Professionalizing Leadership

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Contents

EDITORIAL

Integrating diversity by developing coalitions

Johny Van Aerde, MD, PhD

In this issue of *CJPL*, we celebrate the success of the 2019 Canadian Conference on Physician Leadership (see Pat Rich's article[1] and CCPE recipients[2]).

The theme of this year's conference focused on the leadership challenges surrounding diversity, inclusion, and engagement in the health care system. The first step toward diversity is an awareness of subconscious and conscious biases, then managing those biases and taking action for change toward inclusion and equity. While a successful multidisciplinary team builds on the diversity of its members and their skills in the context of distributed leadership, a different kind of diversity exists at the system level. That systemic diversity is often isolated within the boundaries of "silos"; it lacks integration and has contributed to multilevel fragmentation of the Canadian health care system.[3]

Constitutionally, there are at least 15 delivery systems, with provincial, territorial, regional, Indigenous, and military elements that remain disconnected. Canada's huge size leads to geographic fragmentation, with communities ranging from highly urban to remote and rural locations. Structural fragmentation is further aggravated by different degrees of regionalization and provincialization.

Functional silos exist for patients who require continuity of care: adolescents or elderly may transition between age groups, patients move from hospital to community care. Similarly, navigating the health care system is difficult for patients with multiple chronic ailments. This functional fragmentation goes hand in hand with professional fragmentation because of an increasing number of subspecialties and programs. The absence of essential elements, like pharma- and dental care, from the Canadian "universal" health care system further adds to functional fragmentation for patients and providers. Finally, the uniquely legislated and structural role of physicians makes many of them independent practitioners with a business based on fee-for-service payments, while many other caregivers are salaried employees.

To cross boundaries and integrate the richness of this diversity, coalitions can be formed. Coalitions are strategic (purposeful) temporary or permanent relationships established between organizations, societies, community agencies, or other independent bodies to work together toward achieving a common purpose. The four capabilities in the Develop coalitions domain of the LEADS framework[4] can help improve the chances of success.
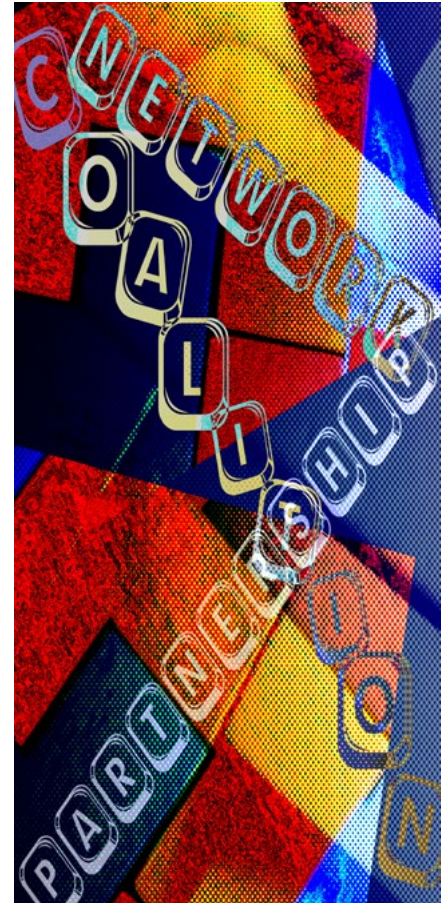
Purposefully build partnerships and networks for results

Depending on the level of commitment, interdependence, power, trust, and willingness to share, coalitions range from networking to merger, with coordination, cooperation, and collaboration lying between those two extremes. The type of coalition

and its purpose also determine whether the relationship is permanent or temporary. At the early beginning, the type, purpose, and objectives of a coalition must be carefully determined and agreed on. Only then can it move on to conversation and agreement on outcomes; a strategy; sharing of resources, benefits, and risks; and building and maintaining trust. A second step is formulating a written agreement with defined responsibilities and accountabilities, reducing the risk of conflict and improving the chances for success.

Mobilize knowledge

This capability comprises several aspects of knowledge: the knowledge of self and others, skills to communicate that knowledge, and the mobilization of knowledge generated in the context of the coalition's purpose. Each partner has to be clear and transparent in

terms of assumptions about self and others. Each participant must possess the skills to engage in dialogue to explore possibilities and discussions to converge on action and outcomes. Honest and frequent communication is an essential building block of trust. Knowledge mobilization for the purpose of the coalition is sometimes called knowledge arbitrage: a process of collectively exchanging, transferring, using, and creating knowledge across organizational boundaries to create new outcomes that benefit all partners as assessed by agreed upon performance criteria.

Demonstrate commitment to customers and service

There must be a clear view of who the customers are and what services are to be delivered. Although our initial response would likely be that the patient is the customer and caring is the

service, in some cases others are the primary customers, depending on what type of coalition is proposed and what its purpose is. With the widespread burnout of professionals in the health care system, for example, those professionals might well be the customers. Sometimes, the government or Canadian citizens in general might be the customers.

Navigate the sociopolitical environment

Lack of attention to this capability might represent the biggest danger for coalitions. Groups may see sharing information as a security threat.[5] Any coalition potentially challenges the identity of each partner, which is why the differences between partners must be recognized and valued as assets. Reaffirming legitimacy by publicly acknowledging the importance and differentiated value of each group should lead

to a win–win attitude. The biggest threat might come from control overlap between parties, which is why both the areas of autonomy and of shared control should be delineated within the context of defined success, not only for each party, but also for the coalition. Fear of domain encroachment is another threat. Once more, communication skills to allow dialogue and conflict management are of utmost importance and increase trust.

Integration of diversity across silos will increase the strength and value of the health care system and improve care delivery. Using the four capabilities of Develop coalitions increases the chances of success.[4] In a similar context, Dr. Marc Bilodeau, CCPE and CHE, and John Crook, CHE, wrote a paper for this *CJPL* issue suggesting a coalition between the Canadian College of Health Leaders and the CSPL.[6]

If CSPL was to choose a coalition with another organization in the future, further research and exploration along the four capabilities would be required. They would help define the purpose, objectives, and duration of a coalition for the organization, its members, and potential partners.

The CSPL membership is strong and growing, as are the number of physicians currently holding a CCPE designation. CSPL wants to continue being vibrant and maximize the value for its members. Carefully negotiated and structured coalitions will add strength and value for our

members by increasing diversity. *You* are CSPL, *I* am CSPL, and together *we* are CSPL. Therefore, we invite each of you to send your thoughts, ideas, and suggestions. As a respected and valued CSPL member, we want to know what you think. Please let us know.

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OPINION

Better governance leads to better health care systems: Physician participation makes for better boards

Chris Carruthers, MD

Health care and hospitals are among the most complicated industries to understand, manage, and govern. Canadian health care is governed by boards responsible for various geographic regions depending on the province or territory. The governors are mostly volunteers.

Each province determines its own scope of governance as appropriate. They have various board structures: some good and some that could be better. Ideally, there should be some consistency of board structures and membership based on best practices.

Some provinces, like British Columbia and Quebec, have a regional structure while others, like Saskatchewan, Alberta, and Nova Scotia, have one governing body for the entire province. Ontario formerly had a tiered governance system with local health integration networks (LHINs) and hospitals maintaining their own boards. Today the hospital boards are still in place but the LHIN boards have been disbanded.

Boards today are actively addressing the need for director diversity, some better than others. The culture and organizational structure of a hospital system is unique and important to understand to achieve successful oversight results. As for all boards, the number one role of health care boards is the hiring and evaluation of the CEO. However, health care boards differ from corporate boards as they have responsibility for safety and quality of patient care.[1]

Diversity of skills is often lacking on health care boards. Although boards are populated with dedicated volunteers, the skill mix could be improved to ensure better governance. Specifically, the knowledge of independent physicians (i.e., not working in the organization) and other health care professionals should be valued as much as legal and auditing expertise. Physicians and nurses know the business and understand patient quality and safety.[2] They are knowledgeable about the culture of an interprofessional organization where physicians are not hospital employees.

Several Canadian corporations and health care organizations have failed or functioned poorly over the recent years. The lack of skill diversity of the directors of these organizations contributed to their failure: Nortel,[3] Research in Motion,[4,5] and Brant Community Health Care System[1] in Canada, and Theranos[6] in the United States are examples. A key deficiency of these boards was the lack of members who fully understood the industry and could challenge the CEO and senior management on their strategic plan and their ongoing operational results.[7]

The risk resource guide of the Healthcare Insurance Reciprocal of Canada states: "Boards must focus on looking after quality, and expect resources to fall out of that process, not the other way round."[9]

The membership of hospital or health care boards varies across Canada. Some boards will have all independent directors, while others will include people, often ex-officio, who are part of the organization. These inside directors, particularly in Ontario hospitals, could be the CEO, chief of staff, chief nurse, or president of the medical staff. Some of these roles may be limited to one or

two years (e.g., president of the medical staff) leaving little time for that person to understand governance and gain enough experience to contribute as a board member.

Some boards have little to no clinical experience among their directors, particularly their independent directors. When a board addresses the skill mix of its membership, it immediately recognizes the need for legal, accounting, governance, communication, business, and information technology skills. Its members often do not identify the need for an independent director to be fully knowledgeable of the health care industry. These boards may rely exclusively on the advice of inside employee directors, who are not independent. Without independent clinical knowledge on the board, there is a risk that the board may not be capable of fully carrying out its fiduciary duties. The board may not have the capability of effectively challenging management on their strategy and clinical quality outcomes. Those directors not from the health care field will need significant education to understand patient quality and safety and appropriate metrics.[8]

The risk resource guide of the Healthcare Insurance Reciprocal of Canada states: "Boards must focus on looking after quality, and expect resources to fall out of that process, not the other way round."[9]

Physicians and nurses know the "business" of health care. Some recent governance reorganizations by provincial governments

have recognized this needed knowledge and addressed it appropriately. Saskatchewan just went through a governance restructuring with one board now of 10 directors, including two physicians.[10] Similarly, the recently established Nova Scotia Health Authority Board of 14 directors, includes two physicians and one nurse.[11]

Ontario had 14 LHIN boards. Many, if not most, lacked directors with direct inside industry skill, knowledge, or experience. A LHIN board that did stand out as an exception was Champlain. Its board chair, J.P. Boisclair, recognized the need for clinical health care knowledge on the board and included two physicians and four nurses among its 12 directors.

These boards are making critical decisions that affect quality of health care. Some of the most important involve resource allocation. They also determine the distribution of medical services: what is to be available in local communities and what services are centralized. Many of these

decisions are based on quality metrics. Similar to the audit and finance committee, which most often are chaired by a director with financial expertise, the quality committee should be chaired by a director with significant knowledge of clinical quality of care. Without such knowledge, it is difficult to understand the decision metrics in this area and the influences on them. Directors with clinical health care experience and knowledge can properly question and, when appropriate, challenge management on quality and safety results within the organization; this is key to successful quality committee and board oversight.

Another gap is the lack of depth of knowledge about governance of board members, particularly physicians. Few physician directors have formal governance training when appointed, and few attend governance education programs after their appointment. This often leads to their inability to understand what is good governance and may contribute to subsequent governance failure (e.g., Brant Community Healthcare System[1]). Physicians who assume

a director's role on any board must be prepared to learn about good governance and directors' responsibilities. They should be provided an opportunity to attend educational programs, such as those organized by the Ontario Hospital Association.[12] Most corporate boards have or should have a budget for director education; health care boards should have a similar budget, not only for physicians but for all directors.

Some governments have recognized the importance of physicians and nurses on boards, but then have limited their participation by making them non-voting directors (e.g., Ontario Hospital boards). Having voting and non-voting directors creates a two-tiered board, which in principle is not good governance. The rights of a non-voting director could vary province to province. Are they excluded from voting on a motion but otherwise have full director rights? Are these non-voting directors limited to attending only portions of the board meeting and excluded from others? Often, non-voting directors' participation can be left up to the chair's interpretation. Being non-voting suggests that they have a conflict; if so, are they additionally restricted on speaking to certain agenda items? In theory, non-voting members don't own the board's decisions as they did not participate to approve motions. As many health care boards already function successfully with physicians as voting directors (Saskatchewan), what is the evidence and proven risks that lead other provinces

(Ontario) to make physicians non-voting directors? I believe all board members should be voting members.

Canadian physicians, patients, and governments should be concerned about the scope of skills and knowledge of the directors of health care boards. Where there are real skill gaps, they should be identified and addressed. Skilled boards should be identified and their diverse skill mix, including clinical knowledge, publicly recognized. I suggest that physician and other organizations, both nationally and provincially, monitor board membership and their skills mix. Many corporate boards are subject to an annual rating on their structure and function[13]; why not a similar rating for health care boards?

We should insist that board membership include independent directors who have experience with health care systems – people who have worked in the system sometime during their career and have clinical experience. Physicians on boards should have appropriate governance education. Two-tiered boards, with voting and non-voting directors, should be discouraged, and all directors should have the same obligations and responsibilities. Diversity of board membership should also be encouraged, as diversity, not only in gender but also in culture, can result in better decisions.

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What is best for Esther? What Canada can learn from the Swedish health care service

Ali N. Damji, MD, MSc, Göran Henriks and Martin Rejler, MD

Health care systems in Canada and Sweden are facing increasing challenges to do with access and wait times for non-emergent issues. Both are seeing the erosion of single-payer health care systems as a consequence of these challenges, and both are emphasizing moving care out of hospitals into community and home care. Sweden has moved ahead in this area and Canadians can learn two key lessons from its experience. First, rather than thinking in terms of what's best for the system or the provider, the Jönköping region in Sweden emphasizes the perspective of "Esther," a hypothetical patient with a life beyond the walls of the institution. Second, viewing patients as copilots in their care has patients learning treatments, such as self-dialysis, with benefits to themselves and the system.

KEY WORDS: health system transformation, coproduction, patient-centred care, Esther

As an experiment, at your next staff meeting, pose this question: "What kind of industry do we work in?" Based on my experience, most clinicians will answer, "health care" or "biomedical." Others may say "teaching" or "research." Almost no one will say, "a social industry." Now, ask that same question in a Swedish hospital or primary care centre, and prepare to be amazed.

Canadians may be proud of our health care system, but its quality ranks 17th in the world.[1,2] Meanwhile, Sweden ranks fourth.[1] Learning from other jurisdictions may very well be one of the most important contributors to the future advancement of our system. This article focuses on two important lessons we can learn from the Swedish health care service.

Similarities and differences

Sweden shares many similarities with Canada – not just the cold climate. Both countries have universal single-payer health care systems that emphasize providing care to citizens based on need rather than ability to pay. Both have rural and remote populations that suffer health inequities compared with their urban counterparts, in addition to health disparities that disproportionately affect refugees, asylum seekers, people of lower socioeconomic status, and Indigenous populations.[2-4] And both are under intense fiscal pressure as health care is consuming increasing tax dollars: in Canada, health care spending is 10.4% of the gross domestic product; in Sweden it's 10.9%.[5] The Jönköping region of Sweden is one of 21 landstings (counties) and has 353 000 inhabitants, 46 health care centres, and three hospitals. Delivery of health care takes almost 90% of the county's budget.[6] Like health care systems in Canada, the Jönköping system is facing increasing challenges to do with access and wait times for non-emergent issues.[2,7] Both are seeing the erosion of single-payer health care systems as a consequence of these challenges, exacerbating health inequities at the population level.

