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EDITORIAL

Influence: leadership starts with “self” language

Johny Van Aerde, MD, PhD

Although leadership is often defined as “the capacity to influence others,”[1] we cannot forget that our inner voice influences the self. That inner voice uses the same language as our external voice uses to influence others. Does a specialized language for leadership exist? How can the language of our inner voice influence us when we interact with the world as leaders? Although most articles in this issue deal with influencing others, this editorial addresses how the language of our inner voice and our mindset influence our approach to the world and offers reflections on how we can make this work better for us as leaders.

Language has a representative and a constitutive role.[2,3] Using the representational or symbolic role, we give descriptions and explanations. For example, the sounds of words, like “hammer” or “chair” communicate what those words represent symbolically. This role is less likely to affect our mindset, as there is general agreement on what those words represent.

However, the constitutive or generative role fulfills a future-oriented purpose by creating new possibilities. This role is particularly needed for complex societal constructs like “equity for all,” or “the roles of a health care system.” Generative language is the bridge between the present and the uncreated future; what we say and how we say it influences not only the future we will create together, but also our own vision of possibilities.[3]

Our mindset and inner narratives can often be our biggest barriers to success. Although our inner voice never stops, we can change its language. Using generative language for our inner voice helps remove barriers that limit our view of what else is possible and what goals are attainable. By modifying the type of language our inner voice uses, we influence our own vision of new possibilities. By changing the language of our outer voice, we influence others in seeing what else is possible for organizations and systems.

The way we see ourselves as leaders is based on our internal, often limiting narratives affected by our mental models, assumptions, and beliefs. For example, if you have to have all the answers to be a good leader, you will not be

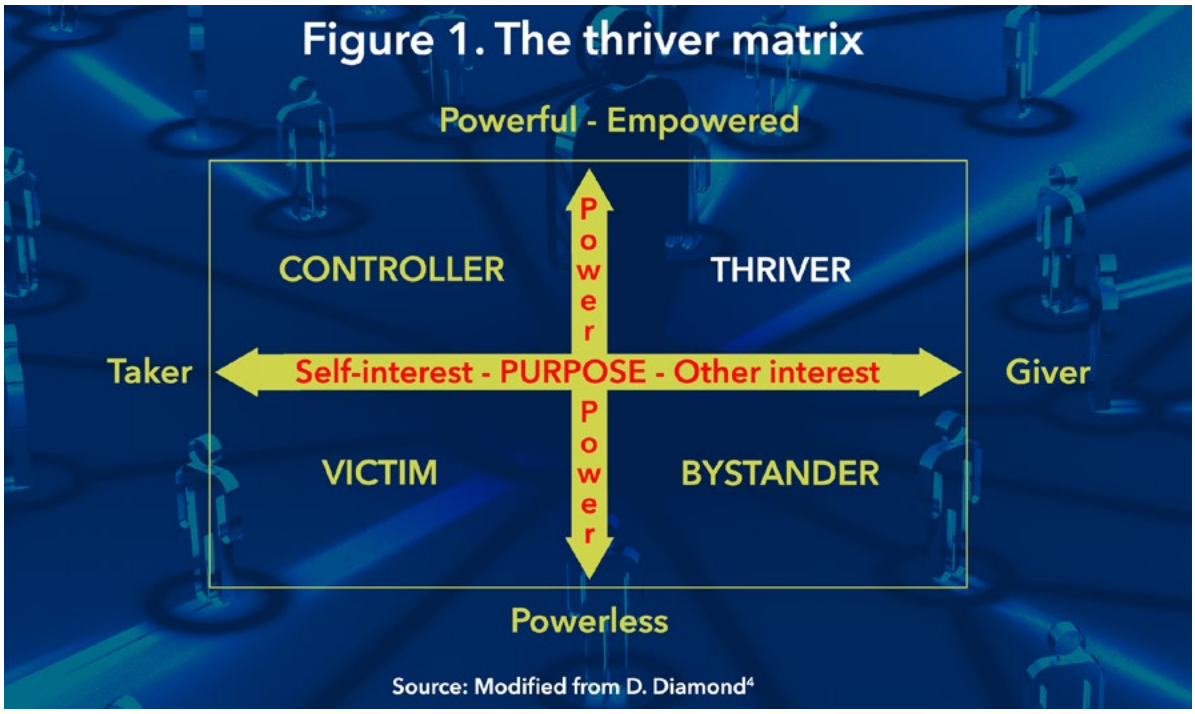

Table 1. Changing from reactive to generative language

Reactive language	Proactive, generative language
There is nothing I can do.	Let's look at our alternatives.
S/he makes me so mad.	I control my own feelings.
That's just the way I am.	I choose a different approach.
We can't afford the cost of an increasing aging population.	Let's involve the elderly in healthy communities.

effective, as you can never have all the answers. What is your mental model of leadership? Do you need to revisit your values, assumptions, and beliefs and examine your mental model of leadership to help you become a better leader? If our mindsets influence the language of our narratives and inner voice, how can we affect those mindsets to change that language?

According to Dr. Dan Diamond,[4] a physician who has worked in many disaster areas, our mindset influences the type of language we use for our inner narratives in two dimensions: power and purpose (Figure 1). People can choose to be powerless or powerful and empowered; people's purpose can run between serving self (being a taker) and serving others (being a giver). The two dimensions – power and purpose – delineate four mindsets that will influence our language and inner narratives. These are mindsets that each of us might use at different times; they are not different types of people. *Controllers* or *manipulators* believe they have the power to make a difference, but it is all about benefits for themselves. *Bystanders* care about the outcome, but don't do anything about it as they underestimate what they can do; their mindset makes them a powerless giver. *Victims*' mindsets make them powerless and a taker: "I don't have any power, I am working in a lousy place, I have to look out for myself." Their underlying emotion and motivation can be fear. In *Man's Search for Meaning*,[5] Viktor Frankl described how to reverse the

mindset of a victim by revisiting purpose and values. *Thrivers* are powerful givers, who feel able to make a difference and make others successful, to be a servant leader for the common good.[6] Thrivers believe that they can make a difference in the service of others, for the organization, or for the system.

According to Covey,[7] there is a third dimension, the freedom to choose or the lack thereof, which leads to a mindset of pro-activity or re-activity. Reactive people are often limited by their mental models when responding reflexively to external stimuli. Proactive people see the freedom to choose their response to a stimulus from the external environment. They are still influenced by external stimuli, physical, social, or psychological, but their response to the stimuli is a value-based choice. As Frankl wrote, the response to what happens to us can be experienced as more painful than what actually happens.[5]

Recognizing our response-ability (our ability to respond) is what will make things happen within our circle of influence. The language of reactive people absolves them of response-ability and becomes self-fulfilling; it becomes a paradigm of determinism in that "I am not response-able, not able to choose my response." Proactive people on the other hand use generative language for working on the things they can do something about, thereby enlarging their circle of influence. In choosing our response to a circumstance, we powerfully affect our circumstance. Our language is an indicator of the degree to which we see ourselves as reactive or proactive. Examples can be found in Table 1.

In *Bringing Leadership to Life*,[1] Dickson and Tholl state, "A leadership mindset is the mental predisposition that shapes our leadership responses, and therefore our level of effectiveness." As a leader, pay attention to what you are saying to yourself. That inner voice is there all the time, but the type of language it uses will generate different narratives for ourselves and influence others into thinking, "What else is possible."

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Patient satisfaction: there is more work to be done

Nahid Azad, MD

Our health care system is under continuous pressure to improve patient satisfaction. Quality methodology is a proven way to focus on patient satisfaction, but it requires cultural change to lead process change. A direct focus on patient experience and satisfaction will drive systemic change throughout the hospital. Multi-level leadership, from front-line clinician to senior executive, is key to successful cultural change for improving my patient satisfaction metrics. Front-line quality initiatives need more support to maximize their impact.

KEY WORDS: quality improvement, leadership, systemic change, patient satisfaction

As a front-line clinician in an academic medical hospital, I am expected to improve my clinical performance. Part of my performance assessment is based on patient surveys. However, as a specialist, my domain of influence in meeting patient expectations is limited and is a small part of the overall patient experience. Several physicians treat the same patients as they move from admission to discharge, following different protocols and directives. I have limited ability to directly change the end-to-end care processes. However, quality methodology provides both the tools to identify care gaps and the potential to drive change into hospital processes, increasing my patient satisfaction metrics.

Quality methodology focuses directly on patient satisfaction rather than on health care providers. Different front-line units may be at different levels of quality maturity,[1] often driven solely by regulatory requirements. We need to move beyond these minimum requirements and make patient satisfaction the primary focus of quality assurance, with regulatory requirements just one of many constraints.

This paper discusses patient satisfaction from the position of a front-line clinician who has led small quality-improvement projects in an academic hospital and has had difficulties obtaining support for operationalizing the findings. It examines the key performance factors for leading the introduction of quality methodology into our front-line units. This challenge is not the application of the technical quality toolkit; these tools are easily learned and applied. The real challenge is to take the tool findings and improve patient experience and satisfaction throughout the hospital. The challenge is to enable people to make the required changes in a rigid system with organizational and process barriers that resist change. The challenge is, therefore, to change the culture within our health care organizations.

Quality methodology[2] is not new; it has been used for decades by many organizations, large and small, and has a proven track record.[3] There are many quality frameworks, methods, principles, and toolkits – including Total Quality Management,[4] IOM 6-diminsions,[5,6] IHI Triple Aim,[7] Six Sigma,[8] Malcolm Baldridge,[9] and LEAN[10,11] – targeted at specific aspects of quality management. The private sector went through a major ISO 900012 quality transformation in the early 1990s as a way to improve both "customer satisfaction" and "employee satisfaction." There is no reason to believe that quality management methods would not achieve similar results in our public health care system. In fact, we require that most medical equipment suppliers have appropriate quality certification.

Figure 1. Standard process structure (based on ISO 9001[22])

Background

First, we have to recognize that we have a "burning platform" and that we will have to change how we provide care. Given the rapidly changing patient demographics (e.g., aging), improving medical technology, and financial realities, the current system, designed decades ago, must change to meet evolving patient needs and expectations.[13-20]

This type of transformation is not for the faint hearted and may lead to process change that, in turn, will often lead to difficult organizational change.

It is said, "Every system is perfectly designed for the result it gets."[21] To change the outcome, we need to change the system. Our system is a network of processes, each consisting of a network of smaller processes. Each process should have an owner. For any given process, the "process activities" need to change to affect the outputs/results. This change requires negotiations with and adjustments by the owners of the input and output processes. Figure 1 summarizes the standard process structure.

For leaders promoting disruptive change, the good news is that quality methodology, by redirecting the focus to patient satisfaction, gives everyone a new perspective. This new perspective provides both the permission and the encouragement to think differently and more creatively. Proven quality tools may reinforce this thinking, help translate thinking into proposed action, and consequently lead to recommendations for process change.

Realistically, within the current environment, organizational momentum and existing barriers may prevent many of the recommended changes from being implemented. To paraphrase Einstein: our thinking creates problems that the same type of thinking will not solve. We need each unit to commit to quality improvement and to be accountable for introducing the innovative changes required to increase patient satisfaction. Moreover, systemic change may be disruptive, impacting many management levels and organizational structures. Senior management can use quality methodology as a tool to lead the type of multi-year cultural transformation they deem necessary.

Therefore, we need to focus on the leadership challenge from the perspective of front-line clinicians and not on the mechanics of applying the prescriptive quality tools. Exactly what support do front-line clinicians need to lead sustainable, innovative change?

