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# Physician Leadership

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# Leadership Skills: Adopt or Bust

## In this issue



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

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EDITORIAL

# Some housekeeping matters from the CSPL and CJPL

Johny Van Aerde, MD, PhD

## Conference news

In keeping with the theme of the previous two issues of our Canadian Journal of Physician Leadership, this year's Canadian Conference on Physician Leadership will focus on "Diversity, inclusion & engagement: the leadership challenge."

We are pleased to announce that from this year on, CSPL will be the sole host of this annual event. For an overview of the program with 19 unique workshops in 32 sessions, 4 keynote speakers, and an awards celebration, please see the back of this journal and the conference web site (**physicianleadershipconference.com**).

## New perks for CSPL members

In 2019, CPSL members will have access to *BMJ Leader*, an electronic publication, rich with research on leadership in the medical world. This journal is not accessible through traditional electronic university libraries. Individual subscriptions go for about $225, 1.5 times your membership fee.

Starting in February, the CSPL is also on Facebook, with a closed group hosted by Dr. Chris Carruthers, founder and first president of the CSPL, and moderated by a few of us. Questions and topics that are crucial and sometimes difficult can be shared and discussed in this safe community of interest. As a CSPL member, you will have received an invitation to join the group; if you haven't, please contact our office (**carol@physicianleaders.ca**).

## In this issue

The CSPL's executive director gives us an interesting look behind the scenes at conference preparations in her article, " Why are conferences so expensive?" You will be surprised to learn about the logistics and hidden costs.

This issue, themed "Leadership skills: adopt or bust," also includes a variety of articles on skills or situations we encounter as physicians. Gervase Bushe writes about generative leadership, a leadership style that is essential in today's world of volatility, uncertainty, complexity, and ambiguity. James Ruiter and Steven Bellemare address some of the newer cultural aspects in the health care system, while Ian Hanna and Joanna Piros share tips on how to communicate more effectively under various conditions.

Graham Dickson reminds us why physician engagement with the health system is important and provides evidence from two provinces showing what a difference it can make. Mamta Gautam, a leader in the area of treating physician burnout, offers a new "equation for health." Lara Hazelton provides insights into how to teach the teacher of leadership skills. James Goertzen explores the link between innovation and compassion.

## Your input

We would love to hear from you. What issues would you like the CSPL – *your* organization – to address? What types of articles would you like to see in *CJPL*? What initiatives do you want to be part of? What can you give the CSPL, and what can the CSPL do for you?

Hope to see you at CCPL2019 in Montréal in April!


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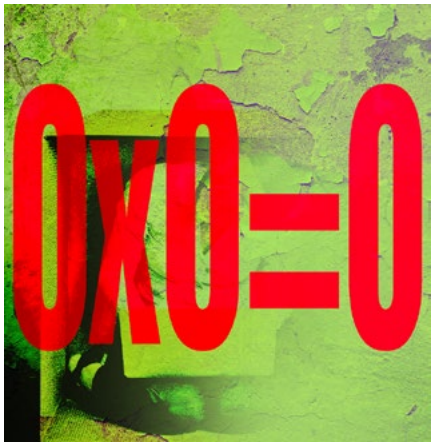
ADVICE

# Quit multiplying by zero to address physician burnout effectively

Mamta Gautam, MD

As I was recently helping my young nephew with his math homework, we discussed the multiplication effect: that any number, no matter how large, when multiplied by zero is still zero. I started to reflect on how this is true in complex human systems as well as mathematical ones. Based on simple multiplication theory, addressing and fixing any "zero" is the only way to have a positive impact on the overall result.

This may be applicable to our efforts in addressing burnout. To date, we have mostly been




focusing on some of the relevant factors, such as individual wellness and resilience, while our attention to other crucial aspects, such as systemic issues contributing to burnout, may have been zero.

I have been passionate about promoting the concept of physician health throughout my career. Having personally experienced serious medical illness as a resident, I recognized early that health care does not support the health of its workers.

## Individual factors

Since I started working in physician health in the early 1990s, I have been focusing on addressing the individual aspects of physician wellness. This is partly because the person in my psychiatric office asking for help was the individual physician.

Furthermore, the hospitals and medical organizations with whom I was speaking were not yet ready to acknowledge the problems in the system that contribute to burnout. It would be decades before we had scholarly publications and data on the need for physician–organization collaboration in addressing physician burnout.[1]

In the 1990s and 2000s, medical school deans would agree on the need for healthy medical students, but would remind me of how much other "real medicine" they needed to include in the curriculum. Although the idea of residents being taught about wellness was supported, the specialty colleges had a list of curriculum priorities that, at that time, did not include physician health.

I learned to be persistent and patient. I bring up this topic as often as I can in conversations. I speak about it, teach about it, write about it, research it, consult about it, and create frameworks and programs to address it.

In the past few years, we have been hearing more about burnout than ever before. We've learned that one in two physicians is suffering from burnout.[2] Burnout is an epidemic hiding in plain sight.

I have also seen progress in recognizing the importance of physician health and hope that we are reaching a tipping point. In 2014, Bodenheimer and Sinsky[3] recommended the expansion of the Institute for Healthcare Improvement's Triple Aim (a compass to optimize health system performance, comprising enhancing patient experience, improving population health, and reducing costs) to become the Quadruple Aim, adding the goal of improving physician/provider satisfaction.

In 2015, the Royal College of Physicians and Surgeons of Canada revised the Professional role of the CanMEDS framework to include key competencies of commitment to physician health, collegiality, and support.[4]

In October 2017, at the World Medical Association meeting, Sam Hazledine successfully lobbied for the modification of The Declaration of Geneva, which is used by physicians across the world and regarded as a modern version of the Hippocratic Oath, to include: "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard."[5]

In 2017, the CMA updated its policy on physician health, recognizing that physician wellness is a key quality indicator and is "attributable to a range of personal, occupational and system-level factors" which must be addressed via deliberate and concerted efforts at a national level.[6] The 2018 CMA Code of Ethics and Professionalism, which articulates the ethical and professional commitments and responsibilities of the medical profession, has also specified commitment to self-care and peer support as a fundamental commitment of the medical profession.[7]

## Systems factors

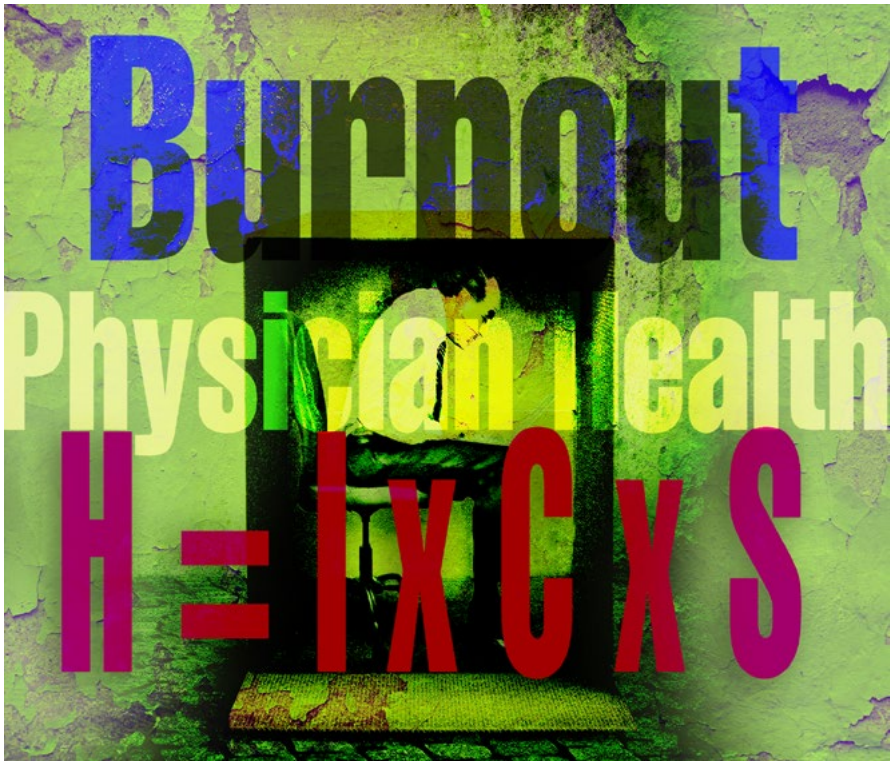
Recently, I have seen colleagues on social media speaking out negatively about the terms "burnout" and "resilience," urging us to stop focusing on and blaming physicians and, instead, concentrate on improving the system in which we work. They assert that physicians start out healthy; it is the health care system that makes us sick and where the focus needs to be for change.

I completely support the view that the health care system has responsibility for the health of its physicians and that we must start making it accountable for this. We need to address workplace issues such as long hours, frequent call, frustration with administrative burden, paperwork, EMR, feeling undervalued and underpaid, frustrations with referral networks, difficult patients, medicolegal issues, regulatory issues, and insurance concerns.

However, we have to be careful not to let the pendulum swing too far the other way and give up all responsibility for our well-being to the system. I feel that we physicians must make sure that we maintain our share of the responsibility for our own health and, therefore, our sense of control. This is not an either/or proposition. I support a model of shared responsibility for physician health, as recently defined in the 2017 CMA Policy on Physician Health.[6]

## Cultural factors

One other aspect stands out as impacting physician health: the culture of medicine. The culture in which we work sets high expectations of trainees and physicians, reinforcing perfectionism and self-sacrifice. It teaches us that the patient always comes first; that we should tough it out, keep going without showing weakness or emotion. There is stigma in our culture associated with disclosing an illness and reaching out for help, making us feel that we have failed. Reviewing



efforts made in the past 30 years, I see there has been advancement, yet recognize that there is still a long way to go.

## A simple equation for health

I offer a simple equation to illustrate such a shared responsibility model. Physician health (H) is the product of individual physician factors (I), the culture of medicine (C), and the system/organization (S).

**H = I x C x S**

Back to simple multiplication theory: if I or C or S is zero, then we are still multiplying by zero and will not have made any progress. We need to ensure that we are working on *all* of these factors.

Physicians need to continue to learn to recognize and manage their personality traits of being conscientious, perfectionist, highly responsible, and delaying their own gratification. They need to retain a sense of control, set realistic expectations of themselves, and learn to say no. Understanding and ensuring that all of the 5 Cs of physician resilience,[8] are addressed and supported is something that we can and must do to contribute individually to our own wellbeing. The 5 Cs are:

1. Control and confidence – having the self-awareness to understand our personality traits and recognize early signs of stress and burnout, so that we can respond with a sense of control and remain confident
2. Commitment – understanding our sense of commitment to our work, ensuring that it continues to bring us joy, and balancing this with our personal priorities.
3. Caring connections – identifying the important people in our personal and professional life who support and sustain us and making concrete steps to maintain and enhance these relationships.
4. Calming – recognizing when we are not feeling calm and identifying strategies to allow our feelings, burn off negative energy, and regain a sense of calm.
5. Care of self – recognizing the need to care for ourselves on an ongoing basis, so we can regularly invest in ourselves to be available to those who count on us.

We need to continue to address the stigma in the culture of medicine. Speaking about our experiences, sharing our personal stories, and supporting each other with empathy and compassion will go a long way.

The system must identify what it needs to address to not overburden physicians, better support their work, and recognize physicians for all that they do. Christina Maslach, creator of the Maslach burnout inventory, describes the six mismatches in the workplace that lead to burnout[9]: a lack of sense of control, insufficient reward and recognition, lack of community, absence of fairness, conflict in values, and work overload. Health care systems and organizations will need to pay deliberate and concerted attention to each of these six issues and create tangible initiatives to improve and eliminate these mismatches to eliminate burnout.

## A complex problem requires complex solutions

Although we are not yet where I envision we can be, we have made a lot of progress in increasing awareness of this issue and reducing the stigma associated with reaching out for help. Ensuring efforts on all aspects of the equation, I, C, and S – the individual physician, the culture of medicine, and the system/organization – is essential in addressing physician burnout effectively and meaningfully promoting physician health (H).

Health care occurs within a complex adaptive system in which elements learn and adapt to changing environments. Understanding and influencing change in our current health care system, such as addressing burnout, requires knowledge of complexity theory and complex adaptive systems.[10,11] Health care problems are not simple, such as baking a cake, where there is a recipe that can be easily learned; neither are they complicated, requiring expertise and coordination, such as sending a man to the moon. Instead, they are complex; like raising a child, there is no formula, a high degree of uncertainty, and the potential for unintended consequences.

Physician health is a complex issue. We cannot solve it with a simple, or even a complicated, solution. Successfully addressing physician wellness requires us to modify our approach to appreciate the complexity and interconnectedness of the contributing factors and to design and develop solutions that arise from the continual engagement and adaptation of all stakeholders. With a shared vision of successful outcomes, we can develop guiding principles with minimum specifications or rules.

We will need to build relationships, collaborate, increase information flow, allow emergence and experiment with options, identify positive deviance where small groups have come up with creative workable solutions, and accept diversity. This will require open-minded, agile leadership.[12] The CSPL white paper[13] states that "Efficient and effective reform of Canada's health care system cannot occur without the active and willing participation and leadership of physicians." Let's step up.

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ADVICE

# Physician: advocate for thyself (because no one else will)

Ian Hanna, BA, BJ

Local leaders are increasingly being called on to advocate on behalf of their professions at the national level. This requires a degree of knowledge, rhetorical skill, focus, and experience. The best way to articulate a point of view is through the use of narrative. A narrative forces you to combine facts and emotion, which are both needed in advocacy presentations. However, the most important thing to remember is this: if you're not telling your story, someone else is. So, prepare yourself and get into the game.

**KEY WORDS:** advocacy, storytelling, messaging, brand, communications

Former United States president Lyndon Baines Johnson was flawed, vulgar, misogynistic, nasty, and arrogant. On a tour, an Army officer directed him, saying "Mr. President, your helicopter is right this way." His reply: "Son, they're all my helicopters."

However, say what you like about LBJ, he could cut to the chase. When he talked about solving problems in government, he said this: "Doing what's right isn't the problem. It's knowing what's right."

And that, in a nutshell, is the problem facing elected official and bureaucrats today. After a few years in government, they discover that it's never a case of deciding between a good idea and a bad idea. The truly awful proposals have a way of being sifted out. What's left are six to eight relatively good options in completely unrelated areas – all offer the prospect of doing some good and improving lives.

To make sensible choices, politicians find themselves talking to people with recent experience on the front lines. They ask them about their experiences and their best guess on how this latest idea might work.