In Canada, wealthy citizens are now seeking care in other countries or paying additional fees to access "concierge medicine,"[8-11] while in Sweden, because of similar
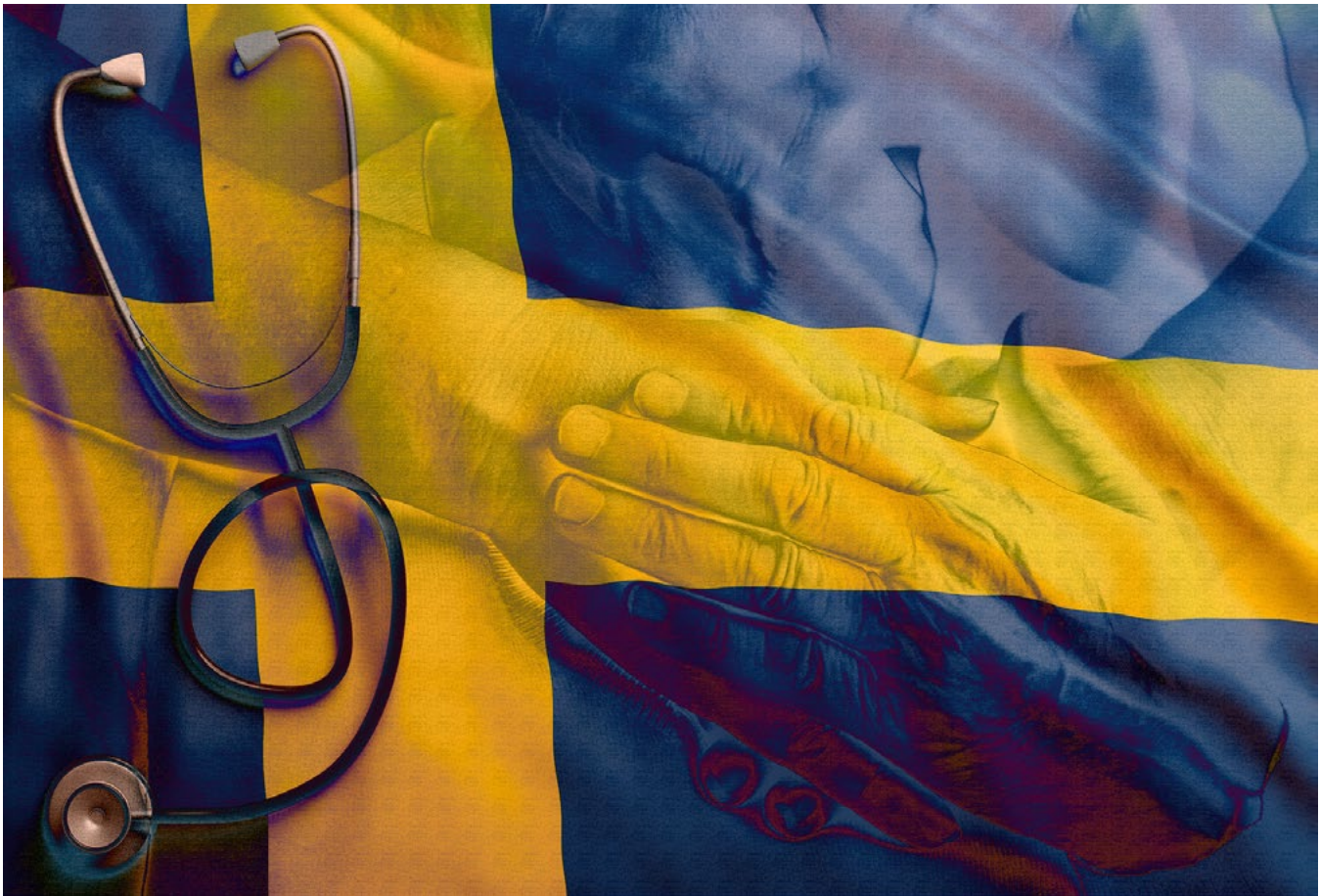
access-related issues, "private doctors" have been allowed to bill outside the public system for their services as a means to entice them to work in underserviced areas.[7,12] Currently, 10–20% of Swedes have private health insurance, which they can purchase through their employers, and this is projected to increase as access challenges grow, particularly in primary care.[12] This gives Swedes with the ability to pay quicker access to services, increasing health inequity. In response to these challenges, both countries are putting a stronger emphasis on moving care out of hospitals into community and home care. However, implementation of that vision remains challenging in Canada.

Delivery of health care differs. In Sweden, health care funding and delivery are almost entirely determined by regional governments, with 5% of care nationalized for specific disease categories (e.g., transplant care).[7] Sweden's regions are much smaller than Canadian provinces.

The Swedish health care system's coverage is far more comprehensive than its Canadian counterpart. Universal pharmacare, home care, long-term care, equipment, and allied health services (physiotherapy/ occupational therapy, psychology, acupuncture, social work, and others) are all funded under the public system.[7] A broader policy directive on addressing the social determinants of health has been adopted in Sweden, including generous parental leave policies (approximately 500 days per child that can be used at any time in the child's life), and free postsecondary education.[13] Moreover, recent changes in Swedish law have mandated that patients must be involved in the design of personalized care plans, leading to a fundamental transformation in how care is delivered.[14] Patient care is seen as a partnership, rather than a unidirectional relationship.

What can we learn from the Swedish system?

Lesson 1: It's all about flipping your perspective

In Jönköping, one of the key ingredients in the success of the health care system is a flipped perspective on quality improvement and change. Rather than thinking, "what's best for the system?" or "what's best for me,

the provider?" the question is always, "what's best for Esther?" Esther is a hypothetical patient, but she is also a person with a life beyond the walls of the institution. She is elderly and frail. She has complex health needs. She lives alone. If she lacks effective primary care, or transitions from the hospital back to home without support, she does not do well.[15,16]

The Esther network has several key features. It is interorganizational and brings together patients, municipalities, social services, hospitals, and primary care centres to address challenges that exist in transitions between sectors. There are informal "cafés" that bring together these organizations, professionals, and patients to allow for sharing and learning. These cafés happen regularly and in person to strategize and address problems, together.[16]

Clinicians are also trained as "Esther coaches," who support projects at the frontline, introduce new ideas, motivate others in their organizations, and introduce a culture of quality improvement. They receive training from Qulturum, the region's quality improvement centre.[15,16]

On the ground, this has led to several unprecedented innovations in the region. In primary care, this mentality led to the advent of team-based care, where patients are followed by an entire team of nurses, physiotherapists, physicians, social workers, and dietitians, who work collaboratively and fully use their scope of practice and skills to serve their patients.

Among specialists, it was most important for patients to be seen as efficiently as possible. Thus, for example, gastroenterologists have trained nurses to enhance their scope of practice to meet the needs of the population. Consequently, nurse-endoscopists perform routine colonoscopies, freeing up time for the more serious cases for gastroenterologists – a change led by the clinicians themselves in partnership with their nursing colleagues.

In the community, thinking about the patient's lived experience led to the development of a mobile geriatrics unit. This team provides specialized geriatrics consultations and rapid investigations in the home setting to prevent unnecessary emergency department visits. Patients' frustration with needing to repeat their stories over and over again to providers led to more streamlined direct admissions to hospital and the advent of case conferences regarding complex patients.[15]

Transitions have been streamlined through telephone and email communication between patients and their physicians. A family physician is able to speak directly with an admitting consultant, thereby being able to admit a patient and bypass the emergency department.[15] All specialty clinics have admitting consultants available to speak to family physicians during regular office hours and book same-day appointments for patients.[17]

Patients are given a "safety receipt" at the time of discharge that

functions as a checklist to ensure that a comprehensive plan has been made.[15] There is systematic follow up of all hospitalized patients within 72 hours.[15] Newly passed legislation now mandates that within 24 hours of a patient's discharge from hospital, home care or long-term care services must be set up by the municipality. Failure to do so results in the municipality shouldering the cost of the additional days spent in the hospital.[7] The system is described as one that moves around the needs of the patient, rather than putting the onus on the patient to navigate the system.[7] For complex patients, a support worker or team is often sent to the home on the day of discharge to ensure the patient is well set up for the transition by making sure necessities, such as a clean bed, food, and the right equipment, are present in the home – even a dog walker if needed.[15]

At the system level, artificial boundaries between health and social services and between layers of government have been torn down. Funding is mobile and flows easily between sectors to meet the needs of the patient. For example, in response to challenges regarding the placement of patients in long-term care homes, the county responded by transferring funds to the municipalities to enable this.[15]

These efforts appear to have paid off. Since the introduction of the Esther project, Jönköping's hospital admissions have decreased from 9300 to 7300, total length of stay for all heart failure patients fell from 3500

to 2500, and wait times for specialists decreased from 48–85 to 14 days over three years.[15,17] Over the same period, hospital readmissions within 30 days dropped from 17.4% to 15.9%, and rehabilitation length of stay fell from 19.2 to 9.2 days.[15] As a testament to its success, the Esther network has also been adopted in the United States, United Kingdom, and Singapore.[16]

Lesson 2: With that flipped perspective, be a copilot with your patients

We've all heard the buzzwords: patient-centred, patient engagement, patient experience. But what about patients as partners?

Batalden et al.[18] describe the concept of coproduction in health care as a system where patients and providers are participants. Their relationship is predicated on civil discourse, shared planning, and shared execution. The ultimate outcome is coproduced high-value health care and better health care for all in society. Simply put, this means that patients and clinicians produce better outcomes when the system supports collaboration and true partnership in care.[18]

One example of such an approach is the self-dialysis clinic at Ryhov Hospital.[19] This a world-renowned example of coproduction that began with the courage to try something different despite the possibility of failure.

The story began with a single patient. One day, he asked his nurse if he could learn to do his own hemodialysis, as he found the long sessions made him feel helpless and he hated the side effects. He wanted to take his care into his own hands. Rather than shut him down, the nurse began to educate the patient, gradually giving him more and more independence under her close watch. Initially the patient struggled, but eventually he learned and began to coach other patients, with the nurses, to do the same.[19]

Today, in collaboration with patients, clinicians assess their confidence and competence and coach patients toward greater independence in their hemodialysis. Typically it takes 4–8 weeks from start to finish for a patient to feel comfortable performing dialysis completely on their own. The unit is open to patients 24/7, and those who become confident and competent in their own hemodialysis can use their own access cards to come into the unit and dialyze themselves when it is most convenient for them, even without supervision. They even set up and shut down their own machines and draw their own blood. So far there have been only three documented cases of patients needing to return to supervised dialysis from the self-dialysis program, and currently 60% of all dialysis patients are a part of this model.[19] The rates of infection associated with dialysis have dramatically decreased since the introduction of the program.[19]

In the pediatric setting, by law, Swedish children should receive relevant information when a decision must be made about them. The laws stipulate that the parents, children, and entire interprofessional team across all sectors including social services must work together to design a care plan that is individualized to the child. After coming up with this shared plan, it is revisited by the interdisciplinary team. Any member (including the child and parent) has equal authority to make changes to this plan, and it is done in a collaborative fashion.[20]

On the wards, patient care has been transformed into a more coproduced format. Instead of traditional rounds, where the hospital team discusses every case in a secluded area and then discusses the plan with the patient, who is in bed, a new approach has been adopted. Every morning, hospital patients are invited to participate in morning rounds with the health care team where they contribute to the discussion regarding their care plan in real time. All the people in the room are introduced as equals. Furthermore, the medical history and social needs are walked through as each participant adds to the story. In the end, the consultant summarizes medical, nursing, and social needs, so that all are informed and ready to act before moving on as the next patient enters the room.

Conclusion

Sweden and Canada share many similar challenges, and learning from the former's approach to finding cost savings by doubling down on patient-centredness may

yield some insights into future directions for Canada. Seeing the health care system as a social industry that responds to the needs and preferences of its users and supporting coproduction are key ingredients in Jönköping's success. Although championing the needs and power of the "health care consumer" runs the risk of being told things we may not want to hear, that approach has led the Jönköping region and the Swedish health care system down an exceptional path where they have engaged and happier physicians, a better patient experience, lower costs, and improved population health.

Health care, at its heart, is about people. Flipping our perspectives, challenging our traditional practices, and bringing patients with us to lead transformation together are effective ways to make meaningfully improvement in our system, so that it can best help people – not just treat disease.

This novel mentality has to start with everyone, whether clinician, leader, or patient. We all have a role to play. To get started, let's take a page from the Swedish playbook, and ask the most important question, at every chance we can: "What is best for Esther?"

The answers may surprise you. After all, we are a social industry.

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NEWS FROM #CCPL19: Work to be done to address diversity in medicine

Pat Rich

In a conference focused on the broad and challenging issue of showing leadership in bringing more diversity and equity to medicine, it was personal stories of discrimination and taking on leadership roles that seemed to move the 350 delegates most.

At the end of the first day of the Canadian Conference on Physician Leadership in Montréal, during a panel discussion, two speakers were given standing ovations: Dr. May Cohen, a pioneer on gender issues and a leading female physician and Dr. Nadine Caron, Canada's first Indigenous general surgeon. They shared the podium with Dr. Henry Annan, a

black Canadian and immediate past-president of the Canadian Federation of Medical Students and Dr. Michael Negraeff, a pain specialist and disabled physician.

"I didn't choose leadership. But there were a number of things I found were voids in our health care system when it came to helping people with pain," Dr. Negraeff said.

With the theme, "Diversity, Inclusion & Engagement: The Leadership Challenge," the conference featured a number of plenary presentations and breakout sessions focused specifically on the challenges of bringing more inclusivity to medicine in Canada today. Addressing diversity is "arguably one of the most crucial issues for leadership and medicine in our time," said Dr. André Bernard, chair of the board of directors for Doctors Nova Scotia.

The conference featured leading experts and current research demonstrating the extent of the challenges facing today's physician leaders, but it also presented moving narratives from physicians who are part of underrepresented groups in medical leadership – women, Indigenous Canadians, medical students, residents, and physicians of colour.

Rather than deal only with the overt bias and racism still facing some physicians, delegates were schooled on the unconscious biases they may harbour that could impact their ability to fairly assess and promote physicians who are not white and male. "I hope this conference has shone

a hard light on the work that still needs to be done," said current Canadian Medical Association president, Dr. Gigi Osler.

Although many agreed with Dr. Osler, speakers such as Dr. Dennis Kendel, a veteran physician leader and mentor, gave object lessons in how those who are privileged can help support and mentor others. In fact, Dr. Kendel helped lead a breakout session with Ottawa psychiatrist and physician well-being expert, Dr. Mamta Gautam, on how male physicians can support their female peers in taking leadership roles.

"I am a poster boy for the 'Old Boys Club,'" Dr. Kendel said, "but I am committed to transforming [this] culture in medicine to foster diversity, inclusion, and equity in our profession. When in a leadership role, our responsibility includes opening doors for others to grow, identifying and removing roadblocks, and providing sponsorship."

The need for ongoing advocacy and support for women physicians to achieve more leadership roles in medicine was an ongoing theme at the meeting. Many speakers quoted similar statistics about the lack of representation of women in the senior echelons of academic medicine despite their having made up half of medical school enrollees for more than two decades now. For example, it was noted that only 17% of current or pending medical school deans in Canada are women.

The conversation about diversity at the conference began with a plenary presentation on the first

day from Dr. Gurdeep Parhar, executive associate dean and clinical professor, Faculty of Medicine, University of British Columbia. He presented data showing how unconscious biases and stereotyping continue to hamper women physicians and physicians of colour. Dr. Parhar also gave delegates practical tips on how to acknowledge and deal with these forms of bias.

"Leaders need to be knowledgeable about aspects of cultural diversity and continue to learn about other cultures," Dr. Parhar said, adding that self-awareness was a good place for physicians to start in addressing their unconscious biases. He also cautioned against blindly relying on those who profess to be experts in a particular culture or race.

A similar presentation, backed by results of numerous well-designed trials, was given on the second day by Dr. Maydianne Andrade (PhD), vice-dean of Faculty Affairs and Equity, University of Toronto. She noted "even people of goodwill" can unwittingly show bias and this does not automatically make you a bad person.

Although Canadians generally value equity and diversity and most Canadian organizations have equity statements, she said there is hard evidence that inequities continue to exist even though they have been recognized for years.

Dr. Andrade provided practical tips on how to overcome bias when assessing other individuals for jobs or promotions. "Leaders can encourage, require, and reward education and performance against targets [but often don't]," she said. "Rigorously monitor your judgements and base them on outcomes," she added. Dr. Kendel commented later: "If you haven't achieved gender balance on the search list for a [leadership] position, you haven't looked hard enough."

A session that was repeated and dealt with advancing a culture of equity and diversity in medicine featured Drs. Osler and Bernard as well as a medical student and a resident of colour. Chika Stacy Oriuwa discussed her experiences as the only black student in a class of 259 at the University of Toronto.

"Advocacy is a form of self-preservation," she said, commenting on why she continued to advocate for the rights of black medical students despite facing overt racism.

A question repeated throughout the meeting was whether there is a need for quotas, with most of those voicing an opinion speaking in favour of some form of affirmative action to address current imbalances.

Addressing inequities "is not for the faint of heart," Dr. Osler also noted, and others talked of facing ongoing discrimination for speaking up on this issue. Dr. Osler spoke about deliberately taking advantage of her role as CMA president to be a voice for inclusion.

"I believe the investments we are making today to move the diversity needle in the forward direction will make it easier for us to get to a place where we can be proud of the representation in our profession, even at the highest echelons," Dr. Annan tweeted. It was a sentiment many delegates in the conference would echo.

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Uncovering physicians' leadership needs in Nova Scotia: a case study

Marina S. Kwak, Sarah Tahir, Alison MacPherson, Lauren Murray, Matthew Madill and Scott Comber, PhD

In response to an identified need for an advanced leadership course for experienced physician leaders, we sought to better understand the specific needs of such physicians in Nova Scotia. In 2017, 51 applications for Doctors Nova Scotia's Physician Leadership Development Program (PLDP) were subjected to thematic content analysis to determine the top physician leadership skills that experienced physicians desired to develop or enhance. To complement this information, we consulted three content experts from PLDP partner organizations and carried out a systematic literature review of five academic databases.

Five themes were identified: effective communication, conflict resolution, project management, understanding organizational dynamics, and relationship management. We recommend that the development of these skills be prioritized for physician leaders in Nova Scotia.

