must also be delivered in writing, and, although it often felt like we were wasting our breath, rigorous attention to each step on the bumpy road of progressive discipline was necessary.

In contrast, a disciplinary hearing felt like detonating a bomb in a crowded room. By definition, this is an adversarial venue where the natural tendency is to drift toward a criminal standard of proof, possibly because of a focus on the impact on the individual physician's career and financial health and the relative absence of the patient voice in the process. Panel selection and support was a logistical challenge, especially given the relatively small pool of colleagues to draw on. Given the stance of the Canadian Medical Protective Association on vigorous defense of physicians, discipline is a lengthy and costly process, with unpredictable outcomes, boxes of paperwork, and exhaustive appeals — rarely a path of choice.

Immediate suspension was the other tool at the heavy artillery end of the spectrum. This necessitated a board hearing to "set bail," followed by a disciplinary hearing, followed by the same lengthy appeal processes.

We also saw added cost, risk, and harm for all parties — including patients and taxpayers — arising from parallel lawsuits. Civil actions are painful and tortuously lengthy procedures with few opportunities to expedite the process. In our experience, litigation plays out over 7–10 years, so be prepared from the outset for an endurance test.

The only other tool we had was negotiated dispute resolution, and this was heavily favoured. We used this approach repeatedly, even for high stakes interventions. Despite some limitations in terms of tools at our disposal, we usually could negotiate an effective position that protected patients and staff alike. But even this route had its challenges. After a resolution was signed and implemented, we could be forced to defend up to the Supreme Court of Canada level.

Lean management and process improvement

The current global trend in health care is to use both a lean management system and lean process improvement tools to drive change. The overall

focus is to remove waste and so improve value, as defined by the customer. In Saskatchewan, Lean is synonymous with Patient First. Lean delivers better outcomes for patients, a better experience for both patients and providers (as it easier to reliably deliver the right service the right way), and lower costs in terms of both taxpayer dollars and risk of patient harm.

The aim of better care, better teams, and better value is not easily achieved overnight, so the work of a Lean transformation is not for the faint of heart. But this is the way we do things now in Saskatchewan – our culture and how we drive true transformational change. It means the quaternary aim of also ensuring joy in work is a realistic new target.

Quality improvement

The next trend is using not just medical science, but also quality improvement science. Our Saskatchewan Health Quality Council has been instrumental in teaching and spreading the use of measurement to support improvement. We know the basic principles: without standards there can be no improvement; you can't improve what you don't measure; what you measure is what you will improve; everything can be measured; and you must transparently measure over time to sustain improvement. An added bonus is that the objectivity of a graph helps truly define the problem and takes the emotion out of tackling it. Now, we see run charts on walls everywhere, from the individual hospital ward to the

hallways of the ministry of health. As a scientist, I love this trend.

The aim of better care, better teams, and better value is not easily achieved overnight, so the work of a Lean transformation is not for the faint of heart.

Of course, evidence-based medicine is a trend that now includes not just research on which therapies work best, but also feedback on how they work in the real world, where individual doctors treat individual patients. I said I love measurement, because knowing how you are doing is especially powerful for physicians. Show them data on how they compare with their peers on important measures of patient outcomes, and most performance issues will solve themselves. We saw this demonstrated repeatedly. Discussions with peers about reasons for variation typically led to practice changes and improvements for patients. This trend needs much greater spread to fully realize its power.

Leadership by physicians

You can't get where you want to go without physicians being part of the structure. Co-leadership is now embedded at every level in Saskatchewan's health system, and the silos are disappearing. Culture is what leaders do, so I know we are in great hands when I see the names on the new Saskatchewan Health Authority organizational chart. A strategic investment made by the Saskatchewan Medical

Association to grow skilled physician leaders meant that there was a large pool of talent to call on to fill these roles.