Six key performance factors

Table 1 summarizes the six key performance factors needed for a successful patient satisfaction program in support of front-line clinicians and the seven associated ISO 9000:2015 and ISO 9001:2015 quality management principles.[23]

Visible executive support, funding, and goals

Executives must continually and visibly support the strategic direction of the quality improvement plan. If it is not clear to everyone that the senior executives are committed to the program, busy staff will recognize this and disengage.

One key element of the process is the executive quality management system (QMS). The QMS is a set of policies, processes, and procedures needed to plan and implement core health care services to meet patient satisfaction goals. Promotion of the organization's quality strategic

Table 1. What front-line clinicians need to lead sustainable, innovative change

Key performance factor	ISO 9000/9001 principle
Visible executive support, funding, and goals	Leadership
Front-line investment (MDs, nursing, multi-disciplinary)	Customer focus, Engagement of people
Strong quality leadership at all levels of management	Leadership, Evidence-based decision-making
Process ownership, documentation, and approval	Process approach, Relationship management
Effective defect management process	Improvement, Evidence-based decision-making
Periodic compliance audits	Process approach

plan and QMS is essential at every opportunity. Executives must continually send a clear message that organizational barriers and entrenched management resistance will be overcome and that change will happen. Staff must be convinced that investing their time and effort in support of change will not be a waste of time or, at worst, a career-limiting decision.

In addition, every leader must be a change agent.[24] Patient satisfaction goals must be among every manager's performance objectives. Quality must be on the agenda of every operational meeting: Are milestones being met? What projects need help? What successes can be celebrated? What best practices can be shared?

Change agents should be recognized, encouraged, and supported. Continual reinforcement of the quality plan will help drive behavioural change throughout the organization. Behavioural change will gradually lead to cultural change; staff will communicate more effectively, transparency will improve, and teamwork will increase. The quality focus will give staff both permission and encouragement to change their behaviour.

One key role of executives is to provide quality program funding. Staff must see words translated into action. Quality programs need dedicated funding for training, specialized staff, and project management.

Front-line investment (MDs, nursing, multi-disciplinary)

To help promote cultural change, quality training is required for all team members, particularly those on the front line. What does a quality-centric organization look like? How does it behave? How do I behave? What is our QMS? How do I fit in? What is in it for me? Are we doing a good job? How do we know?

By investing in front-line training, executives demonstrate that the change is real and that they are committed to achieving the quality goals. Change will not be effective unless endorsed and supported by front-line personnel.

It is critical that leadership support these first two key performance factors, as they demonstrate the intimate relation between management and front-line staff. Front-line staff will identify many specific opportunities to improve patient satisfaction. On the other hand, executives have the power to change the system, but are too distant from patients; they need front-line input to determine which system changes are required.

Strong quality leadership at all levels of management

Each organizational unit has unique aspects. Consequently, the

Figure 2. Alignment of the quality management system at each level with higher levels

QMS for each unit must be tailored to that unit, in support of and aligned with the higher-level QMS (Figure 2).

The quality officer in each unit is responsible for developing the unit's QMS, including patient satisfaction metrics. These officers provide focused leadership to influence the operational managers to develop key metrics, benchmarks, and both quality assurance (QA) and continual quality improvement (CQI) projects. The quality officer owns the unit QMS and the operational managers own the key operational metrics. The unit quality metrics must align with higher-level metrics.

Naturally, there will be resistance; the quality officer must recognize and help overcome that resistance (seizing the opportunity to educate staff further on the quality agenda) to help both management and staff embrace change. Resistance provides valuable information for change agents. Furthermore, the quality officer must be a senior team member with both credibility and authority, in addition to appropriate communication and influencing skills.

Process ownership, documentation, and approval

Quality programs focus on processes of care rather than individuals. Part of the quality officer's role is to ensure that policies, processes, job aids, and associated records all have owners and that these owners periodically update, review, and approve the processes according to the unit QMS. Approved process documentation is stored in the QMS library. Members must be trained to ensure that approved processes are adopted. Process documentation, compliance, and ongoing improvement are key to achieving quality goals.

Naturally, each process receives input from other processes and delivers outputs to other processes, many of which will be outside the unit's organizational boundary. The quality officer must work closely with other quality officers to facilitate this process evolution and adoption, ensuring no gaps or overlaps.

Effective defect management process

There are two classes of defects: issues identified internally and issues highlighted by patients, caregivers, or patient advocates.

An essential part of quality methodology is the recognition of problems and opportunities (quality defects). The reporting of defects in meeting patient expectations is a positive action, an action that is necessary to meet quality goals. Associating defects with a process rather than an individual and encouraging the reporting of both problems and opportunities are critical parts of the quality culture. Our current processes often do not include soliciting feedback from other internal units. Quality initiatives, focused on patient satisfaction, will require more comprehensive feedback from patients.

Quality training for everyone includes training in the defect management system. A process

may be incomplete (defective process), a process may not be followed (non-conformance indicating a training issue), or a new patient satisfaction opportunity may be identified (process improvement). A database is required to track all reports, with clear ownership assigned for the resolution of each defect. In many cases, defect analysis leads to QA corrections and small projects. Less frequently, defect analysis highlights major care gaps that require larger CQI projects or programs to introduce new processes and potential organizational changes. The triage step will determine which defects need resolution and in what timeframe.

Periodic compliance audits

There are two key metrics in a quality program. The first is whether patient satisfaction is improving and on track to achieve our goal. We can influence but not control this metric – our patients will tell us. The second is under our control: do we pass our internal quality audits? Audits assess compliance with our QMS and our operational processes. It is doubtful that we can achieve our external goal if we do not achieve our internal goal.

Translating theory into action

At the Ottawa Hospital (TOH), many examples demonstrate the successful application of the key performance factors listed above. Quality is the first of five directions in the TOH strategic plan.[25] TOH has taken a number of significant steps to actively support culture change and to encourage front-line quality initiatives in support of improved patient satisfaction. It has established a Quality & Patient Safety Department, including the Centre for Patient Safety, to offer technical expertise/tools, and to provide forums to share ideas and promote best practices.[26] One key accomplishment of this group was to facilitate/expedite the approval of QI projects by the Research Ethics Board. This step removed a major roadblock that prevented many quality projects from starting. The TOH-wide electronic health record system (Epic, Verona, Wisc., USA) will provide a framework for more front-line input into processes, directly impacting patient satisfaction.

However, in my experience, the success of executive-led projects is not necessarily matched by that of front-line initiatives. Recommendations from patient satisfaction surveys, feedbacks, and related pilot projects at the unit level have not been fully operationalized, regardless of findings. Management may be reluctant to discuss either organizational or process change. It is difficult to tell whether funding or resistance to change is the real problem; as a result, patient satisfaction opportunities could be missed.[27,28] On the other hand, larger executive-led projects, with end-to-end funding, have better success.

An example of a larger comprehensive CQI activity at TOH is the Lung Cancer Care Project.[29] This 2.5-year project was initiated to improve patient satisfaction by reducing wait times. The result was an impressive reduction from 92 to 47 days from referral to initial treatment. Sustained management and executive support resulted in the redesign of 12 major patient flow processes, 57 workflow changes, and the removal of 270 constraints. Resources were provided for consultation, system design, and software development.

This project developed the Ottawa Health Transformation Model within the TOH strategic plan framework to help align the key domains of people (culture), processes, and technology. Process documentation and integration were built into the automated workflow management system. Defect management was provided by a project management steering committee that met weekly. Regular audits track performance via a dashboard that reports performance indicators for each process step. Most important, this project has introduced a sustained cultural change that has resulted in improved satisfaction for both patients and staff/providers.

Conclusion

Quality goals cannot be achieved without strong, visible executive commitment reinforced by active leadership at each organization level. The six key performance factors will help leaders introduce the cultural change that is required to enable front-line clinicians to drive change in the system and raise our patient satisfaction metrics.

Although executive-level projects often succeed, front-line initiatives often "die on the vine." Lower-level management needs concrete patient satisfaction improvement objectives to force them out of their comfort zone, take on risk, and support meaningful quality projects, leading to continual operational improvement. Management appointments should likely be shorter to encourage innovation; long-duration appointments tend to encourage complacency.[30]

It is true that health care is a complex system; however, large, complex private-sector companies have successfully navigated the quality challenge. We can do this.

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This article has been peer reviewed.

OPINION

Thriving health care demands thriving physician leadership

A simple approach to 21st century physician leadership

Steve Foran, PEng

The presence of exponential change and the absence of thriving physician leadership create the perfect storm that could leave the health care system vulnerable to disruption and possibly make the system, as we know it, irrelevant. On the other hand, thriving physician leadership has the potential to be the catalyst to drive internal change and create a thriving health care system of the future, one that Canadians will continue to rely on as they have for generations. Thriving physician leadership, while difficult to achieve, is extremely simple and is best developed by building a more grateful frame of mind.

It is critical that we get health care right so that, as a system, it thrives. For me, we need to get it right so that every Canadian can live a respectful, dignified life.

It's naive to think that the existing system won't be disrupted. The exponential growth and change in technology and science are driving disruption in all industries, and health care will not be immune. Given the magnitude of the public investment in health care, this disruption is likely to come from outside the system. Frankly, the potential financial reward creates an attractive incentive for the private sector to disrupt the system.

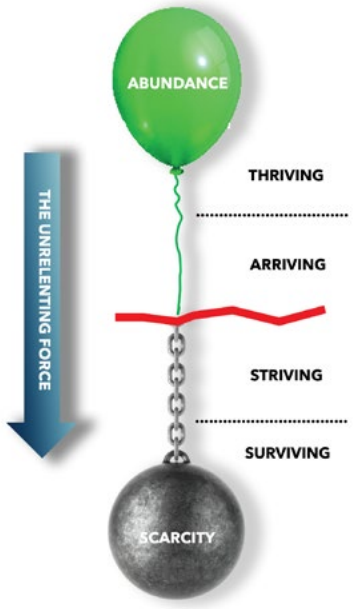
I was at a conference last fall where Peter Diamandis spoke on innovation and disruption.[1] When asked about how disruption will happen in highly regulated industries that are slow to embrace change (with reference to health care), Diamandis was emphatic. Paraphrasing his words: disruption will be driven from outside the industry and it will make the current system irrelevant. These words still reverberate in my mind, given that he's a MD with a breadth of first-hand experience in the field of applied innovation. We can have well-equipped hospitals with the most advanced technology and the best models of care, but a thriving health care system also requires thriving physician leadership to deal with disruption from outside.

I've come to learn that, although I don't like discipline, I much prefer self-discipline over external discipline. If I will be disrupted, I would prefer to be the disrupter rather than someone else doing the disrupting. This is where leadership comes in.

If asked to describe leadership in a single word, 10 people are likely to use 10 different words. For me, that one word is "influence." Leadership encompasses both influence over oneself and influence over others. Your ability and my ability to influence are determined by our mindsets, which are shaped by our established attitudes and beliefs. Our mindset determines how we make sense of the world and dictates how we show up as leaders. Figure 1, The leadership mindset hierarchy, illustrates four possible mindsets from "surviving" to "thriving."

Before examining each of the four mindsets, it's important to note that you don't have to match every single characteristic associated with each level. In fact, you may be at a point between levels or, depending on the day, you may switch from one level to another. The bottom line is that there are exceptions, so you don't have to perfectly match the definition to understand where you spend most of your time on the leadership hierarchy.