KEY WORDS: physician leadership development, LEADS framework, conflict resolution, project management, health care, communications, organizational dynamics, relationship management

Identifying experienced vs. developing physician leaders

A review conducted by the Rotman School of Business for the Canadian Medical Association (CMA) identified the need for an advanced leadership course for experienced physician leaders.[1] In 2015, Doctors Nova Scotia (DNS) began working with Joule Inc., a CMA subsidiary, to develop a program aimed at improving the skills of such physicians. A core focus of this program is on systems thinking and the skills needed for solving complex problems. This work culminated in the Physician Leadership Development Program (PLDP),[1] which began accepting applicants for 25 seats in 2017. When 61 applications were received, DNS interpreted that as indicating a substantial need for leadership training.

This study defines experienced leaders as: those in senior leadership roles, e.g., zone chief, site leader, department head, or those who demonstrate leadership competencies found in senior roles, such as applying approaches to innovation and design thinking and having coaching skills and/or knowledge to effectively influence and navigate complex systems. Developing leaders are those who are new to, or early in, their career and have no experience in senior leadership and no demonstrated leadership competencies associated with senior leadership roles.

Among the 61 PLDP applications in 2017, 51 captured the leadership development needs identified by experienced leaders. The other 10 were excluded because they did not meet our criteria.

Health care in Nova Scotia

The health profile of Nova Scotia and its shifting population demographics demonstrate a need for physician leadership

Table 1. Leadership skills chosen by at least 5 of the 51 Nova Scotia physicians applying to the province's Physician Leadership Development Program in response to the question: "What leadership skills are you hoping to enhance by participating in this program?"

Skill	Frequency of mention
Leading change	23
Effective communication	12
Conflict resolution	12
Project management	11
Self-awareness	9
Understanding organizational dynamics	8
Relationship management	7
Managing diverse stakeholders	7
Engaging stakeholders	5
Systems thinking	5
Strategic planning	5

in health care delivery and economics. An estimated 61% of the population is classified as overweight, with rates of diabetes, high blood pressure, arthritis, heart disease, and respiratory disease 9% above national averages.[2] Concurrently, the province's demographics are shifting because of an aging baby boomer population, which is increasing health costs[3] and is projected to increase the burden on the health care system.[4]

Physician retention is an ongoing issue, with burnout a significant contributing factor.[4] Physician burnout has a cascading effect on the health care system, as it is shown to decrease quality of patient care and physician retention, and increase physician migration.[5] Decreased retention, coupled with an increasingly strained health care system, may make Nova Scotia a less desirable place to work, which directly relates to and threatens

the province's ability to recruit and retain physicians.[6]

In 2014, the provincial government released a report discussing the challenges and strategies to overcome them.[4] Leadership may be one such strategy, as research conducted by the Mayo Clinic shows that leadership styles can mitigate physician burnout and positively affect quality of life.[7] A partnership agreement emerged, and the province's PLDP was developed in partnership with Joule and CMA, in consultation with the Nova Scotia Health Authority (NSHA), IWK Health Centre, and Dalhousie Medical School (personal communication, B. Johnson, senior communications advisor, DNS, 9 Jan. 2019).

Methods

To understand the leadership needs of experienced physician leaders, qualitative data were

collected: from PLDP application forms received from DNS; through consultations with content experts; and via a systematic literature review of essential leadership skills recommended for physician leaders. Data from the three sources were then aggregated and analyzed using thematic content analysis[8] to identify relevant themes and patterns.

For this study, answers to the first three of the four questions on the PLDP application form (Appendix A) were analyzed as they were most relevant to discovering leadership skill needs identified by experienced physician leaders. Each question was analyzed separately, and the responses were coded into themes. Themes were sorted to form three groups based on frequency of in-text mentions: major, unique, and leftover. Passages and abbreviated topics were coded, and codes were adjusted as new data emerged, which resulted in a codebook. Codes were transformed into categories using descriptive wording and then the number was reduced by attempting to group topics and establish interrelationships.

The data were assembled and preliminary analysis was performed through detailed discussion of themes and sub-themes. Questions one and three (Appendix A) provided insight into the motivating factors that lead physicians to improve their leadership skills. Question two was used to identify the leadership skills physicians desired to enhance, based on frequency of mentions (Table 1).

Applications to the Physician Leadership Development Program

Via its newsletters and websites, DNS invited experienced leaders to apply to the 2017 PLDP. DNS listed program components, selection criteria, and key outcomes for the program. A total of 61 applications were received and were reviewed by a selection committee composed of representatives of DNS, Dalhousie University, NSHA, IWK, and Joule (B. Johnson, 9 Jan 2019, personal communication).

Of the 61 PLDP applications, 51 were analyzed for the purpose of this study because they met the definition of experienced leaders. The selection process was done by scoring each candidate based on the questions asked in PLDP applications (Appendix A).

Consultations with content experts

Three experts were consulted for their various perspectives in the fields of leadership, leadership education, and development, more specifically, physician leadership content expertise.

On 9 Nov 2017, Ms. Andaleep Ali, then associate director at Joule, was interviewed because of her expertise in physician leadership curriculum and program development across Canada. On the same date, Ms. Lorie Campbell, executive coach and leadership development professional with NSHA, was interviewed because of the knowledge she has gained

from coaching interactions and experience with NS physicians. On 14 Nov. 2017, Dr. Lara Hazelton, director of faculty development for Dalhousie University's Faculty of Medicine, was interviewed. Dr. Hazelton is an expert in the field of medical education, specifically in leadership development for physicians both internal and external to Dalhousie University.

Each leadership content expert was asked the same semi-structured questions, for example, which skills they considered most relevant for developing physicians (Appendix B). Shorthand notes were taken and thematic content analysis[8] was applied to extract themes and patterns.

Systematic literature review

A third source of information on physician leadership needs was a systematic review of five databases. ProQuest, PubMed, Canadian Electronic Library, Web of Science Citation Review and Scopus were searched using the following keywords:

- "LEADS" AND "physician" AND "leadership"
- "physician leadership development"
- "workshop" AND "physician leadership"
- "facilitation" AND "physician leadership"
- "physician leadership" AND "education"

To ensure relevance, only data from the last five years (2012–2017) were included. Concurrently, a scan of the grey literature with the same time restrictions was conducted. All searches began at a global level to ensure extensive results, and papers referring to new or developing physician

Table 2. Top broad themes and associated sub-themes identified as essential for physician leadership listed by frequency of mention in a systematic literature review of 87 selected articles.

Rank	Themes	Sub-themes
1	Emotional intelligence[11-19]	• Self-awareness • Self-management • Social awareness • Relationship management
2	Effective communication[11-14,19-21]	• Conflict resolution • Listening and feedback • Negotiation • Awareness of regulatory and legal framework
3	Change management[8,12-14,17,19,20]	• Implementing change • Leadership in change • Building resilience • Project management
4	Systems thinking[13-15,19,22-24]	• Identifying interdependent parts of organizations • Understanding organizational dynamics • Strategic thinking

leadership were highlighted. LEADS was used as a search term to generate results relevant to the Canadian healthcare system.[9] In all, 87 articles were reviewed.

Results

PLDP applications
Table 1 lists the top skills experienced Nova Scotia physician leaders desired to enhance. These are the skills chosen by at least five of the 51 physicians applying to the PLDP in 2017.

Content expert consultation
During consultations with content experts, we identified various areas as integral to developing physician leaders. These are (in no particular order):

- Chairing meetings effectively
- Effective communication skills
- Conflict resolution
- Project management
- Principles of organizational identity (i.e., clarifying roles of committees, working groups, and task forces)
- Group facilitation
- Having difficult conversations

Literature review
The literature review revealed four broad themes as important to physician leadership as well as a number of sub-themes (Table 2).[10-23]

Overall findings and comparison
Based on thematic content analysis of PLDP applications, consultations with content experts, and the literature review, we uncovered four broad themes and seven associated sub-themes that

were mentioned in at least two of the three data sources (Table 3). If a theme was mentioned in two of the three methods, it was considered by the researchers to be significant to physician leadership.

Five sub-themes were mentioned in all three data sources: effective communication, conflict resolution (a component of effective communication), project management, understanding organizational dynamics, and relationship management.

Discussion

Effective communication was clearly an important broad theme. In the PLDP application responses, 12 of 51 physicians expressed a desire to enhance their communication skills with stakeholders to effect change (Table 1). Harris et al.[24] showed that early and mid-career physicians appear to underappreciate the value and importance of communication skills and relationship building.

Conflict resolution, a sub-theme of effective communication, was also mentioned by 12 PLDP applicants (Table 1). The ability to manage and resolve conflict may only be present when a physician can communicate her/his ideas effectively. In expert consultations, conflict resolution was noted as crucial for developing physician leaders and essential for effective leadership.[25] This ability is necessary for building effective relationships and can assist physicians in

dealing with high-conflict personalities (L. Campbell, personal communication, 2017). Thus, teaching skills in conflict resolution is integral to developing comprehensive and innovative health care leadership.

Project management, a sub-theme under change management, was mentioned by 11 PLDP applicants (Table 1). The literature review supported the importance of project management and highlighted how project-based teamwork contributes to organizational cohesiveness, synergy, and innovation.[12] The expert consultations supported the importance of project management and raised the need to improve financial and business skills of physicians for them to successfully manage projects.

Understanding organizational dynamics is a sub-theme under systems thinking and was mentioned by 8 PLDP applicants (Table 1). Experts stated that improved knowledge of roles and expectations could be used to address inefficiencies in the Nova Scotia health care system (L. Hazelton, personal communication, 2017). It is also noted by Clausen et al.[25] as crucial to achieving health care transformation, as it helps physicians understand which actors in the system could be targeted to effectively implement change.

In this study, *relationship management* pertains to the management of conflicting personalities. It was cited by 7 PLDP applicants (Table 1), who

Table 3. Leadership skills needed by Nova Scotia physicians as self-identified by experienced physician leaders and determined through expert consultations and a literature review.

Theme	Sub-theme	Source of data		
		PLDP applications	Expert consultations	Literature review
Emotional intelligence		x		x
	Self-awareness	x		x
	Relationship management	x	x	x
Effective communication		x	x	x
	Conflict resolution	x	x	x
Change management		x		x
	Leadership in change	x		x
	Project management	x	x	x
Systems thinking		x		x
	Understanding organizational dynamics	x	x	x
	Strategic planning	x		x

Note: PLDP = Physician Leadership Development Program.

revealed a desire to improve their ability to manage difficult, high-conflict, or apathetic people in team settings. Skill in relationship management also enhances team building and interdisciplinary collaboration. We classified relationship management as a sub-theme of emotional intelligence, which was a common theme in PLDP applications and the literature review. However, content experts did not mention emotional intelligence explicitly, but emphasized the development of sub-themes, particularly awareness of one's current leadership style.

Improving physician leadership skills can have significant benefits, including collaboration and the effective use of limited health care resources.[22] Further, strong physician leadership has been linked to improved patient care and system outcomes as well as physician retention. Hence, finding ways for physicians to improve

the five main skills identified here would be highly beneficial.

Conclusion

The five skill sets we identified are areas of focus for improving physician leadership in Nova Scotia. This is the first time that both experienced physicians' self-identified needs and experts' identified needs for developing physicians have been captured in a Nova Scotia context. Addressing these leadership needs would create stronger physician leaders in the province.

Physician leadership has been directly related to the improvement of both health systems and outcomes.[7] Further, having organizational support for physician leadership is an important factor in leadership advancement.[26] Therefore, we recommend the continued development of physician

leadership programs by DNS with content delivery methods to address the five theme sets identified in this study.

Appendix A. Relevant questions from the Physician Leadership Development Program application form

1. Describe your strengths and areas of development as a leader.
2. What leadership skills are you hoping to enhance by participating in this program?
3. Tell us about a challenge specific to physicians in Nova Scotia that you are passionate about. How do you think your involvement in this program will support you to drive change towards this?
4. What have you done in the past 5 years to develop yourself as a physician leader (i.e. training, formal/informal mentorships)?

Appendix B. Questions posed to content experts

1. How much importance does your organization place on physician leadership?
2. How much importance does your organization place on early-stage

(developing) physician leadership?

3. What programs does your organization currently offer or previously offered in relation to physician leadership?

4. How do you anticipate physician leadership development impacting your organization?

5. How do you anticipate early-stage (developing) physician leadership development impacting your organization?

6. What skill sets does your organization view as most important in the development of early-stage (developing) physician leaders?

Acknowledgements

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Author attestation

Marina S. Kwak is the lead author and contributed substantially to the

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PERSPECTIVE

Breaking health care leadership silos

Colonel Marc Bilodeau, MD, and Lieutenant Colonel John Crook, MPH

Leadership is a critical factor for successful health care reform. Leadership development is, therefore, vital to ensure that future leaders have the right competencies to succeed. Building on the journey of two military health care leaders, this article argues that current leadership development frameworks and the sponsoring health care leadership organizations lack integration, considering that physicians and non-physicians are trained separately and belong to different networks. The Canadian Armed Forces experience is used to demonstrate a more integrated professional development framework. Based on shared leadership principles, such a model could improve the likelihood of success of the health care transformation currently underway in Canada. The Canadian College of Health Leaders and the Canadian Society of Physician Leaders share a common purpose and should be collaborating more to enable partnerships at the local and regional level, thus contributing to the Develop coalitions domain of the LEADS framework. Such enhanced cooperation will ultimately ensure better patient care today and improve population health tomorrow.

KEY WORDS: shared leadership, professional development, Canadian Armed Forces, integration, partnership, collaboration

The importance of leadership in health care organizations has gained attention in the last few decades. Leadership competencies, like those espoused in *Bringing Leadership to Life in Health: LEADS in a Caring Environment*,[1] have become vital components of clinicians' training programs in addition to health care management programs. Leadership is also likely to remain a critical factor in the success of health care reforms currently underway in Canada.

Canadian membership-based health care leadership organizations have put much effort into leadership development in support of such transformation. In this article, we argue for a more integrated leadership development framework and network to position us better to transform more efficiently our health care organizations and systems through the expansion of coalitions, as proposed by LEADS.[2]

CCHL and CSPL: a historical background

The Canadian College of Health Leaders (CCHL), formerly known as the Canadian College of Health Service Executives (CCHSE), was founded in 1970 (**www.cchl-ccls.ca/**). Almost 30 years later, the Canadian Society of Physician Leaders, formerly known as the Canadian Society of Physician Executives, was brought to life (**www.physicianleaders.ca**). These two organizations bring together approximately 3000 and 700 members, respectively. They both create a home for health care leaders and give legitimacy to such leaders being professionals in their fields.

CSPL came into being at a time in the Canadian health care journey

when physician leadership was recognized as bringing value to the system and physicians were given more responsibility in leading health care organizations. Although we can find CSPL as a partner organization on the CCHL website, the opposite is not true: there is no mention of CCHL on the CSPL website. It is fair to say, based on our recent experience, that despite sharing common ground and principles, the two organizations are operating in silos.

Our experience in the Canadian Armed Forces

Health care leadership in the military, as in any other organization, is a critical aspect of how we deliver health care to our military members. Although the Canadian military organization at large offers many leadership development opportunities very early on in a military career, they relate more to the command aspect of the role and not so much to the leadership component. However, the uniqueness of health care in the military organization requires a different approach.

This approach is familiar within the Department of National Defence, making it unique among federal departments: the chief of the defence staff and the defence deputy minister share the leadership of the department as mandated by the minister.

In the last 15 years, the Canadian Forces Health Services Group, the organization responsible for the delivery of health care to Canadian Armed Forces members, has also adopted a model of shared leadership between physician and non-physician leaders. Our leadership stories are provided here for readers who want to learn more about where we are coming from and what prompted us to write this article (see text boxes).

There were some growing pains with this new model, as shared decision-making is challenging. For this to work and be fully optimized, we had to start exposing more of the two leader groups to each other. We did that by hosting an annual Clinic Leadership Proficiency Training, a week-long event where military health care leaders are brought

together to discuss key leadership challenges and share best practices. The 10th such event took place last October.

In addition, a few years ago, we started a "boot camp," just-in-time preparation for those about to start their new role in a shared leadership team. This training is intended to expose them to the challenges they can expect in their new professional relationship, to provide them with a tool kit, but also expose them to their physician or non-physician counterpart before they assume their new role. As the rotation of the physician and non-physician leaders is seldom fully synchronized, we rarely have the dyad trained together, but at least each group is exposed to the other. The next step will be to create a training syllabus, whereby the two-person "command team" will participate in joint training. These two activities have, without a doubt, demonstrated their value over the years as evidenced not only by the positive feedback received from participants, but also by the success our organization has had in executing its mission in support of the CAF, here and abroad, year after year.