The trend toward a strong talent management strategy for physicians is catching up to that used in other industries. The simplest strategy is to always have room for a star and never to be so desperate you take someone who is not a good fit. It is critical that you have a reliable way to select for talent. Locum contracts, for example, are a way for everyone to "test the waters" and determine where you are starting from. Then, you need good onboarding processes to ensure each individual's continued growth and their long-term success.
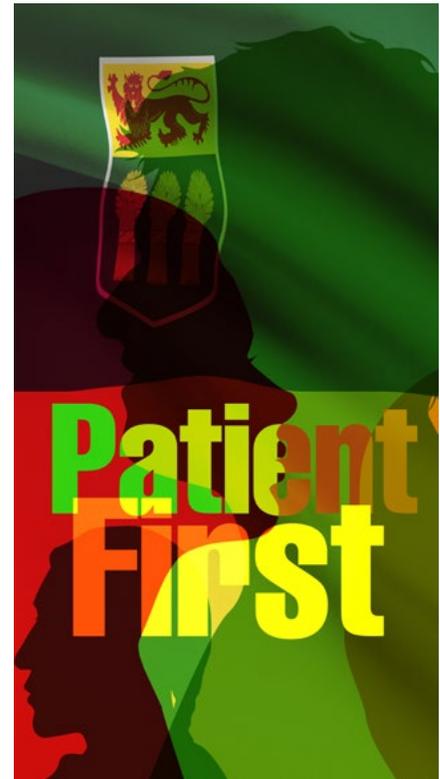
Physicians typically have long careers and are often with your organization for many decades;

so, your strategy must reflect this reality. You will be competing to retain talent, and your superstars will have many options. Don't give them a reason to leave. That means you need a way to address toxic behaviours that might lead to a poisonous environment. Equally important is having leaders – right up to the board level – who have the courage and energy to tackle these problems, instill your organization's values, and remain committed to quality care.

Like any organization, you will likely have problems with only a small percentage of physicians. This is a good trend: to treat physicians like the other members of the care team, following the principles of natural justice and progressive discipline.

But patient- and family-centred care may be the tool that underpins it all. The trend to truly put the patient first means their interests trump those of providers. It means their voice is the one we hear best and that our customers are happy with the value we provide. That is definitely a trend we all want – for ourselves and for our loved ones.

Author

Joy Dobson, MD, CCPE, has served in various leadership positions during her clinical career in anesthesia and critical care. As SMO and VP medicine in Regina Qu'Appelle Health Region, she was "head coach" for almost 600 physicians in the southern part of Saskatchewan who provided care to 400,000 patients. Currently, she is providing consulting services to 3sHealth while enjoying a transition to non-bedside practice with a focus on system improvement.

Correspondence to:

dr.joy.dobson@gmail.com

2019 call for nominations
CSPL Excellence in Medical Leadership Award
(Chris Carruthers Award)

Nominations are being sought for the CSPL Excellence in Medical Leadership Award (Chris Carruthers Award). This award is presented to a physician who has made an outstanding contribution to the development and mentorship of medical leaders in the field of health services leadership and management.

Nominees must be Canadian physicians who are members of the CSPL. Nominations may be submitted, accompanied by suitable documentation, by any physician member of the CSPL. Documentation will consist of a completed nomination form, a detailed letter qualifying the nominee, and the nominee's curriculum vitae. Nominations should be submitted in typewritten form and can be sent electronically or by mail.

Nominations should be addressed to: Chair, Awards Committee, c/o Carol Rochefort, Executive Director, Canadian Society of Physician Leaders, 875 Carling Avenue, Suite 323, Ottawa ON K1S 5P1 or email carol@physicianleaders.ca.

Deadline for submission: February 15, 2019

Nominee:

Title:

Address:

Telephone: **Email:**

Nominated by:

Address:

Telephone: **Email:**

In a detailed letter of nomination, please describe how the nominee has demonstrated outstanding abilities in one or more of the following categories:

- **Commitment to enhancing the role of physicians in the management of health care delivery organizations**
- **Leadership in a hospital or health region management role**
- **Significant contribution to leadership development in CSPL or any related organization or program of provincial/national scope (e.g., affiliate organizations, CMA/PTMAs, PLI)**

In addition to the nomination form, letter of nomination, and curriculum vitae, please provide additional letters of support to the postal or email address above.

INTERVIEW/BOOK REVIEW

Dr. Victoria Jones: physician, leader, mother, and author

Achieng Tago, Mellissa Ward, MD, Megan Delisle, MD

Women's careers and leadership opportunities look drastically different today than they did 20 or 30 years ago, a phenomenon that has been well captured in the media. However, a story less often told is how this is changing the face of motherhood. Becoming a parent is inseparable from the career choices women make. As more and more women physicians are pursuing leadership positions, it is important to discuss how this shift affects motherhood. The traditional motherhood role is not a reality for many working women today. Achieving gender equity in the workplace is currently at the centre of many political spheres, but Dr. Jones wanted to draw attention to the other gender issues women face that are often silenced.