Hence, the role of advocates. You have to be at or near the table when the important decisions are being made. Once there, you have to use the short amount of time available to present the most compelling case possible. You must effectively explain why your proposal should be funded at the expense of others. And don't feel bad about being part of the competition. There was someone there before you and someone after you. They're both trying to steal your lunch money.

## Crafting your message

I believe there were two main problems with most of the advocacy efforts I saw in the political arena: narcissism and the excessive use of abstractions. I'll start with narcissism because it's the easiest to remedy.

We all like to talk about ourselves. We all like to talk about things we find interesting, like our chosen profession. We speak in


jargon. We use acronyms. We find internal organizational processes and decision-making criteria fascinating. However, the rest of us don't share your enthusiasm. Quite frankly, flaunting your insider expert knowledge is closer to "mansplaining" than anything else. Perhaps we can call it "occupational mansplaining." We are the "ins" and the people we are talking to are the "outs."

Avoid this trap. It bores people to tears. Instead, focus on your customer/patient/client. Find a story about an individual who was searching for vital help that only you could provide. Articulate what is called the "unique value proposition": what can you do that no one else can do, or at least do as well?

Using a narrative structure in your advocacy work is the best way to avoid problem two and move from the abstract to the concrete. People don't understand trade agreements like Brexit and NAFTA. They want to know if they'll still have a job. Bernie Sanders's campaign manager, Jeff Weaver, was on a break from politics and running a comic book and gaming store in Virginia when he was tapped to lead the Sanders campaign. Mr. Weaver had a visceral understanding of what motivated people.

In a December 2017 edition of the *Washington Post*, he said: "Anybody running for office right now has to talk about the reality that people are facing in their own lives. People aren't interested in abstractions."[1]

Advocacy must take as given that politicians like to win. Telling them how your idea will unlock popular support while actually doing some good is key.

## Know your audience

Advocacy is nothing more or less than getting the right people with the right pitch in front of the right decision-makers. But it's not as simple as you think. You need someone who's worked inside the system to act as a guide. They appreciate the natural rhythms of the political calendar and can highlight times and people to focus your efforts.

Once in, spend a lot of time on your pitch. Rehearse it. Shop it around. What's obvious to you is opaque to others. Lucy Drescher is head of parliamentary advocacy for Results UK. In a 2016 *Guardian* article, she emphasizes the need for clear and simple messages that convey passion and promote credibility:

> It is important to have evidence to demonstrate the difference the change will make in people's lives, so do your research. Passion without evidence is rarely effective; conversely evidence alone is insufficient. You need both.[2]

This is a point made repeatedly in advocacy literature and one explored extensively in Nancy Duarte's excellent book *Resonate*.[3]

You should also understand the limitations of time and bandwidth experienced by your audience. Jess Phillips, a prominent Labour MP for Birmingham Yardley in the United Kingdom, dedicates an entire presentation on her website to the subject "How to lobby an MP."[4]

According to Ms. Phillips, the thing people forget is that politicians get dozens of requests every day. You need a definitive "ask". If you simply appear in their office and make a generic request for support, you may be one of a hundred organizations to do that. Phillips says the key to advocacy

is to not be the same as everyone else.

**Brands provide people with the information they need to make a decision between one thing and another. Put more bluntly, it's what people say about you when you're not in the room.**

## Know your brand

There are side benefits to working on your advocacy messaging: it tends to remind you of the need to revisit your brand. Most of the people I work for firmly believe everyone, inside and outside of their group, understands the brand. Further, they believe here is an internal consensus on the values underpinning that brand.

Usually, nothing could be further from the truth. This is particularly true when there hasn't been a brand refresh in a few years, or a large staff turn-over.

Brands provide people with the information they need to make a decision between one thing and another. Put more bluntly, it's what people say about you when you're not in the room. Brands precede advocacy. A discussion about advocacy without reference to the brand will wander and become unfocused.

Brands also push you away from abstractions and toward a story. Embedded in every brand are stories – stories about origin, stories about scarcity or desirability. Clarity of brand will help you develop a narrative that will become crucial in your advocacy efforts. Brands are the words and actions that define you. They reflect your values, which have more to do with your origins, your intentions, and your priorities.

In a recent *Quartz* article, the author articulates the subtle but important distinction and relationship between brand and values. Walt Disney, the article states, is synonymous "with iconic film characters and the world-famous theme parks that bear his name."[5]

Walt Disney's values were slightly different. Profits are important, but for a reason: "We don't make movies to make money, we make money to make more movies."[5]

## Final words of advice

Leave something behind, so that people remember who you are and what you said. Some people learn by listening. Some learn by doing. Others absorb information in written form.

Advocacy literature should look different from all other corporate or government writing. It should be colourful. It should have pictures and lots of white space. It should invite people into the words, not scare them away.

You do this by composing short sentences, using simple words. Sentences should be 12–15 words in length, not 50 or 60. If you don't write like this naturally, there are plenty of websites available to assist you. For example, Grammarly (grammarly.com) is fast and easy and the Hemingway Editor (hemingwayapp.com) is quite visual and emphasizes simplicity of sentence construction.

Good reporters make average editors and often terrible newsroom managers. Don't think you'll automatically be good at everything. Ask for help.

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ADVICE

# Strategic communication: you can often get what you want (Mick Jagger was half right)

Joanna Piros, BJ

Strategic communication, be it on an individual physician level or health care organization wide, is key to getting what you want. Fundamentally, strategic communication takes account of objectives, target audiences, and understanding how human beings process information and make decisions TODAY, before determining tactics or simply winging it.

## Strategy before tactics

All important communications should be strategic. Whether you are tasked with speaking to media on reactive or proactive issues in health care, medicine, or research; engaging communities and stakeholders; or attempting to influence and persuade in the workplace, strategy must come before tactics. After all, you don't operate, treat, or prescribe before you diagnose.

The basic structure of strategic communications is knowing your outcome, understanding your target audience and what they need from you, and choosing the best who, what, where, when, why, and how to make it happen.

As physicians, you do a great deal of acquiring knowledge and information, sorting and contemplating that information, and then sharing it with your patients, staff, and colleagues. The volume of that information precludes giving it all so, given time constraints, you curate, thereby managing meaning for others.

As physician leaders, you are also called upon to manage meaning on a larger stage: political advocacy, research defence, health care initiatives, capital funding, and so on.

You may do that through interviews with media or through presentations to groups of people, from small to very large. The strategic underpinning of your communications is applicable across all those platforms, although the tactics will change based on the situation and the audience.

Successful information transfer today persuades people of your approach or initiative and it relies on content, carefully curated for the audience and married to performance.

Start thinking of your presentations, even your conversations, as performances and not just information dumps. We are a generation raised by television to expect content in digestible bites, massaged and made appealing, with most of the thinking done for us. A colleague of mine calls today's humans "cognitive misers," forced to make increasingly complex decisions based largely on emotional grounds. We do this because it's all we have time for.

## And now, the news

When I was first hired as a "girl reporter," and that's what they called us, at a Vancouver radio station in the late 70s, I worked a variety of beats, traversing the city with my large tape recorder, attending news conferences, business speeches, union halls, court registries, and the police station, collecting interviews and information which would be quickly written up as field reports. To file my stories, I had to use a telephone booth as there were no cell phones then. I would call the station desk (10 cents), read my copy into the telephone while it was recorded by the person


on the news desk, then I would unscrew the mouthpiece on the public phone (imagine), attach my alligator clips to the wires, insert the jack into the tape recorder, and push play, sending the recorded interview down the line to be added to my story.

Needless to say, the technology of news gathering has changed dramatically and so has the news product. Similarly, the technology we all rely on to communicate with one another has changed, as has the quality of our communication and the way we make decisions.

In those early newsroom days in radio, and subsequently television, we had many mantras: "never let the facts stand in the way of a good story," "integrity – a word frequently misspelled," and "information is power." My contention is, in today's environment, information is not power: it is noise and we are drowning in it. Every day we attempt to drink from a fire hose, struggling not to choke. Power today belongs to those who can manage all that data, curate it for a specific objective and audience, and make it immediately useful, understandable, and relevant.

The "new" news is no longer your only channel to reach a broad audience. You have your own websites, entirely capable of "broadcasting" your own video content, your own social media platforms, and digital and hard copy publications.

When you do interact with traditional media, strategy is even more important than ever; timeliness is critical; and your comments have to be shorter, faster and smarter than ever. We want our spokespeople and leaders to be more personal and simultaneously more public. We want to participate more in the stories we follow and we want to know what we want to know when we want to know it.

When planning to interact with reporters, you must know what you want out of the exchange at the same time as you anticipate what the reporter wants. Reporters are assigned to come back with stories so the more you can address that need, while keeping your eye on your desired outcome, the

more likely you will be to get the coverage you desire.

There are no guarantees, however. One of the axioms of journalism is to always give the "other perspective." Sometimes the other perspective comes from someone with nothing more than an axe to grind, but, in the interests of objectivity, we rarely take your word on any subject, no matter your expertise. If you announce a medical breakthrough, I will inevitably have to find someone to question its cost, efficacy, or ethical context. That's not unlike the naysayers you come across while communicating in the workplace so you must plan ahead.

## Strategy and the brain

We are always concerned about security breaches and hacks of our servers and computer systems, but the most sophisticated processors in the world are also the most vulnerable to hacks – our brains! We know so much about how people process information, through the use of functional MRIs and ongoing behavioural research, and what we know is that our mental hard wiring, combined with our emotional software, makes it relatively simple to take advantage of the vulnerabilities.[1] The good news is we can take advantage of those vulnerabilities to ethically influence people by the way we structure the information we give them.[2]

Another colleague often says, "Emotion blocks cognition." I'm sure most of you have firsthand experience with that. When you give someone an unwelcome diagnosis, they likely don't hear anything else you say after. I believe that's why patients are often asked to bring someone along who can actually listen to what comes after the bad news.

For me, the idea that emotion blocks cognition is not necessarily a bad thing. If we want people to be open to our "facts," we must first set the emotional table to help them want to hear more.

## Audience analysis

One of the first steps in planning a strategy is to identify the target of your persuasive attempts and gather as much information about them as possible. What are they struggling with right now? Has something major recently occurred to affect their equilibrium or is something looming? Yes, this kind of field research takes time but it pays off in results. Often you can get the lay of the land by talking to the one perfect source.
In most large organizations, persuasive communications occur at various levels and stages and are rarely a single shot over the bow. You want to be clear on who specifically you are trying to influence at each stage. Sometimes you will recruit an influencer who will support and promote your cause to others; sometimes it will be someone who will give you resources you don't possess or introductions you require.

Once you have identified the target, it's important to understand what you have in common and what separates you. The critical thing is to know how you can help them in the process of helping yourself. It's hard to be persuasive when the goal is entirely self-serving.

How much does the target know about you and your initiative, and which aspects of it might be important to them?

And finally, so many great persuasive presentations fail because the ask is not sufficiently

overt. You must be clear on what you want people to do once your conversation is over.

## Structuring content

There is a tremendous amount of research that tells us how we interpret, understand, and store information. We now have proof that engaging the limbic brain before inviting the neocortex to get involved is the most successful avenue to persuasion. We also know that story and metaphor are a direct hardwire to the limbic brain and that we all interpret information through a lens of self-interest.

You can take a page from the structure of news stories, asking yourself what the headline of your pitch would be if it were directed to the specific audience. In other words, what is the most important *who* to them? Most often it is the audience itself, whether that's a group or an individual. Often people are concerned about timing so *when* is significant. People have to be clear about the *what* and, the more technical and complex the concept, the harder you must work to ensure they understand. Location is addressed by the *where*, the all important aspect of what's in it for them is generally the *why*, and the process itself is the *how*.

In a news story the most important WWWWH and sometimes why appear in the headline and the first sentence. In other words, the punchline is at the beginning of the joke. The number of competing sources of information, and constant demands for our time, mean that structuring your information like news ensures the most important information comes first before distraction and disinterest threatens. Even your emails will be more persuasive if you signal the headline in the subject line, and structure the body of the text with the most important information at the top.

## Performance

Well curated content must be married with performance or it's simply not engaging. If you're not engaging, you won't be successful because we're too easily distracted by everything else clamoring for our attention.

To become an engaging performer takes time and practice. It's an interplay of how you look, how you sound, and what you say, in varying degrees. In my work coaching and training literally thousands of people to be better performers of their own story, I am convinced that wherever your bar currently sits, it can be raised. It's the most lucrative competitive advantage available to you, if you're willing to put in the work. If it were easy, every fool could do it, and the competitive advantage would be lost.

## Our top story

No matter who you have to persuade, inform, or motivate, the tools are the same along a continuum of strategic communication. At the very basic level you must know your audience and what you can do for them, before you ask them to do something for you. Learn how to assess that audience and curate your content for them specifically. Create a plan to ensure communication supports larger goals, and spend some time learning about how we are hard wired to make snap decisions in an increasingly noisy world. Get comfortable being a performer because, as the Bard observed, all the world is a stage and we are the players.

**In a news story the most important WWWWH and sometimes why appear in the headline and the first sentence. In other words, the punchline is at the beginning of the joke.**

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## Author

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# Generative leadership

Gervase R. Bushe, PhD

In recent years, a growing chorus has raised concerns that conventional ideas about leadership are not adequate for responding to today's complex organizational challenges. The notion that good leadership astutely analyzes a problematic situation and provides a vision that shows the way to success doesn't work in complex situations. This article offers a different image of leadership that has proven effective for managing conditions of uncertainty, ambiguity, and volatility: "generative leadership." A description of when conventional modes of leadership (in complicated situations) and generative leadership (in complex situations) are most appropriate is followed by some behaviours and perspectives that characterize generative leadership. The article concludes with some thoughts on generative leadership in health care and some of the challenges leaders face in leading generatively.

**KEY WORDS:** generative leadership, generative change, dialogic organization development, complexity, visionary leadership, health care

## The difference between complicated and complex

The right kind of leadership depends on the kind of challenges leaders face. Heifetz[1] was one of the first to provide a taxonomy of decision situations that contrasted complicated "technical problems" with complex "adaptive challenges" (see Table 1[2]), arguing that the single most common failure of leadership was to treat adaptive challenges like technical problems. Snowden and Boone[3] offer a different but complementary model focused on the ability of decision-makers to understand or uncover cause–effect relations.