The existing literature contains a fair amount of evidence that shows the benefit of a shared, collaborative leadership model in health care organizations.[4] Some authors claim that the collaboration between medical and administrative leaders has a positive impact on quality of care.[5] Others indicate that shared leadership results in less variance in decision-making and helps

improve communication and clarify responsibilities.[6,7] There is also evidence that such models promote clinical effectiveness as a subcomponent of overall quality of care.[8] Finally, others argue that "a shared, distributed, or collective approach to leadership is necessary to address complex problems."[9]

This approach requires the development of a collective leadership identity, shifting from "I" to "we." This has been our personal experience: the more we expose health care leaders to each other, the more we improve collaboration and understanding of each other and their respective groups. In the end, these efforts to enable collaboration have made us more efficient in executing our health care mission.

Marc's story

As a physician in the Canadian Armed Forces (CAF), I have been fortunate to be exposed to leadership roles very early on in my career and for the last 15 years of my work within the organization. I learned about CSPL in 2010 by attending Physician Leadership Institute workshops. I decided to join the CSPL a few years later and became a Canadian Certified Physician Executive in 2014. This was a means for me to connect with a network of like-minded physician leaders who were experiencing similar challenges.

I was always intrigued by my non-physician military health care leader colleagues who belonged to what I perceived

to be a closed circle of CCHL members. I say closed circle because, as a non-member of CCHL, and not being a Certified Health Executive (CHE), my organization did not fund my participation in the CCHL's annual National Health Leadership Conference (NHLC). Therefore, I decided to join the CCHL in 2016 and started the process to obtain the CHE designation, which I was awarded in 2017. During the same period, I also joined my local CCHL chapter (Northern Alberta) as many of my non-physician military colleagues were actively involved in this organization. In June 2018, I finally attended the NHLC for the first time.

These recent experiences were a revelation for me. Being in contact with this group of accomplished and professional leaders allowed me to realize that the challenges they were facing, and the resulting discussions, were the same ones that my Canadian Certified Physician Executive colleagues were having, as witnessed by my readings in this journal and my participation at the Canadian Conference on Physician Leadership (CCPL).

I also noticed something quite telling: the near absence of physicians at CCHL events and of non-physicians at the CCPL conference. Well-established silos are separating physician and non-physician health care leader groups and this, I believe, prevents us from realizing the

full potential of our health care systems. This has motivated me to write this article.

John's Story

As a health care administration officer in the CAF, I, too, was exposed to leaders in health care at a very early stage in my career, which began almost 25 years ago. With formal internal training, professional development opportunities, and observational learning, leadership lessons and experiences were readily available. Furthermore, as a non-clinician health care leader, I was strongly encouraged to become a member of the CCHL. Alignment with that organization was of strategic importance, so that we could professionalize the non-clinician leadership core, a recommendation of a 1999 internal report.[3]

From my point of view, joining the CCHL was an opportunity to broaden my understanding of leadership in health care and to become a member of a group of professionals committed to excellence in health care leadership. Furthermore, college membership was recognized with credits toward advancement in the CAF. One was recognized for demonstrating a willingness to take on the challenge of life-long learning, personal professional development, and dedication to honing one's craft. As members of the college, we were also encouraged to become actively involved in our local chapters. Since becoming a member of the college, I have been actively engaged in

Executive Committee work for seven of the last nine years. I have found it to be professionally and personally rewarding, and have made several contacts with like-minded people across the country.

Similar to Marc's experience, I found that physicians who were CCHL members were a rarity. In fact, hearing that a physician had pursued a CHE seemed out of the ordinary. Until meeting Marc, I was oblivious to the existence of the CSPL. Clearly, there was a common need that both these organizations were trying to fill, each approaching it from its own point of view. When Marc invited me to co-author this paper, I took it as an excellent opportunity to offer the perspective of a non-clinician health care leader who has worked closely and successfully with a physician leader. I believe our example can be used as a model for others to emulate. Each of us has benefited from the "cross-contamination" of each other's point of view and experience. The leadership skills required to be an effective and transformative health care leader are not the inherent purview of any one professional group. By working together, we can successfully address the complex challenges that face our health care systems.

A case for collaboration

Collectively, our personal experience, our organization's experience, and a growing body of research suggest that there is potential for significant benefit for the health care organizations we lead if our two groups increase their collaboration, by Developing coalitions, as described in LEADS, a framework familiar to both groups.[1] Ultimately, we all share the same purpose: to achieve the best results possible for the patients and populations under our care by using appropriately the limited resources made available to our organizations. We must do this by continually improving and transforming our health care systems to adapt to the ever-changing environment. We firmly believe that our organizations might have reached a level of maturity that now position them well to engage in a deliberate process aimed at expanding their scope of influence, thus improving overall health care governance. Browning et al.[10] describe this as "boundary spanning," a concept that encourages health care leaders to "draw on networks and relationships as they work system-wide to meet the mission of healthcare."

Many other factors are predisposing us to work more closely with each other. First, we all come from very different backgrounds: physician, non-physician clinicians, health care administrators, and non-health care administrators. Our diversity is a strength, but only if we expose our expertise and uniqueness to the others. We all bring different talents to the table, and this mix of talent makes us better as a team by a multiplicative versus an additive factor.

Second, we speak a common language, and that language is LEADS. This framework is the building block of both the Canadian Certified Physician Executive and Certified Health Executive credentials. The importance of sharing such a model for capability development in health care has been emphasized in the United States, some authors arguing that this is a driver for the performance and quality of health care systems.[11]

Third, there are numerous fora where members from both groups are meeting and sharing their thoughts regularly. However, the Canadian Health Leadership Network is the only one listing the organizations as partners on its website.[12]

Finally, we need to build on the trend of growing interprofessional collaboration in health care leadership development programs.[13] Such integrated programs have proven to create a better understanding between professional groups and to break down barriers.[14]

This alignment predisposes our two national health care leadership organizations to integrate better and leverage opportunities for collaboration that could have a synergistic effect on our efforts to transform our health care systems. This is, in our opinion, the perfect illustration of the Develop coalitions domain of the LEADS framework, that is "the practice of collaboration between organizations and organizational leaders as they work together."[1]

Table 1: Examples of collaborative activities between leadership groups

National	• Joint national leadership conferences • National collaboration agreements • Cross-representation on national boards
Regional	• Inter-professional leadership development programs • Joint events at the CCHL chapter level • Regional collaboration agreements • Cross-representation on chapter-level boards • Task-based/ad hoc coalition
Local	• Just-in-time preparation for new shared leadership teams • Local collaboration agreements • Joint participation in study tours/field trips • Task-based/ad hoc coalition

So what?

Although a lot has been written regarding why shared leadership development and practices bring value, the literature is not as strong on how to operationalize it. Our intent here is to propose a few ideas, based on our experience, that we believe could be implemented to strengthen our partnership (Table 1).

First, although increased collaboration at the national level is desirable, an even more significant benefit would be realized where the common values are much more tangible and concrete, i.e., at the local or regional level. Current local health care leadership networks are mostly disjointed, with health care administrators, family physicians, medical and surgical specialists, nurses, academics, trainees, and others each with their own forum for sharing their experiences and challenges. Most CCHL chapters are almost exclusively composed of non-physician members. Similarly, most physician leader groups exclude non-physicians.

The health care leadership world is not large enough to allow us to divide ourselves into smaller groups, thus reinforcing the already existing silos. Through better local and regional collaboration, in the form of coalitions, we could increase diversity and, ultimately, improve the quality of health care governance, considering the common challenges to which we are all exposed. Such enhanced integration will allow us to know each other better; foster trust, mutual respect and understanding of roles and expertise; and lead to increased collaboration and synergy at the organization and, eventually, system level. This would also allow, as suggested in the literature, for a stronger emphasis on context and relationships.[15]

Through this article, we are calling for the deliberate formation of a coalition and a broadening of the local and regional networks of health care leaders to improve our chances of success with the health care transformation in which our two groups are equally invested. These local and regional

partnerships could be facilitated and enabled by agreements between national organizations and local (academic, professional, institutional) ones. Initially, this will require willing representatives of various organizations to come together in a deliberate partnership, guided by a "clear and compelling vision" to achieve a specific result.[1] This vision could be something as simple as "best patient outcome" or "optimizing health." It may also include having representation on each other's board, jointly hosting local events, as well as attendance at national-level webinars or other similar fora. The recent Ontario Hospital Association Health Care Leadership Summit is one good example.[16] Another option is the so-called "study tour" or "field trip" that can be organized to include members of the other organization. A task-based, ad hoc coalition is another way of enhancing the collaboration between the two groups and could be considered for any health care project whatever the scope. In a recent lecture attended by one of the authors, a senior

physician leader commented that while trying to improve quality in a large health care organization, she and her counterpart would meet monthly to share a meal. The only ground rule: do not talk about work. The idea was that they would get to know each other on a personal level, and then they could trust each other better and support each other when it was time to take risks.[17] An easy first step might, therefore, be as simple as extending a personal invitation to a health care leader colleague from another group to a networking or training opportunity, or even out for a cup of coffee. To support this ideal, health care leaders can participate together in these no-risk but potentially high-payoff activities.

Unfortunately, coalitions do not happen by themselves. They are at risk of failing because of lack of sustained focus or prioritization, lack of continuity in key leadership positions, lack of trust between the parties, lack of a clear governance structure, a disconnect between the strategic desire, the local realities, and needs of both/all parties. All these potential obstacles must be anticipated and mitigated to achieve success, meaning that such coalition-building requires a deliberate approach with appropriate planning to be successful.[1]

Still, health care leadership is about us, the individual leaders who are making health care delivery happen daily. We, therefore, all have an individual responsibility to optimize our shared leadership with our colleagues. Our front-line clinicians and staff discovered decades ago that working together is the only way to effectively care for our patients: perhaps it is time for their leaders to follow their example.

Acknowledgement

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Leadership defined for our generation and the next

Jaason M. Geerts, PhD

The evolving nature of how health care is delivered in Canada requires effective complex adaptive systems, which depend on capable leaders, including physicians. Understanding the core concepts of "leadership," "leaders," and "team members" is the foundation for the "great task of our generation," which is creating and leading the kinds of systems needed to meet the opportunities, challenges, and uncertain future of modern health care. Based on a literature review and consideration of theoretical and practical implications, three definitions are provided, along with discussion of their composite terms. Leadership is a process that involves leaders and team members collaborating meaningfully to realize a shared vision. Leaders are individuals who take responsibility and accountability for this process, and team members contribute to it intentionally. These definitions support models of shared and distributed leadership and informal leadership, as well as recognizing the importance of diversity. Management and power are also addressed, as are the implications for organizations, leaders, and team members.

KEY WORDS: leadership, leader, team member, follower, system transformation, management, power

The evolving nature of how health care is delivered in Canada presents unprecedented opportunities and challenges, as well as an urgent need for effective leadership.[1-5] The many examples of centralization at the provincial, regional, and multi-site health network levels have led to shifts in governance and organizational structures, which require enhanced coordination of personnel, services, and resources. Similarly, health care environments and organizations are increasingly being understood as complex adaptive systems, in which advanced capabilities and processes are needed to lead effectively.[6-9] Recent technological innovations provide unique opportunities for quality improvement; however, they can be expensive and challenging to implement department- or system-wide.[10] Tightening budgets and an unsustainable rising cost of care confound efforts to achieve the "triple aim" of health care provision.[8,11] The triple aim began as a quality improvement framework that simultaneously involves striving to improve population health, the quality of patient care and patient experience, and access to and affordability of care.[12,13]

To maximize opportunities in modern health care in the face of these tensions and challenges, system transformation, evidence-based change management strategies, and — most important — effective leadership are essential.[8,14,15] Effective leadership is a significant determinant of improved clinical outcomes in health care organizations,[16-18] as well as financial performance.[19-21] It is important that this leadership is demonstrated by all health care professionals,[22] including physicians, as effective *physician*

leadership has been associated with improved patient care and hospital performance.[3,4,23-29] Physicians hold many formal and informal leadership roles in health care organizations, they influence how a substantial portion of organizational resources is allocated, including through prescribing treatment and medication, and they play a crucial role in driving improvement initiatives.[15,30] These are some of the reasons that physician engagement and leadership are vital to system transformation in health care organizations.[19,28,31]

Harvard surgeon and author Atul Gawande summarizes our point in health care history, from a physician's perspective:

> We have now found treatments for nearly all of the tens of thousands of conditions humans can have and we've reached the point where we've realized, as doctors, that we can't know it all. We can't do it by ourselves… [consequently], making systems work is the great task for my generation.[32]

"Making systems work" is only possible with competent physician leaders as champions, who collaborate with other health care leaders and team members.[1-3,11] Understanding the core concepts of "leadership," "leaders," and "team members" is the foundation of the noble and challenging work that our generation is tasked to undertake. These concepts are also important to define amid discussions of distributed leadership and flatter organizational structures, informal leadership, followership, and the prospect of facing uncertain and "alternative futures" in a health care context.[33]

Definitions summary

The following definitions are the result of a literature review, including grey literature, and consideration of the theoretical and practical implications of each component of the definitions. The three definitions are presented together initially, followed by elaborations on, and implications of, the composite elements of each.

Leadership is the process of leaders and team members collaborating meaningfully to realize a shared vision.[34]

A **leader** is anyone who takes responsibility or is ultimately accountable for the process of realizing a shared vision in a given situation.[34]

A **team member** is anyone who collaborates intentionally in the process of realizing a shared vision. [34]

Definitions explained

Leadership is the process of leaders and team members collaborating meaningfully to realize a shared vision.[34]

Leadership is understood as a process that is broader than a person or position and implies activity, whereas "relationship" (with followers) and "capacity" do not necessarily. For example, a situation in which a positional leader (person and role) and a follower (in a professional relationship) do nothing for a prolonged period does not appear to characterize leadership adequately, even if the pair have the capacity to act.

There are two essential roles in leadership: leaders and team members, both of which contribute to the leadership process intentionally. This implies that team members are not blind followers, ignorant to the overall purpose and direction, nor are they coerced to participate. Including both leaders and team members in the definition also avoids a common mistake of defining leadership by simply describing what a leader does,[35] which is similar to restricting a definition of "education" to the actions of a teacher.

The term "collaborating meaningfully" suggests that each person's contribution to the process is important and valued. This concept is similar to a theatre production: even if actors only have two lines, when it is their turn to speak, the entire momentum of the play rests on them. This is especially pertinent given the team nature of much of current health care delivery.

Finally, the collaboration of leaders and team members is directed toward creating a future reality that resonates with each of them. This is supported by an organization's mission, which is its day-to-day mandate that is intended to lead to the vision. In health care, a

vision ideally has care for patients, families, and communities at its heart.[36] For example, the vision of St. Joseph's Health Care, London, is: "We earn complete confidence in the care we provide, and make a lasting difference in the quest to live fully."[37]

The vision of the future aspect of leadership distinguishes it from management, which, at its core, strives to make current operations more coordinated, effective, and efficient.[38]

*A **leader** is anyone who takes responsibility or is ultimately accountable for the process of realizing a shared vision in a given situation.[34]*

This definition reinforces the notion that being a leader does not depend on holding an official title or position and supports the concept of informal leadership. This is not, however, to negate the importance of formal positions. The efficient and effective operation of organizations depends, at least in part, on established roles and accountabilities. Consider an orchestra without a conductor, for instance.

It is also important to differentiate between formal and informal leadership, as there are distinct advantages and challenges associated with each. For example, informal leaders tend to take the lead only when the opportunity suits them, whereas formal leaders are inevitably responsible for all problems facing the organization, whether they prefer to handle them or not. Informal leaders tend not to have an abundance of resources at their disposal and must establish their own social capital to influence others, whereas formal leaders normally have more substantial resources and positional authority, often with the ability to impose consequences for non-compliance.[39]

Consequences for non-compliance are characteristic of management, rather than the inspiration aspect of leadership described above. Power, as the opposite extreme of leadership, often used synonymously with "authority," is understood as the ability to force others against their will to achieve one's ends, whether that force is exercised or not.[39-41] To illustrate the distinction, management is like a contract:

one enters into it freely, but once agreed upon, one is subject to its conditions, an example of "voluntary coercion." Prison and military dictatorships are examples of power where authority figures impose conditions and mandates on others without giving them the option of refusing, which can involve *total* coercion. Although in practice, the distinctions among the concepts of leadership, management, and power are not always clear and, in many ways, they can overlap, one differentiating factor among the three is the degree of inspiration versus coercion leaders or authority figures use to achieve their goals.

The definition of team member above also means that as the leadership process advances, people can alternate between leader and team member at different times. This flexibility enables the most suitable people to lead in a given situation and affords those with diverse skills and backgrounds opportunities to lead, which they might not have in a rigid hierarchical structure. Recent work on the importance of diversity and its effect on team and organizational performance reinforces this fluid approach to leadership roles.[42]

The factors that determine who is assuming leadership roles are taking responsibility and being accountable for the process in a given situation. Responsibility and accountability can generally be assumed by the same person or they can be shared. For example, speakers at a conference function as leaders by virtue of leading

their sessions; however, the conference chair is also a leader by being ultimately accountable for the quality of the event and content presented. Understanding leadership this way, versus simply as what a leader does, is conducive to models of shared and distributed leadership.