We sat down with Dr. Victoria Jones to discuss her new novel, *The Silence of Motherhood*[1] in which she addresses themes such as domestic violence, abortion, single parenting, and miscarriage, and how these issues influence how women physicians lead. Dr. Jones recalls being told that she would not be hired as a surgeon or become a leader if she chose to have kids. Professional women struggle with such experiences every day in silence, and rarely share them out loud. This book aims to change the silence of motherhood in the culture of medicine and bring these conversations to the forefront.
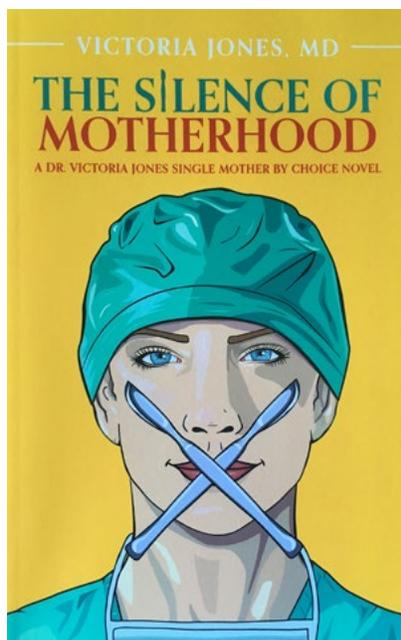
Silence is the central theme of Dr. Jones' book. All of the characters experience silence in different ways and for different reasons.

"It is one word that everyone can look at and say that they have some understanding of what the meaning of silence is," says Jones. "I think that everyone, both men and women, have experienced times in their lives when they love silence and times when they don't love silence. There are many different emotional qualities the word brings up."

Framing the book around the theme of silence allows everyone to relate. Depicting gender issues as women's issues or victimizing men creates further divide and can make things worse. Framing gender issues in a way that everyone can relate to allows people to come together and drive change.

Powerful examples throughout Dr. Jones' book allow readers to experience first-hand how women physicians are silenced. Reflecting back on her time as a resident, Dr. Jones remembers seeing a woman being silenced for the first time, "When I was a resident, our section head was female, and she was actually the person who said, 'I would never hire you if you had children.' I think that this is often what is touted about women, that women are harder on other women than they are on men. One time she said to me, 'I have to be harder on you, because you have to learn how to survive in this profession.'"

Dr. Jones can only imagine the hardships her section head experienced to drive her to

no longer have the vision and strength to make things better for the next generation of women. "When you talk about the silence of womanhood, I think that was really the first time I had experienced it in someone else where she could have really been standing up for things. Even I sometimes have trouble paying it forward. Sometimes I think about going back and telling her I see truly why she had become the person she was." The culture of medicine becomes so engrained in us and we become socialized to accept things the way they are. This creates a fear of change and is one of the reasons gender imbalances still exist.

Some women feel they need to step away from leadership roles, not necessarily because they lack the qualifications, but because they cannot envision having the additional responsibility. Balancing motherhood with a busy career is already challenging enough. Women often feel the weight of having to choose between being a mother and pursing leadership positions.

"I have always been very goal oriented," says Dr. Jones. "When I became a mother, my relationship with my goals changed. With children, they have to be more refined, be exactly what you want to do. Is this going to benefit you, your career and your home life? I still have goals, but they are fewer now, and they are very much more focused. In the past, I could put almost anything on that list, say okay this is feasible, but now it's really what fits with who I am, because you change as a

person when you go through these different experiences."

The added work of a leadership role with minimal compensation or a reduction in clinical responsibilities can seem even less attractive to mothers in medicine, as they traditionally are the primary caregivers and responsible for organizing the household. However, women are often silent when it comes to asking for what it would take for them to take on leadership roles.

As Dr. Jones explains, "When I was section head I said 'I am only doing 30% clinical and you are going to pay me for doing all of this other stuff. I am going to make at least the average salary of a general surgeon in doing this role, and this is what this is going to look like when I am the section head.' I think women are often scared to ask for the things that would make it possible for them to take on leadership roles."