Figure 1. Leadership mindset hierarchy[2]



Surviving

Surviving is drudgery; your world is a battleground. It feels very lonely and overwhelming. You just can't seem to get to your priorities and, when you do, it seems like another one or two priorities have been added to the long list. You suffer from poor sleep and don't pay attention to what you eat. Exercise would help relieve your stress, but you never exercise; there's no time and, if there were time, you would want to just relax. When you look at others, it seems like everything is stacked against you and what you're trying to achieve. It is hard to muster the energy to move forward, and it seems that you're constantly crushed by financial pressures and plagued by a myriad of challenges that never seem to end.

Striving

Striving is hard work. You are driven to succeed but there's seldom enough time in the day to get to everything, let alone work on your priorities. You find this exhausting. You say you get enough sleep, but deep down know you're fooling yourself. You know what you should be doing when it comes to exercise and nutrition, but you just don't have the time. You've got goals, but you are frustrated because you are not anywhere close to your desired progress, and when you look at what others are doing, you feel like you should be doing better than they are. You hate being unable to spend quality time and quantity time with family and friends or on the fun things you used to always have time for. Financial pressures and other life challenges regularly determine what you can and cannot do. You truly know and believe there is more to life, although there are days when it just doesn't feel that way.

Arriving

Arriving is a good place to be. You are generally satisfied in all areas of your life, but the feeling doesn't last – it's intermittent. This is also true with family, friends, and doing the fun things, when time just flies by. You've got it, but not as much as you'd like. You're regularly achieving your goals in all areas of your life, have no serious financial challenges, but are easily frustrated by others who you feel don't deserve the success they've attained. You're generally satisfied with the balance of exercise, sleep, and nutrition, feeling that, for the most part, it works. There are times when you feel that your life is controlled by others and your energy is being spent on the many challenges you face, rather than on the things that bring you joy and happiness. Some days you feel as if you're back to striving or surviving.

Thriving

When you are thriving, the world is your playground and you are very satisfied with all aspects of your life. You lead a meaningful, purpose-led life and compare yourself only to your own idea of who you want to become. Family and friends are important, as evidenced by the amount of time you choose to spend with them. When you are with them, you are present without distraction. You don't apologize for the time spent on hobbies and fun activities that bring you joy. While you may or may not be wealthy, financial pressures are virtually non-existent. You recognize your interdependence with the people around you by contributing with your unique gifts to those in your community, be it down the street or across the planet. You have lots of energy and enjoy optimal health because you adhere to proper sleep, diet, and exercise routines. You're not a health fanatic; you've just figured out that healthy living doesn't have to be a chore. You still have lots of challenges, but you neither let them define you nor let them get in the way of achieving your goals. You are busy but your schedule is controlled by you, not by others.

The unrelenting force

Within our brains is an unrelenting force that is constantly pulling us back down into survival mode. It is composed of two smaller forces. The first is negative attribution

Contrast the characteristics of the two mindsets:

Surviving mindset	Thriving mindset
• not enough resources (scarcity) • winners and losers – competition • based on fear • narrows options • triggers avoidance behaviours • doesn't feel particularly good	• acknowledges resources present (abundance) • mutually beneficial – collaboration • based on openness and love • expands options – broadened thought, creativity, and possibilities • induces approach behaviours • generally feels good

bias, the human tendency to focus on the negative, inducing fear-based behaviour. The second component is adaptation. A universally relatable example is compensation. Remember your first pay raise? You were happy for a while but within a month or two, you adapted and, suddenly, your new pay rate was no longer enough, leaving you with a mindset of scarcity.

The invisible barrier

Finally, there's a menacing invisible barrier between striving and arriving that keeps most people stuck in the struggle of scarcity and survival. The barrier appears whenever you let your guard down by losing sight of a simple but powerful belief: you are worthy and have much to be grateful for.

When you lose sight of this belief, the barrier appears. It disappears when you consciously hold the belief. The barrier can't be seen, but it continually influences your mindset and the way you think, feel, and act. The highest risk for the barrier keeping you in survival mode is when you are caught off guard by a hectic patient schedule, when you're overwhelmed by administrative demands, when you get into an argument with your spouse, or from any of the countless workplace or life stressors.

Obviously, our goal is to spend more time thriving and less time surviving.

Martin Seligman, the founder of positive psychology, developed the PERMA model for human flourishing (think thriving) which is rooted in 24 positive character strengths, such as hope, openness, bravery, and honesty.[3] Because it is difficult to work on 24 strengths, Scott Barry Kaufman, one of Seligman's colleagues, asked, "What if we can work on just one? What is the single character strength that is the best predictor of a flourishing life?"[4] So, as part of a larger study on introversion that involved more than 500 participants, he did an analysis on what is the best predictor of human well-being. He found that only gratitude and love of learning independently predicted well-being, and the single best predictor was gratitude.

My struggle to thrive

Last year, our son Nick had a full hip replacement four days after his 28th birthday. He had no serious accidents nor sports injuries growing up, and the cause remains unknown. Only one hip was affected; no sign of arthritis. As parents, it was upsetting to learn that one of our kids required a procedure of this magnitude. There was the heartache we felt because of the pain he had been living through, and the impact the surgery would have on his life during recovery. This was magnified by the uncertainty it held for his future, knowing this wouldn't be his last hip surgery, either. There was the anxiousness as we approached the surgery date: "What if something goes wrong during surgery?" All of this thinking was survival thinking, which is quite natural; however, it did not need to define how we dealt with the situation.

I was committed to finding good in the situation. I asked, "What's good about the fact that Nick needs a hip replacement at age 28?" I surprised myself with how quickly the list began to grow.

- Nick would no longer be in pain
- He had a top-notch surgeon, who had successfully completed this operation thousands of times
- Our health care system took care of the expenses, so it wouldn't encumber him with any financial burden
- Nick was in good physical shape, so his recovery would go quickly and he'd be back to normal life in no time
- He was able to get the surgery scheduled quickly and conveniently between his school terms, so it had little impact on his education
- Although the new hip is unlikely to last him the rest of his life, technology is making replacement hips last longer and longer, so he may only need one more
- Nick had a very positive approach to dealing with this
- His wife Kelsey was there to care for him and help him through his recuperation
- He was able to borrow a walker and a few assistive aids without any cost to himself

This list of "good" was reassuring to me as a father. The fact that I can see so much good in this

situation doesn't mean that I don't care or that I'm not compassionate about the pain and suffering our son experienced or would have to deal with through his recovery. It was quite comforting because, like any human, in the lead up to the surgery, I could feel the unrelenting force at work. "What if something bad happens during surgery?" "What if he doesn't wake up?" Pragmatically, I had little control over either of these nagging concerns, but I would go back to my list of good and realize that my survival mindset was trying to mislead me.

"Look, we've got a very talented surgeon who does this surgery almost every day – a couple times each day – and he does it very successfully!" My ability to see the good in the situation, allowed me to turn to logical evidence, which helped me deal with the less than ideal aspects of his circumstances. It returned a sense of control to my world for something that I had absolutely no control over. More important, being able to see the good in this very serious situation prevented anxiety, fear, and a survival mindset from spilling over into the other areas of my life.

As a physician leader, you work within a health care system that is stretched to its limits. To transform this into a thriving health care system, now more than ever, we need thriving physician leaders, who are unwilling to be defined by the daunting challenges they face.

In a recent study, researchers asked acute care nurses in Oregon to consider everyone who thanked them – patients, families, physicians, charge nurses, or co-workers.[5] They found that being thanked more often at work was positively related to a nurse's satisfaction with the care they provided that week, which subsequently predicted sleep quality, sleep adequacy, headaches, and attempts to eat healthily.

To be a physician leader who expresses gratitude and brings about a culture in which the entire health care team feels appreciated, it is critical to develop a grateful mindset. The most researched and proven way to do this is to create and maintain the daily habit of making a list of three items for which you are grateful.[6] Don't rely on making the list in your head; write it down or record it electronically. Give this new practice a few weeks and notice the improvements you experience. Try this one habit, and if you want to know more about grateful leadership, email me: **steve@gratitudeatwork.ca.**

Although building a grateful, thriving mindset is not easy, it enables us to navigate the complexities and challenges of life in a collaborative, proactive manner. Each person has his or her own natural disposition to being grateful, and everyone has their own share of life challenges and tragedies, making it easier for some people to find gratitude and more difficult for others. As we develop the practice of gratitude, it becomes easier over time, and our disposition to gratitude increases. Although not a magic pill that will cure everything, if practised on a regular basis, gratitude has the power to induce positive disruption from within the health care system. That practice of gratitude begins with each one of us.

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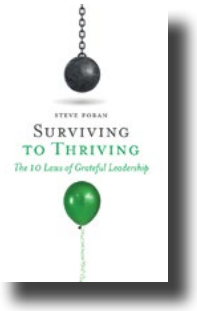


PERSPECTIVE

Will barbers regain their role as medical practitioners?

Milton Packer, MD

Reproduced with minor modifications from a blog post on MedPage Today[1] with permission from Dr. Packer.

Until recent history, people did not seek the expertise of a physician in the hope of a cure. Doctors primarily provided comfort by the compassionate communication of a diagnosis, often accompanied by the symbolic prescription of herbs and salves. The physician acted as a supportive guide to the unfolding of a natural course of events. This approach is embodied in one of Hippocrates' pronouncements, "Cure sometimes, treat often, comfort always."

In the first millennium of the common era, physicians were in short supply. The talented few lived an elitist existence, typically attached to wealthy or powerful royal families. Famed physicians, such as Galen and Avicenna, were able to formulate ideas and write books, because they were supported by wealthy patrons. The poor, who had no access to physicians, turned to the clergy, who spent much of their time practising medicine. Building on existing relationships of trust, priests could attend to someone's physical and spiritual needs simultaneously. However, the church believed that spiritual men should not be focused on worldly cares. Thus, during the latter half of the 12th century, it insisted that priests were "expert physicians of souls rather than to cure bodies."[2] The practice of medicine was strictly forbidden, especially when it required cutting or burning.

Where then would a "commoner" go for procedural interventions? Barbers – with their expertise with knives and razors – stepped up to fill the need, by offering a wide range of surgical procedures to their customers. On a given day, they might provide a haircut, an amputation, a tooth extraction, or the application of leeches. All of these filled the barbershop with blood and bandages. When wrapped around a pole, they formed a spiral of red and white stripes. The original barbershop pole with the red and white stripes was born in France; later the United States added a blue stripe for patriotic reasons.

From the 12th century onward, the expertise and practices of physicians and barbers became distinct, leading to a troubled relationship between the two groups. Physicians who received university training believed they had privileged access to specialized knowledge and felt superior to the barbers, who had no specialized education and treated only commoners. To highlight the distinction, physicians insisted that they wear long robes, while barbers could wear only short robes. The practice of long white coats for physicians and short white jackets for barbers persisted into the late 20th century.

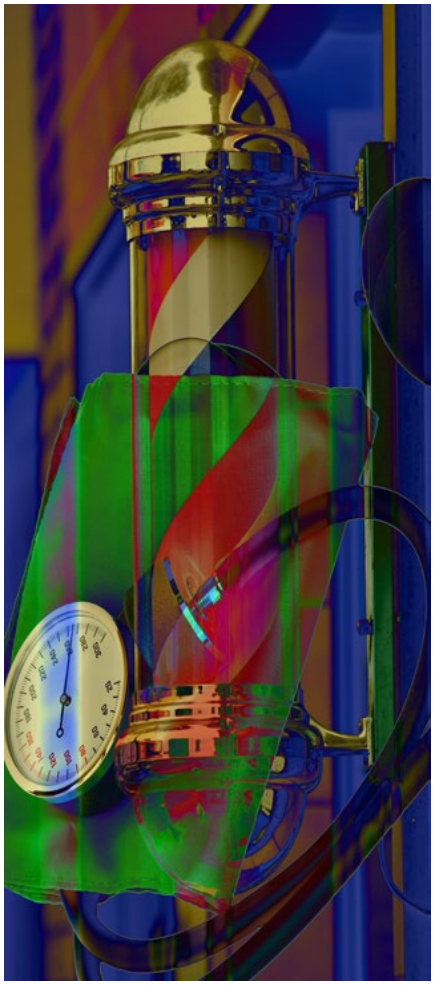
Surgeons eventually differentiated themselves from barbers in the 17th and 18th centuries, but physicians and surgeons remained distinct specialties for several hundred years. When surgeons eventually co-mingled with physicians at medical schools, they wore long white coats – to emphasize to the world that they were not barbers, but were now part of an elite profession.