Complicated decision situations are those where the application of technical expertise can uncover cause–effect relations. In complex decision situations, however, there are too many interdependent and unpredictable variables, so that cause–effect relations are only understandable in retrospect. Some argue that any decision situation that requires

**Table 1. Characteristics of technical problems and adaptive challenges[2]**

| Technical problems | Adaptive challenges |
|---|---|
| Easy to define operationally. | Difficult to agree on what the "problem" is. |
| Lend themselves to operational (process and procedures) solutions. | Require changes in values, beliefs, relationships, and mindsets. |
| People are generally receptive to technical solutions they understand. | People generally resist adopting other-defined values and beliefs. |
| Often can be solved by authorities or experts. | The stakeholders have to be involved in solving. |
| Require change in just one or a few places, often contained within organizational boundaries. | Require change in numerous places, usually across organizational boundaries. |
| Solutions can often be implemented relatively quickly by changing rules or work processes. | Adaptation requires experiments and new discoveries as well as wrong turns and dead ends. |
| Stay solved until something else changes. | Adaptation creates new problems that will have to be adapted to. |

the consent of human agents is a complex one.[4,5] They argue that people are not simple stimulus–response organisms, but rather they interpret and make sense of their experience in idiosyncratic ways; how decisions, plans, and proposal's will be interpreted and acted on is never fully predictable.

## The problem with conventional images of visionary leadership

Pick up any book or article on leadership and chances are pretty high that "vision" will be a central defining characteristic. The popular distinction between transformational and transactional leadership rests on this notion that real leaders can see a solution, or a preferred future, and can articulate this in a way that captures followership. This includes the expectation that leaders provide "winning" goals, targets, and strategies that others can steer by.

Although the business press and leadership texts laud the visionary attributes of founders of highly successful companies, they tend to ignore the high percentage of failed visions. Nor is there much recognition of the increasingly complex and even chaotic situations leaders face and for which there are no clear solutions or even solution paths. Studies of actual strategy implementation and of companies that succeed in complex, fast-changing environments find that those that followed a singular vision provided by "charismatic" leaders tended to fail.[6]

## So then, what works?

The argument proposed here, consistent with a variety of studies over the past decade,[2] is that in complicated situations, conventional top-down, planned change approaches to leadership and decision-making are appropriate. When effective, state-of-the-art solutions to problems exist, or when cause–effect relations can be analyzed and understood, then applying technical expertise, identifying best practices, and implementing them using change management approaches can work, given the usual caveats about the need to manage structural, political, and cultural issues during implementation.

**Pick up any book or article on leadership and chances are pretty high that "vision" will be a central defining characteristic.**

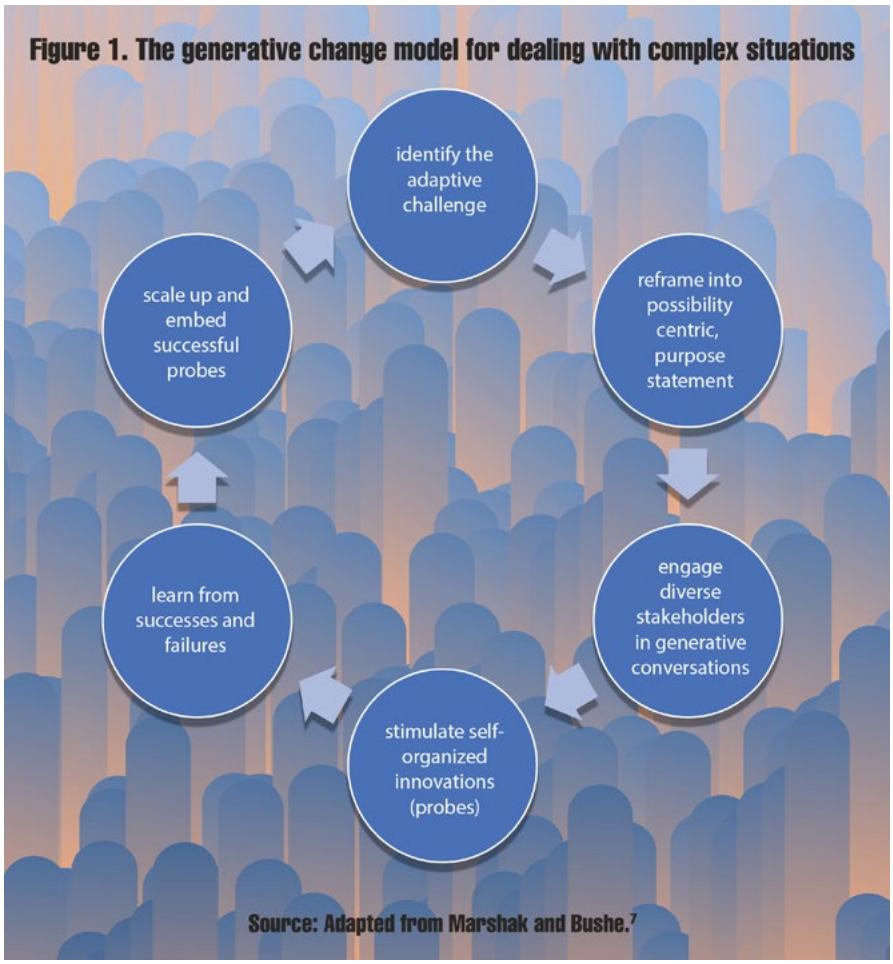
In complex situations, however, a different, *generative change* approach is appropriate.[7] Essentially, generative change requires identifying the issue or problem that needs to be addressed and framing it in a way that will motivate the variety of stakeholders who are "part of the problem" to engage in coming up with new ideas. They are invited into conversations intended to stimulate many self-initiated, fail-safe innovations and see what works. Those innovations that do work are then nurtured and scaled up. As opposed to a top-down, identify and then implement the best solution strategy, this is a top-down-bottom-up, learn as you go strategy.[2]

## Actions of successful generative leadership

Rather than saying "I know the answer, follow me," generative leaders say, "I know the challenge, and I invite you to decide what you will do about it." To do this successfully requires identifying not a problem, but a "purpose" that captures something the stakeholders, who ultimately have to act to successfully address the challenge, care about.

A vision identifies, in concrete terms, a future state. A purpose identifies what the group or organization is trying to do every day and often is not something that will ever be fully realized. For example, a vision might be to have 10 needle exchange clinics operating throughout a city, whereas a purpose might be to eliminate AIDS. Generative leadership reframes issues and goals into compelling purposes that capture stakeholder attention and motivate them to initiate innovative actions.

One or more conversations are hosted,[8] where the key stakeholders are invited to discuss the issues, self-organize into groups that have a common set of interests and motivations, and design, proto-type, or otherwise come up with ideas they are willing to act on. There is no attempt by leaders to "pick winners"; people are asked to just go do it. An environment of creative possibility is established, with the expectation that not all innovations




will succeed. An important role of generative leadership is to closely track what takes place after these conversations and events, support promising initiatives, remove barriers, spread what is being learned by both successes and failures, and scale up and embed successful innovations (Figure 1).

Here is an example of a generative change process: the chief operating officer of a fast-growing health care organization serving a global customer base of patients with a range of difficult-to-address diseases and afflictions was concerned about growing problems with poor patient outcomes resulting from hospital errors. She was well aware of the need to think and act systemically to improve patient safety, but there were already plenty of behavioural guidelines in place.

She believed the crux of the problem was relationships among the care providers. It was how doctors, nurses, and others interacted and communicated that caused the breakdowns that jeopardized care. The medically trained members of the organization were vertically siloed by their specialties and agreed on very little other than that their specialty needed more money. What patients wanted and needed varied by the nature of their medical condition, compounded by different health care practices and cultures in the global communities the organization sought to serve.

There were also technological and medical innovations coming down the road that needed to be considered, such as the greater use of AI and robots. Unfortunately, the complexity of the situation, the wide range of perspectives, and a lack of agreed upon criteria was compounded by the lack of clear agreement on any system-wide changes that might be needed to reduce errors. Attempts to raise the issue tended to result in different groups blaming each other and/or attributing the problems to growth and hiring the wrong people.

Looking for a way to capture the inherent motivation of all the people in the organization that would improve relations across different groups and ultimately result in reduced errors, the COO challenged everyone to propose new initiatives to "improve our ability to enhance the quality of life of all we serve and touch." A series of "dialogic organization development" events brought together highly diverse groups of people from inside and outside the organization. Some were as short as 90 minutes, a few lasted two days. Each was part of an attempt to launch experiments that people were personally committed to.

Surprising things emerged. For example, at a one-day workshop, after examining the strengths and weaknesses of familiar ways of talking about the organization, its mission, and challenges, one of the participants proposed, "We have to be more like an aqueduct.

Strong vertical pillars supporting lateral channels of life giving substance that flow from us to the people and communities we serve." The participant then drew a rough diagram of an aqueduct.

Somehow this "generative image" captured something new and exciting in the participants who began to discuss how their parts of the organization could be more like an aqueduct. Small groups were encouraged to self-organize around some aspect of the organization they wanted to change to be more like an aqueduct. One of these groups was composed of different parts of the cardiac unit, and they developed improved communication and coordination (the life-giving flow) processes. More important, they developed a shared commitment to working together that reduced cardiac errors 50% within 6 months.

**Generative leadership is not a description of a person, but a style of leading that works in specific situations.**

Generative leadership is enhanced by the use of generative images, a combination of words that can create new conversations and stimulate people to discuss and imagine things they weren't able to before.[9] A highly generative image is compelling; people want to talk about it and act on it. "Sustainable development" is the iconic generative image of our time, a combination of words that transformed the conversation about "environmentalism" when it was first coined, and continues more than 25 years later to catalyze innovative ideas and actions.

Important qualities of a generative image are that it hasn't been discussed before, no one is sure how to do it, but it seems like an attractive notion. It is the ambiguity that allows for innovations to emerge and the attractiveness that compels people to act on them. Few generative images have the widespread appeal of sustainable development; most, like "be an aqueduct" are only generative in the contexts in which they are used.

There are a variety of methods for hosting conversations and for architecting a sequence of conversations to take on complex, adaptive challenges, documented and described in the field of dialogic organization development.[10] However, as Bob Marshak and I[11] have emphasized, the success of these methods depends more on the mindset of the leaders and change agents using them, than on the methods themselves.

## The mindset for generative leadership

Generative leadership is not a description of a person, but a style of leading that works in specific situations. A single leader could (and probably should) use different leadership approaches in different situations. To use a generative leadership style successfully requires ways of thinking or a mindset that includes several key assumptions about organizations and the processes of organizing, which are described briefly below.[11]

**Organizations are social networks of meaning-making that create the realities people experience and react to.**
Generative leadership assumes people are sense-making beings who operate on the interpretations they develop about what things mean.[12] Often, these arise out of the informal interactions people have with their networks of trusted others with whom they talk to make sense of what others are doing and saying.[13] Different groups in the organization can develop very different perspectives, assumptions, and narratives that guide their thoughts and actions. Generative leadership is sensitive to the ways in which organizations are streams of conversations and cognizant that resolving complex problems requires changing the conversations that normally take place and the narratives people hold.[14,15]

**Groups and organizations are continuously self-organizing and recreating themselves, but disruption of repetitive and limiting patterns is required for adaptation to complex problems.**
Generative leadership assumes that patterns of organizing are created, maintained, and changed through the day-to-day conversations people have in ways that are mostly out of awareness.[16] A change in those patterns requires them to be disrupted in some way, and

generative leadership recognizes disruption as an opportunity for new, more adaptive patterns to emerge.[17] This is in stark contrast to conventional managerial mindsets that see disruption as a failure of leadership. Disruption does not have to be conflictual or scary (although it sometimes is). Inspiration can be just as disruptive as fear. In general, enough disruption has occurred when the people involved believe that the way things have been no longer works and they can't go back.

**When problems are too complex for anyone to analyze all the variables and know the correct answer in advance, the best approach is to use generative change processes to develop adaptive ideas and solutions.**

Generative leadership operates, implicitly or explicitly, from a "generative change" model.[7] Table 2 contrasts conventional planned change with generative change. Rather than attempt to deal with complex situations with a planned change approach, generative leaders use an emergent, more bottom-up approach that incorporates insights from complexity science.[18,19] Emergence is nature's way of changing, in which order arises out of disorder, and increasingly complex organization comes out of disruptions to existing order. Using any of the dozens of dialogic organization development methods available,[20] or just their intuition, leaders lead a process that stimulates stakeholders to self-organize and initiate action, then monitor and embed the most promising initiatives.[21]

**Table 2. Contrasting planned change with generative change**

| Aspects | Planned change | Generative change |
|---|---|---|
| Approach | Social engineering: Identify problem and desired change, analyze required interventions, direct implementation. | Social innovation: Identify desired outcome/purpose, engage stakeholders in ways to stimulate innovative possibilities, motivate and support stakeholders to innovate. |
| Use when | State of the art approaches and solutions exist. Leadership believes it has enough clarity about the situation to sanction a planned change effort. | Beyond state-of-the-art approaches and solutions are needed. Leadership is uncertain about how to achieve agreement or specify solutions for the desired state. |
| Methods | Scientific and engineering oriented<br>• Analyze data<br>• Problem-solving approaches | Social interaction (dialogic) and social agreement oriented<br>• Focus on desired futures<br>• Possibility-inducing approaches |
| Change through | Convergence on a solution and effective top-down implementation.<br><br>Sense — analyze — respond. | Generate many possible innovations and effective top-down/bottom-up improvisation.<br><br>Experiment — learn — amplify. |
| Desired outcomes | Acceptance and implementation of changes that address problem(s) or achieve desired results as quickly as feasible. | Self-organizing adaptive actions and/or transformations that can be scaled up and embedded in timely ways. |
| Role of leaders | Performance oriented and directive; front-loaded effort.<br><br>Provide *vision* of desired future state.<br><br>Provide resources and clear roles and goals.<br><br>Provide/resource tools and techniques that will diagnose the real issues and provide practical solutions.<br><br>Accept or reject proposed solutions and direct others to implement. | Possibility oriented and supportive; back-end-loaded effort.<br><br>Name the *purpose* that motivates stakeholders.<br><br>Provide resources and clear boundaries.<br><br>Provide/resource opportunities to strengthen the relationships and communications that will stimulate the emergence of adaptive actions that people will self-implement.<br><br>Support, scale up, and embed most promising innovations. |

**Any solution to a problem of organizing will inevitably create a new problem; so, instead of trying to find the "right" answer to how best to organize, accept any answer that stakeholders will run with. Managing adaptive challenges is a never-ending process, and increasing the adaptive capacity of the team, organization, or larger network, while tackling a specific complex issue, is an important objective.**

No model of organizing will ever be right for every organization, nor can any organization perpetuate itself without evolving its model of organizing. Human beings will never develop a definitive solution to how to divide up work and then coordinate that work in a conclusive way, as effective collective action rests on a set of tensions. Paradoxes,[22] polarities,[23] and competing values[24] are different ways of describing these tensions. For example, organizations have to adapt to external demands while, at the same time, standardizing internal operations. Working through people and relationships and working through impersonal processes and routines are both necessary.