One of the ways Dr. Jones manages single parenthood and a thriving surgical career in her book is by having a live-in nanny, but this choice comes with its challenges. Having children can result in the "mother bias," a type of implicit bias where mothers are not perceived as fit for leadership roles, and when mothers do prioritize work, they are seen as an irresponsible parent. Facing these micro-aggressions is an additional reason mothers may choose not to seek leadership positions.

The characters in *The Silence of Motherhood* experience various challenges, such as domestic

violence and abortion. These are powerful examples of what women face, often alone and in silence. These experiences are even more challenging during medical training and occur during critical moments of professional identity formation.

"Residents are already in a difficult position, because they have no power to do anything and it is impossible for them to think objectively about what they were going through. I think residency does that to you sometimes. It pushes you down so much that you have other personal things that you are trying to deal with, and it doesn't even allow you to see that these things exist."

In Dr. Jones' book, she depicts a very strong resident with clear leadership potential, who experiences many of these different difficulties. Maintaining professionalism at work and putting her patients before herself, she is unable to think clearly about how these experiences are affecting her well-being, which predisposes her to burnout. Women in medical training often report higher rates of burnout symptoms than men.[2] These early years of training often determine whether women can see themselves being supported as future leaders in the profession.

To sustain the increasing number of women in leadership positions, it is important to think critically about how these positions will adapt to the unique challenges some women face around motherhood. Dr. Jones' book has a powerful impact on

readers as it demonstrates, in an uncensored fashion, the intense struggles women face during their childbearing years, often at the peak of their careers. Supporting future generations of women in leadership needs to include strategies targeted at improving this. This includes re-examining our implicit biases around the role of motherhood and fatherhood. Just as motherhood has been silenced, fatherhood has equally had its challenges in establishing itself in the culture of medicine.

The Silence of Motherhood is the first book of what is intended to be a series detailing, from an insider's perspective, the life of a woman who learns the delicate balance of being a physician, leader, and mother. Dr. Jones is currently working on the second book, with an expected release date of December 2018.

References

1.Jones V. *The silence of motherhood*. Victoria, BC: Friesen Press; 2018.
2.Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med* 2014;89(3):443-51. doi:10.1097/ACM.0000000000000134.

Authors

Achieng Tago is a medical student at the Max Rady College of Medicine, University of Manitoba.

Mellissa Ward, MD, and **Megan Delisle**, MD, are residents in the section of general surgery, University of Manitoba.

Correspondence to:
umtago@myumanitoba.ca or megandelisle@gmail.com

VOLUNTEER WANTED
Looking for a volunteer editor-in-chief

Do you love networking? Are you passionate about health care and health systems? Would you like to stay informed about what is happening in physician leadership across Canada and internationally? Are you interested in reading, analyzing evidence, writing and reviewing papers or books?

In 2019, the Canadian Journal of Physician Leadership (CJPL) will be celebrating its 5th year of publication. The founder and current editor-in-chief, Dr. Johny Van Aerde, is ready to hand over responsibilities, and we are looking for a new editor-in-chief to maintain the vibrance of the journal. This is an exciting volunteer opportunity, particularly for physicians who want to contribute to and give back to their medical community.

Below are a few attributes of the editor-in-chief position. Ideally, we would like a CSPL member, but we are willing to accept applications from non-physicians with a health care background.

Requirements
•good verbal, electronic, and written communication skills
•experience and connections to develop and maintain a network of knowledge experts across Canada
•some experience in writing editorials and other articles and in critical thinking
•willingness to volunteer 60–70 hours per issue (4 issues/year): researching and writing an editorial and/or papers as required, connecting with potential and active authors, reviewing papers and synthesizing comments from external reviewers, communicating with editorial board and authors to incorporate reviewers' comments and improve papers, communicate with copy editor and managing editor, determine and manage content
•knowledge of the national, provincial, and, to some extent, international past and present issues as they relate to health systems and system transformation, as well as the factors influencing health systems and health
•understanding and knowledge of the theoretical and practical aspects of leadership

The editor-in-chief must be able to attend and network at our annual Canadian Conference on Physician Leadership and communicate with the CJPL editorial board and with the CSPL board. The successful candidate will be supported by an outstanding copy editor, the designer of the journal and website, a managing editor and a 20-member editorial board that assists with reviews.