A team member is anyone who collaborates intentionally in the process of realizing a shared vision.[34]

Five fundamental leadership capabilities are implicit in our definition (note: this is not an exhaustive list of key leadership capabilities):

- Crafting or championing the shared **vision**
- **Inspiring** others to actively collaborate and align, rather than simply comply
- Setting and communicating the **strategy** that maps out the plan of how to realize the shared vision
- Creating an organizational **culture** that promotes experimentation, innovation, and leadership, and enables and supports team members to contribute in a meaningful way
- Taking responsibility and being **accountable** for the success of the process or some aspect of it (this is fundamental and the main distinguishing factor between leaders and team members)

*A **team member** is anyone who collaborates intentionally in the*

process of realizing a shared vision.[34]

"Team member" is preferable to alternatives, as it values the *person* in a way that "subordinate" does not, for example,[41] nor does omitting them from the definition of leadership. This term also values the contribution of each person by implying that each plays an important role, as every member of a sports team does. The definition also states that team members are aware that they are contributing to the leadership process and do so willingly, rather than passively or blindly, which "follower" could suggest. Finally, this understanding implies that all team members identify with, and share in, the vision.

It is not necessary to select a term for members of an organization who are not inspired to identify with the vision and simply come to work each day and tacitly comply, nor for others who may disagree with the organization's vision or strategy but decide not to object explicitly and instead reluctantly comply. The implication of the definitions presented here is that leaders and team members should endeavour to creatively engage others and encourage them to collaborate meaningfully to realize the shared vision, without oversimplifying the issue of how to prioritize one's time and energy among colleagues according to their degree of engagement.

In summary, these three definitions suggest that although there are differences in the roles of leaders and team members, mainly concerning accountability,

instead of focusing on dividing people dichotomously into two groups, what is most important is appreciating that leadership is an ongoing collective effort to realize the vision. Leadership is rarely a simple process and is often laden with challenges that exceed the scope of this article to address. This is intended to be the philosophical foundation for understanding leadership. Nuances, limitations, and best practice examples of the real-world application of these definitions, particularly in the context of health care organizations, can be discussed in a subsequent article.

Implications for organizations

The first implication of these definitions for organizations is that leadership is a continuous process that ideally involves the active collaboration of everyone in the organization,[43,44] not a behaviour exhibited by the few who hold official positions. Total engagement of all staff is not presented as the expectation or norm, but rather the goal to which organizations aspire on an ongoing basis.

A second implication is the importance of striving to ensure that the organization has a vision that is shared among all stakeholders. Within the larger vision, departments or teams can create customized visions to reflect their unique role. Inspiring others to contribute meaningfully to realizing the vision is a key leadership function. The leadership process is enhanced when a clear

organizational strategy is in place, especially one that is informed by input from multiple stakeholders. This strategy can be reinforced by an organizational culture that expects individuals and teams to take the initiative to realize the shared vision and that supports and celebrates them when they do. This includes encouraging them to experiment with innovative ways to achieve their goals in a safe and supportive environment.

Large-scale innovation can be expensive and time-consuming, and advocating it does not ignore the value of alignment of effective system-wide protocols and processes. Innovation can simply refer to creatively finding ways to realize the shared vision, including in individual instances at point-of-care, within the organizational structure. Furthermore, in a complex adaptive system, the ability to innovate is vital.[45,46] The more people in an organization who develop effective leadership skills and experience and are prepared

and encouraged to use them, the greater the overall organizational capacity and adaptability. When these organizations also promote and support innovation, they become more resilient and able to implement change and system transformation more effectively, as the culture facilitates these processes. This understanding of leadership also demonstrates a recognition that diversity (of people and leaders) leads to better overall performance.

Finally, organizations can demonstrate the value they place on leadership by incorporating it explicitly into regular staff performance evaluations, recruiting, development opportunities, promotions, and succession planning. Although beneficial, this degree of alignment takes time to generate, particularly in larger organizations or in those that have deeply entrenched existing structures. The concept of learning organizations suggests that investing in increasing organizational

capacity and system-wide cultural alignment is worthwhile and leads to improved engagement, adaptability, and performance.[47-49]

In summary, regardless of their role(s), when people genuinely believe in the importance of an organization's vision, can see themselves in it, feel that they contribute meaningfully to realizing it, and feel supported, then performance, engagement, morale, and job satisfaction increase.

Implications for individuals in formal positions

Those in formal positions must remember that leadership does not happen automatically by virtue of one's title or position; it requires inspiring others and other capabilities. Leaders are responsible for engaging team members to share in the vision, partly by involving them in its creation when possible. They also focus on motivating others to contribute meaningfully, as well as explicitly celebrating these contributions, especially in direct reference to how those efforts advance progress toward realizing the shared vision.

These definitions also prompt leaders to consider the extent to which they are inspiring others to collaborate, versus relying on managerial consequences to orchestrate alignment. Leaders are additionally charged with setting the strategy and consulting multiple stakeholders to design or refine it. Finally, leaders should champion and promote an organizational culture that encourages everyone to experiment with innovative ways to realize the vision and that endorses leadership at all levels.[35,43] This involves not only enabling others to take responsibility as leaders, but trusting and supporting them to do so, which builds their capacity and adaptability. This understanding also distributes leadership; respects and encourages diversity of people, ideas, and approaches; and flattens the hierarchy, while still maintaining the accountabilities of positional leaders.

Implications for individuals not in formal positions

Those who are not in formal positions find uncommon advocacy in this understanding of leadership, and they and their organizations stand to benefit significantly as a result. There is a recognition that team members and informal leaders are typically the ones who, often at the point of care, make their organization's vision a reality for patients and other stakeholders. The implication of the definitions is that anyone can be a leader by taking responsibility in a given situation for an aspect of the leadership process. From this perspective, every team member and leader is valued and their roles are affirmed as being necessary to realizing the vision. Team members should consider how they see themselves in the vision and how they can most meaningfully contribute to realizing it. They are responsible for collaborating with leaders, providing input into the strategy, and offering or experimenting with new ideas and innovations.[50] These tasks are also associated with "followers," who are defined as "individuals who adopt the leader's goals temporally (e.g., following someone's directions to a place) or structurally (e.g., accepting someone's positional authority) and freely accept the influence of leaders."[51,52] The definitions allow for situations where team members can immediately transition to a leadership role by taking responsibility for an initiative and, in fact, imply that they are expected to lead in this way whenever appropriate. A final implication for team members is that they are key players in creating and sustaining the desired organizational culture by encouraging colleagues to contribute meaningfully and innovate and by celebrating and supporting these efforts.

Those in formal positions must remember that leadership does not happen automatically by virtue of one's title or position

In summary, for organizations, positional leaders, informal leaders, and team members, the essentials of leadership are individually and collectively making meaningful contributions to realizing the shared vision, which is aligned with the strategy and supported by a culture that encourages experimentation, innovation, and taking responsibility for the leadership process.

One caveat

Despite the exciting nature of leadership in terms of future possibilities, leadership cannot exist without management and the follow through that management can provide. Leadership, in its purest form, involves leaders and team members who are so inspired that they self-manage. Although this is the ideal to which organizations can strive, it is important not to be impatient with instances when progress is dubious or team members are not meeting expectations. Leaders and team members can best serve their organizations by leading by example,[53] encouraging their colleagues to lead, celebrating instances of success, and continuing to promote a supportive culture with an unwavering commitment to the vision with the confidence that results will come. In addition to results, these efforts have the potential to lead to the kind of increased organizational capacity and adaptability needed to face the future opportunities, challenges, and "alternative futures" in health care, as well as "making systems work."

Conclusion

If it is true that, in health care, the great work of our generation is to make systems work, then certainly effective leadership, including by physicians, is essential. It is important to begin with a clear understanding of leadership, as well as the roles of leaders and team members, in the process of realizing a shared vision. In health care, this vision must be patient- and people-centred to achieve the triple aim. It should also be understood that realizing this vision requires the active collaboration of leaders and team members, a strategy informed by multiple stakeholders and a culture that encourages and supports efforts to make the vision a reality. This is the task, challenge, and opportunity for our generation and the next, which the philosophical foundation presented here is intended to enhance.

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An emergency department's journey toward cultural change: a case study

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Peter Drucker famously said "Culture eats strategy for breakfast." In health care, the way things are done, rather than what is done, can make the difference between an engaged workforce and an apathetic one. This case study looks at how the Kelowna General Hospital's emergency department staff changed their way of doing their usual work and improved their engagement and, subsequently, their quality of care. The article highlights methods leaders can use to uncover previously underground barriers that are affecting engagement. We review the differences between technical problems and adaptive challenges and add to other research that suggests command-and-control leadership is rarely effective in complex systems such as health care.

KEY WORDS: complexity, health care, leadership, workplace culture, engagement, adaptive challenge

The Kelowna General Hospital (KGH) Emergency Department (ED) knew it had cultural challenges as evidenced by recruitment and retention struggles. High turnover rates and poor interprofessional communication among care providers were barriers to providing quality medical care. The ED leaders understood that the reasons for the hospital's inability to retain staff were multifaceted and that, to increase retention, they would have to begin by uncovering the key underlying issues to better understand their culture. A process was initiated with interviews, a customized survey, and focus groups with ED staff and physicians.

Culture can be defined simply as "how we do things around here." The ED leaders discovered that, although everyone knew *what* they had to do, the *how* was not always obvious to the care team. Staffing levels, break coverage, lack of understanding of roles, responsibilities, accountabilities, performance feedback, and a lack of communication between roles at times led to dysfunction in the processes of patient flow. Specialty consults, hospital services' response times, patient volume management, inpatient admission, and discharge planning were all challenges that impacted the ED culture at KGH.

Changing culture requires a vastly different process than other problems, in that culture is intertwined with interpersonal relationships, group dynamics, traditions, and power imbalances. Culture issues are adaptive challenges as opposed to technical problems.[1]

In this paper, we review how the leaders of the KGH ED moved from thinking they had a simple technical problem, which would require an expert to tell them how to solve it (best practice), toward understanding that they had an adaptive challenge, which was much more complex. We elucidate how the leaders were able to let go of control strategies and allow a process of adaptation to occur with the beneficial side effect of increasing engagement of staff. Despite an increase in patient demand and having to support the surrounding community during flooding and forest fires, the department showed vast improvement in its culture in just one year.

Literature review

Health care literature is replete with evidence of the importance of engaged workers as a driver

of quality patient care.[2,3] An emotionally engaged workforce is one of the solutions to what currently ails the low quality of care that defines Canadian health care.[3] Engagement statistics provide evidence that what is being done on the management and leadership front to shift health care culture toward increased engagement is not working well. The Canada Human Resources Centre[3] states that only about 25% of people are actively engaged at work. Management and leadership are consistently at the top of the list of complaints.[4]

Changing the culture of teams so that they are emotionally engaged and take ownership of their work would seem to be a herculean task. There are no recognized therapists for dysfunctional health care teams as there are for dysfunctional families; instead health care organizations expect their leaders to know how to address these issues. However, this type of culture problem cannot be solved using the traditional command-and-control leadership style often seen in health care, but instead requires a major paradigm shift.[5] This begins with an understanding of the difference between technical and adaptive problems.

Technical problems are those where cause and effect are understandable. Many problems in health care fall into this category, and solutions come in the form of best practice guidelines, evidence-based medicine, and the like.[1] Traditional change management approaches can be successful in solving technical problems. Adaptive challenges are those where cause and effect do not

apply.[1,5] An example is ensuring optimal patient flow through the ED. Teams must come to a common understanding of their current state and adapt their behaviour to achieve a new state, which is the definition of culture change. The solutions are not known at the outset, which means traditional change management approaches are less likely to be successful.

Culture-driven challenges are often characterized by a cycle of failure and a persistent dependence on authority. Understandably, leaders gravitate toward using technical solutions, especially those that have worked in the past, because they reduce uncertainty and are easier to apply.[1,5] Practising adaptive leadership requires helping people navigate through a period of disturbance. This

disequilibrium can catalyze conflict, frustration, avoidance, panic, confusion, and fear.[6]

The consequence of using command-and-control leadership practices to solve adaptive problems is what Chris Argyris[6] calls "organizational traps." Organizational traps arise when workers feel unable to speak their mind openly and without fear. When there is fear of reprisal, issues go underground and become undiscussable. The results include cultures with unhappy workers, dysfunctional teams, and disengagement. Many packaged, off-the-shelf products designed for enhancing team effectiveness focus on symptoms or by-products of undiscussables, rather than the undiscussables themselves.

The people connected to the problem must own it and do the work together so that solutions emerge.[5] This requires leaders to abandon traditional command-and-control methods that demand fail-safe business plans with defined outcomes.[1] Instead leaders must allow team members

to experiment, to fail, and to try again. Leaders must learn to facilitate adaptation.[4]

Neuroscience[7] teaches us that for adaptation to take place, the brain needs to create new neuropathways, rather than fighting against old, entrenched ones. The more we focus on the problems we have, the more ingrained we make them. Rather than trying to re-wire or deconstruct existing neuropathways, neuroscience suggests that we leave the problem wiring where it is, and focus wholly on creating new wiring. This is the essence of adaptation and culture change.[4] Ensuring that the new way of working arises from the ideas of workers where the problem exists allows new neuropathways to emerge in their brains and creates adaptation.

Leaders are often promoted for their technical knowledge and decision-making capabilities.[6] Thinking for others and solving problems have historically been core functions of leadership

roles, with intrinsic and extrinsic rewards often validating this approach.[4,5] The juxtaposition of traditional leadership behaviours (solving problems and making decisions for employees) and recent neuroscientific findings related to brain wiring and re-wiring illuminates many factors contributing to the disengagement and apathy that exists in health care, with direct application and relevance for leadership and management practices.[4]

Methods

The ED culture work required a mixed methods design. The ED and KGH site leadership, with the help of an organizational effectiveness consultant (OEC) agreed to the method. (Figure 1)

Figure 1. The engagement process at Kelowna General Hospital's Emergency Department

The following steps in the process reflect actions, which include adaptations to the planned method based on findings that emerged as the work progressed.

1. An Engagement Steering

Figure 1. The engagement process at Kelowna General Hospital's Emergency Department

1. Interviews	2. Custom survey	3. Focus groups	4. Action plan	5. Re-survey
•Anonymous, stratified sampling of all ED roles •Participation by 28% of ED team members •Key themes & undiscussables identified •11 interviews conducted outside ED	•ED culture-specific questions developed from interview themes •Questions about thinking, feeling, and intent to stay were asked •Baseline measure of the current state developed •72% response rate for baseline survey and 48% response rate for re-survey	•Survey data shared in 6 interdisciplinary (ED) focus groups and 1 physician focus group •Focus groups discussed and prioritized issues and developed proposed solutions •51 ED team members participated in focus groups	•Focus group results integrated into an ED action plan with leadership responses •Document provided a roadmap for success by tackling priority issues determined by the team •Facilitated buy-in and commitment to change	•Redistribution of the same survey •Re-survey results demonstrated areas of progress and opportunities for additional focus •Provided a point of reflection and celebration for changes taking place

Figure 2. The 10 most significantly improved factors according to physicians at Kelowna General Hospital's Emergency Department

KGH ED Physicians: 10 Most Significant Improvement Scores From 2016-2017

Factor	Score
Safe/Timely/Quality Pt...	57
Supplies Equipment	51
Consults/Hosp...	51
ED Manager Models Ldr...	51
Pt. Care Delivery Feelings	50
KGH Leaders: Follow...	50
Culture: Morale is Positive	48
ED Manager Timely...	46
Change Management	44
Safety Training	43
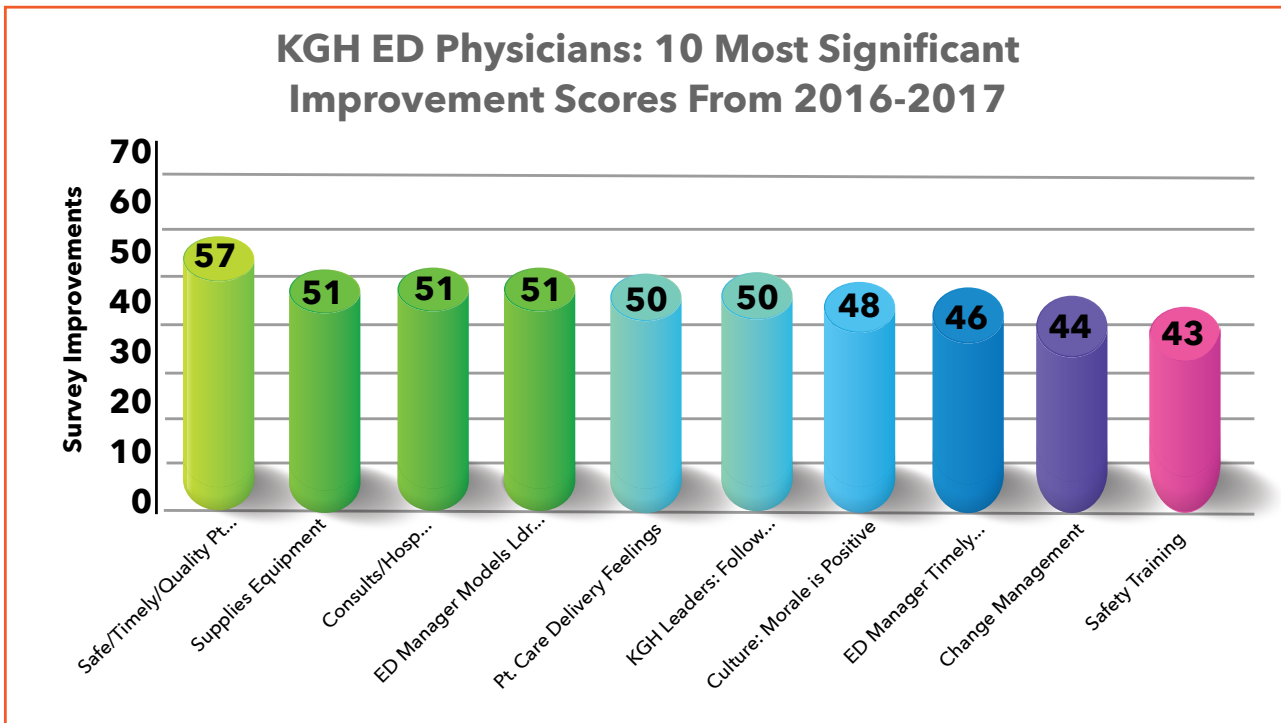
Figure 3. The 10 most significantly improved factors according to nurses at Kelowna General Hospital's Emergency Department

KGH ED Nurses: 10 Most Significant Improvement Scores From 2016-2017

Factor	Score
Critical incident debriefs	29
KGH leaders: understand roles/responsibilities	26
Standardized orientation	23
Day-to-day work: feelings	20
KGH leaders: ED vision & goals	19
Transfer of care best practices	16
ED manager values feedback	16
Courses/certification	16
Physician/nurse teamwork	14
Break coverage support	12

Committee was established to provide oversight, insight, and feedback on the process as each step unfolded. Its membership consisted of: one service director, the head of the Medical Department, the ED manager, a BC Nursing Union representative, and the OEC. The committee convened before and after each step to coordinate logistics, planning, adaptations to the process, and information sharing.