Because effectiveness is bipolar, there are no timeless solutions to problems of organizing; today's solution will be an unavoidable cause of a new set of problems to be solved tomorrow. Everyone who is reading this article has experienced the iterations of adaptive actions that organizations go through over time. First, we centralize, and then we decentralize only to centralize again. It is hubris for leaders to believe that complex organizational issues can be solved "once and for all." This is not a new insight; the origins of sociology go back to the seminal proposal that a variety of social forms evolve through this dialectical process.[25]

## Generative leadership in health care

Generative leadership can be used in small groups and large organizations. It can be used by physicians managing a family's mobilization to support a loved one's treatment, by hospital administrators to tackle organizational issues, and by government agencies to work on system-wide issues.[26-28] The first step is to be able to identify the difference between complicated and complex problems. Table 3 provides a few health care examples that contrast what are essentially technical problems (where a more scientific-engineering approach to management and change is appropriate) with the kinds of adaptive challenges that may best be addressed through the social-dialogic approach of generative leadership. Table 1 provided useful guidance on how to identify the differences.

**Table 3. Examples of complicated and complex problems in health care[2]**

| Complicated, technical problem | Complex, adaptive challenge |
|---|---|
| How do we ensure that nurses know the safest methods for lifting patients? | How do we improve the health and wellness of nurses? |
| How do we ensure accurate information is provided during handoffs between care providers? | How do we increase collaboration among care providers? |
| How do we reduce errors in medications delivered to patients? | How do we get patients to take more responsibility for taking their meds? |

Although there are now decades of studies that show the superiority of generative change processes for producing rapid and transformational results,[29-31] using generative leadership processes requires courage and a higher than average level of socio-emotional intelligence. Leaders have to "let go to let come,"[32,33] a difficult process that will evoke anxiety in both themselves and their followers. Some of this anxiety will be due to the dominant leadership narrative that effective leaders have the right vision and are responsible for setting goals and organizing plans.

Although the virtues of engagement, empowerment, and participative leadership have been extolled for decades, the reality is that a certain percentage of people expect their leaders to have all the answers – or else why are they the leader? Basic beliefs about leadership are violated, in both those they report to and those who report to them, when a leader says "I don't know the answer" and "I am going to engage stakeholders in an emergent process that I cannot predict or control."

Letting go of control is likely to make more visible the underlying paradoxes and polarities that are part of the reason adaptive challenges are so complex and not amenable to technical solutions. The ability to see, appreciate, and work with paradox, to "hold the space of not knowing" in a way that avoids either/or polarizations and at times even transcends both/and to a place of "because…" is a hallmark of later-stage, post-conventional sociocognitive development.[34-36] This will require physicians who want to use generative leadership to engage in personal development processes quite different from skill training and knowledge acquisition,[11] which instead develop the emotional, social, and systemic intelligence of the whole person.

The main point of this article has been to describe and explain the need for a new form of leadership that is emerging to take on the increasing complexity of organizational life. Generative leadership is different from transformational or transactional leadership, in that it doesn't provide a vision, goals, and roles or analyze problems in order to make decisions. Instead, generative leadership articulates the purpose that inspires stakeholders to take on complex

issues, stimulating as many self-organized initiatives as possible, seeing what works and learning as they go, in a never-ending process of adapting to the complexities of collective life.

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*This article has been peer reviewed.*

OPINION

# Is health care innovation simply an act of compassion?

James Goertzen, MD

Northern Ontario makes up 87% of Ontario's land mass, is inhabited by 6% of the province's population, and has the highest rates of cancer and diabetes, along with cardiovascular and respiratory disease in Ontario. Disease prevalence is highest among the 13% of Indigenous northerners.

Providing health care in Northern Ontario in the future will be challenging, as the lifestyles of our citizens include high rates of obesity, alcohol consumption, smoking, and substance abuse.[1] In our northern setting, physicians offer care that reflects their community's needs and often includes a wider scope of practice allowing their patients to receive care closer to home.[2]

Optimizing and reforming health care in Northern Ontario and the rest of the province will require engagement of physician leaders,[3] compassionate leadership, and innovation.

But what is the link between compassion and innovation? Is it possible that health care innovation is (simply) an act of compassion?

Reforming health care is not only the work of individual leaders. Rather, transformation is nurtured when organizations adopt enterprise-wide collaborative leadership models.[4] It is the leadership that can role model and support a compassionate culture by influencing the actions of individual people within their organization.[5] Compassionate organizations are the result of compassionate acts, and leadership can support or discourage compassionate acts.[6]

But what is compassion in the workplace and how can it be recognized? Atkins and Parker[7] and Worline and Dutton[8] propose that compassion is a process that can be articulated and observed. Initially, a person notices or recognizes the suffering of another. Next, the person makes sense of the suffering – a cognitive process. This is followed by an emotional response where the person feels empathy or concern for the suffering of the other. This can then lead to an action to alleviate the suffering in some way that is meaningful.

There is a growing body of evidence in health care that


compassionate leadership is linked to a compassionate workplace that supports organizational innovation.[9] Innovation involves taking risks, and that requires people in the workplace to feel supported and valued. Innovation is possible when both the leadership and others in the organization accept the possibility of failure. In many ways, failure can be reframed as suffering, which can be addressed or alleviated within a workplace where compassionate acts are the norm.

As we ponder our roles and responsibilities in supporting the transformation of health care in Ontario, where compassion is central to the way we give and receive care, where do we start? When you witness the suffering of a colleague, consider an act of compassion. Consider your leadership role in supporting the compassionate acts of others. Realize that both can be a catalyst for making your workplace a compassionate and innovative organization that is a force for

positive health care change in our communities.

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# Developing faculty to teach leadership

Lara Hazelton, MD, MEd

Leadership education is increasingly incorporated into the early stages of medical training, but it is not always clear who should teach and how they should be prepared. Teacher training (faculty development) must be responsive to the needs of a variety of instructors, including physicians who may be unfamiliar with the topic of leadership themselves. This article looks at the limited literature on faculty development for teachers of leadership and recommends approaches.

**KEY WORDS:** leadership teaching, leadership training, medical leadership, physician leadership

## Teaching leadership to medical trainees

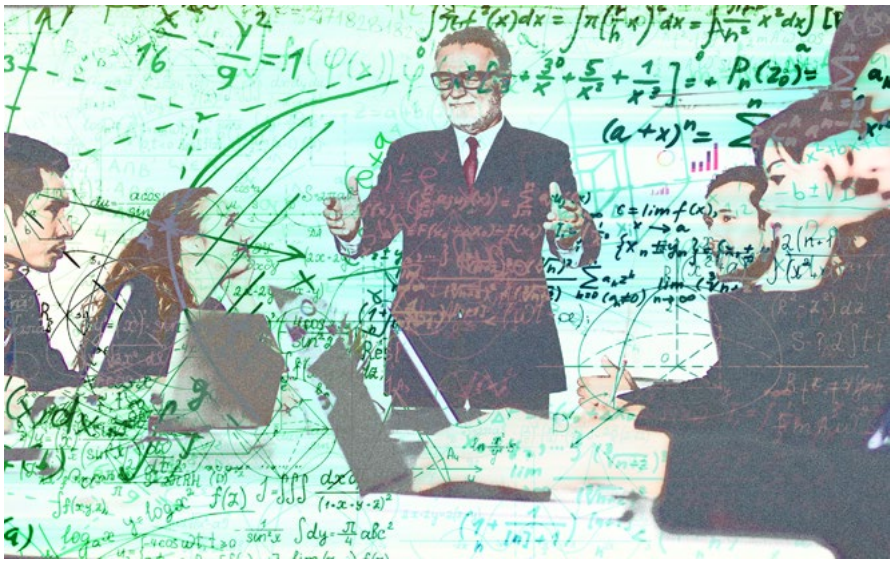
Physicians play an important role in the health care system and must possess strong leadership and managerial skills to contribute effectively.[1,2] The value ascribed to leadership education is increasingly reflected in the accreditation requirements for programs in undergraduate medical education (UGME) and postgraduate medical education (PGME).[3-5] Although this is an exciting trend for those involved in leadership education for physicians, the expansion of the curriculum at both levels raises the question of who is going to teach leadership to medical students and residents and how we can ensure that they are prepared to do so effectively.

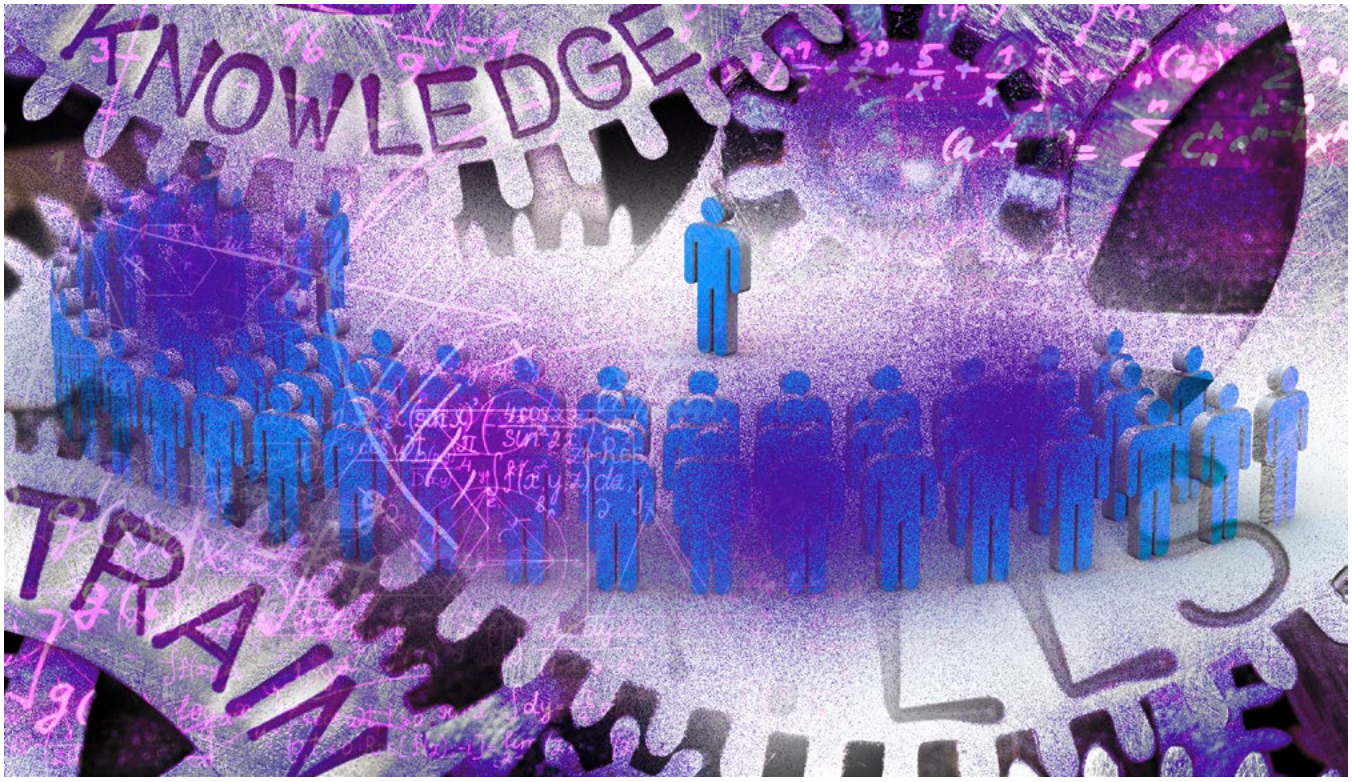
Much of what physicians learn about leadership happens during clinical experiences through role modeling and informal instruction. In addition, the Future of Medical Education in Canada survey of Canadian medical schools in 2015 identified a range of approaches to leadership instruction, including seminars, service learning, and advanced degrees.[4] At the PGME level, the most common methods are lectures, small group activities, case studies, projects, mentoring, and coaching.[6] However, whether teaching occurs formally or informally, on the wards or in the classroom, there is the opportunity for teaching to be improved through faculty development.

## Faculty development for physicians

Faculty development is a term used to describe teacher preparation for both faculty and non-faculty instructors. It can usefully be divided into training, educating, and developing teachers. Training focuses on the acquisition of skills required to fulfill a specific role, education produces a range of abilities generalizable across settings, and development encourages personal as well as professional growth.[7]

Faculty development can target specific competencies needed to carry out teaching activities.






For example, a residency program director might decide to teach leadership to residents using a series of cases about transformational leadership.[8] Implementing this would require knowledge of transformational leadership on the part of the person creating the curriculum, as well as objective-writing and case-writing abilities. Anyone using a case to teach must be skilled in facilitating small group discussions, evaluating learning, and providing feedback. On the other hand, if the program director decided to introduce a mentorship program, department supervisors might benefit from faculty development sessions on how to be good mentors.[9]

Faculty development is easiest when the teacher is already a content expert; for example, teaching a surgeon how to give feedback on suturing to a resident. However, in the area of leadership, depending on the instructor, it may be necessary to address content knowledge as well as teaching skills. Many physicians do not feel prepared to be leaders, let alone teachers of leadership.[10] It is rare to find a teacher who combines knowledge of both leadership and medicine.

One approach to filling the gap is to is to identify change agents who can be equipped to develop curriculum and introduce new content to colleagues, who can then become teachers.[11] An example of such a program is the Royal College's Advancing Safety for Patients in Residency Education (ASPIRE) program, which prepares faculty to teach quality improvement.[12] Physicians with an interest in leadership can become local experts, resource people, and role models for both learners and colleagues. These champions can then provide formal teaching, presenting content explicitly to learners through lectures and other didactic methods. Faculty development can be useful to help them develop their instructional skills or learn more about curriculum design.