If you are interested in pursuing this opportunity, which may be for a defined period, or if you would like further information, please contact the CSPL executive director by email at carol@physicianleaders.ca

BOOK REVIEW

The 10-80-10 Principle: Unlocking Dynamic Performance

Sunjay Nath
Pocketbook, 2011

Reviewed by Johny Van Aerde, MD, PhD

During the 2018 Canadian Conference on Physician Leadership, keynote speaker Sanjay Nath had the audience laughing as he comically unpacked the content of his book, *The 10-80-10 Principle*. In 57 pages, he combines a modified 80-20 Pareto concept with elements of the Influencer framework.[1]

According to the 10-80-10 principle, any group or organization can be divided into three groups based on their behaviour: people who share an organization's goals, people who don't share them, and people who are looking for direction. Although the numbers can vary and are more relative than absolute, the first group forms the top 10%, the second group is the bottom 10%, leaving an 80% majority group with no real direction in the middle.

Belonging to one group or another doesn't mean that you are "good" or "bad": the categories are based on behaviour, not personality traits. Therefore, the 10-80-10 principle can also be applied to any social gathering, family, sport team, and even to behaviours of one's self.
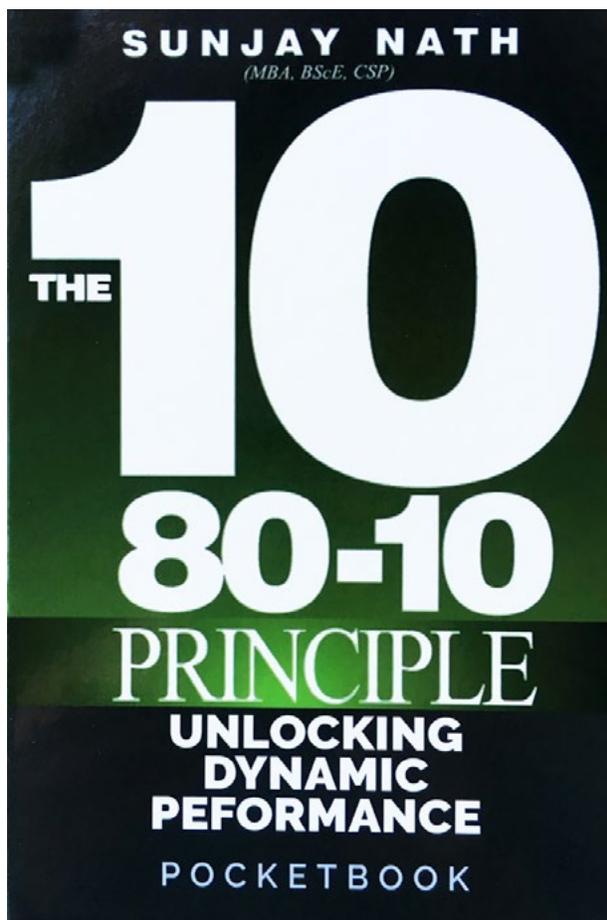
For leaders, the key is to focus on the 10% already supporting the organization or you, as they can be your champions to influence the 80% who are looking for direction. Directly targeting the bottom 10% is an ineffective strategy, as they are probably set in their thinking and behaviour and require too much time and energy to be influenced to change. Although influencing the majority 80% is important, the resources needed to reach such a large group are limited. For that middle group to drive momentum, they need a catalyst, which is where the top 10% comes in. Once that army of champions has influenced the 80% majority, 90% of the entire group is on board. At that point, you can go after the bottom 10%, which is likely to subdivide into followers and those who will abandon the cause or organization altogether.

The end of this book, how to apply the 10-80-10 principle, is a little weak and deals with awareness, choice, and time. The strength of the book lies in its main message: that we often waste time on the 10% who cannot be influenced anyway and that we are much better off to work with the top 10% by using them as champions to help influence the large middle group.

Reference

1. Patterson K, Grenny J, Maxfield D, McMillan R, Switzler A. Influencer. Toronto: McGraw-Hill; 2013.

Author

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

Correspondence to:
johny.vanaerde@gmail.com

BOOK REVIEW

The Introverted Leader: Building on Your Quiet Strength
Second edition

Jennifer B. Kahnweiler, PhD
Berrett-Koehler Publishers, 2018

Reviewed by Johny Van Aerde, MD, PhD

Our workplace cultures are skewed toward extroverts, but The Introverted Leader has practical tips on how to lead as an introvert. The typical characteristics that are the strength of an introvert – listening, preparation, and calmness – also happen to be great qualities of leaders in general.