2. 28% of the ED staff and physicians (n = 43) participated in confidential interviews. An additional 11 interviews were conducted with a representative sample of clinical stakeholders who interact with the ED. The purpose was to uncover the strengths, challenges, and issues potentially impacting the ED team's effectiveness and culture. The themed data gathered from the interviews became the key content for a customized engagement survey. Clinical stakeholder summary themes were also shared in step 3 (focus groups). Early engagement with medical staff was a key to the project's success.

3. A customized engagement survey was designed to measure the specific themes that emerged from the confidential interviews. The 63-question survey was used to gather qualitative and quantitative data to develop a baseline measure of the culture. The summary themes reflected in the various comments sections provided

context and specificity to help illuminate the quantitative results. The results were tabulated and presented in chart and graph format by ED role and an all-roles combined report. A 72% response rate for the survey was achieved.

4. The survey results were shared in seven facilitated focus groups, which included 51 participants. Each group prioritized the issues to be worked on and developed proposed solutions for the highest priorities. After the focus groups were finished, the data were analyzed to integrate the priorities and proposed solutions into one ED action plan. Six out of the seven key priorities identified were within the ED's scope to influence and improve.

5. An ED Liaison Committee – consisting of the ED manager, representative site leadership, and the ED department head – and an ED Engagement/ Quality Working Group that included physicians were established to support the ongoing work of implementing the action plan. A re-survey was completed at the 16-month mark after the initial survey. The participation rate was 48% for the ED, with 60% of the physicians completing both the baseline and re-survey. This completion rate for physicians is atypical and signifies that the process of engagement was also atypical and effective.

The qualitative and quantitative data gathered showed that significant positive changes had

taken place. Figure 2 highlights the areas of most significant improvement for physicians. Figure 3 highlights the most significant improvements for nurses.

Actions

Although many changes took place, the following actions are believed to have had the most significant impact.

- Daily participation by the ED manager in interdisciplinary team huddles
- Staff huddle board/ communication boards created
- Front-line led working groups established
- Development of standard work and communication processes
- At triage, physician included with a triage nurse to improve timeliness of patient access to services

Every day, the ED manager would be physically present to hear concerns from the front line, face-to-face, much like a Gemba Walk used in LEAN methodology. On the staff huddle board, staff could post improvement ideas, and progress on their suggestions was monitored and presented weekly. This proved to be better attended and more effective than the typical department staff meeting. This simple change allowed all staff to feel their voices were heard and to begin to trust that management was taking their concerns seriously. Having one's voice heard, understood, and acted on

when appropriate is recognized as a powerful engagement strategy. Physicians and front-line workers were supported in their suggestions for improvement.

The addition of front-line team leads to each discipline in the ED was proposed and supported. It allowed for improved communication between the disciplines and patient care coordinators and had the added benefit of improving succession planning.

The decision to include a physician at triage was an initiative that came directly from the front line. The effect of this change was dramatically improved patient wait times to see a physician.

Improved one-to-one engagement of management with their staff in the form of performance feedback and reviews allowed each staff member to communicate to their manager their purpose and interest in ED work, thus increasing engagement and ownership of the delivery of safe and effective quality care.

Discussion

Organizational and team cultures are layered and complex living organisms.[1] In many regards, getting to the root causes of team ineffectiveness is like peeling back the layers of an onion. Focusing on the "above ground" issues alone would not have resulted in the transformational results evidenced in the re-survey data. In this instance, more significant engagement of the KGH site leadership was a key adaptation to the process, once an understanding of the key issues and challenges surfaced through the interviews. Leadership awareness and support is critical for addressing various bottlenecks and improvements, and ED leadership participation in key ED engagement meetings became a strategic lever for realizing improvements over time. Those involved included site leaders,

managers, physician leads, and charge nurses.

Although the issues and outcomes are specific to this ED, the process and method are relevant and applicable to all sorts of teams experiencing ineffectiveness, conflict, lack of cohesion, mergers, acquisitions, and other significant changes.

The changes that took place within the Emergency Department over the course of a year are correlational, not causational. Other factors and influences in the system may have contributed to and/or caused these significant changes to occur. However, by devoting time and attention to the issues at hand and by providing support for the process to surface and generate the root causes and solutions, the conditions were primed for positive change.[6]

Copious amounts of literature and theories exist surrounding the topic of organizational culture and culture transformation. What appears to be missing is the roadmap for facilitating such change. External cultural change agents are advantageous to build the trust that must pre-exist before the surfacing of undiscussables can begin. Once the below-the-surface issues are being discussed, the team can address them and collectively work through the associated emotions to develop solutions.

Conclusions

Culture is the way business is done in any organization. It is predictable that, when an organization goes through any type of change, the culture will be affected.

Organizational culture determines and limits strategy[8]; this is evident when significant changes are introduced or take place. Although there is no one magic bullet, leaders who can anticipate and prepare for significant changes to culture processes will have the advantage of developing more adaptable, collaborative, and resilient teams.

When the culture of an organization gets in the way of its mission, a well-defined, albeit arduous, process can be implemented to uncover the undiscussables and allow those involved to advance relevant and sustainable solutions.

This case study highlights a method leaders can use to uncover staff barriers when needing to implement change and impact workplace culture.

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Author attestation

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Patient safety in a new age of understanding

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Engaged health care teams are necessary for any improvement in quality or safety. But health care teams will not engage simply because we ask them to do so. Any improvements in health care will require leaders to understand the why of disengagement. In the first of this three-part series – Disengagement in health care: today's new culture – we began to understand why only 57% of health care workers are engaged and why that number is decreasing annually. We now examine how health care's approach to safety and quality has unwittingly been complicit in building this disengagement.

KEY WORDS: physician engagement, patient safety, quality improvement, resilient health care

It has been 20 years since the Institute of Medicine's landmark report, *To Err is Human*,[1] was presented to Congress. Is there anything to celebrate? Although pockets of excellence exist,[2-4] the number of deaths resulting from preventable adverse events keeps rising.[5,6] Over the last 20 years, it appears that we have been arguing over the numbers, while "action and progress on patient safety is frustratingly slow."[5] The overall harm rate has stalled at 10%.[7] This lack of progress can, in and of itself, act as a disincentive to front-line teams. To understand why the impact of efforts has been minimal, we need to examine our recent past as it pertains to quality and safety.

The human as a liability

Humans are inattentive, make mistakes, and routinely break the rules. Classified loosely as cognition error, inattention tends to be caused by memory slips and lapses. An example is a misdialed telephone number. These types of error occur with great frequency in health care. In the past, such slips would be retrained away, but does re-teaching a telephone number really help prevent misdialing it in the future? Retraining satisfies societal corporate responsibility, but does nothing to reduce the likelihood of recurrence: no change in the rate of harm ensues.

From a human-centric perspective, both inattentiveness and mistakes have been well addressed by an approach known as "just culture." Just culture postulates that with cognition-based errors, the worker is already punishing him- or herself; thus, the right approach is to console the colleague involved. With errors caused by mistakes, training is the appropriate approach with no punishment. However, knowledge alone will do little. It is its application in our interprofessional environment that is key to modifying the harm rate.

A final category of human error exists where just culture and more routine approaches to error might suggest punishment. This category can be classified as routine violations. Sabotage, and the intentional harming of a patient, must be stopped immediately and punished. However, deviance is often normalized and added to the routine violations column and – depending on how just culture is implemented or how the deviance is interpreted – may lead to unintended consequences because of the fear of punishment.

Normalization of deviance has been defined as: "People within the organization become so much accustomed to a deviant behaviour that they don't consider it as deviant, despite the fact that they far exceed their own rules for elementary safety."[8]

At face value, it is totally logical to punish all forms of deviance.

However:

- What were the factors that encouraged the team to make the decisions they did?
- Can every rule actually be followed in hospitals' busy units?
- Is every deviance bad?

As an extension of the last question: what would happen if positive deviance was punished because it was not recognized as such or tolerated? Positive deviance occurs naturally as humans make changes to complex processes, to find a better way of doing things.

So how common is deviance?

The reality of the matter is that deviance is ubiquitous. In any human endeavour, four types of work are described:

- Work as imagined – individuals imagine what the work is, but in their role, they do not actually do the work
- Works as prescribed – a work process is created, like a policy, procedure, or guideline
- Work as done – what the work actually looks like, when translated and performed by those who do it
- Work as disclosed – what those who do the work actually report the work to have been (heavily influenced by the presence or absence of psychological safety)[9,10]

Ideally, these types of work would all look the same. However, they rarely resemble each other. Why? The answer becomes clear as we learn that there are over 600 policies, procedures, and guidelines in place at the average hospital to guide the front-line team in a day of work.[11] There are simply too many rules for anyone to know about, remember, look up, follow, or keep up-to-date. In 2016, the half-life of medical knowledge was just 5.5 years; thus, keeping 600+ policies up-to-date is impossible.[12] In 2015, Johns Hopkins reported that in one of its intensive care units only 40% of patients received "proper treatment" despite the use of bundles and checklists, in part because there was not enough time to apply them all.[13]

Work as done cannot resemble work as prescribed

The organization is under stress, the stress of production in an environment of economic and workload challenges.[14] These challenges, and the need to continually "produce," lead the organization to seek efficiency from its staff.[15] The need for efficiency, which comes at the expense of thoroughness, amounts to the organization giving tacit approval to work as done even if it deviates from the rules.

When something goes wrong, the organization, in hindsight, realizes that the team should have been thorough in that particular instance. Thus, the worker can be held accountable for a rule that they could never have followed in the first place. The frequent judgement: harm occurred because the worker did not follow the rule. This is simply untrue; no one can say whether the incident (or another) would – or would not – have occurred if the rule had been followed in this instance, i.e., in the multidimensional, unpredictable, and complex environment that is health care today.

As a final consequence, two things are likely to follow as a result of the investigation: a new policy will be created to try to prevent recurrence, and the original rule will not be improved. Our teams get yet another policy to follow,

workers remain disengaged, and no change in the rate of harm ensues.

In summary, equating deviance with rule breaking contributes to the silence surrounding the fact that work as done does not resemble work as prescribed. It can lead to multiple ways of doing things in the same case, which can be chaotic and increase harm. Staff disengages, and nothing changes.

Care is not linear

The early days of patient safety saw the development of linear foundational models to help us understand error causality.[16] Policies (or protective solutions to error) evolved, but they inferred that care was *linear* and presumed *average workload*. This traditional thinking remains despite our new understanding of complexity. Care is in fact multidimensional, and there is rarely a day with an average workload.

Furthermore, if care is understood to be multidimensional and tightly coupled,[14] then it becomes evident that the linearity of safety models has led us to produce linear protective solutions to sequences of events that may never actually occur again. In other words, a series of apparently sensible decisions, made by a team, balancing a unique multidimensional context, with a unique sequence of events will likely never recur in that same way again.

The creation of these protective solutions can have unintended consequences: the diversion of resources from other important tasks (opportunity cost), increased risk in other areas (collateral damage), and inefficiency (600+ protocols) (Andrew Kotaska, MD, School of Population and Public Health, University of British Columbia, 2018, personal communication). It also means that we are always playing catch up, as opposed to creating resilient teams that can "absorb" and catch errors before they occur, or limit the damage when they do occur[17] (Michael Gardam, MD, Schulich Executive Education Centre, York University, 2018, personal communication).

Looking at safety in the traditional sense is disengaging

Safety is understood as a non-event: the absence of harm. In other words if nothing bad happened, the patient was safe. This makes measuring safety nearly impossible. How do you account for something that did not happen? Assuming we knew the denominator, if we determined that a harm event occurred at a rate of 1 in 5000 activities, any intervention put in place to reduce its occurrence, would typically need another 5000 activities to reveal the intervention as effective.[18] This is not engaging to the health care team, as it amounts to introducing an intervention and watching for the occurrence of nothing. While important to understand why the system fails, any safety gains achieved in reviewing harm events alone means that quality improvement is

reactive to harm, and only picking off at the episodic chances for improvement. This approach is traditional and has become known as protective safety, or safety I.[10]

Current "safety management is based on analyzing situations where something went wrong – a set of snapshots of a system that has failed, described in terms of individual parts or system structures."[19] This is reinforced by typical hospital safety management structures that expect stability, certainty, and predictability and seek to control, manage, and restrict – in other words attempt to engineer-out failure.[20]

The disconnect is that modern day health care does not function in a stable, certain, and predictable environment. Nor does it function on stable, certain, or predictable patients with stable conditions. The status quo safety solution – treating health care like an aircraft carrier or a nuclear power plant – is incongruent with the real environment it purports to protect. Thus, it is highly likely that engineering-out failure alone is not an effective or engaging method of enhancing safety in a complex and adaptive system.

Culture

Likely, the most important factor in making a successful team is culture. On the 15th anniversary of the publication of *To Err is Human*,[1] the National Patient Safety Foundation (NPSF) convened an expert panel to examine and understand the slow

pace of improvement in safety. Its report, entitled *Free from Harm, Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human*,[21] identified culture as the key.

Culture is often summarized as "what we do around here," which makes it appear as a monolith that no single person could change. But if we see culture as "what we choose to tolerate," then each one of us plays a critical role in making the changes necessary to develop the culture we wish to see. Quality improvement in health care is best focused on achieving that culture – a culture by design. The importance of creating a positive culture is supported by a 2017 systematic review published in the *British Medical Journal* that highlights the positive correlation between culture and patient outcomes.[22]
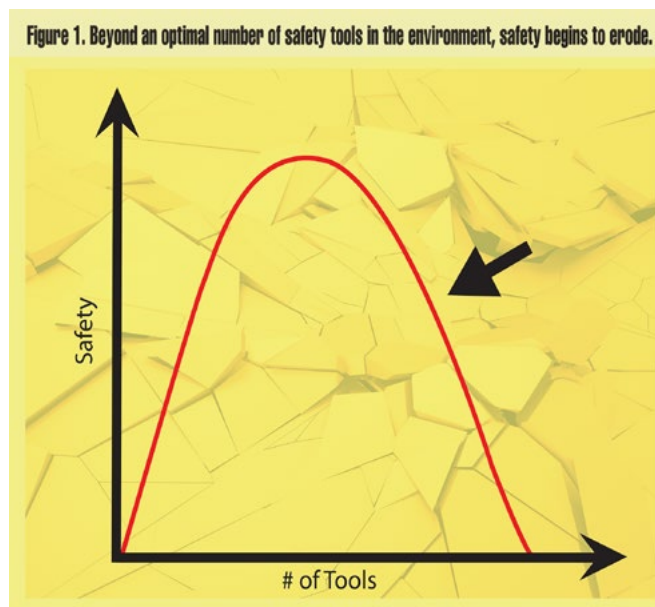
Knowledge

Also discussed in the NPSF report was Schultz's concept on knowledge.[21] He is said to have stated that knowledge moves in three sequential phases: superficial simplicity, confusing complexity, and profound simplicity. Safety in health care is currently in the state of confused complexity.