Much of learning about leadership occurs informally. Yet, even when teachers think they are teaching leadership, learners may not perceive this to be the case, a reminder about the importance of making teaching explicit as well as implicit.[13] Naming many of the activities in which physicians routinely participate (such as conducting ward rounds) as a means of displaying leadership can make these roles visible and allow for reflection on one's leader identity. Faculty development

should also address strategies to assist learners in meeting objectives (whether in a clinical or classroom setting) and provide training for clinical supervisors on the use of evaluation tools.[14-16]

It has been suggested that faculty development should move beyond traditional approaches and focus on identity, growth, and empowerment.[17] Becoming part of a community of practice can help facilitate this growth, and those with an interest in leadership development may choose to join groups like the Association of Leadership Educators or attend conferences, such as the Toronto International Summit on Leadership Education for Physicians (TISLEP). TISLEP has also developed Sanokondu (sites.google.com/site/sanokondu/), a free online resource with curriculum that can be used to teach residents and other learners about leadership.

**In selecting leadership instructors, it is important to consider how they will be perceived by learners.**

## Non-physician instructors

In the area of didactic teaching, recruiting leadership teachers requires some combination of training physicians and looking outside of medicine.[18,19] A review of the literature on leadership education in UGME found that the most commonly identified instructor type was clinical faculty (38%), but a significant number of nonclinical faculty were drawn from other departments (e.g., business schools) and the community.[20]

In selecting leadership instructors, it is important to consider how they will be perceived by learners. Although concerns about credibility may be an issue for physicians who feel uncomfortable teaching new topics, physicians do bring a knowledge and experience of medicine that may be very influential with learners. Research has shown that learners make judgements about the credibility of feedback based on the instructor's clinical ability, personal characteristics, and the quality of the "educational alliance."[21,22] The educational alliance is the relationship that exists between the student and the teacher, and it is influenced by interpersonal factors including whether or not the student believes the teacher is genuinely invested in helping foster their learning and development. Credibility in leadership education may also be influenced by whether the instructor has lived experience in leadership or comes from an academic background.[23]


Unfortunately, we know little about how medical trainees view physician versus non-physician leadership instructors. For example, heavy reliance on non-physician instructors in resident teaching may send a hidden message that leadership is not core to what physicians do, or it may convey the useful concept that physicians can learn from others outside medicine. Until more is known about how credibility judgements are made in leadership education, instructors drawn from outside medicine may benefit from some insight into the culture of medicine as well as general faculty development on how to teach.

## Future directions

As the field of leadership education grows, we can hope to see more research asking not only whether interventions are successful, but also how they might be improved and what constitutes best pedagogical practices. As is frequently the case in medical education, we don't know if interventions significantly impact leadership behaviour in practice; if they do not, does the fault lie with the curriculum, poor teaching, organizational barriers, or other factors?

From a faculty development point of view, more information should be included in publications about who teaches leadership and what

is involved in their preparation. Those responsible for recruiting leadership teachers would benefit from knowing more about how learners make credibility judgements about instructors, and how these instructors serve as role models.

Faculty development has the potential to improve leadership education. The ultimate beneficiaries are not only the students, but also the patients and the health care system. However, faculty development should, ideally, give something back to the teacher, too. Fink writes, "Every time you teach, you have an opportunity to learn about teaching and about yourself as a teacher."[24] And, it might be said, every time you teach leadership, your own influence extends a bit further and you become more of a leader yourself.

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# Optimizing physician leadership and engagement in two Canadian provinces: a journey of discovery

Graham Dickson, PhD

The first part of this paper describes the rationale for optimal physician leadership and engagement and the recommendations in the Canadian Society of Physician Leaders (CSPL) white paper pertaining to "what provincial medical associations can do" to optimize this. The second reports efforts being made in British Columbia and Saskatchewan to realize the spirit of the CSPL recommendations. Both projects are efforts of co-creation: doctors and non-doctors, building health systems of the future, but creating them together. The third part outlines achievements and lessons of discovery learned along the way that they – and other jurisdictions of a similar wont – can integrate into their journey.

**KEY WORDS:** physician leadership, engagement, Saskatchewan, British Columbia, system design, communication, dyad structure, facility engagement, evaluation


In 2017, the Canadian Society of Physician Leaders' white paper entitled "Accepting our responsibility: a blueprint for physician leadership"[1] argued for improvement in the level of physician leadership and engagement in Canada's health care system. Two years later, progress commensurate with its recommendations has been made in Saskatchewan and British Columbia.

## Optimal physician leadership and engagement: what is it, and why is it important?

A partnership with physicians is necessary to achieve the highest quality of patient care in modern, changing health systems.[1-4] The CSPL white paper outlines how doctors can achieve optimum physician leadership and engagement to ensure that reforms are in the best interests of patients. But what is meant by the term, "optimum physician leadership and engagement"? "Physician engagement refers to the active and willing participation of physicians in local, regional, and provincial efforts to improve health in Canada" (p. 6).[1]

Recommendations at the *provincial* level were as follows:

We recommend that provincial ministries and medical associations take steps to:

1. Initiate negotiations to develop an enabling policy framework that formalizes and supports regional and organizational efforts to realize effective physician leadership and engagement.
2. In the absence of an appetite in both parties to enter into such negotiations, build trust as a first step toward

an increased willingness to negotiate.
3. Work with universities and health research agencies, both provincially and nationally, to identify best practices; either conduct or gather research on the impact of various models of physician leadership and engagement; and share that knowledge widely with potential partners.
4. Publicize the benefits of meaningful physician engagement and leadership by explicitly recognizing those benefits.
5. Provide financial support for physician leadership development and remuneration for physicians in leadership roles.

## Two case studies: Saskatchewan and British Columbia

Under the leadership of their medical associations, and in partnership with their ministries of health, BC and Saskatchewan have engaged in the challenge of increasing physician leadership and engagement, and their approaches reflect the letter and spirit of the CSPL recommendations.

**Saskatchewan**

The vision for the desired future health system for Saskatchewan is *Better Health, Better Care, Better Value, and Better Teams for Saskatchewan People*.[5] In early 2016, a working paper dedicated to exploring the future physician role in a redesigned and integrated patient-centred health care system[6] was enthusiastically received by the SMA's Representative Assembly. SMA leadership was given the mandate to pursue these ideas with their counterparts in the Saskatchewan Ministry of Health (SMOH).

In July 2016, the SMOH and SMA held a two-day "visioning session," where vigorous dialogue ensued, highlighted on the second day by a cry of frustration from a member of the SMA: "Why do you [representatives of the ministry] think we [the doctors] are so powerful, but we feel so powerless?"

**The vision for the desired future health system for Saskatchewan is Better Health, Better Care, Better Value, and Better Teams for Saskatchewan People.[5]**

The session ended with the following statements of agreement endorsed by all present at the meeting – representatives of SMOH, SMA, the Saskatchewan College of Medicine, Health Quality Council, and regional health authorities[7]:

- Our common goal is improved patient care within a high-performing, sustainable health care system.
- Over the next few months, information will be gathered locally, nationally and internationally to help us determine the best way to continue collaborating to build a better health care system for Saskatchewan people. The input of Saskatchewan patients and their families, health care providers and others will be an important part of this ongoing work.

Since this vision session, the partners have held two years of dialogue and action to achieve an optimum level of physician leadership and engagement in Saskatchewan's health care system. These efforts had to run in parallel with health reform priorities of the Saskatchewan government, such as amalgamation of 12 health regions into one.[8]

Advancing physician engagement and leadership in Saskatchewan continued in two streams: a local, physician-led demonstration design project and physician participation and leadership in "single-region" transition efforts.

As part of the physician-led demonstration design project, the SMA president and CEO communicated regularly with SMA membership about the nascent design project, through written updates, verbal presentations, and discussions at local medical association meetings and the SMA's semi-annual Representative Assembly (Bonnie Brossart, CEO, SMA, personal communication).

In March 2017, a learning session was held with the original participants in the 2016 visioning session. Medical and policy leaders from Kaiser Permanente in the United States were invited to talk about the actions they employed to achieve a physician partnership approach to service

delivery. Dialogue about what might work or be customized to work in Saskatchewan ensued and was shared broadly with SMA members.

The demonstration project was initiated in the former Prince Albert Parkland Health Region (now part of the Saskatchewan Health Authority) to engage almost 140 doctors in co-design of how the physician community could work with the local administration. These issues included

- building better relations between doctors and their health authority colleagues
- using data more effectively to make decisions and concomitant policies and practices to facilitate improved accountability and support ongoing improvement
- improving physician leadership
- issues relative to appropriate physician remuneration

This project was designed to be led by local doctors so that they would "own the work" (Dr. Joanne Sivertsen, past-president, SMA, personal communication, April 2018).

Following the Kaiser Permanente learning session, local physician and administrative leaders from the former Prince Albert Parkland Health Region signaled their interest in exploring a new care model. In November 2017 following local discussions, a survey was prepared by the SMA and SMOH to determine physician interest; more than 70% of physicians responded. A

desire for physician-led design was evident: a large majority of respondents indicated that physicians should have a greater role in system design and that innovative approaches designed by physicians would improve health care quality and outcomes.

At about the same time, a small, dedicated group of seven Prince Albert physicians took on a more focused role in advancing these ideas and ambitions with their colleagues to discern: "What will make or break it for you in participating in this project?" Several local physicians committed to learning more about the Patient's Medical Home framework and Ontario and Alberta's primary care reform efforts.

All of these preparatory sessions and discussions led to a design event in late October 2018, where physicians, health care providers, administrators, ministry

bureaucrats, patient and family advisors, and community leaders came together to articulate "a more specific and detailed expression of a new model of health care delivery that describes governance and organizational design structure, leadership, data and analytics, and compensation models that will improve care and the experience for Prince Albert and area citizens and improve the work experience of health care providers."[9]

In the other stream – physician participation and leadership in single-region transition efforts – initially there was a risk that the restructuring process might slow down a focused effort at improving engagement practices. However, from the outset the decision was made to engage physicians in redesign and implementation in a manner that reflected the spirit of the agreements discussed in the July 2016 visioning session.

Physicians became central to the provincial regionalization process in three ways. First, two physicians became part of the provincial transition team. These doctors played an instrumental role not only in informing transition efforts and strategies, but also in communicating progress on the transition to their medical colleagues, most frequently in local, face-to-face meetings. Second, a physician advisory group was established, consisting of 25 physicians from all areas of the province. This group met every six weeks throughout the transition process, and most of their recommendations were implemented. Third, a dyad structure in which physicians were partnered with non-physician administrators was adopted province-wide.

In keeping with the journey metaphor, achieving optimum physician engagement in Saskatchewan is an ongoing process of discovery, relationship building, and commitment. A great start has been made; yet a sustained effort over time is needed to achieve the desired goal (Brossart and Sivertson, personal communication).

**British Columbia**

On 1 April 2014, Doctors BC signed a Memorandum of Understanding Provincial Engagement (MOUPE)[10] with the BC Ministry of Health and six region CEOs, to commit to "and be mutually accountable for strengthening and clarifying their relationship with physicians at provincial, regional, and local levels" (p. 1). More specific goals were to:

- Enable effective alignment of strategic planning on issues significantly affecting physicians
- Enable strategic level discussions on major issues/ policies affecting the Parties
- Support the development of effective relationships at senior decision making levels and
- Support the improvement of engagement and consultation and mutual accountability between physicians and Health Authorities at Regional and Local levels throughout the province

The MOUPE offered a 5-year (expires 2019), $63 million fund to support facility-based physicians and their relationship with the health authority at their site. "Facility Engagement is a provincial initiative that originates from the Physician Master Agreement. It aims to strengthen relationships and engagement between health authorities and facility-based physicians, to improve their work environment and the delivery of patient care."[11]

In a 2013 membership survey, Doctors BC had identified a high degree of aggravation with respect to doctors' perceived lack of influence and voice in hospitals. Health authority representatives (physician leaders and non-physicians) agreed to improve communication and physician input into decisions affecting patient care and the quality of the working environment.

To operationalize the fair distribution of funds and to ensure that they were dedicated to the goals of improving physician facility engagement, the Specialist Services Committee (SSC) – a joint clinical committee with physician and ministry of health/ health authority representation – was tasked with overseeing the program, defining the conditions under which funds would be distributed and administered, and determining how the overall project would be evaluated. The SSC is housed at Doctors BC and headed by Dr. Sam Bugis, a well-respected surgeon.

The approach to facility engagement was to revitalize an

existing structure in the hospital: the Medical Services Associations (MSAs). As the collective voice of doctors at a hospital, many MSAs were struggling to find a role or have any influence. Infrastructure was created that allowed a transfer of funds to each MSA reflecting the size of the hospital and the number of doctors. Criteria for obtaining funding were developed.[12] Facility engagement liaisons support MSAs and health authority leaders and facilitate conversations between them.


A third initiative was an independent formal evaluation led by a team from the University of British Columbia. In 2018, four years into the initiative, the formal evaluation is a year away from completion. However, numerous factors suggest that significant progress is being made. "If the point of the exercise is to have doctors speaking more meaningfully with each other, and with the health authority, we are seeing significant progress" (Dr. Sam Bugis, chair, Specialist Services Committee, Doctors BC, personal communication). At the time of writing, 73 facility engagement initiatives are up and running and all health authorities are involved.

Progress appears to be a result of two factors: physicians have taken up leadership roles in their facility; and health authority leaders (physicians and non-physicians) have moved meaningful change forward in their institutions. In many instances, doctors are also working better together to fix what they might otherwise have seen as someone else's problem.

**Discussion**

These two cases were chosen because they were very clear efforts to enhance physician engagement and leadership. Although they are very different in approach, there are some common elements that promote ongoing success.

- **A residual level of trust must exist at the highest levels** – Initiatives like these could not have begun if trust was not in place before any formal meetings were held. This trust must be at two levels: personal trust between the leadership groups of each entity; and procedural trust, in that agreements negotiated in the past had been adhered to by both parties.
- **An initial dialogue and formal agreement between the parties**, i.e., between the ministries of health and the respective medical associations, provided the impetus for further action.
- **A top-down and bottom-up approach to change** – In both instances, agreements that were made at the provincial level were translated into opportunities at the local or regional levels. In both instances, the medical associations supported their physician members in understanding the opportunities available to them and then created "physician owned" processes by which the doctors themselves could co-create change meaningful to them with their non-physician administrative partners.
- **Connection of efforts to the provincial change agenda** – In both instances, all parties recognized that success in creating health systems of the future requires the active participation of physicians as partners in the design of remuneration systems, accountability systems, and new service delivery models.
- **Support for physician leadership** – In both instances, opportunities for physicians to step up and take a leadership role were created. Education supports were provided and are still provided, in the form of Physician Leadership Institute courses and time to attend workshops, conferences, and other events.
- **Ongoing efforts to build new "engagement" structures** – New structures were implemented, such as dyads in the Saskatchewan Health Authority's organizational structure[13] and, in BC, project teams at the facility level that involved both physicians

and administrators. These structures demanded more dialogue and discussion between partners and were vital to the success of the new partnerships.