The elitism of physicians and surgeons provided great satisfaction to those with a medical degree, but little comfort to patients. From the 1940s through the 1970s, the relationship between doctors and patients was distinctly hierarchical. Physicians presented themselves as the authoritative source of medical knowledge and did not expect to have their recommendations

questioned. That is not to say that physicians lacked compassion. Indeed, if a patient could find a knowledgeable and kind medical doctor, the bond between the two was therapeutically powerful. Under these ideal circumstances, physicians could provide both comfort and a cure, and, in return, patients provided gratitude and trust. That trust was the centrepiece of the therapeutic relationship. However, over the past 30 years, much of the trust that grounded the patient–physician relationship has been undermined. Today, physicians often seem determined to spend as little time with patients as possible. The history and physical exam are perfunctory, and questions are frequently swatted away with little time for listening. In response, admiration for physicians has waned and patients have become suspicious of physicians' motives in prescribing medications or recommending procedures, resulting in low adherence to treatment.

Adherence is particularly problematic when people need to take multiple medications on a daily basis for years for an asymptomatic condition, such as hypertension. Hypertension is poorly controlled in the community – particularly in socioeconomically disadvantaged populations that are often also mistrustful of their interactions with the medical profession.

To solve this problem, Dr. Ronald Victor, a hypertension specialist, asked what would happen if we could identify a trusted individual within the underserved community who could be trained to measure blood pressures and provide emotional support for treatment? People would interact with this trusted individual on a regular basis to obtain measurements of blood pressure and reinforce the use of medications.



The solution: the barbershop. The barbershop plays a central role in the social fabric of black men in underserved communities. Men visit barbershops on a regular basis, and each has a relationship of trust with his barber, established through repeated and often personal conversations that transpire during the haircuts. As a result, the barber was perfectly positioned to measure the blood pressure of every client at regular visits, and then immediately connect those with hypertension to specially trained pharmacists to prescribe generic medications on site.

Dr. Victor and his colleagues carried out a cluster-randomized trial to prove that his idea would work.[3] They recruited 319 black male patrons with hypertension from 52 black-owned barbershops. In half of the barbershops, men were assigned to the barber-pharmacist intervention, and, in the other half, barbers simply encouraged lifestyle modification and doctor appointments. After 6 months, a blood-pressure level of less than 130/80 mmHg was achieved by 64% of the participants in the intervention group versus only 12% in the control group!

Why did the idea work? The men paid attention to their blood pressure and took their medications because the treatment was based on a relationship of trust that transpired in a place of trust. In contrast, their hypertension was not controlled if the men were simply reminded to see their physicians.

The historic parallels of this study are striking. About 1000 years ago, barbers stepped up to provide essential medical care to underserved communities who had no access to academically trained physicians. Now, barbers are stepping up again as trusted members of the community to link people to essential treatments that they would be reluctant to take if prescribed by a physician.

In many ways, the divide between those who provide care and those who need it has not changed over the past 1000 years. Ten centuries ago, academically trained physicians were not interested in treating commoners. In the current era, underserved populations do not trust physicians to care for them, perhaps because they believe that physicians are driven by self-interest. The patterns of disconnect a millennium apart are eerily similar.

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Note from the editor: This article reinforces the idea that relationship-centred and whole-person care are more important than the older paradigms, patient-centred or physician-centred care, which only focus on one element of the relationship. Dr. Victor's study also demonstrates two underlying principles of the LEADS framework at work: caring and distributed leadership. Caring is as important in healing as curing, and healing works best within the context of distributed leadership and shared responsibilities.

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Correspondence may be provided online at MedPage Today: **https://www.s4me.info/threads/will-barbers-regain-their-role-as-medical-practitioners.7228/**

Coaching competencies for physicians

Nancy M. Merrow, MD

In this article, I am proposing that physicians and medical leaders draw on the growing knowledge base within the profession of coaching and use related competencies to broaden their skills in encounters when change is being contemplated. The ability to advance those conversations to goal-setting and being held accountable and empower the individual to draw on their own resources in problem-solving is a widely applicable skill set in medical practice, teaching, and leadership.

KEY WORDS: coaching competencies, goal-setting, artful questions, accountability, behaviour modification

The International Coach Federation defines coaching as "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential."[1] In medical practice and leadership, there are many opportunities to explore a coaching style of interaction. Whether you are interacting with patients, trainees, peers, or whole programs and departments, having a method of communication that inspires and enables behaviour change is a useful skill. Whenever you are faced with a person or group that wants things to change, there is an opportunity for coaching.

Use coaching competencies when the issue at hand will only be resolved if the person takes action.

Coaching is not the same as mentoring or sponsoring. A mentor is someone who has traveled the path that the mentee is on or wants to be on. The mentor shares experiences and offers wisdom, advice, and connections that accelerate the mentee's achievements. A sponsor is someone who has recognized someone's talents and potential, and supports their progress and advancement when opportunities arise. Some of us never know who our sponsors have been.

Coaching is focused on building capacity in the person being coached (the coachee), such that the achievement of their goals is fully credited to their own commitment to action. A coach uses artful questions to clarify the coachee's goals, help to align their aspirations with personal values, increase their commitment to action, and hold them accountable to their intentions. In a formal longitudinal coaching engagement, there is a specific rhythm to the encounters that the coach uses to continuously build on the stated goals, steps taken, and results achieved by the person. We are not suggesting that the physician is in coach mode over extended periods; however, we see the coaching style of conversation as one tool that can be very useful once the physician has explored the utility and circumstances that make it powerful.

A model for "coaching as medicine" was co-created with my colleagues, Dr. Cecile Andreas, a family physician and Certified Executive Coach in Cranbrook, British Columbia, and Dr. Jamie Read, a family physician and Certified Executive Coach in Toronto, Ontario. At the Canadian Conference on Physician Leadership in 2016, we described various communication techniques that focus on changing behaviour, including brief action therapy, cognitive behaviour therapy, and

motivational interviewing. Most clinicians have some knowledge of one or more of these techniques, and each has a place in the compendium of methods used in practice. We introduced coaching as a related competency that is applicable with patients, with trainees, with colleagues, and with others when you have a leadership role.

The coach does not give advice. The coach presumes that the person being coached is fully capable of making choices and taking action.

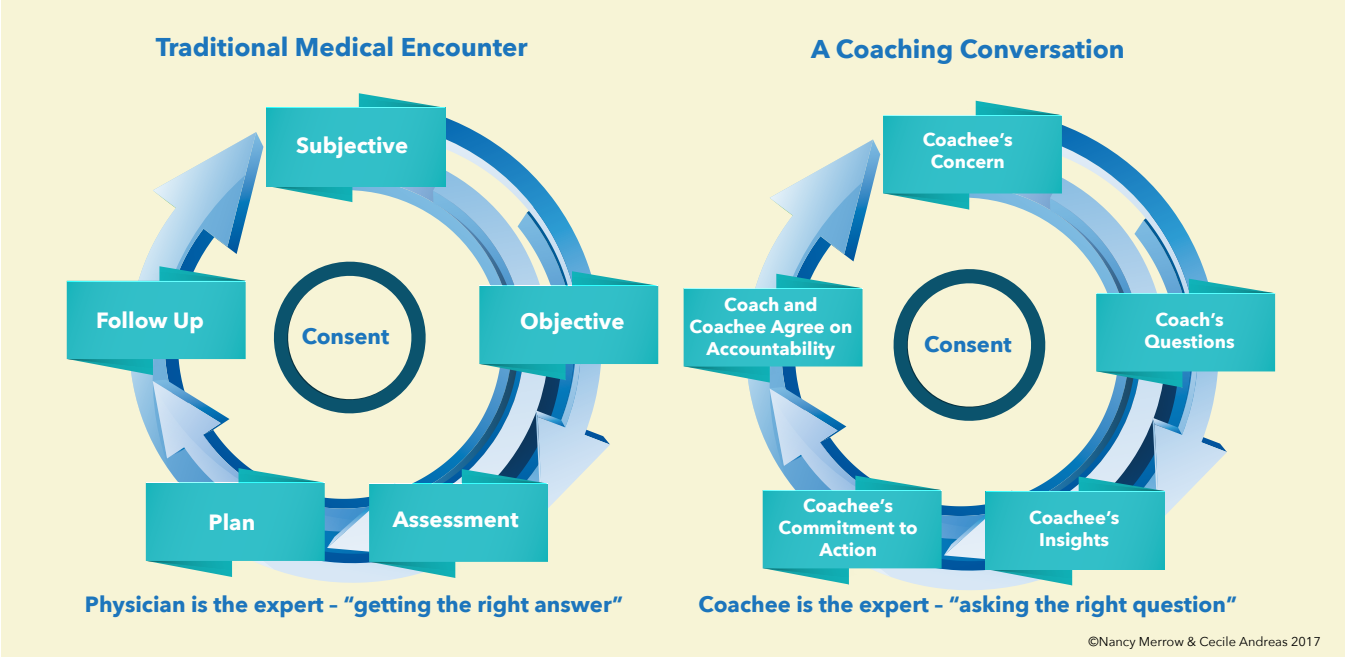
Coaching is not therapy. In the world of medical practice and leadership, your "client" may be a patient, a trainee, a colleague, or someone who reports to you as their boss or leader. In this article, I am proposing that physicians and medical leaders can draw on the growing knowledge base within the profession of coaching and use related competencies to broaden their skills in encounters when change is being contemplated. The ability to advance those conversations to goal-setting and being held accountable and empower an individual to draw on their own resources in problem-solving is a widely applicable skill set in medical practice, teaching, and leadership.

A fundamental premise of coaching is that the coach holds the stance that the coachee is fully capable of managing their own life and circumstances. If this is not the case, coaching is not the correct technique. Coaching is initiated by a person who has an issue that they are trying to address. They may feel stuck. They are asking the coach to help them, and the coach takes a positive, appreciative, and curious approach to how the person is pursuing their goals. The role of the coach is to create a relationship within which questions can be asked that provoke the person into new insights about the issue, the options, and the person's willingness to act. The coach holds the person accountable for their stated intentions.

In the illustration below (Figure 1), we compare the traditional medical encounter with a coaching session. In any kind of "helping" encounter, the consent of the person being helped is essential and should be explicit. The coach asks the person whether they want to be coached. As in a clinical encounter, confidentiality is of the utmost importance. Many issues that lend themselves to the coach approach are intensely personal and challenging for the individual and must be held in a safe space that develops between the coach and coachee.

At the beginning of a coaching session, the coach uses questions to establish clarity on the goal for the dialogue. The goal belongs to

Figure 1. Coaching versus medicine



the coachee and the coach sets aside their own agenda for what they might hope will be achieved. It is essential that both parties are committed to work toward the agreed upon goal of the session. The three Cs – *consent, confidentiality*, and *commitment* – are common to clinical work and coaching.