Superficial simplicity was a state in which we naively believed that the adoption of some of the safety approaches from the airline industry (a complicated system,

not a complex one) would lead to significant improvements in health care quality and safety.

Confusing complexity is the current presence of over 600 policies, guidelines, checklists, and procedures guiding our front line personnel in their day's work.

Profound simplicity is a situation where the right balance of policies and guides exists along with a better understanding of the system and the people we work with – a state yet to be realized.

Figure 1. Beyond an optimal number of safety tools in the environment, safety begins to erode.

Paul Gluck (past chair of both the NPSF and the Council for Safety in Women's Healthcare) proposed the graph in figure 1, where care becomes less and less safe once a certain number of safety tools are present in the environment. We have passed the crest of the curve and the arrow indicates that we are somewhere on the downslope in terms of safety. Today, there are well-described instances of "checklist fatigue," and many examples of work as done looking very different from work as prescribed. In short: "A worker

following a safety rule can create a condition to enable safety to emerge. Too many safety rules can overwhelm, and frustrate a worker, enabling danger to emerge."[20]

In Part I,[23] we explored why legislating adherence to "rules" was not effective, yet health care organizations continue to respond to safety concerns by producing more and more policies, procedures, and guidelines. However, there seems to be little interest in understanding why following them seems to be so difficult. As an industry, we keep trying different ways for guidelines and best practices to be successfully implemented. This is akin to pushing string uphill. In a complex system, one needs to work *with* the forces at play, not against them.[24]

Health care is a complex adaptive system

Finally, complexity science tells us that health care is a complex adaptive system. This is best explained by first describing what simple and complicated systems are. This is Snowden's Cynefin framework as adapted by Zimmerman and Gardam[2,25]:

A **simple system** is baking a cake.
- Following a list of simple linear tasks/processes will lead to the creation of a cake.
- The process can be easily taken apart, understood, rebuilt, and the outcome

achieved again and again.
- Safety features can be put in place to reduce the likelihood of failure in achieving the outcome. Those features include lists of ingredients, standardized tools, and process maps (recipes). Importantly, these safety features also increase the likelihood of success.

A **complicated system** is placing a human on the moon.
- Following multiple and intricate linear tasks with interdependencies that must be completed in the correct order and followed to the minute detail will get a human on the moon.
- The process can be broken down, understood, rebuilt, and the outcome achieved again and again.
- Safety measures can be put in place to reduce the likelihood of failure in achieving the outcome. Those measures include checklists, and strict adherence to rules and standard operating procedures (these features work to engineer-out failure). Like those of a simple system, these safety features also increase the likelihood of success.

Stringent safety measures developed for complicated systems will work in simple systems. The airline industry and nuclear power stations are complicated systems.

But as unpredictability increases, a system becomes complex; an example of such a system is raising a child.

- A complex system is a multidimensional process that cannot be broken down, understood, rebuilt, and the same outcome obtained. There is no guarantee that if you raise one child successfully, the same "recipe" will lead to a second success.
- Safety measures to reduce the likelihood of failing to successfully raise a child do not exist, per se. Instead, we naturally gravitate toward general principles or simple rules that increase the likelihood of successfully raising the child: love, guidance, nurturing, consistency (these features do not work to engineer-out failure, they work to engineer-in success).

In a complex system, solutions used for simple and complicated systems have limited utility; they do not reduce the likelihood of failure and may, at times, increase it.[26] They can cause harm through unintended consequences. History is rife with examples; Apollo 13 and the landing of US Airways 1549 on the Hudson River are two. In both, a complicated system was disrupted by an unpredictable event. In that moment, they went from being complicated systems to complex ones. In both cases, human ingenuity saved the lives of those involved, whereas following the rules in place would likely have caused the death of all.

Finally, a complex adaptive system adapts to meet the needs of its unpredictably changing context. It does so because of the flexibility of its people,[24] a fact lost on many

except for those doing the flexing. It is a flexibility that is restricted by current safety approaches.

Note: although health care is a complex adaptive system, it contains elements of simple and complicated systems. Therefore, further improvements in safety are not about the abolition of work done to date, but a balancing of the right safety tool for the right part of the system within the whole.

What does all this mean?

Complex challenges require a different approach from the ones leaders have been familiar with. This approach must combine critical examination of the system's components, balanced with a keen understanding of the interactions of the people who work in it.[25] An opportunity exists to combine the traditional focus on engineering-out failure (protective safety or safety I) with engineering-in success (productive safety or safety II), which views safety as a dynamic event – analyzing the 4999 times out of 5000 that an activity went well, understanding why it went well, and increasing the likelihood of future successes.[10,18,26,27]

Engaged health care teams are necessary for improvements to occur. But health care teams will not engage because we ask them nicely. Leaders need to fully understand what has led us to this point. Only by understanding our past and current context can we hold the keys to future improvement. Parts I and II of this series of articles have explained

our current situation. In Part III, we will bring together those elements and present a way forward to improve engagement in, and the safety of, health care.

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*This series is an expansion of the thoughts and ideas in "Implementing patient safety initiatives," by the same author.[27]

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2019 CSPL Excellence in Medical Leadership Award
(Chris Carruthers Award)

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

Susan Shaw, MD

Dr. Susan Shaw balances a rewarding career in Critical Care Medicine and Anesthesiology with clinical and system improvement work at the local, regional and provincial level in Saskatchewan. She is currently Chief Medical Officer with the Saskatchewan Health Authority and Board Chair for the Saskatchewan Health Quality Council. Dr. Shaw has also been a successful department head, a physician leader with the Saskatchewan Surgical Initiative, co-led the Saskatoon Health Region Safer Every Day Breakthrough Initiative, and spent time working with the Saskatchewan Medical Association as the Director of Physician Advocacy and Leadership. Dr. Shaw is looked to as a leader in patient-centred care, physician leadership, continuous improvement, and large-scale change. Susan lives in Saskatoon, Saskatchewan with her husband and two teenage children.

A few excerpts from her letters of recommendation…
I can attest to Dr. Shaw's leadership abilities and her talent for leading people, and I can confidently say that she motivated HQC executive and staff to do what they knew they needed to do, which is one of the basic truisms of leadership. She excelled at guiding the HQC toward goals that mattered, even if the goals were ambitious, and persevered when they were unpopular. I saw firsthand how her leadership skills supported her efforts to knit together productive networks of influencers across a range of health stakeholders, including patients, physicians, Ministry of Health officials, researchers and others. I don't think it is an overstatement to say that her leadership at HQC strongly advanced a culture of health care improvement throughout Saskatchewan's health care system. Bonnie Brossart CEO, Saskatchewan Medical Association

Dr. Shaw is, in my opinion, an embodiment of all characteristics the Chris Carruthers Leadership award seeks to recognize – commitment, leadership experience in both acute care and health system settings and an individual who has made a significant contribution through her service and leadership, both provincially and nationally. I have been consistently and genuinely impressed with Dr. Shaw's leadership skills. She has that rare ability to connect with individuals at all levels of an organization – from technical staff such as me, to Directors, senior leaders and analysts. She always has a keen eye to the future, and, is brilliant, collaborative, transparent, open, and honest. Maureen Anderson, M.Sc, PhD (candidate), Researcher, Saskatchewan Health Quality Council

Susan is a seasoned leader with the patient placed firmly at the centre of every decision. She is committed to continuous improvement, high quality patient care and patient safety. She has a gently persuasive but steadfast leadership style that has earned her the respect of her physician colleagues as well as other health care leaders and providers. Kevin Wasko, MA, MD, CCFP (EM), Physician Executive, Integrated Rural Health, Saskatchewan Health Authority

CQIP is a program that is designed to develop emerging clinical quality improvement leaders. As faculty, Dr. Shaw had a key role in both delivering the curriculum as well as being a mentor to participants in the program. Her willingness to share her leadership experiences – both the successes and the challenges –was enormously beneficial to the participants. Dr. Shaw not only taught the content, but also demonstrated what it means to be a physician leader. Her strength of purpose, skillful collaboration, and commitment to patient and family centred care showed learners not just the "what" of leadership, but also the "how" and the "why". Shari Furniss, BA, BEd, MEd, Director, Learning and Development, Health Quality Council (Saskatchewan)

Dr. Shaw is among the program's most popular instructors. The participants report that they learn a tremendous amount of useful knowledge from her, and she regularly receives one of the highest program evaluations. She is not only very knowledgeable, but she can also impart this knowledge to our physician leaders in a personable and professional way. She relates to their experience and challenges with humility and passion. All these qualities are not often embodied in one person. She is a model of health care provider, health care leader and professional instructor. Moreover, despite her increasing portfolio in Saskatchewan, she continues to fit our program into her calendar. Daniel Skarlicki, PhD, • Edgar Kaiser Chair of Organizational Behaviour,Sauder School of Business, UBC,

Dr. Shaw is an incredibly talented and giving individual who gives tirelessly of herself. As a leader she continually seeks innovative ways to approach challenges and is a true "out of the box" thinker. Yet at the same time she is able to ensure collaboration and cohesion amongst her team. As an individual, her genuine care for everyone is evident the moment that you meet her. She is truly special, and I am grateful that I have had the opportunity to know her and work with her. Serese Selanders, Founder and CEO, ORA, Board Member, HQC

One of Dr. Shaw's strengths is her ability to engage others in order to establish meaningful relationships with those with whom she works. She is consistent in her commitment to demonstrate expertise and growth in her leadership role. Dr. Shaw works tirelessly to improve the quality of healthcare offered to the people of Saskatchewan through engaging, developing and supporting the physicians who provide treatment. Another strength Dr. Shaw has is the compassion and empathy she has when addressing complex and difficult challenges especially involving personnel. She is always thinking of how to solve the issue while maintaining the relationship with the patient, physician or healthcare provider. Preston Smith, MD, Dean of Medicine, University of Saskatchewan

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Professional-izing physician leadership

Johny Van Aerde, MD, PhD

There is a need to professionalize leadership development in Canada; for physicians, that need has increased with the inclusion of the new role of Leader in CanMEDS 2015. For the health care system, LEADS provides a set of standards for guiding leadership development for each individual health care worker and for all organizations. This paper addresses how to engage physicians in leadership roles and explores what professionalized leadership might look like.

KEY WORDS: physician leadership development, professionalism, physician engagement, certification, LEADS

Optimizing physician engagement

According to Spurgeon et al.,[1] physician engagement is a two-directional social process: the organization must reciprocate for the engagement of individual physicians in high-quality care by incorporating opportunities and processes in which they can participate (Figure 1). The model of professional engagement contains two dimensions: individual capacity, which reflects skills leading to increased self-efficacy and personal empowerment to tackle new challenges (horizontal axis of Figure 1), and organizational opportunities reflecting structure and cultural conditions that prompt doctors to become more actively engaged in leadership activities (vertical axis of Figure 1). Depending on what conditions are missing, professionals can feel powerless, frustrated, or challenged. Spurgeon showed that medical engagement is positively associated with organizational quality, including lower mortality.[1,2] Once doctors become engaged systemically, the scores for patient experience improve as well, as was seen at the Cleveland Clinic.[3]

The LEADS framework[4] and the Spurgeon model[1] can be integrated to engage physicians and other health care professionals. When everyone who works in an organization possesses the necessary skills and is offered opportunities, transformation happens. LEADS provides a set of expectations and standards that can be used to guide both leadership development for the individual physician and the organizational culture and structure by embedding the framework systemically. That embeddedness, e.g., including physicians in governance and offering purposeful committee work and projects, motivates physicians to take on organizational opportunities when they come along because they have the skills to do so. As a result, physician engagement increases and more doctors move into the upper right quadrant of the model. Evidence indicates that increasing the percentage of doctors on boards has a positive impact on organizational performance and patient experience.[5] Examples of organizational opportunities include quality improvement initiatives[6,7] and incorporation of physicians in the provincial health care governance structure, as in Saskatchewan.[8]

St. Joseph's Health Care in London, Ontario, used the LEADS framework when it embedded leadership development programs into its structure and culture for all leaders. For physicians, LEADS capabilities were integrated with CanMEDS competencies, in collaboration with the London Health Sciences Centre and the Schulich School of Medicine & Dentistry. As a result, the organization's culture is one of ongoing learning and evaluation: LEADS-based self-assessment and 360 evaluations are used to review goals, strengths, and areas for growth, in alignment with

templates for role descriptions for all leaders. The evaluations are also used to optimize talent management as part of the organization's succession planning, all integrated as part of the leadership development culture of the organization. For physicians, the 360 evaluation is aligned with both LEADS and CanMEDS.

To improve physician engagement, the LEADS framework can be integrated into organizations in a way that fulfills Spurgeon's[1] medical engagement model for both dimensions (Figure 1). How could this model be used to professionalize leadership?

Professionalized leadership development for physicians and other health professionals

Unlike the professions of medicine and law, leadership has no standardized body of knowledge, core curriculum, or skill set, and there are no generally accepted metrics or qualification criteria. By and large, different individuals and institutions pursue and design their own education paths in a leadership "industry" that consists largely of countless different programs in many different contexts, each claiming to teach how to lead.[9]

According to Barbara Kellerman,[9] markers associated with professional status in medicine and law are:

- Generally accepted body of knowledge
- Extended education and

training
- Required continuing education and training
- Clear criteria for evaluation and (re)certification
- Clear demarcation of those within the profession and those without
- Explicit commitment to the public interest and a code of ethics
- Professional organization with the power and authority to monitor the status of the profession and the conduct of its members

Education, training, development: knowing, doing, being

There are three different but intertwined elements in leadership learning: education, training,

and development. Although these three words have been used interchangeably, they have different meanings. According to the 70/20/10 concept of blended learning, 10% of learning takes place through education in the classroom by knowledge transfer and formal learning.[10,11] This is the *knowing* or expertise component of leadership learning.[9] Twenty per cent of learning is acquired through training, by *doing*, what Kellerman calls experience.[9-11] It comprises the practice and acquisition of skills derived from the classroom knowledge, sometimes in simulation situations.[12] Those two elements, education and training, reflect learning about *what* leadership is and are represented by the horizontal axis of the Spurgeon diagram.

Figure 1. Medical engagement model and blended learning
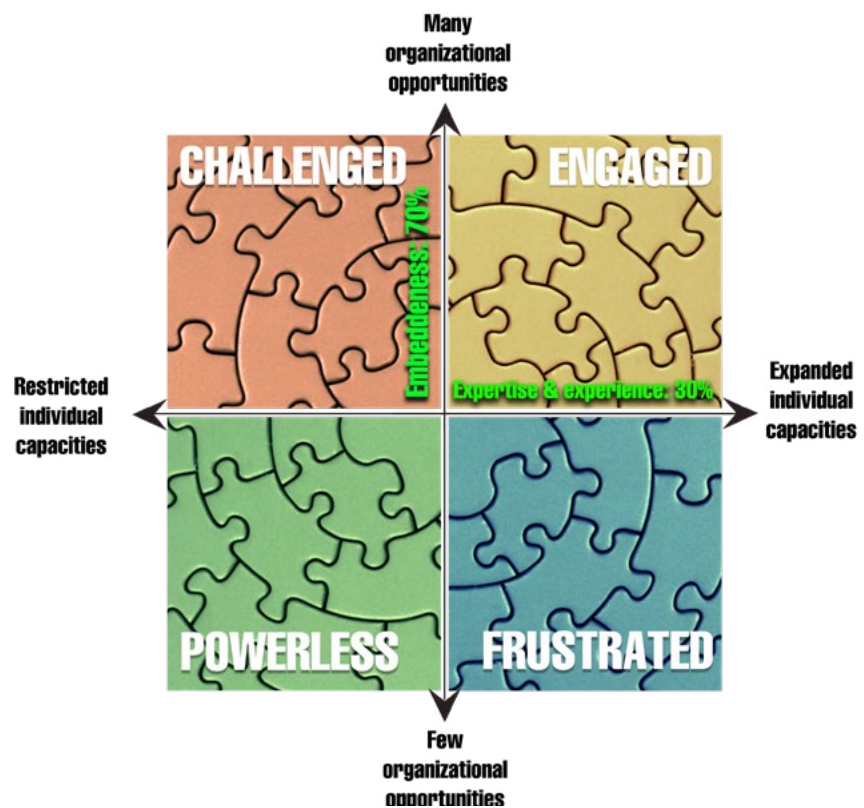
The Holland Bloorview Kids Rehabilitation Hospital in Toronto, Ontario, which employs about 1000 people, has developed a 90-minute session for each of the 20 LEADS capabilities. Given that resources, particularly time, are limited, people have welcomed the 90-minute session inside the hospital. Knowledge, relevance, and potential application are explored for each capability in an integrated and real-life fashion, thereby facilitating transition into the workplace. This is where leadership learning programs often stop as learners return to their work environment where the culture is not conducive for ongoing learning to develop leadership skills.