- **People need to change their behaviour to embrace engagement needs** – For engagement to be successful, all those who wish to see a result must themselves change their behaviour. Doctors BC and SMA board members had to dedicate significantly more time and energy to dialogue with key ministry officials, as well as the structures and processes in place provincially to facilitate reform. Physicians in both Prince Albert and in BC facilities had to step up and become actively involved in various dialogues with their colleagues and in projects to create positive change.
- **Use of existing models, with support and enhancement of their role** – In Saskatchewan, rather than building new models of engagement, the parties formalized the dyad structure, which had been in place in some regions, across the province. The operationalization of these roles has been enhanced. In BC, the use of the MSA as a legal entity to formalize approaches to improve facility engagement reinvigorated a somewhat moribund model and enhanced its role in creating engagement.
- **Parallelism** – Once an engagement project has been initiated through joint agreement of physician and non-physician members, it is vital that the two parties remain "in parallel" for the duration of the project. If one party gets ahead of the other or if regular dialogue and discussion are not happening, conflict tends to develop and the energy needed to maintain engagement dissipates.

## Summary

After four years of effort in the case of Doctors BC and two years by the SMA in Saskatchewan, both groups refer to the initiative as a journey, not an event. Both projects are efforts of co-creation: doctors and non-doctors, building health systems of the future, but creating them together. As long as the trust generated at the beginning of the two projects can be maintained, progress in relationship building will continue. Trust is the lubricant for engagement, and optimal physician engagement is doing it, experiencing it, learning from it, and ultimately enjoying the process, rather than the outcome.

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# Leveraging the power of a just culture to promote accountability and inform system improvement

Steven Bellemare, MD

Leaders must ensure that staff align their behavioural choices with the values that underpin their organization's vision and mission. When adverse events occur, the just culture model emphasizes accountability by acknowledging that adverse events are typically the result of both system design flaws and the behavioural choices of the health care providers in the system. Leaders are accountable for the design of the system and for managing health care providers' behavioural choices. Individuals are accountable for their own behavioural choices as well as for reporting both their own errors and system flaws.

**KEY WORDS:** values, patient safety, health care, just culture model, accountability, discipline, at-risk behaviour, human error, reckless behaviour, adverse events

A physician is verbally abusive to a nurse on the telephone. A resident delays attending a deteriorating patient on the ward. A surgeon operates on the wrong limb. Whatever the situation, adverse events in health care typically involve human beings who, through their behavioural choices, played a role in the genesis of the event. The effective management of such individual choices can play a key role in improving patient safety.

The amount of insight providers have into the impact of their behaviour on the safety of care is a key factor in their ability to improve their practice and deliver safe medical care. Much has been written on the topic of health professional insight and the results are worrisome: we are poor judges of our own performance and unskilled at identifying our learning needs.[1-3] However, through the establishment of a just culture and the use of effective coaching, health leaders can play a crucial role in filling this insight gap. Holding health care providers accountable for their actions and providing an opportunity to help individuals identify areas where they can alter their behaviours can promote safe care.

## Your values, your culture

Leaders expend considerable effort working with staff, patients, and other stakeholders to create vision and mission statements that establish purpose and guide operations. To operationalize a vision, leaders must interpret and deconstruct it into a set a values that staff can use as a compass to guide their decisions. Whether it be to provide cost effective care, to act in the patient's best interests, or to maximize patient turnover, clearly articulated values serve as the foundation on which a workplace culture is built. One might define a unit's culture as the extent to which health care providers, through their behavioural choices, will be protective of their unit's shared values. It's about what people do when no one is looking.

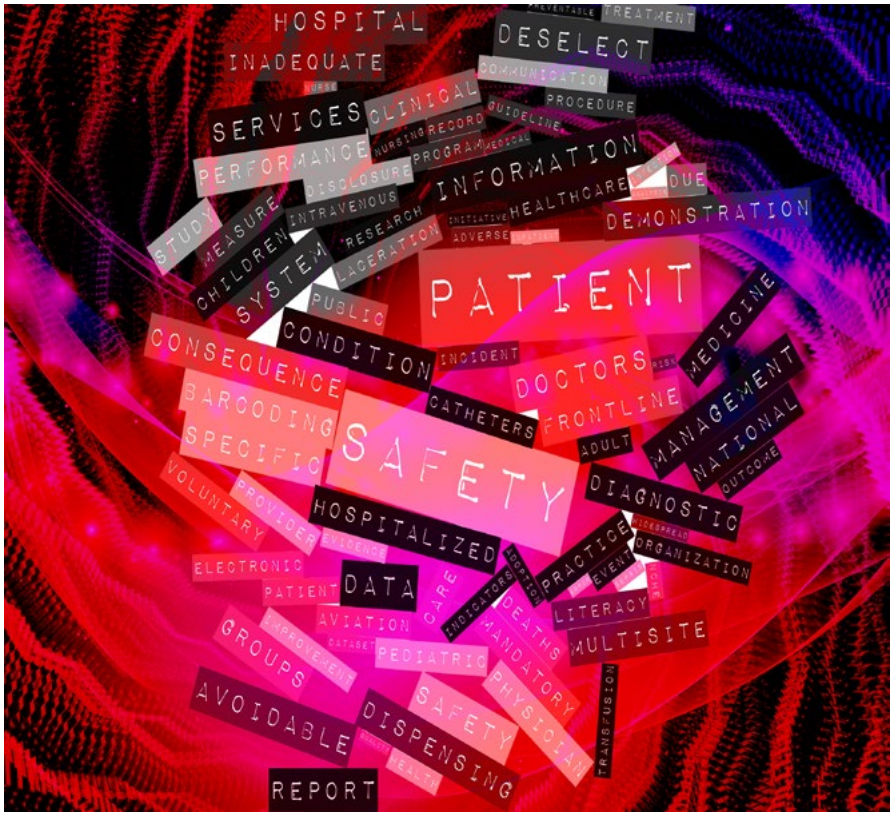
## Behavioural drift

Establishing our values clearly is foundational to achieving reliable and safe care, but it is not sufficient. To manage a system that strives for safe care, we must understand drift and manage it.

Our training teaches us to follow time-tested methods, such as conducting proper clinical assessments that include both a history and a physical examination, considering a broad array of differential diagnoses, and adhering to established processes. In reality, however, over years of practice, we become increasingly comfortable with our tasks and we start to drift.[4] As we develop expertise, we employ heuristics[5-7] – cognitive shortcuts – and begin to bypass steps in processes to maximize our efficiency and accomplish our "mission." Our assessments become more cursory, we limit our histories and physical examinations a bit too much, we don't consider other possibilities as formally, and we don't wash our hands as we should.

As we stray from expected behaviour and manage to tame our unwieldy task lists, all without apparent harm to patients, we become increasingly comfortable with our "new normal," which deviates from best practices, yet, nevertheless, gets things done – seemingly safely. In other words, we become comfortable with an increasing risk of harm that we do not readily perceive. We lose sight of the fact that this new normal is, in fact, unsafe. Often, it takes an adverse event and the ensuing quality-of-care review to remind us that we have unwittingly strayed from safe practice into a riskier one.

> *Health care providers drift away from rules, policies, and their training as they gain comfort with the tasks they are performing.*




## Moving from theory to practice

With values firmly established and communicated and drift theory firmly in mind, leaders must then turn to tame drift by ensuring that staff align their behavioural choices with the values that underpin the institution's vision. Leaders can achieve this directly, through their managerial decisions, or indirectly, via their influence on policy and through distributed leadership and alignment.

Without the benefit of clearly articulated values to guide our actions and frequent reminders to that effect, our daily mission often overshadows our ultimate purpose: to provide care without doing harm. The typical physician's daily mission often boils down to getting through their day's to-do list, which may include seeing a large number of inpatients and an equally large number of outpatients, as well as returning telephone calls, managing dozens if not hundreds of laboratory results, and communicating with elusive consultants, to name but a few tasks. This daily cognitive overload, combined with drift, creates a perfect storm of circumstances that increase a health care provider's risk of making behavioural choices that do not align with safe medical care principles.

## Dealing with adverse events through accountability

In creating accountability, leaders have two roles: foster learning and influence culture. First, to foster truly effective and healthy learning systems, leaders should seek

to ensure psychological safety. Psychological safety is foundational to safe care. It empowers everyone to speak up, identify safety risks, and make suggestions to manage recognized vulnerabilities without fear of reprisal or ridicule.[8-10]

Edmondson[11] has written extensively on creating psychological safety. Easily implemented leadership behaviours, such as being inclusive and open to learning and suggestions as well as encouraging questions and curiosity, can promote psychological safety. In addition, inquiring specifically about the psychological safety of one's team can have dramatic impacts on fostering the birth of highly competent teams.

Second, as architects of workplace culture and keepers of the learning system, leaders must, through their actions and influence, design and shape systems that allow for ongoing risk monitoring, identification, and management. Every patient safety incident and near miss can provide valuable insight into potential system improvements, but only if the events are reported and discussed without fear of reprisal.

When they occur, patient safety incidents can be dealt with in several ways. In the "name-blame-shame" model, we discipline and single out those involved in the incident and make them "examples" to improve the system overall. This approach breeds fear and may lead health care providers to cover up their mistakes, thus depriving the system of valuable learning opportunities and improvement.

An alternative approach, the "systems" model for addressing adverse events, was conceptualized to account for the multiplicity of factors that contribute to such events.[12] In this model, the provider is viewed as but one element of a much more complex system that creates the conditions for an adverse event to occur. Although this method challenges our thinking

about adverse events and their prevention, care must be taken not to minimize the individual provider's role in the incident.

**At-risk behaviour is an unconscious choice to act in a given fashion, born out of a misguided perception of the risk involved. Behavioural drift is the unconscious process that usually gives rise to at-risk behaviours. For this reason, at-risk behaviour represents a significant threat to patient safety.**

The just culture model seeks to emphasize accountability by striking a balance between these two approaches. In a just culture, we acknowledge that adverse events are typically the result of various combinations of system design flaws and the behavioural choices of the health care providers operating within the system.[13] In a just culture, both the health care organization – and, by default, its leaders – and frontline providers are accountable. Leaders are accountable for the design of the system they operate and for managing health care providers' behavioural choices. For their part, individuals are accountable for their own behavioural choices as well as for reporting system flaws, including their own errors, as they encounter them.

Implementing a just culture model promises to minimize health care providers' fears of unfair reprisals by making expectations clear and ensuring that behavioural choices are managed transparently and fairly according to expectations, without bias based on the outcome of the event.

## Three situations, three interventions

The just culture model recognizes three broad situations that can lead to adverse events: human error, at-risk behaviour, and reckless behaviour. It also dictates three distinct approaches to managing these situations.

Human error is, by definition, inadvertent and unavoidable. As such, the appropriate managerial intervention is to console the health care provider involved. Because its prevalence may be influenced by both system and personal factors, leaders dealing with human error should consider whether a contributing factor was at play and how it could be addressed so that similar errors can be avoided in the future.

At-risk behaviour is an unconscious choice to act in a given fashion, born out of a misguided perception of the risk involved. Behavioural drift is the unconscious process that usually gives rise to at-risk behaviours. For this reason, at-risk behaviour represents a significant threat to patient safety.

It also provides leaders with the strongest opportunity to effect change, through coaching. Coaching is a values-supportive positive conversation designed to help health care providers identify an unperceived risk or to recalibrate their perception of a known risk. Its goal is to help providers use the organization's values as the guiding framework within which to ensure that their decision-making favours an expected behaviour over one that may at first glance seem easier, equivalent, or more efficient in helping them accomplish their daily mission.

The key to successfully managing at-risk behaviour does not lie in reminding people of the rules. Rather, it lies in improving health care providers' choices by making them aware of the risk (if they did not see it) or by changing their perception of it (if they have misinterpreted it). In addition to coaching, as with human errors, due consideration should be paid to personal and system-based performance modifying factors – those factors that shape a person's choices and that can be addressed and modified when identified.

Taking disciplinary action for at-risk behaviour does not serve the cause of establishing a just culture, as it may discourage disclosure of adverse events and near misses and greatly diminish opportunities to coach and reframe risk. That said, there are situations where the management of at-risk behaviour may require escalation to disciplinary action, typically when coaching has been ineffective or the behaviour is repetitive despite efforts at addressing personal and system performance modifying factors.

The third situation is reckless behaviour. Infrequent in occurrence, it involves intentional risk-taking and reckless disregard for a known, substantial, and

unjustifiable risk. Because reckless behaviour is an intentional choice, the appropriate managerial intervention involves disciplinary action as a means of sending a clear message that such behaviour is not tolerated.

Disciplinary action should follow due processes of natural justice and can take many forms, as dictated by the circumstances. Formal meetings with high-level executives, letters of reprimand, remedial learning, undertakings to improve behaviour, suspensions, and termination of privileges are all potentially effective, escalating methods of addressing reckless behaviours.

## No harm, no foul?

Not all at-risk or reckless behaviours lead to patient safety incidents or even to near misses. In fact, although data for health care are sparse, as in other industries, the large majority of such behaviours do not lead to harm.[4] Nevertheless, each observed episode of at-risk or reckless behaviour should be managed according to the above principles.

A "no harm, no foul" attitude is a significant obstacle to the establishment of a culture of accountability. Outcome bias – the tendency to take action based on the severity of the outcome – may cause leaders to punish human errors that have had disastrous outcomes, such as death, and ignore reckless behaviours that have resulted in no observable harm. Such an internal lack of consistency will instill a sense of cynicism and disengagement among a unit's staff and undermine leaders' efforts to create accountability for everyone. Leaders' strongest tools for conveying the message that they are serious about accountability are reliability and standardization of approaches when dealing with the three situations described above.

## Promoting safe care

Caring providers take the outcomes of the patients they treat to heart. They do their best to manage workloads and numerous competing demands. As leaders, we can help health care providers develop insight into their actions by always providing feedback on how well these actions align with our values. A just culture approach helps to create a stable supportive workplace in which we can assess our work, improve on what we see, and create a system that minimizes the risk of harm.