In a traditional medical encounter, using the SOAP format, the clinician gathers *subjective* information by asking specific questions to elicit and understand the patient's complaint. The questions are structured to add to the history of the complaint with pertinent positive and negative details. Generally, the clinician is using information to narrow down possible causes of the complaint and form a differential diagnosis. *Objective* input is obtained by physical examination, observation, and various investigations as appropriate. The assessment is reached by the physician using information, diagnostic acumen, and experience. A plan is proposed to the patient, and the next step is agreed on, including who will do what, and how follow up will occur. In the sometimes-hectic pace of clinical encounters, the rhythm of the cycle is often very rapid, but identifiable.

In a coaching conversation, the cycle is also identifiable and can be closely aligned with the clinical skills physicians use every day. The coachee brings a concern. The coach focuses very carefully on what the person wants and helps them frame it as a goal. If the goal is not clear, the rest of the conversation will not likely yield a fruitful next step or plan. The clinician, in coach mode, uses questions to clarify the person's goal and to help insights emerge from the person. Artful questions will cause the person to reflect on what they need to do and what needs to be different to make progress toward their goals. It takes practice to design your questions for the best impact. The coach maintains a firm attitude of non-judgemental belief that the person can make choices and take action on their own issues.

When acting as a coach, the physician checks often to ensure that the coachee is comfortable with the conversation. Challenging a person and holding them accountable in a relationship with a power or authority differential requires tact, kindness, and authentic concern for the psychological safety of the person.

The coach works hard to resist offering advice. The coach ensures that, at all times, the person maintains ownership of the issue, the potential solutions, and the next steps. The plan belongs entirely to the person, who takes away the tasks necessary to achieve the next step toward their stated goal. The coach ends the encounter with establishing how the person wants to be held accountable for their commitment to next steps and may participate in some way, such as agreeing to another session or receiving a message about tasks accomplished.

In a traditional medical encounter, the clinician has most of the responsibility for flushing out the likely causes of the patient's complaint, for knowing the possibilities that need to be investigated, and for proposing plans of treatment. The clinician is the expert and is focused on finding the right answers. In coaching, the coachee is the expert and the coach's job is to ask the right questions. You will know you are on the right track when the person pauses after one of your questions and then states an intention. When the intention arises, the coach uses more questions to define the level of commitment to act. A wrap-up question that establishes what will be done and by when leads to the coach asking the person how they would like to be held accountable. The responsibility for progress toward the person's goals rests completely with them, and the coach helps by reliably following up on the accountability plan that they agree on.

There is no need to spend excessive amounts of time to use the coach approach. It is just a different way of managing the structure of the conversation, and we have had lots of experience with brief interactions no longer than the average office appointment that create the right atmosphere for change.

Try these questions to change the conversations you have with people about their goals. Notice the coach generally does not ask "why," as this requires the person to justify their approach. The best non-judgemental, open-ended questions start with what and how.

There are related competencies in the field of medical practice that do not need to be duplicated in a coaching model.

Table 1. Sample of artful questions to use when adopting the coach approach

• What will get you moving on this?
• What is getting in your way
• What is keeping you from acting on this?
• How important is this to you on a scale of 0-10?
• How confident are you that you can make this change on a scale of 0-10?
• How can you clarify what you need to know?
• What are the resources you will need?
• What would change your attitude about this?
• What would make it easier for you to take risks?
• What do you believe will happen if you make this change?
• What would be different if you resolved this?
• What is the worst thing that could happen if you did that?
• What three things could you do to manage that scenario?
• Is there another way?
• What is most uncomfortable about this change?
• What if nothing changed?
• What is one decision you can make to get things going?
• What is one thing that would make the biggest difference in your life?
• What support do you have to address this challenge?

Core competencies for coaching

Our adaptation of coaching competencies to the clinical setting and medical leadership has a place in your toolkit of behaviour modification techniques, in the management of situations that depend on the patient or person making choices, decisions, and changes. The goals and the solutions are theirs. By acting as a coach when people bring you problems that are within their control, not yours, you build their capacity for problem-solving. Further, the relationship is clarified and strengthened, whether it is doctor–patient, teacher–student, or leader–team member.

There are related competencies in the field of medical practice that do not need to be duplicated in a coaching model. In a series of articles in future issues of CJPL, I will adapt eight core competencies for the coach approach for physicians and medical leaders and discuss the specific skills that comprise each (Figure 2). At the Canadian Conference on Physician Leadership in April 2019, we explored "Listening at the next level," which will be the focus of my next article.

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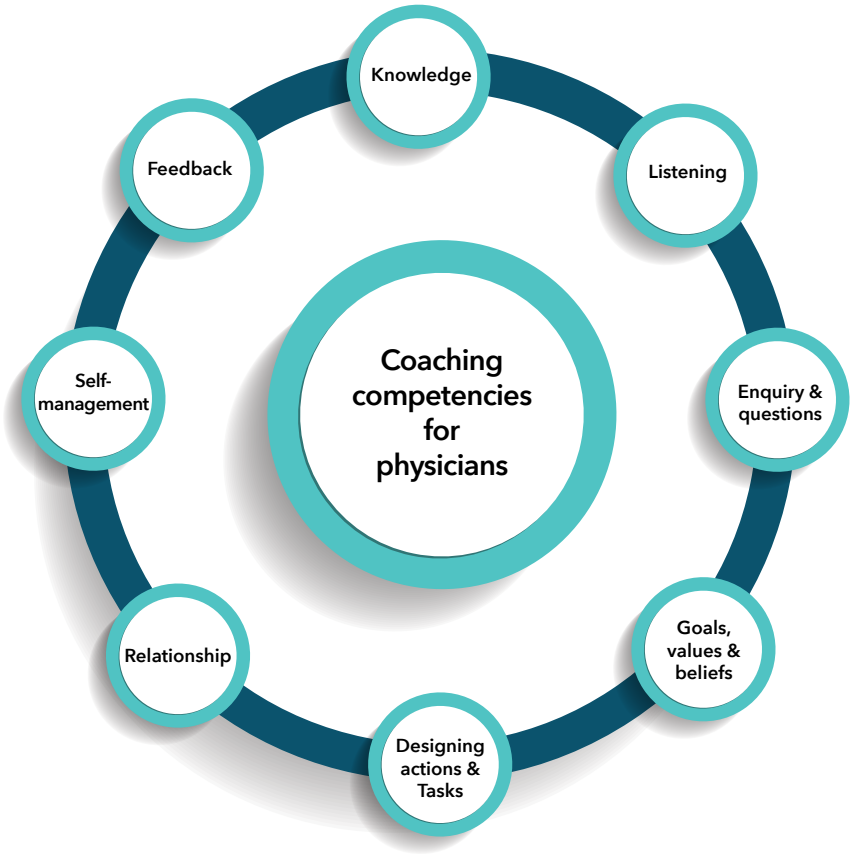
Figure 2. Core competencies for the coach approach



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Engagement: it's all about the *how* of implementation

P. James A. Ruiter, MD

Implementation of initiatives is a challenge – change always is. But understanding the current context, in both engagement and safety, reveals some important insights into an approach for successful implementation of patient safety initiatives. In this third and final article of a series, I present a way forward, based on work with over 300 health care teams using the moreOB program approach.

KEY WORDS: quality improvement, patient safety, physician engagement, implementation, resilience engineering, complex systems

In parts 1[1] and 2[2] of this series, we made the case that, to effect meaningful and sustainable improvement in the quality and safety of health care, it is essential to re-engage front-line staff. However, physicians and front-line staff need to know that their input is valued and that, when they do engage, their reward for doing so is timely, relevant, and needed change.[3,4]

Accordingly, *ownership* is required, not *buy-in*.[1] The front-line team must help identify the problem, own the problem, develop an effective solution, and implement it. Leadership's role is to build the infrastructure and provide the capacity to support the approach. Leaders become the enablers of the process.[5]

Rebuilding engagement

Developing front-line ownership to support the implementation of projects requires leveraging those who understand how the work is actually done and can, therefore, best project how any change will impact them within a complex and adaptive system.[1,3,5-8] There is little doubt that an ownership-focused approach needs guidance, nurturing, support, and time. However, once established, the unit flourishes and transforms from reactive to proactive.[9] This investment is what Gardam calls "going slow to go fast" (M. Gardam, personal communication, 2018).

In our experience, successful engagement requires the leadership of a small representative interprofessional group from the unit.[10,11] This core team is the driving engine of successful change.[7] It must represent every professional group in the given unit. Its role is to select and prioritize relevant improvement projects, develop interventions, and manage their roll out. This "engine" may not, at least initially, feel comfortable in this role and it is fragile: it must be nurtured and empowered.

To effectively implement change, the core team needs to be unranked, a heterarchy, which is visibly supported by the formal organizational leadership.[7] Such nurturing is not a traditional role for leadership, but without it, meaningful and creative improvements that really work in the specific context of the unit will be stifled.[12] Support can only occur following organizational alignment. Although the capability of the core team is important, only the organization can provide the capacity for the team to exercise its newfound capability. Without organizational alignment, leadership, both at the meso and macro levels, will not support the core team or its recommendations, and lack of engagement will persist. Finally, a key requirement for the team to thrive is progressive movement toward the establishment of a psychologically safe unit, one where people are not hindered by interpersonal fear.[13]

It is important to enable the core team to experience success quickly. Early quick wins built into implementation plans will rally the rest of the department

and encourage the core team to continue its work. Although continuity is valuable, turnover on the core team is also important to prevent its burnout, allow for fresh ideas to germinate, and prevent the formation of a new hierarchy.

Although traditional department leaders may not be the best choice to lead the core team, they need to be present to facilitate realizing the identified changes. Ideally, the core team should be led by front-line staff and include balanced representation of the professions that make up the unit. As such, having interprofessional co-chairs is optimal.

Re-integration of safety into quality

The team must work on a relevant intervention meaningful to the majority of the unit, and not seen as directed from the top down. This helps develop ownership and addresses the ever-important question: what's in it for me? The intervention should be built on a robust continuous quality improvement (CQI) framework, one that helps make the improvements "sticky." It also offers the opportunity to re-marry safety with quality.[1,11] The use of a robust CQI framework makes sure that every part of the intervention has a deliberate purpose in achieving the chosen goal within a human-centred work environment, one that understands and supports how people learn, unlearn, and apply.

The initial focus of the core team should be on closing the unit's perceived quality gaps. Focusing on perceived gaps helps ensure the relevance of the project to most. It allows for quick wins, and develops comfort and skill in the core team's growing capabilities. As the core team matures, structures must be put in place to help identify the unit's un-perceived gaps. This approach is proactive and adds to a positive culture, which further supports the re-engaging of staff. Of note, none of these activities is a reaction to harm events; as a result, most of the improvement in the quality of care occurs within a positive context.[2]

Key elements of a robust CQI framework

It is a given that psychological safety is being built while the process described is being developed, and that every activity is interprofessional.

1. What have we learned that may be important for our unit/department to work on? What is the gap?

2. Is the gap relevant to our unit/department, population served? Endeavours that are not relevant to the unit or wider team should be abandoned. If they are relevant: what would success look like? In other words, what are we trying to achieve? How much? By when? What are the measures?