If education and training are about *what* leadership is, then the remaining 70% is about *how* to lead. This part, the *being*, should take place in the organization through such action learning as day-to-day activities and problem-solving.[10,11] Kellerman uses the term "leadership development" for the individual and "leadership embeddedness" for the learning organization within which the learner works.[9] The Holland Bloorview Hospital provides real-time coaching and 360 evaluations for leadership learners to develop each capability in their work environment. St. Joseph's Health Care also exemplifies an organization that has embedded leadership development into its entire structure and culture, as described above.

It is clear that embedded leadership development and the related organizational opportunities require life-long learning for the individual; for the organization, it means integrated talent management and succession.[7] Professionalizing leadership around LEADS capabilities would make talent management consistent across organizations and indeed the entire health system.

The leadership system: leader, follower, and context

Leadership, as a system, is complex and has three components: leader, follower, and context. Although the leadership industry has focused on leaders and leadership, no attention has been given to the learning and development of followers. Yet, we are all followers at certain times and in particular circumstances. Kellerman argues that, besides leadership programs, there should also be learning for followers, both what it is and how to follow.[9]

The fashion is to talk about shared and distributed or team leadership, while the follower is often portrayed as submissive.[9] The word "follower" must be redefined, as it allocates a value and a stereotype of submission – as the word "leader" portrays dominance. Leadership and followership are about relationships. Followership is not a person but a role within a relationship. What distinguishes followers from leaders is not intelligence or character, but the role they play in the relationships they develop. Effective followers and effective leaders are often the same people playing different parts for the same project simultaneously or at different times or in separate spaces. The qualities that make effective followers are pretty much the same qualities found in effective leaders.[9,13,14] Meanwhile, most organizations

assume that leadership skills have to be taught but that everyone knows how to follow.[9]

The third part of the leadership system, context, is a function of many elements, including culture, goals, diversity and social context, process, structure (functional and physical), task, systems perspective (stable, complex, or crisis), and time.[15,16] Some situations can make leadership difficult. For example, geographic separation makes true distributed leadership difficult, while today's pressure on time can also influence outcomes.[9] As embeddedness or context is a major part of leadership development, it has to become integrated into leadership professionalization across the health care system.

LEADS for professionalizing physician and health care leadership

With the release of T*o Err is Human*[17] by the Institute in Medicine in 1999, the medical profession had no choice but to become engaged systemically in quality control and leadership. In response to changing demands in the field, medical leadership has been undergoing a paradigm shift from the traditional autocratic role physicians played to more collaborative clinical and administrative leadership. Until a few decades ago, physicians did not receive any dedicated leadership or management development because they were considered leaders automatically by virtue of their profession. As a result, without evidence-based

best practices showing what effective leadership is, anything goes. Doctors often conceptualize and practise management and leadership skills by observing others and learning on the job.[1]

The need for leadership development and professionalization has also created a need for changes in medical education.

In 2015, the Royal College of Physicians and Surgeons of Canada (RCPSC) changed the CanMEDS Manager role into Leader.[19,20] The LEADS framework has been adopted by the RCPSC and the College of Family Physicians of Canada (CFPC). The CFPC has embarked on the development of a curriculum to align the competencies of the CanMEDS 2015 role of Leader with the LEADS framework. Joule's Physician Leadership Institute, under the umbrella of the Canadian Medical Association and with the support of the Canadian Society of Physician Leaders, aligns its professional development leadership courses with the LEADS domains. The Canadian Certified Physician Executive designation is awarded by the CSPL, based on certain educational requirements and senior leadership experience aligned with all LEADS capabilities.[21] Renewal of the certificate after five years requires the same rigorous process.

A professionalized certificate as described by Kellerman[9] should further be developed throughout the Canadian health care system.

The two-year fellowship program from the Royal Australasian College of Medical Administrators is one of the best examples of a professionalized leadership degree for physicians. Progress toward professionalization is also being made in the United Kingdom where the Medical Leadership Competency Framework (MLCF) was jointly developed by the Academy of Medical Royal Colleges and the National Health Service's Institute for Innovation and Improvement in conjunction with a wide range of stakeholders. The MLCF describes the leadership competencies doctors need to become actively engaged in the planning, delivery, and transformation of health care services. Learners can then enter 12-month Clinical Fellow Schemes for emerging clinical leaders outside clinical practice, offering them the opportunity to develop skills in leadership, management, strategy, project management, and health policy.[22] Clinical fellows have the opportunity to work with senior leaders to fast track their leadership skills and experience in a diverse range of organizations. The Faculty of Medical Leadership and Management hopes that introduction of the fellowship will be the beginning of a professionalized leadership learning program. As for leadership competencies, it is interesting to see international consistencies between England, Australia, and Canada.

The need for leadership development and professionalization has also created a need for changes in

medical education. For example, the Association of the Faculties of Medical Education in Canada states that:

> Medical leadership is essential to both patient care and the broader health system. Faculties of Medicine must foster medical leadership in faculty and students, including how to manage, navigate, and help transform medical practice and the health care system in collaboration with others.[23]

A great example of how LEADS can be integrated in resident education is Sanokondu, a non-profit, international collaboration of health leadership educators and organizations with an interest in health leadership development. A set of modules portraying real clinical scenarios was developed for residents and preceptors, based on the five domains of LEADS and several roles of CanMEDS 2015, mainly the role of Leader. Sanokondu has made those modules available free of charge online (**https://sites.google.com/site/sanokondu/**).

In conclusion, there is a need to professionalize leadership development in Canada. For the health care system, LEADS provides a set of standards for guiding leadership development for the individual and for organizations. Just as CanMEDS provides a framework to standardize professional competencies for medicine, LEADS can serve as a similar

model to standardize leadership capabilities for professionalizing leadership.

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This article has been peer reviewed.

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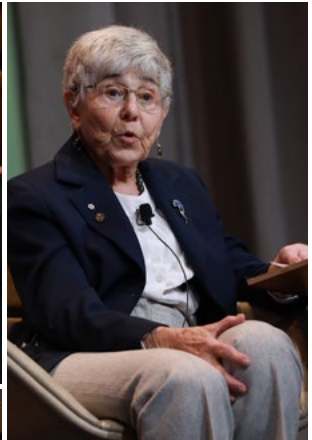
The Empathy Effect

7 Neuroscience-based Keys for Transforming the Way We Live, Love, Work, and Connect across Differences

Helen Riess, MD, Sounds True, Boulder, Colorado, 2018

Reviewed by
Johny Van Aerde, MD, PhD

Dr. Helen Riess, a neurologist, uses elements of psychology, emotional intelligence, sociology, and organizational culture in her book, *The Empathy Effect*. The construct of empathy is best understood as a human capacity consisting of different but integrated elements that enable us to be moved by the plights and emotions of others. Our empathic capacity requires a specialized brain circuit that allows us to perceive what others feel, process the information, and then respond effectively. Our brain is primed to experience others' pain for two reasons: to teach us what to avoid ourselves and to motivate us to help the injured person. Empathy uses the same neuronal circuits as mirror neurons, allowing us to vicariously experience others' pain by understanding and feeling what others are experiencing.

There is an emotional and a cognitive component to empathy. For the longest time, experts believed that empathy was something you were born with. Recent evidence proves that, just like leadership skills, the cognitive component of empathy can be learned. Specific training can increase perception, perspective-taking, and self-regulation skills so that we are not overwhelmed by the suffering of others, which might lead to our own distress and burnout. To facilitate that learning, Riess developed and tested a tool with the acronym EMPATHY.

The seven elements of EMPATHY are linked with non-verbal communication: E for eye contact, M for muscles of facial expression, P for posture, A for affect, T for tone of voice, H for hearing, and Y for your response. Their conscious use triggers awareness by engaging the prefrontal cortex. In one study, the tool caused physiologic parameters, like skin conductance and heart rate, to resonate between physician and patient. Unfortunately, the model is trademarked and the book does not provide much information about the required training. However, in a telephone conversation with Dr. Riess, this reviewer found out that much has to do with practising the skills of self-awareness and management, communication, and change leadership.

After its introduction in such hospitals as the Cleveland Clinic, patients' experience improved when they were treated with empathy, which led to greater trust, more compliance with treatment, and better outcomes.
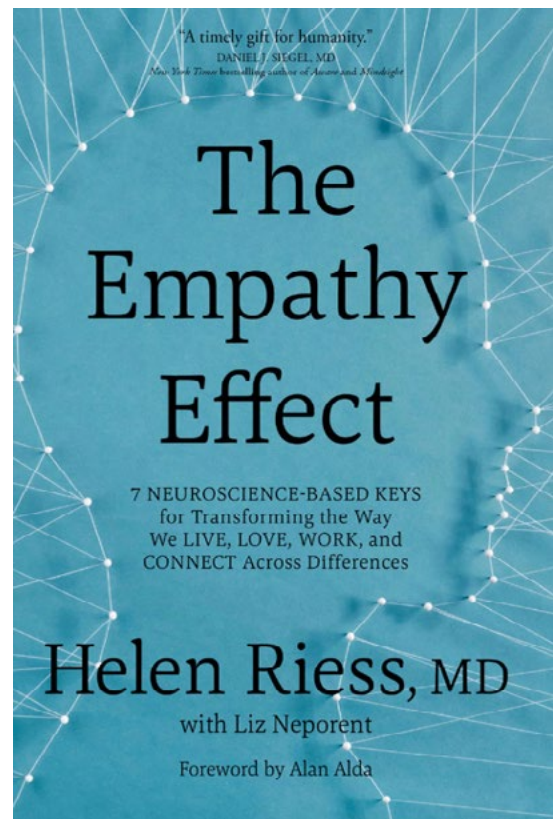
Dr. Riess has some evidence that practising the EMPATHY tool as individuals and embedding its use in the structure and culture of collaborative organizations improve working conditions.

For physicians, implementing the tool systemically led to more job satisfaction and less burnout. Physicians who displayed these mostly non-verbal behaviours were rated as warmer and more competent by their patients. It is interesting that practising basic people skills and portraying empathic emotional intelligence make us appear more competent. Although there is some indication that the tool helps manage emotional overload and reduce the risk of depression and burnout, further research is needed.

The book is not only important in helping us in relationships with

patients, but also in seeing how we view the world primarily from the perspective of the various clans or guilds to which we belong. We are less likely to feel empathy toward others who do not fall into our in-groups or tribes. If humanity truly wants to live by the principles of diversity, it has to try to understand "the other" and the other's perspective, as it is difficult to withhold empathy when you get to know somebody.

In the heavily fragmented Canadian health care system, we need the skills of empathy as part of a strategy to integrate all silos. Similarly, as we move more and more into multidisciplinary teams, we need to master the skills of empathy.

Riess also addresses self-empathy, self-care, and how empathy starts with self. Before we can offer empathy and compassion to others, we need to practise self-kindness and mindfulness when we experience our own emotions, and remember that humanity is a shared experience. This book covers several capabilities in the L, E, and S domains of the LEADS framework. *The Empathy Effect* is a good read if you are interested in how empathy can benefit individuals, teams, hospitals, and the entire health care system.

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That's What She Said
What Men Need To Know (And Women Need To Tell Them) about Working Together
Joanne Lipman
Harper Collins, New York, 2018

Reviewed by L. Calhoun, MD

On the front of this book is the quote: "ATTENTION, GOOD GUYS: This book is for you. It is a rare guide on championing gender equality that you'll actually enjoy reading and it is full of strategies for improving your workplace," Adam Grant, *New York Times.*

I am not male, so can't vouch for the veracity of this claim, and I can say that, throughout the book, Lipman avoids man-shaming and helps women empathize with the mental model of men who are sensitive to women's struggle for equality.

Lipman has one overarching message that is echoed throughout her book: if the world of work is going to get to gender equality, men need to help. And women need to invite them in, educate them about the problem and how the world of work improves when women are treated as equals.

This suggestion may be anathema to the usual feminist viewpoint: that only women working together can solve the gender equality problem. However women have been trying to fight the patriarchy solo for a long time and have not been successful. Recall the definition of insanity: when you keep doing the same thing over and over again and expect a different result. We need to try a different strategy.

In her introduction, Lipman points out that many men already see women as equals and want to speak up or act on women's behalf, and yet men feel intimidated and terrified of saying the wrong thing. She quotes Wharton psychology professor, Adam Grant, who has written about women's issues saying that he is berated by readers, asking what right he has writing about women. "Men
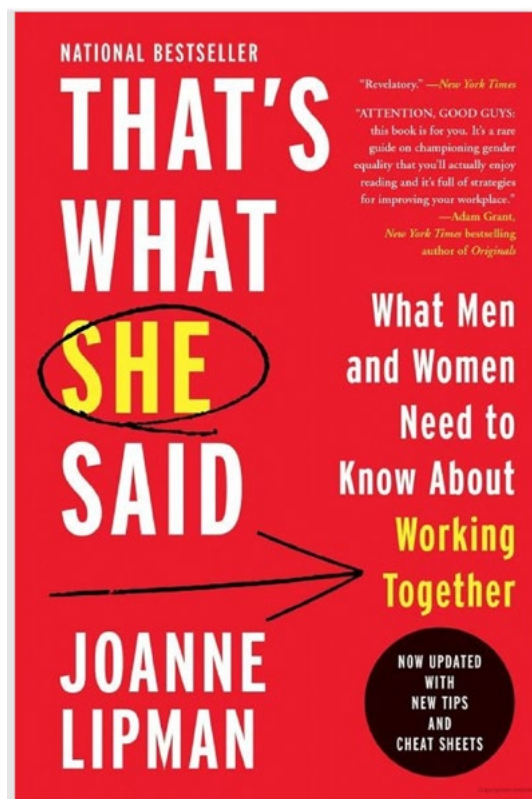
are baffled, uncertain, they feel awkward, and it all rolls up into steering clear of particular topics or of women altogether" (page xv).

Lipman makes an excellent point: if women aren't educating men about how they can help and men are too afraid to speak up then it is no wonder that the topic is avoided. How can we make change if we can't even talk about the issue?

Lipman uses stories and annotated research as she digs into and elucidates what men need to know about women's experiences. There is no male castigation and no victim blaming. She manages to set out many of the common areas where women are treated unequally and provides data on how often this happens and what may be underlying the behaviour.

Lipman starts out with a chapter called "The secret lives of women (a primer for men)," in which she uses story and research in an easy-to-read chapter that details all the things that women do to try and fit into "a culture that is not quite our own." For example, how we work hard to be nice and not too aggressive so as not to raise the ire of men, how we attribute our success to luck instead of our grit and intelligence, and how we keep silent when our good ideas are attributed to a man.

The second chapter, "She'll make you more successful," provides the foundation for answering the question "What is in it for me?" that men may ask when thinking about allying with women in the fight for gender equality. Lipman

provides numerous evidence-based answers in an easily read and understood narrative.

The subsequent four chapters are the meat of the book. Lipman reviews much of what has already been written and is known about bias, double standards, and how women's self-perceptions get in their own way. The titles are catchy. "We're all a little bit sexist" explores unconscious bias and its various ramifications. "The twelve most terrifying words in the English language" reveals what we are learning about the evidence behind diversity training, which is not positive. And that we can't always trust our own internal narrative to be true. In "She's pretty sure you don't respect her," the classic double standard is explored: men are respected even when they have not proved their competence, whereas women need to prove their competence repeatedly before respect is even a possibility. In "She deserves a raise. But she won't ask you for it," Lipman details what is known about women's self-perceptions, as well as the assumptions male managers make about their female employees.

The final four chapters shine a light on actions taken in some sectors of society. "Blind auditions: solving for bias, emotion and other stuff you can't control" walks through how the music industry dealt with gender bias by holding blind auditions and the resulting improvement in the gender mix of orchestras in much of the world. "Invisible women: the world's greatest untapped resource" deals with women who have left the

workforce to raise children and the difficulty they have coming back to work. Lipman claims that the GDP of the United States could be greatly enhanced should these women be properly employed.

In "The next generation: the Harvard experiment," we get a detailed look at an attempt at creating gender neutrality at Harvard and the resulting outcomes.

The last chapter, "The best place in the world to be a woman?" explores what happened in Iceland after the banks crashed in 2008. A fascinating story that Lipman tells from the outside in as well as from the inside out.

Lipman has left out talking about intersectionality for the most part, in that she assumes whiteness and cis gender. As a white cis-gendered woman, I don't have the viewpoint needed to identify more specific areas where Lipman may have been too narrow in her research.

I highly recommend this book for leaders. Women will find it validating and useful to understand why the topic seems so fraught. Men will be enlightened on the issues and emboldened to speak up.

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