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**Editor's note:** Dr. Bellemare will be co-presenting a workshop entitled "Managing physician performance: the importance of natural justice" at the 2019 Canadian Conference on Physician Leadership.

# Disengagement in health care: today's new culture

P. James A. Ruiter, MD

In an environment of disengagement, re-engagement of staff can be achieved and is highly rewarding. To be successful, what is needed is a clear understanding of the health care context, the current state of patient safety, and why people behave the way they do. With this understanding, coupled with a process that respects it, engagement is not only possible, but can be predictably achieved. The first of three parts, this article presents an overview of the key concepts rather than an exhaustive exploration. It aims to challenge current thinking by bringing together key elements that make implementation of quality and patient safety initiatives challenging.

**KEY WORDS:** physician engagement, liberating structures, patient safety, quality assurance,

Speaking of re-engagement in health care would be of little value if light were not first shed on the topic of disengagement.

In 2015, only 57% of health care workers considered themselves engaged,[1] 10% fewer than only five years earlier. Almost a third (30%) considered themselves as "just contributing" to their role, and 13% assessed themselves as either "actively disengaged" or "hostile." This situation has been steadily worsening since figures have been tracked.

## What is engagement?

For physicians, engagement has been defined as: "The active and positive contribution of physicians within their normal working roles to maintain and enhance the performance of the organization, which itself recognizes this commitment by supporting and encouraging high-quality care."[2]

But looking solely at one profession when all are required for the organization to succeed is short sighted. Thus, a broader definition of engagement includes: "a sense of work-related well-being associated with worker motivation."[3] Re-engaging the team will never succeed if one focuses on a uni-professional approach. As such, the rest of this series will speak of the issue from an interprofessional perspective.

## Why has disengagement in health care become the norm?

Answers can be found if we just turn our attention inward. In early 2018, I facilitated a meeting involving a 55-hospital health system. Fifty senior leaders, middle managers, educators, and front-line team members came together to discuss how to improve quality of care and of life at work. The issue of disengagement came up, and I used a TRIZ (a liberating structure[4]) to help bring insight to the audience about some of the reasons.

A TRIZ invites participants to list activities that would contribute to creating the *exact opposite* of what is desired. In this case, participants were asked to express what would be needed to create the worst possible engagement in a health care quality project. As is often the case with TRIZ, participants thoroughly enjoyed the process as they listed elements that would result in total disengagement. Three scribes were required to keep up with flip-charting the flow of ideas!

The next step was to review the list and identify which elements, if any, were part of the system's existing initiatives. A full 100% of


the listed items – items that would contribute to disengagement – were acknowledged as present in their initiatives. Although the attendees were shocked, this should have come as no surprise to anyone.

Have we designed our health care system to disengage its own workers? Inadvertently, maybe we have. The following are some of the contributing factors.

## The flavour of the week

Humanity's desire for quick fixes extends into health care. This desire has led to a revolving door of programs, historically dubbed "the flavour of the week." Reinforced by the requirements of regulating bodies, the issue is also known as "institutional attention deficit disorder" (M. Gardam, personal communication, 2018).

This phenomenon has been accentuated by yet another revolving door: turnover among senior leadership teams. "The turnover rate for healthcare CEOs remains at a record high – 16–20% between 2011 and 2015."[1] New CEOs look to gain early wins and build legacies of success; and they want things done their way. New leadership teams lead to changes in processes and approaches, allowing only a few programs the time necessary to be fully implemented, monitored, and adjusted to actually make a difference.

The flavour of the week leads to worker fatigue and disinterest. Disengagement builds.

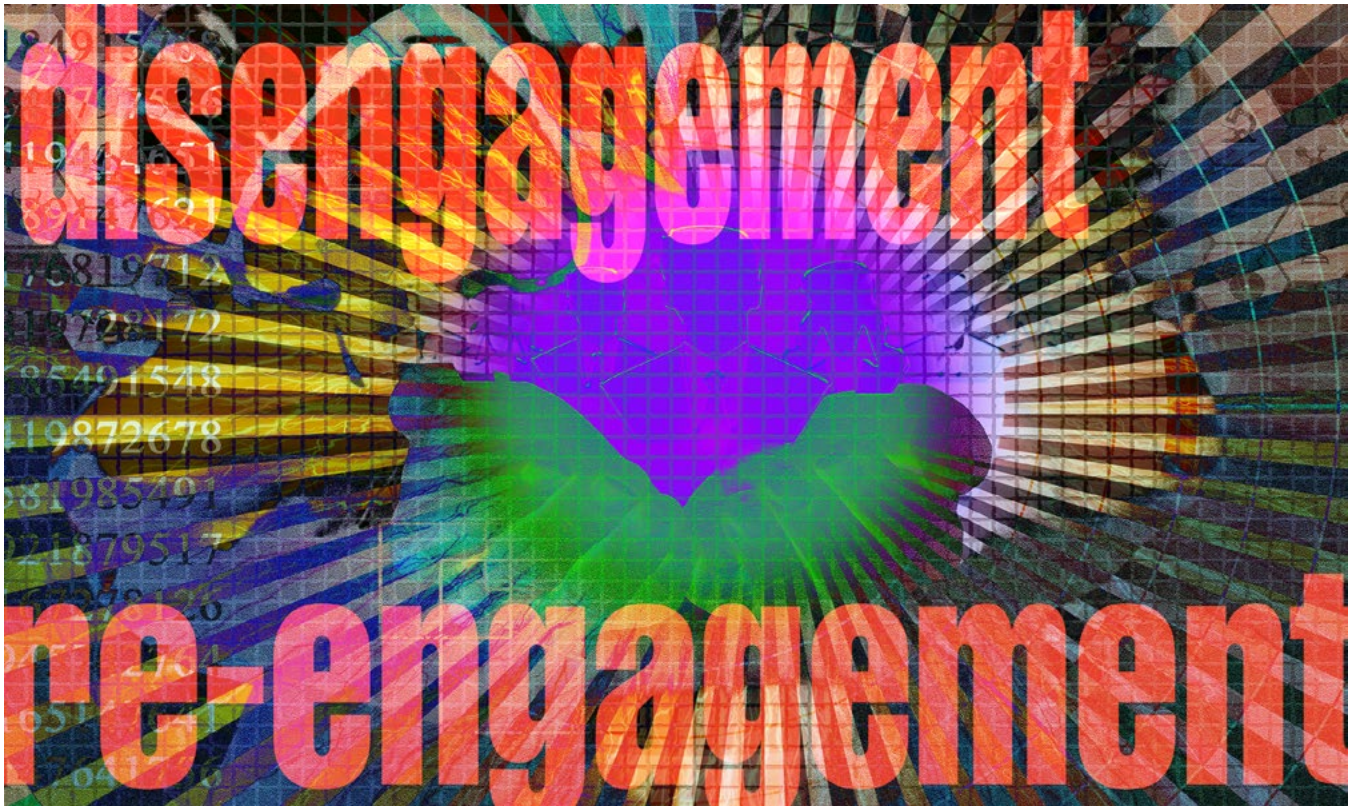
## Just get it done

The perceived easiest way to implement anything is to have people simply *do it* through the management of hospital staff. Although this appears easy, as a strategy it does not succeed. After all, if it were that easy, it would have been done already. Why do we still have problems with hand washing?

Much of what we have to do to improve health care has already been described. It is the *getting there* that is the hard part.[5] Experience reveals that the "just get it done" approach leads to unsustainable solutions and a weak team, and further contributes to disengagement.[6]

## Buy-in: is it truly what we seek?

An extension of "just getting it done" is seeking buy-in. Leaders all too often seek buy-in from health care teams, which on the surface may appear to be a sound approach. Yet, if we dissect what this means, we begin to understand why it is not what leaders want at all.




Consider some context for this statement: when leaders seek buy-in, they are asking colleagues to accept the leaders' solutions. This acceptance process occurs late in the development of the solution, a solution that likely had minimal input from the team that is asked to implement it.[7] Leaders will rationalize that their colleagues were too busy to provide input and that they were doing colleagues a favour by doing all the work. In fact, leaders did not create the capacity for team members to take part. Simply put, in seeking buy-in, leaders are actually seeking the team's acceptance of an externally created process.

What we need to create is not buyers of the change, but "investors" in it.[8] Zimmerman and colleagues[7] explain that if one actually achieves buy-in, it is evidence of an unhealthy organization, because the result is a team that is content to follow orders and put in time rather than engage. Furthermore, if something is wrong with the process, the team is quick to point to the leaders and state: your process, your problem.

The team remains disengaged and is not part of the solution, rather is part of the problem. Furthermore, evidence shows that such change, imposed by others, is often opposed overtly or covertly.[9]

## Safety and quality

In our zeal to try to "fix" safety, safety is seen as distinct from quality. In 2017, Berwick observed that when he hears "quality and safety," he hears "fruits and bananas."[10] In essence, safety has been severed from what he calls the "big tent" that is quality. When seen from a certain point of view, quality – which is the "evidence" – can be considered universal; the problem lies in its application, which is very much site and context specific.

In other words, while quality is overarching and can be broadly applied, safety is more site-specific and must be locally determined. As a result, many of us have witnessed excellent evidence-based processes that are simply not safe in certain contexts: in the brick-and-mortar structure/design of a unit, in combination with existing processes, to the population served, or even in the geographic location of service, to name but a few.

We must bring safety back into that big tent and accept that the process can, and should, be adapted to local context. If a team knows an evidence-based process to be faulty in the context of its practice, it will not use it, thereby decreasing trust in other

processes and further fueling disengagement.

## Data glut and its impact

Don Berwick[10] identified the quagmire that is "big data" today. He says: "In pursuit of incentives, we've glutted ourselves with metrics. I think we are way beyond a level of toxicity. It's not just safety. We have to go on a diet."

Front-line teams often have data used against them, what I call the "weaponization of data." We are scolded for our caesarean section rates, or we lose funding because of our unit's low census.

Finally, imposed targets and key performance Indicators can have unintended consequences and lead to "perverse outcomes."[9,11]

We need to flip data on its head. Data can, and must, drive engagement. Data must become the reward of a job well done. Accordingly, what is measured needs to be relevant to the team tracking it. It must be produced within a reasonable time from implementation of an intervention and must be in a form that speaks to the unit.[12]

## Challenge the myth of the disinterested

Disinterest may be resistance to change. People will resist change for many reasons; however, in their own personal context, their resistance (whether passive or not) makes sense. It is critical to develop ways to engage these people.

It should come as little surprise that a person may become disinterested if they have tried to contribute and make change and seen nothing come of it. In fact, these resisters may become the most engaged contributors when they see the results of renewed efforts for change that include them.[8]

## Is it disengagement or burnout?

Burnout has been defined as: a job-related emotional response to stress in the work environment characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment.[13]

The physical attributes of burnout and disengagement are the same. In other words, a disengaged person will look the same as a burnt-out colleague. Furthermore, burnout in health care is difficult to self-identify, as many of the warning signs have been trained out of us through our educational processes. As a result, by the time it is diagnosed, it has taken strong hold on the individual, often leading to the abandonment of a career – or worse.

How prevalent is burnout? "Burnout in medicine is an epidemic hiding in plain sight."[14] Burnout is omnipresent in today's health care environment and has been called an occupational hazard with a reported rate of anywhere from 25% to 75% depending on the area of health care.[15] Burnout must be addressed urgently; with far too many of our colleagues succumbing to it.[16]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*This article has been peer reviewed.*

This is the first of three articles on the topic of disengagement:*

- *Disengagement in health care: today's new culture* sets the stage by introducing some of the issues affecting engagement of health care workers.
- *Patient safety in a new age* reviews patient safety's role in disengagement through a complexity science and human behaviour lens.
- *Engagement is all about ownership* presents an ownership-based approach to re-engagement that takes into account both the context and the new understanding of safety and quality and integrates them into a process that is simple, purposeful, reproducible, and successful.

*This series is an expansion of "Implementing patient safety initiatives," by the same author, which will appear soon as chapter 5 in Obstetrics and Gynecology Clinics of North America (doi.org/10.1016/j.ogc.2019.01.005).

PERSPECTIVE

# Why are conferences so expensive?

Carol Rochefort, CAE

"Why is the cost to attend this event so high?" I can tell you exactly why.

I am not a professional meeting planner. However, I have been the executive director of the CSPL for the past 20 years, and hosting an annual event is just one component of the job.

The changes that have occurred since my first conference are like night and day. In the early days, we just had to find one suitable meeting room that could hold 100–150 people. We would start working on the program a few months before the event and telephone (not email) potential speakers. No speakers' fees were required.

Once we printed our one-page program with a registration form on the back, it was mailed to our members with a stamped return envelope enclosed. Then we sat back and waited with baited breath to receive the forms and cheques (no credit cards, debit, ETF, etc.). The process was simpler then, but the stress (especially for the president who covered the initial costs using his personal credit card) was still there until you had enough registrations to cover the cost of the event.

**Participants then begin to expect speakers who are not only experts, but also educational, entertaining, and, when possible, funny.**

Fast forward 20 years, and the simple annual meeting from 1998 has morphed into this large, complex, time-consuming beast that requires multiple steps and processes – and more money. Each conference has been a great learning experience, but even though I gain a little more confidence each year, the stress and worry grow as the costs and size increase.

Here are some of the changes that have occurred over the past 20 years. They might give you some insight into why the cost of our event has increased from $350 in 1998 to $1100 in 2018.

## Speakers

Before the World-Wide Web, one located speakers mainly through word of mouth or by calling in favours from friends and colleagues. Today, the Internet has made finding speakers an amazing process. Once you have a theme or specific topic, endless hours can be spent viewing thousands of potential speakers from around the world. Many have video clips, which give a good idea of what you are purchasing.

The downside is that participants then begin to expect speakers who are not only experts, but also educational, entertaining, and, when possible, funny. The cost associated with finding the perfect speaker comes at a price, and each year I need to be a little more creative in my negotiating skills. I have reached out to speakers recommended by participants, only to find out that their fee is in the $75 000–$100 000 range plus first-class travel for themselves and economy travel for their handlers. Yes, they have handlers! I find myself chuckling a little when I respond to these speakers by stating that their fee is my entire conference budget.

## Venue

Some might think that finding a venue for a wedding is difficult, but that is nothing compared with professional events. The one large room is just not adequate these days. We require breakout rooms, separate rooms for lunch and breakfast, a large space for plenary sessions, office and registration space, exhibit space, and of course additional rooms for that impromptu meeting.