   It is important to find measures that speak to the unit and are likely to improve sooner rather than later. They become the reward for engagement; these are leading indicators – pulse points or vital signs.[14,15] Avoid overabundance: one or two measures per project are fine. This will help avoid data glut.[1]

3. An intervention, led by the core team to close the

gap, needs to be built and executed. To be successful and support the process as well as the way humans learn and unlearn, three fundamental elements are required:

- What individual learning activities must be completed by each member of the larger team – as base knowledge – to begin to close the identified gap? Identifying these allows all staff to begin a discussion on application of knowledge within their unique context with the same evidence in mind.
- Although a common knowledge base is necessary, it is not sufficient: the translation and application of knowledge to practice within a unit's unique context must occur. This is a "contact sport."[16] For knowledge to be applied successfully in a complex system (which requires an approach agreed on by all professions), it must be processed through an interprofessional venue[6] – unit-wide workshops or in-situ simulations – designed to question and challenge the status quo.[17] Knowledge must be assessed through the lens of every profession in the unit for it to be applied in the most effective way in that unit's context. As a result, the interprofessional venues are not lectures, but case discussions that challenge the unit to discover how best to apply the knowledge in the unit's unique setting. This is how robust solutions and harmonization of care occur: the re-integration of safety into quality.
- Finally, as humans will revert to older ways through habit, a reminder-process with a view to sustainability of the new must be integrated into the intervention. When the core team moves on to its next project, what has been left in place to act as a reminder to embed the newly agreed-to knowledge in the fibre of the unit?

4. Reflection then occurs: analysis of the success and challenges in achieving the measures and going through the change process. An understanding of what worked well, and what did not, makes the core team more and more effective and efficient as it tackles new projects. This is the fast part of Gardam's phrase, "go slow to go fast."

Quick wins

At least one or two of the recommendations that come out of the interventions, that are relatively easy to implement, and that have tangible impact should be initiated and communicated quickly. This visible action helps reverse the trend of disengagement and builds evidence that the front-line's voice is valued.[4]

Experience suggests that if some recommendations gleaned from interprofessional venues cannot be enacted within 2–3 weeks, it is probably better not to start – the organization is simply not ready. "You only have one opportunity to make a good first impression." If the core team fails on launch by not creating meaningful change as perceived by the unit, engagement will be the victim. Disrupting traditional processes and applying recommendations swiftly to see tangible benefits is critical in making the core team, and the process, successful.[7,18]

Remedies to linear thinking

In-situ simulations (an example of an effective interprofessional venue) can act as remedies to linear thinking.[7] They offer an opportunity to stress organizational processes and their safety boundaries.[18] They foster an awareness of the interdependencies among professionals that is essential to robust successful quality improvement efforts supporting a resilient organization.[19] The perspective of each profession is important in finding the local solution to the local problem; every profession seeing the problem through their unique lens facilitates creative, comprehensive, and durable solutions that reduce the organization's vulnerability.[3,20] Furthermore, the activity can function to build trust and develop the interprofessional team culture.[13]

Reconciling WAP with WAD2

It is in the interprofessional team-based venues that one begins to reconcile work as prescribed

(WAP) with work as done (WAD). True psychological safety must be established to encourage the small voice in the back of the room to state: It is all well and good that our policy says X, but we had Mrs. Smith here last week, and we did Y. These moments are key to understanding how to learn from the way work is actually done.[18] When research evidence is placed in tension with the health care workers' experiences, it leads the team to accept a social proof and develop a unit-based harmonized approach: evidence-based practice. Quality and safety are reunited so that the solution fits as well as possible into the unique context of that unit.[6] These opportunities need to be anticipated, nurtured, and facilitated for true relevant change to be accelerated.

Quality can be spread, safety is local[1]

Solutions in complex adaptive systems[2] do not travel well between contexts.[14] This explains why system-wide standardization attempts can fail. Although quality per se (the evidence) can be seen as "universal" and, therefore, is transferable, safety (or the *application* of the evidence) is site specific. As a result, some solutions just cannot be standardized, and health care teams implicitly know this. The willingness of all levels of leadership to visibly support and facilitate modification of processes to take into account local context is another win for culture, engagement, and safe quality care.[4]

Be deliberate

In the CQI-based approach, nothing is done by chance; everything is part of a deliberate plan led by the core team and communicated clearly. A simulation done on the unit or a series of interprofessional workshops are not tasks done by rote on a schedule, but an integral part of a quality improvement project specifically designed to arrive at tangible results. These results include the narrowing of team-selected gaps that matter to the unit. Everyone will know the why of any activity and how it relates to improvements on the unit. The path to success is easy to follow and visible to all stakeholders who want to know (always begin by working with those who want to work with you).

Guidance may be needed

Although the above elements are necessary, they may not be sufficient. Many core teams benefit from a coach who understands complexity science, high reliability organizations, organizational and behavioural psychology, resilience engineering, and the importance that relationships play in complex adaptive systems.[2,7] A partnership is established between the coach and the core team, who understand their own context, culture, community, geography, physical plant, etc.[7] After developing an implementation plan together with the core team, the coach keeps the team accountable to the timelines it has set for itself.

Furthermore, the coach guides the core team against using a poor solution for a problem, such as using a tool created for a complicated system but ill-suited to a complex one. The use of inappropriate tools leads to front-line fatigue, disinterest, disengagement, and continuation of work as done.[2] Combining the coach's expertise with current safety and quality improvement techniques, along with the core team's local context knowledge, experience, and skill, helps core teams successfully navigate their unit's patient safety journeys.

In our experience, we find that engaging an external coach, who is not an employee of the hospital, is a strength and allows the coach to help the core team identify and remove barriers to success.

Evaluate to improve

The importance of evaluating the process of change by the rest of the department cannot be overstated. Measuring engagement of the larger team, in the intervention designed by the core team, is itself a leading

indicator of movement toward a culture of patient safety *by design* and of successfully embedding a powerful implementation engine that can then be leveraged for other projects. In this way, a powerful and robust process that respects how humans change and learn is developed, leading to a new culture *by design*; this, in turn, provides leverage for the front line to lead systemic changes necessary to advance safe quality care.

Routine debriefing

A final powerful approach to consider on your journey is the deliberate implementation of routine debriefing of normal cases. In health care we often debrief the bad, as we should. However, debriefing the good allows us to better understand how and why we managed to succeed, allowing us the opportunity to improve processes to recreate the good more often (again psychological safety is necessary for the unit team to be open in disclosing what work as done truly looks like).[13] It also allows teams to remedy small system glitches (and other un-perceived gaps) that may have been identified along the pathway of care, but never led to harm.

Furthermore, debriefing the good changes the safety and quality conversation. In hospitals that only debrief the bad, quality improvement occurs infrequently as a reaction to a negative outcome.[2] As a result, improvement occurs episodically and predominantly within a negative context. Debriefing when cases go well builds an increasingly positive culture.

What can physicians do?

Safety science has evolved to what is now known as its third era, while health care's approach to safety is, in many ways, firmly entrenched in the first era described by Heinrich in the 1940s and 1950s[19] – safety processes developed for systems that do not even come close to resemble the complexity of health care today. It is time to move forward, and physicians can, and should, play a leading role, no longer accepting out-dated approaches to develop improvements in quality and safety.

This series has looked at why, in general terms, the status quo is not working and is only serving to disengage the very people who are holding the system together. The status quo is neither supporting our colleagues, nor those we serve. Physicians can, and should, lead the prescription for change.

The approach presented in this article is not considered as an integral part of typical work for most professionals. However, it is clear that it needs to become so. Physicians are leaders in our health care system, and their involvement is integral as they invest in system improvements that improve quality of life at work and the quality of care their patients receive. The process described speaks of interprofessional work, a sine qua non for best outcome. It is about "going slow to go fast."

> It is clear... that the next great saving in lives (human life of those we serve and the professional lives of our colleagues) will not come from a new instrument or a new pill but from a well-executed, proven, effective, and reproducible patient safety approach that seeks to place safety into the DNA of our health care teams.[21]

As physicians invest in change – and in developing a culture *by design* – they mold the change. They can choose to be on the sidelines and be buyers of change created by others, and never find true joy at work – or they can be investors and own the change. At the end of the day: If not we, then who?

Conclusion

Engagement is all about the *how* of implementation. Leveraging ownership requires a complete understanding of what created the disengagement we all witness today. If it sounds like this series describes the growth of psychological safety and of a culture to bring about successful engagement and implementation of safety initiatives that matter to the front line, then our purpose has been successful. Safety is all about that culture.[13,22] I have presented a process based on experience and an understanding of health care and safety today from the perspective of a complex adaptive system to lead units to that culture by design. Complex systems are not built; they are grown, tweaked over years from their very unique

context, to a point where they just work, and their performance is inextricably linked to culture.[7] For too long, safety in health care organizations has been managed as in a complicated system: by restricting humans in the activities they perform. In many ways, this has led to disengagement. It is time we recognize that while parts of health care are indeed simple and some are complicated, the largest components are complex and adaptive. If we are to see major movement in safety and quality, it is those who do the adapting that must be leveraged to make it happen – the human as the resource – in balance with the human as the liability.

Systemic change will occur from the ground up, as leaders allow the process to occur. As relevant change begins to occur, it will rebuild the engagement of our workforce to bring about renewed successes in patient safety. We need to work with our complex system, not against it. Every one of us plays a central role in the evolution of that realization.

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Using attachment theory to understand and support health care workers under stress

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Attachment theory aids our understanding of fundamental aspects of interpersonal relationships and stress response. As such, it can add to our understanding and support of health care workers in stressful circumstances. This paper introduces attachment theory and summarizes the current evidence that relates attachment to aspects of employment–specifically absenteeism, burnout, and leadership. Suggestions are also made for using attachment principles in management.

KEY WORDS: attachment theory, workplace stress, physician leadership, burnout, absenteeism, management

What is attachment theory?

Attachment theory is a well-established, empirically derived theory of interpersonal psychology. Its founder, John Bowlby, first wrote about attachment in 1969,[1] and, in the years since, many investigations have revealed how infants form attachment to their primary caregiver (typically referred to as the mother, although others may also serve as a primary caregiver) and the extent to which that model of relationship behaviour is maintained across one's lifespan. Another highly relevant area of study relates attachment insecurity to an individual's pattern of stress response.[2]

Attachment is an interpersonal behavioural system, selected because of its value for increased reproductive success, that serves to maintain safety for a primate infant born before it can independently care for itself. This allows time for further brain development. This initial period of immaturity and vulnerability is one in which the primary caregiver and infant need to be closely allied and connected to ensure survival of the infant. Children develop a particular pattern of responsiveness to their primary caregiver's behavioural and emotional responses to their temperament, emphasizing infant behaviours that maintain contact and safety and de-emphasizing less reliable strategies. The outcome of this behavioural shaping is such that infants can be categorized into one of several attachment subtypes.[3] In adulthood, the same subtypes can also be detected and are denoted attachment "styles," although they are referred to with different labels in the adult attachment literature. The terms we will use are secure, preoccupied, dismissing, fearful, and disorganized.

Attachment subtypes are variations of normal, not psychopathological states. They are the outcome of the tailoring of expectations and behaviour to the fit between the primary caregiver and the infant. Behaviour shaped in infancy may not be the best fit for interpersonal relationships as one matures, so some aspects of one's attachment style may create a strain in adult interpersonal relationships. When the individual is not stressed, behaviour is not determined by their attachment style, because attachment behaviour is "state dependent," i.e., it is only manifest at times of attachment stress, such as interpersonal strain.[3] The purpose of this paper is to clarify the extent to which attachment style manifests in the workplace, what impact it might have, and how appreciating and addressing attachment can advantage physician leaders in managing their teams.

Although it is rare to see pure states in human behaviour, it is helpful to understand prototypic descriptions of attachment subtypes. This is most easily done by invoking two perspectives: the person's belief in themselves (confidence) and their belief in others (trust).