Kahnweiler presents her theory in the first two chapters of this book. Chapter one describes the six key challenges for introverts: people exhaustion, fast pace, interruptions, pressures to self-promote, emphasis on teams, and projecting negative impressions of being disengaged simply because introverts often think more and speak less.

Chapter two introduces the reader to the four Ps that comprise an introvert's strategy: prepare, presence, push, and practise. Step one, preparation, includes working on a game plan. Careful planning fits with the introvert's style and gives him or her confidence to
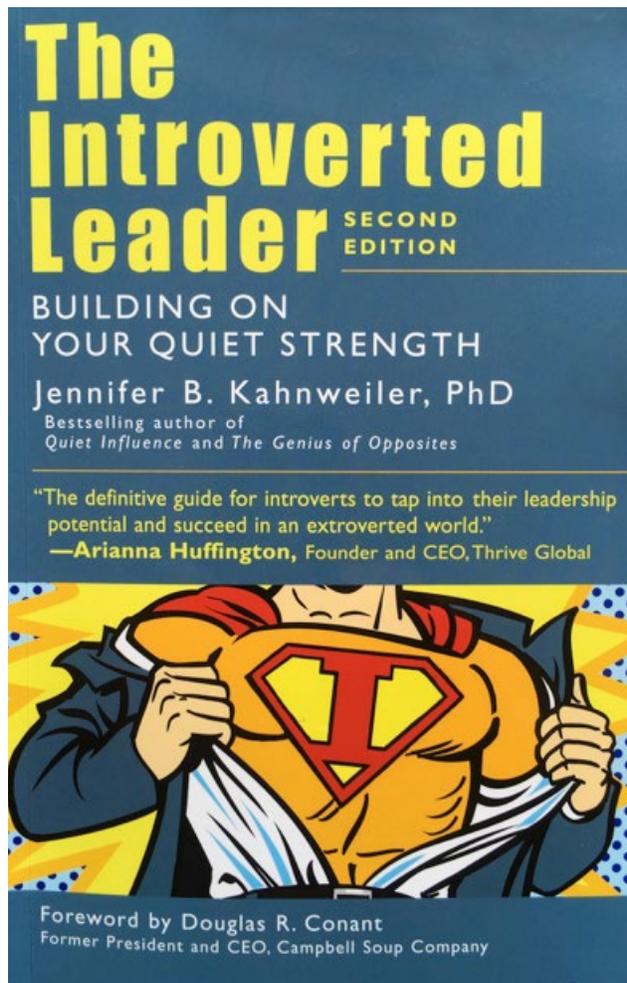
handle situations as they occur. It might mean understanding your team and its members, knowing yourself, or creating the appropriate environment. Presence means being focused on the present moment in a way that allows you to be with people. It includes listening, paying attention, and flexing your style. Push, the third step, is likely to put the introvert outside their normal comfort zone as it means taking action with others. The last step involves practising and simulating new behaviours in a supportive environment.

After a set of questions to determine your introverted leadership skills in chapter three, the rest of the book offers practical tips on how to apply the four Ps and lead well in common situations, including leading projects, delivering powerful presentations, and leading meetings.

Although this book focuses on an important aspect of personality, it does not deal with any of the other characteristics that make up the richness of our personality and add to diversity of our behaviour as a leader, as an individual, and as a team member.

Author

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

Correspondence to:
johny.vanaerde@gmail.com

CANADIAN JOURNAL OF PHYSICIAN LEADERSHIP
ADVERTISING RATE CARD 2018/19

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

The journal is published in electronic format only — PDF and online — and delivered to the desktops of over 2000 physician leaders across Canada. The latest issue of this quarterly journal can be viewed at **www.cjpl.ca**

ADVERTISING RATES (taxes not included)

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

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

Canadian Conference on Physician Leadership

Fairmont The Queen Elizabeth Hotel • Montreal, Quebec

Registration Now Open

Diversity, Inclusion & Engagement:
The Leadership Challenge

April 26-27, 2019

2 Day Pre-conference courses — April 24-25, 2019
Building and Leading Teams
Leading with Emotional Intelligence
Personal Leadership: Identifying Your Core Values and Vision

1 Day Pre-conference courses — April 25, 2019
Leading Coalitions: Navigating Cultural and Professional Silos
New — Just Culture
Nouveau en français — Culture juste

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

www.physicianleadershipconference.com