It's now necessary to hire professionals to help locate the right hotel/conference space, in the right location, in the right city.


Bookings have to be made 2–3 years in advance. Once the location that you hope will meet all the needs has been found, you must sign a complicated contract that could bankrupt small organizations if they had to cancel within six months of the event.

Although everyone enjoys a five-star hotel and meeting facility, no matter how expensive or new the hotel, you will never be able to make everyone happy. The management and staff at these hotels continue to amaze and impress me each year. When you meet with the hotel management team just before the event, you have to be impressed by the number of staff who are going to be taking care of the event and the participants for the next few days. There is no request, no matter how strange, that the hotel team will not fulfill to make your event successful.

## Program

The conference program is now a 20-page glossy brochure giving participants full details about the experience they will have and what they will learn during each session. Not only will participants receive a copy of the brochure by mail, but they can also access it on the conference website or download "the app" to their communications device. These additional formats require expertise, staff, and money to create.

The program must offer participants not only keynote addresses, but also a variety of breakout sessions, panels, networking opportunities, and coaching/mentoring sessions, and all must be interactive and provide the participant with tips, techniques, and takeaways. Again, these extras require staff, time, and money.

Anyone organizing a health care conference knows about the time and work involved in applying for continuing professional development credits. The fees for this have increased over the years and the application process can be a little daunting. The *National Standard for Support of Accredited CPD Activities* describes a set of ethical standards and expectations relating to sponsorship support that physician learning activities must meet to be accredited. Physician participants are encouraged to attend events that are accredited.

## Food and beverage

In the early days, when we asked participants to state any food

observances/allergies, we would receive fewer than 10 responses, usually noted as severe allergies. At our most recent conference, close to 200 people reported food allergies/observances, sensitivities, and diets, which we then forwarded to the hotel.

One year, the hotel prepared a large number of special meals as requested by participants – at an additional cost of $5000 – and only a few participants actually picked them up. Those special meals were thrown out. Needless to say, we don't do this anymore. Instead, we attempt to accommodate all food requirements and observances in a buffet-style format.

Again, the hotels continue to amaze me with how much effort they make to accommodate as many requests as they can, but this definitely entails an additional price.

One cost that most participants are not aware of is the price of tea and coffee. Some participants have asked why we can't have a tea/coffee station available all day. The price, including all gratuities and taxes, works out to $6–8 for an 8-oz cup – no "bottomless cups" here. If you want to fill your large travel mug, consider that a $20 dollar cup of coffee!

## Technology

I am sure no one is surprised to learn that keeping up with the demands of technology is a never-ending additional cost. Participant expectations must be met if we want them to return the following year. However, costs rise every year because of upgraded devices, the demand to provide parts or all of the event on video, webinars, etc.

**Conference registration can no longer be by cheque only. Online registration is a must! Registration software must be purchased and significant annual fees paid to maintain the software.**

In the early years, we would borrow one or two data projectors and bring them to our event. Today, we spend over $45K solely on the audiovisual component of our event. Keep in mind that for every additional workshop or session, we have to rent data projectors, screens, microphones, clickers, and any other device the speaker may require per day. Don't forget the expertise of on-site technicians for the duration of the event. Other significant technological costs are website software and design, apps, and conference registration software.

## Conference registration

Conference registration can no longer be by cheque only. Online registration is a must! Registration software must be purchased and significant annual fees paid to maintain the software.

Registration must include payment by credit card and, for some larger events, debit and electronic transfer. The conference host must pay significant credit card fees (3–5%), which participants don't see; if they cancel, we pay it twice, which is why there is an "administration fee" for canceling.

As a small, non-profit organization, we set the prices so that we can at least break even or sometimes turn a small profit to invest in other CSPL activities like the journal.

## Sponsors

Sponsorship is the part of event planning that I find the most challenging, but a must for small non-profit organizations like the CSPL. Asking for money is not easy, and there are fewer and fewer sponsorship dollars to be had. In addition, participants have paid good money to attend the event; so, the sponsors must be relevant and worthy of their attention and vice versa!

In the early years, sponsorship dollars were plentiful and ethical reviews were not required. This allowed for significantly lower registration costs for event attendees. Today, for a number of reasons, companies and organizations question the value of their sponsorship at your event. Guidelines, including ethical reviews, must be followed, especially if you are applying for accreditation.

"Less is more." I believe our success in the past few years has been a result of having fewer but relevant sponsors. With fewer sponsors, it is easier to create a warm welcome between sponsor and participant. Allowing sponsors access to participants at breaks, meals, and receptions seems to

work: sponsors are pleased with the one-on-one contact, and participants are happy to have learned or taken away some knowledge about the sponsor.

## Summary

I hosted my 20th annual meeting in 2018, and it doesn't get easier. My stress level definitely runs high before the event (just ask my husband). Only when the opening keynote speaker is on stage, the room is full, and participants seem to be engaged do I finally breathe. This is not saying that problems won't arise during the event, but at that point I realize there is nothing more I can do. Then, I look forward to having a glass of wine or two during our welcome reception and getting caught up with returning participants and meeting new ones.

For anyone who hosts a conference or other event, I hope you at least nodded your head a few times and thought, "That is exactly right." For those who have not, I hope I have provided some insight into the costs, staff, patience, and effort that go into our annual meeting.

Hope to see you at the CCPL in 2019!

## Authors

Carol Rochefort, CAE, has been executive director of the CSPL since its inception.

Chris Carruthers, MD, is the founder and first president of the Canadian Society of Physician Leaders.

## Some interesting points and changes over the years

Chris Carruthers, MD

- In the first years of the CSPL, Carol and I anxiously looked at weather reports and potential flight cancellations before a meeting. The absence of 15–20 attendees would mean a deficit. Minimal hotel room occupancy was guaranteed. We had no reserve funds in the early years to cover deficits.
- We had to pick a city attractive to those attending. For many years Vancouver was the top of the list as participants added holiday days to enjoy the city.
- Saturday and Sunday, traditional meeting days, became less popular as physicians wanted to spend more time with their families. Many left early Sunday for home, particularly from Vancouver for those heading east. We switched to Friday and Saturday to accommodate these wishes and it has worked well.
- Five-star hotels are costly and you are obligated to use in-house services, such as catering. Conference centres are even more costly and require you to use union employees. Shopping around for competitive pricing on many of the services is not an option.
- The expectations of participants have increased tremendously. At the early meetings, we held one workshop at a time for everyone. Today, we have to offer several options, so that attendees can pick a subject they are particularly interested in learning more about. However, this is much more expensive.
- Carol's 20 years of experience have significantly minimized the risks surrounding meetings. Carol is a pro!

BOOK REVIEW

# All Together Healthy: A Canadian Wellness Revolution

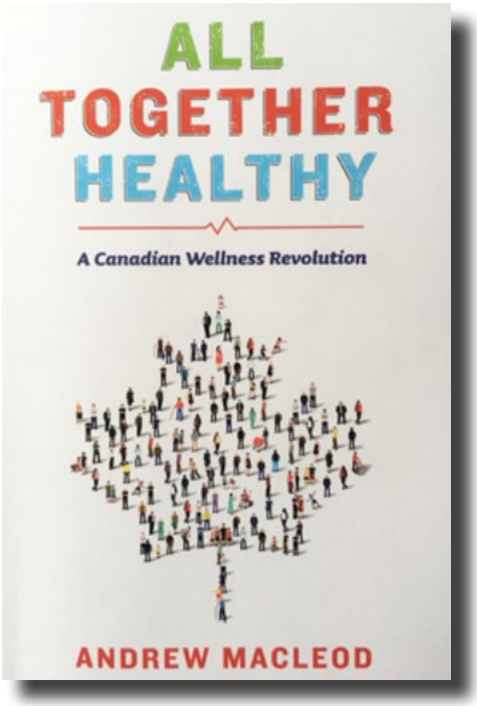
Andrew MacLeod
Douglas-McIntyre, 2018

Reviewed by Johny Van Aerde, MD

Do you have limited time and want to read only the best and most recent publications on what makes us unhealthy and what stresses the Canadian health care system the most? If so, *All Together Healthy* by Andrew MacLeod, a journalist from Victoria, is the book for you. Well written and easy to read, the book is an integrated compilation of not only the data on socioeconomic contributors to population unhealth, but also the historical context of Canadian politics and reports by Romanow, Epp, Naylor, and Lalonde among others.

After addressing the better known effects of living conditions, wealth status, and the environment on health and well-being in the first chapters, MacLeod makes interesting connections between underlying societal ailments and mental health, and between tent cities and the current crisis of substance abuse.

In the final chapters he makes the reader think deeply by asking who is responsible for population health: is it the physicians, hospitals, health authorities, public health departments, governments, patients, or citizens? He surmises that, while our health care system is structured so that physicians' top priority is providing and advocating quality care for each patient, population health should be the responsibility of all.




MacLeod shows the reader that the culture of disease is embedded in the structure, politics, and economy of our Canadian society and health care system. The health industry benefits from idolizing illness, and the public is unwilling to change its beliefs and perception that health means having the latest technology, more hospital beds, and the newest medication. On that basis, politicians have to make decisions to satisfy the public and the industry, while the media sensationalize the many non-evidenced technological breakthroughs. As a result, those decisions and beliefs maintain health disparities and prevent resources from being invested in population well-being.

This book is a must read for every physician, health care provider, politician, patient, and indeed every Canadian citizen. The only distraction of the book is its subtitle, *A Canadian Wellness Revolution* as the evidence clearly demonstrates that there will be no wellness revolution in Canada soon.

## Related resources about the Canadian health care system


- Advisory Panel on Healthcare Innovation. Unleashing innovation: excellent healthcare for Canada. Ottawa: Health Canada; 2015. Available: https://tinyurl.com/yypo6kc9 (accessed 5 Jan. 2019).
- Health care in Canada: what makes us sick? Ottawa: Canadian Medical Association; 2013. Available: https://tinyurl.com/y6xfqxrn (accessed 5 Jan. 2019).
- Marmot M. *The health gap: the challenge of an unequal world.* New York: Bloomsbury Press; 2015.
- Martin D. *Better now: six big ideas to improve health care for all.* Toronto: Allen Lane; 2017.
- Picard A. *The path to health care reform: policy and politics.* Ottawa: Conference Board of Canada; 2013.
- Simpson J. *Chronic condition: why Canada's health-care system needs to be dragged into the 21st century*. Toronto: Allen Lane; 2012.

BOOK REVIEW

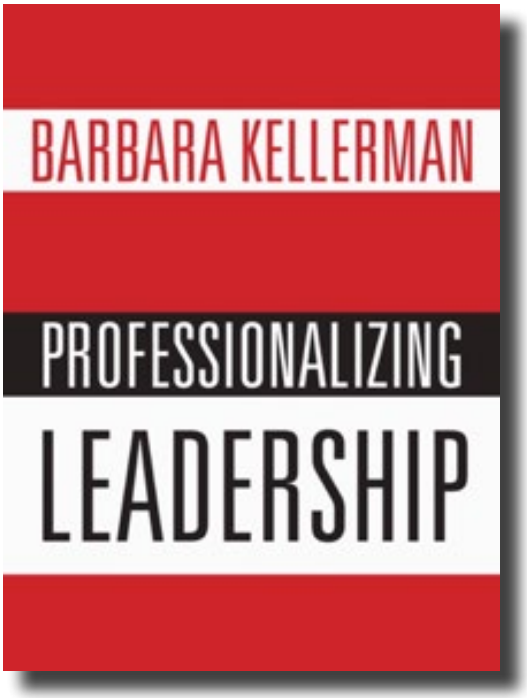
# Professionalizing Leadership

Barbara Kellerman
Oxford University Press, 2018

Reviewed by Johny Van Aerde, MD

In *Professionalizing Leadership* by Barbara Kellerman, who was a keynote speaker at the 2012 Canadian Conference on Physician Leadership, I found four messages:

- Leadership is not a profession and it should be
- Leadership development requires life-long learning and is more than just education or training
- Leadership is a complex system with three elements: leaders, followers, and context
- Leadership programs are leader-centric and have ignored followers' need for knowledge, skills, and development




Kellerman explores how medicine and law have evolved from occupations into professions over the last few centuries, now requiring extended periods of education, training, and development. She then examines why leadership is an occupation rather than a profession, and she finishes by offering suggestions for professionalizing leadership in the future and what can be done to bestow on leaders the dignity associated with professionals.

Markers that are associated with achieving professional status, as in medicine, include: extended education and training based on a generally accepted body of knowledge; required continued education and training; clear criteria for evaluation, certification, and recertification; clear (cultural) demarcation between those within the profession and those without; explicit commitment to the public interest and to a code of ethics; and professional organizations with the authority to monitor the status of the profession and the conduct of their members.

Unlike medicine and law, leadership has no body of knowledge, core curriculum, or essential skill set. It has no widely agreed-on metric, no clear criteria for qualification, and no professional body or association to guarantee minimum standards and oversee the conduct of its members. Therefore, today's leaders don't qualify as professionals.

Three essential verbs – educate, train, and develop – are critical components of leadership learning. Even though they are used interchangeably in the leadership industry, they are different. The education component is the acquisition of knowledge, *knowing*. The training element pertains to skills, the *doing*. Development, which comprises the previous two components, means life-long practice based on accumulating experiences, the experiential learning or being.

In medicine, education happens in real or virtual classrooms, training in the clinical settings of hospitals and practices, and development through life-long learning, years of experience, and continuing medical education, which are measured through recertification. To become a practising professional takes time, much longer than a day, a week, a month or even a year-long leadership program.

If we draw a parallel, what would each of those three verbs mean for leadership learning, and how can they help leadership transition from an occupation to a profession? These questions cannot be answered without seeing leadership as a complex system with at least three parts: leaders, followers, and contexts. Leadership programs have always been leader-centric, not dissimilar from the outdated

physician-centred model. Just as the health care system has shifted from physician- to patient- to relationship-centred care, leadership must move away from focus on leaders and include followers. Leadership programs must not only focus on leaders, but also the followers who have different needs for knowledge, skills, and development, particularly as all of us are followers sometime or somewhere.

After reading Kellerman's book, I see that the Canadian Certified Physician Executive credential is somewhat a reflection of what professional leadership for physician might look like, as it is based loosely on defined requirements for knowledge, skills, and development. I also wonder how the Canadian Society of Physician Leaders might become an organization that helps professionalize physician leadership and leadership development more generally.

This book is not for everybody, but for those who are interested and passionate about leadership and leadership development, this belongs on your book shelf.

## 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.

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