Although individuals with a "secure" attachment style are unlikely to present with difficulty in interpersonal working relationships, understanding this style provides a helpful contrast to the following insecure types. The secure person has both adequate self-confidence and adequate belief in the responsiveness of others. Their confidence allows them to function independently, and their trust in other people leads to effective group behaviour. The stress response of secure individuals is not easily triggered, but is responsive when required and returns rapidly to baseline, meaning these people respond to stressful events with a proportional reaction, without prolonged distress.[4]

All other attachment subtypes are "insecure." The person who is low in self-confidence and emphasizes trust of others has "preoccupied" insecure attachment. This denotes a preoccupation with proximity to another person in order to feel safe. To obtain and maintain the presence of the other person, such people "hyper-signal" attachment needs. In infants, this signaling consists of crying or clinging, but in adults it often manifests as interpersonal neediness that is difficult to soothe. Preoccupied people frequently feel stressed by their perception of being inadequately connected, and their stress response is often activated, which makes it poorly adaptive to specific circumstances. They tend to be experienced as needy or fragile and, when most distressed, can drive people away, rather than recruit support.[4]

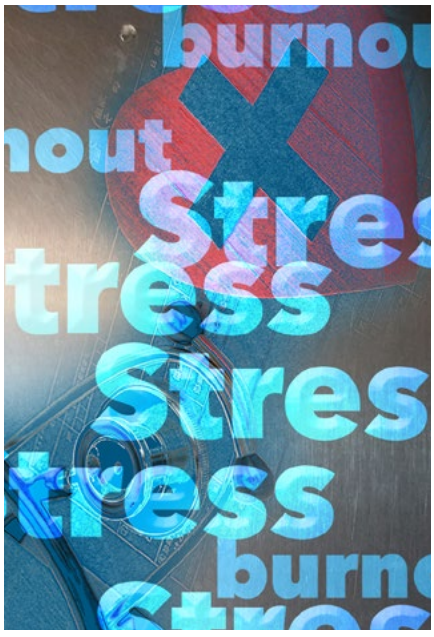
At the other end of the spectrum is the person who has more self-confidence than trust in others. Such people fall into the "dismissing" subtype, as they dismiss the need to have other people close to them. More positively described as "self-reliant," they will elect to work on their own and may experience interpersonal relationships as threatening because of their experience of being shamed or humiliated for interpersonal need in their developmental years. Such people may not come across as overly friendly to co-workers, but will typically be identified as capable of carrying out tasks on their own.[4]

Some people have had sufficiently difficult developmental years that they have neither confidence in themselves nor trust in others. They are described as "fearful" and present interpersonally as scared, angry, or painfully shy. They have distress based on their low self-confidence and fears of inadequacy, but also believe that, if they appeal for help, they will be ridiculed or abandoned. The behavioural solution for this is to retreat and, in employment circumstances, such individuals often end up doing routine repetitive tasks that do not demand response to novel circumstances or interpersonal communication. They essentially feel perpetually stressed.[4]

Finally, people who have had a traumatic upbringing may also have low confidence and poor trust in others, but rather than settling into one preferred behavioural modus operandi, they are better understood as "disorganized." They feel consistently under threat and vacillate between withdrawal/defence and attack/surrender. Interpersonally, they are experienced as chaotic workers in a group and they evoke strong, typically rejecting, interpersonal reactions.[4]

The literature on the impact of attachment styles in primary care doctor–patient and psychotherapeutic relationships is now substantial.[5-7] The insights

provided by this have been helpful in understanding how to structure communication or interactions to reduce the stress created by patients' attachment insecurity and make medical recommendations more likely to be adhered to, with less conflict between patient and provider. For instance, for the preoccupied patient, regularly scheduling appointments, independent of crises, creates better structured, less fragmented care and an overall reduction in the intensity of distress. For the dismissing individual, however, allowing them to approach the health care worker in their own way, on their own time, respecting their need for independence, is a better strategy.



One size does not fit all: for instance, the space provided for the dismissing individual would precipitate abandonment fears in the preoccupied individual. It is the specificity of response that optimizes communication. It is also useful to keep in mind that, although we assign an attachment style to an individual, the style is only activated in the context of a relationship, so actions aimed at improving these difficult interactions can usefully be undertaken by either or both parties of the dyad.

From an attachment framework, difficulties in employment that pertain to interpersonal situations can be understood as stressing the individual to the point that their "default" attachment pattern is activated, causing them to act accordingly. This is not necessarily the best fit for the here-and-now circumstances, so conflict can occur, especially if all parties in the interaction are similarly stressed.

The relevance of attachment style in employment

Attachment style correlates with organizational behaviour.[8] In general, secure attachment is associated with less problematic job performance. Specifically, it is associated with higher job satisfaction,[9] less negative spill-over from work to home,[10] less reporting of hostile outbursts in the workplace,[11] workers who are less prone to psychosomatic illnesses or actual physical illnesses,[12] and better organizational citizenship.[13]

Similarly, insecure attachment, in general, has been associated with lower job satisfaction,[11] greater anxiety about rejection by co-workers,[9] feeling unappreciated and misunderstood,[10] having more anger or distressing emotions in the workplace,[14] more insomnia and physical problems,[15] less instrumental help offered,[16] and significantly less support-seeking or support-giving behaviour.[16,17]

The following summaries serve to make the point that attachment status is a useful lens for understanding behaviours that are both helpful and challenging in the workplace. Given our basic understanding that those with insecure attachments are less likely to have well-tuned stress response, one may conjecture that the subjective states of lower job satisfaction or the presence of anger or distressing emotions, as listed above, indicate vulnerability on the part of workers with insecure attachment to feeling more stressed, more often, than their secure counterparts.

Burnout

Various investigations have examined burnout in workers from the perspective of attachment theory. Summarizing available information across six studies of 2184 workers, Pines[18] found a negative correlation between secure attachment and burnout and a positive correlation between insecure attachment styles and burnout. A further study[19] also found that, among 393 employees, attachment insecurity was related to more job burnout. The link between preoccupied attachment and burnout was partly mediated by lower appraisals of team cohesion, and the link between dismissing attachment and burnout was fully mediated by lower appraisals of organization fairness. Halpern[20] examined

paramedics exposed to a critical incident from the perspective of attachment and found fearful insecurity to be associated with depression and maladaptive coping, with slower recovery from social withdrawal and physical symptoms after a stressful event. Therefore, attachment insecurity appears to create vulnerability to experiencing the workplace as stressful in ways that are specific to the type of attachment insecurity and that are correlated with burnout.

Leadership

Much of the work examining leadership efficacy from an attachment theory perspective has been carried out in the context of the military. For instance, Davidovitz[17] demonstrated that Israeli officer leaders who had preoccupied attachment style had lower task efficacy, whereas those with dismissing attachment style had lower emotional efficacy. Units with leaders with a dismissing attachment style were reported as being less cohesive, perhaps because of such leaders' characteristic de-emphasis of the relevance of interpersonal relationships. Leaders with both preoccupied and dismissing attachment styles were ranked by the members of their unit as having poorer performance as leaders. Furthermore, members of units where the leader had a dismissing attachment style tended to show decreases in mental health over time.

Mikulincer[15] also demonstrated that Israeli military recruits with secure or dismissing attachment styles were more likely to be nominated as leaders by their peers than those with preoccupied attachment style. Berson[21] found that securely attached team members were more likely to emerge as leaders in experimental groups.

Ronen and Mikulincer[22] reported on 85 work groups from 71 non-military organizations including 483 subordinates and 85 direct managers. They used hierarchical linear modeling analyses to show that the managers' insecure attachment style predicted higher job burnout and lower job satisfaction among their subordinates and that the effect was mediated by ineffective caring for others on the part of the managers.

Furthermore, attachment orientation influences style of leadership. Secure attachment has been associated with a relational leadership style with maximal delegation and a fostering of exploration.[23] Dismissing attachment in a leader is more associated with task-oriented leadership style and minimal delegation.[23]

Hardy and Barkham[24] examined 219 employees receiving psychological treatment for stress at work. They found that preoccupied attachment style correlated significantly with reported anxiety about work performance and work relationships, whereas dismissing attachment style correlated with concern over hours of work and difficulties in relationship at home and in social life. They also demonstrated that work relationship problems associated with insecure attachment were significantly helped by psychological treatment.

Absenteeism

In hospital-based health-care workers, attachment insecurity was significantly associated with impairment in overall sleep quality and physical symptomatology.[25] Attachment anxiety (which contributes to preoccupied attachment) was also associated with depressive symptoms and an increased number of sick days. In 448 employees, Krpalek et al.[26] found insecure attachment style to be positively associated with both absenteeism and presenteeism (present but not really working).

Intervention

If attachment style is a determinant of how workers behave, what are possible mitigating factors? There are no empirical data on this, but operating from the principles of attachment theory,[27] several broad suggestions can be made.

Activation of the attachment behaviour is a response to stress, typically separation, fear, or perceived attack; thus, if the issue is not intermittent and stress related, it is unlikely to be dependent on attachment style. However, given that the main trigger for attachment behaviour is a sense of insecurity, then whatever one can do to increase felt security in an organization

should keep stress-related behaviours to a minimum. Increasing open communication, predictability of work, and keeping individuals operating within their sense of competency could all contribute to a working environment that feels interpersonally safe.

Securely attached people are unlikely to present a challenge in interpersonal functioning, as the combination of confidence and trust makes them highly adaptive to changing demands or environments. When interpersonal behaviour is problematic, it could be helpful to consider that the individual has an insecure attachment style, and if so, what type. The behaviour associated with fearful and disorganized people is typically sufficiently intense that it is not difficult to detect, and tailoring of the job to the limitations of the individual may be helpful.

When stressed, people with preoccupied attachment style may have an amplified perception of their own incapacity (low confidence) and feel a need to recruit others to their aid (higher trust). In response to this, regular supervisory meetings to reassure them that they do not need to signal distress to engage support, but that it is readily available, may be helpful. Keeping a good fit between capacity and demands of the work task may also minimize triggers.

Those with a dismissing attachment style are less likely to complain or request accommodation, because of their self-reliance and relative lack of investment in others, creating a propensity for independent activity. Hints that this style is active include complaining that others are contributing less, or being dismissive of the constraints of co-workers. As leaders, people with a dismissing attachment style tend to dismiss the psychological state of team members and are inclined to focus only on task completion,[17] which may create interpersonal tensions in the team. However, this same tendency can read as independence and strength, which are valued in many organizations. Tailoring the job to these strengths, by allowing a worker with a dismissing attachment style to focus on tasks and make decisions for themselves may minimize interpersonal friction.

Summary

An appreciation of attachment theory may help physician leaders optimize understanding of interpersonal relationships. The attachment theory perspective provides a useful lens for understanding sources of interpersonal strain in the workplace and individuals' comfort with teamwork. Using this point of view, the workplace and the individual can work together to improve the fit between them and minimize sources of friction and difficulty.

Further resources

A recent article in the popular press addressed this topic: Saunders EG. The 4 "attachment styles" and how they sabotage your work–life balance. New York Times 2018;19 Dec. **https://tinyurl.com/ya9qunq5**

Online videos introduce and summarize attachment theory: Maunder and Hunter. Intro to adult attachment, How do I become more secure? Attachment and health – symptoms, worry and healthcare use. **https://www.youtube.com/watch?v=GHHCy1IHTUc**

To find out your own attachment style, go to the Self-Assessment Kiosk, and do the relationship style questionnaire (Experience in Close Relationships, medical version, ECR-M16): **http://bit.ly/2ccH0tx**.

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This article has been peer reviewed.

BOOK REVIEW

Cracking Complexity

The Breakthrough Formula for Solving Just About Anything Fast

David Benjamin and David Komlos
Nicholas Brealey Publishing, Boston, 2019

Reviewed by Laura Calhoun, MD

Since learning the difference between technical problems and adaptive challenges more than a decade ago, we have known that the traditional command and control structure is not conducive to solving the complex problems of health care. Understanding complexity theory and knowing how to tell when a problem is simple, complicated, or complex was helpful, but no one has come up with a standardized process for *solving* complex challenges. Until now. This book builds on the work of Argyris[1] and Heifetz et al.[2] and lays out a process or formula that, if used with fidelity, may be the answer we have all been searching for.

Canadian authors, David Benjamin and David Komlos, show how using the formula can engage and align teams, cross silos, create space for innovation, and solve complex challenges in a consistent and replicative process.

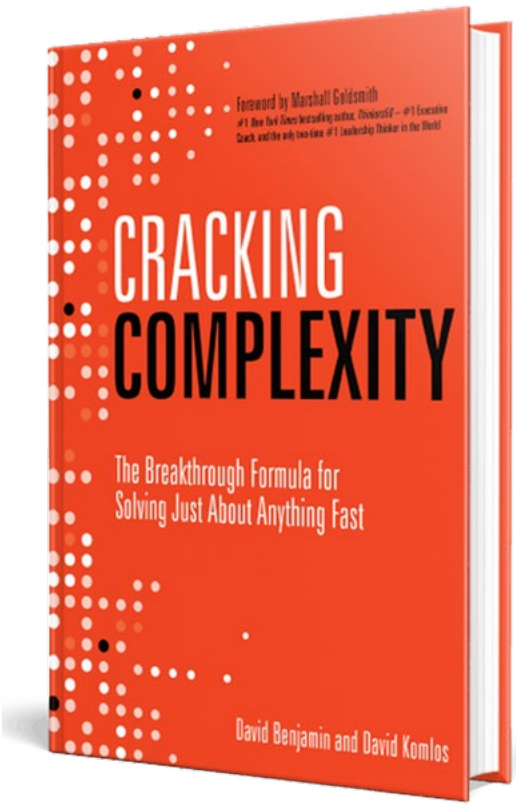
The beginning chapters deal with a review of complicated vs. complex and introduce the reader to three companies that have used the formula successfully. Over the course of the book, the same companies are followed, allowing for "how to" and real-life stories, which help the reader see how the steps in the formula actually work.

Complex challenges are "the confounding head-scratchers with no right answers, only best attempts." Having a wedding is complicated; having a happy marriage is complex. Rolling out a new EMR to enable transformation is complicated; transformation is complex.

Benjamin and Komlos have invented some metaphors and analogies to help the reader gain understanding quickly. One I liked in particular is called "the Lion in the Office."

"Imagine you walk into your place of work one morning, open your office door, and see a lion sitting on your desk, licking its chops. In the blink of an eye you are able to *sense* the lion, *absorb* the implications of its presence on your desk, *think* about your options, *decide* on a good course of action, and *act* (very likely by turning around, slamming your door and running in the other direction).

"The lion is the metaphorical complex challenge. The sensing, absorbing, thinking, deciding, and acting are the steps needed to overcome a complex challenge. But these steps are distributed among different people or teams in an organization. Even when the challenge is big and scary, or the opportunities highly compelling, people across and around your organization are seeing them in different ways at different times." The authors use the acronym SATDA as a heuristic which is one of many they have made up to make the reading of this book lively.



A graphic representation of their process, much like a graphic representation used to guide the treatment of illnesses, is presented early on in the book. There are 10 steps in the formula and each subsequent chapter is a detailed review of a step with an accompanying story from one of the companies with whom the reader is now familiar.

Step one of the process is

"Acknowledge the complexity." A table lists all the questions a leader can ask to determine if the challenge is complex or complicated. For example:

"Have you solved the problem before and then been able to implement that same solution successfully in a variety of similar situations?" If the answer is "yes" then the problem is complicated. If the answer is "no" then it is complex." They go on to list a variety of sub-questions along these lines, which are extremely helpful in teasing out the subtleties.

Step two is "Construct a really, really good question." The book acknowledges that this step in itself is not easy. They give some helpful hints, which they call "rules of Q." One of the rules of Q is: "When jumping into complexity, do that from any part of the deck because it is all one pool." Here is one of the really, really good questions: "How can healthcare organizations in our state work together in new ways to improve outcomes for patients struggling with mental health issues?"

Rather than list the rest of the steps, here are some of the principles that can be pulled out of the formula. They are the same principles elucidated by Heifetz et al.[2] a decade ago.

1. Every complex challenge needs its own solution.
2. The people with the problem must own and solve the problem.
3. No one person or team can see the problem in its entirety.
4. The solution to the problem is unknowable ahead of time.
5. Deciding who needs to be at the table and what the right question is can be done ahead of time.
6. The traditional hub-and-spoke consultation model will not work.

Solving a complex challenge requires people with different views to come together to listen and learn from each other so that solutions can emerge. The authors call these types of conversations "engineered collisions." They lay out how to manage these collisions so that everyone learns, everyone listens, and everyone observes. And they emphasize that these collisions can't just occur once, they need to be iterative and occur three times before solutions emerge.

The downside to the formula is that, to be successful, the people who own the problem and the solution need to show up and work together for three straight days. The first half day is spent making the agenda, because only the people who own the solution know what really needs to be talked about. By letting go of control in this way, leaders ensure that any "elephants in the room" surface, which ensures that the emotional aspect of any complex challenge is dealt with as part of the solution.

The engineered conversations take place over the next 2½ days. These are set up in a manner than ensures everyone talks to everyone else three times. This means the number of conversations is $n(n-1)$. If there are 20 people who own the solution, there will be $20 \times 19 = 380$ conversations. The formula describes exactly how to do this in a step-by-step manner that leaves the reader quite convinced that, with the right people, they can tackle any complex challenge.

The book goes on to lay out what to do with the solutions that emerge: how to create an action plan with metrics and a time line. Because the people who own the problem have come up with the solutions, they are already engaged and aligned. Because the right people are in the room, the silos have already been breached. People know what they need to do together to solve the challenge, what might get in their way, and how they can mitigate potential obstacles.

This book is a game changer. I highly recommend it for leaders at all levels.

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BOOK REVIEW

dare to lead

Brave Work. Tough Conversations. Whole Hearts.

Brené Brown
Random House, 2018

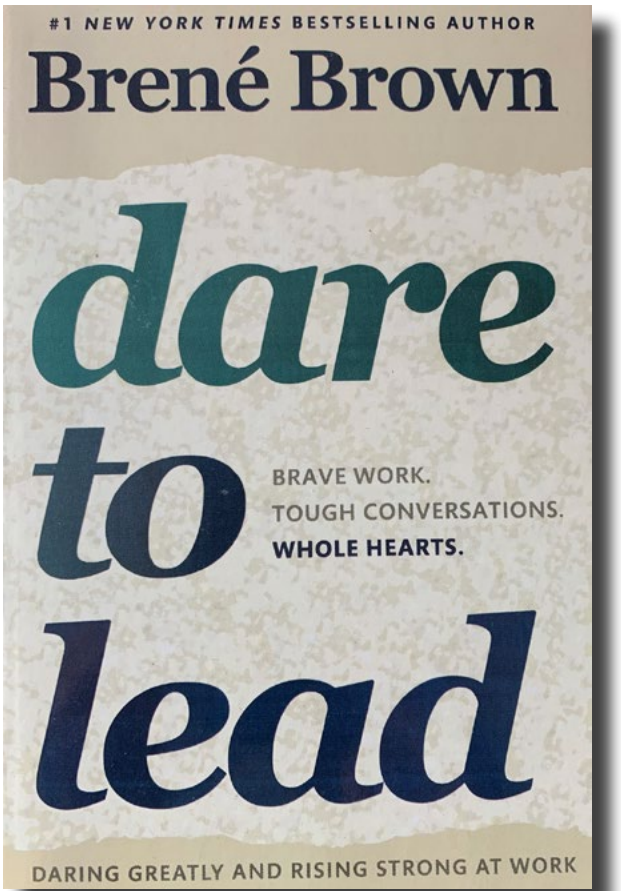
Reviewed by Denis Fortier, MD

Brené Brown, PhD, LMSW, a researcher at the University of Houston, has spent her life studying and writing about courage, vulnerability, shame, and empathy. She has now taken these important lessons and applied them to the workforce and to leadership.

This book helps leaders (and other people) understand and work toward a more vulnerable and courageous style of leadership.

Early in this book, a quote from Theodore Roosevelt summarizes the theme well. It goes like this:

> It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.



Brown uses this famous speech to launch her book, which she organizes in four broad sections.

Part 1: Rumbling with vulnerability

In this section, which makes up two thirds of the book, Brown invites us to "step into the arena" without armour and to fully understand what that means. Stepping into the arena in this way requires a deep understanding of who we are and what causes us to "armour up." Based on Brown's research, the answer lies in understanding vulnerability and shame, understanding our shame triggers, and finding ways to navigate all of this with courage, empathy, and self-compassion. The lessons in this section of the book are relatable as much to our personal lives as to our professional lives.

Part 2: Living into our values

In this section, Brown encourages us to further understand self-awareness and does so through the lens of understanding our own core values. A practical workbook companion helps guide readers through this section and toward finding their core values.[1]

Part 3: Braving trust

In this section, through storytelling, Brown defines trust and the importance of building trust in leadership. Trust is not built around earth-shattering events, but rather in the smallest of moments over time, through small but consistent relationship-building blocks.

In her earlier books, and again in this one, Brené Brown walks us through the BRAVING inventory. It has taken me a while to

remember it and longer yet to fully understand and appreciate its value.

B is for boundaries – Respecting boundaries, yours and others.
R is for reliability – You do what you say you will do.
A is for accountability – Own your mistakes. Apologize.
V is for vault – As in, I only share stories that are mine. Stories that others have shared with me remain in my vault, not to be shared with others.
I is for Integrity – Courage over comfort. Do what is right not what is easy.
N is for non-judgement – The ability to lean into difficult conversations without judgement.
G is for generosity – Try to be generous in your interpretation of what others say or do.

Part 4: Learning to rise
In this last section, Brown summarizes the lessons in this book and uses a three-step format to help navigate rumbling in the arena.

- ***The reckoning:*** This is an information-gathering time: external information (data, facts, etc.), but also internal information (becoming aware of how you feel, of why you feel what you are feeling). All the lessons in Part 1 of the book prepare you for this critical first step into the arena.

- ***The rumble:*** Walking into the arena without your armour by staying present, curious, and empathic is both vulnerable and courageous. It will get messy, and there may be dust and sweat and blood. But this is where leaders can make a difference. Vulnerability is not weakness. It is courage.
- ***The revolution:*** Brown's message about courageous and daring leadership, leading with empathy and vulnerability, presents opportunities to transform our culture, our workplace, our organizations.

A lot of information is packed into these pages. Be prepared to return to this book, or the audiobook for those so inclined, because you will learn and relearn some of the lessons better with the second or third reading. Brené Brown also has a *dare to lead* website with free downloadable workbooks to enhance your experience (https://daretolead.brenebrown.com/).

Those of you familiar with Brené Brown's past work will recognize much of what she has to say. For those of you who have not heard of her, this book may encourage you to read some of her other works.

See you in the arena my friends.

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