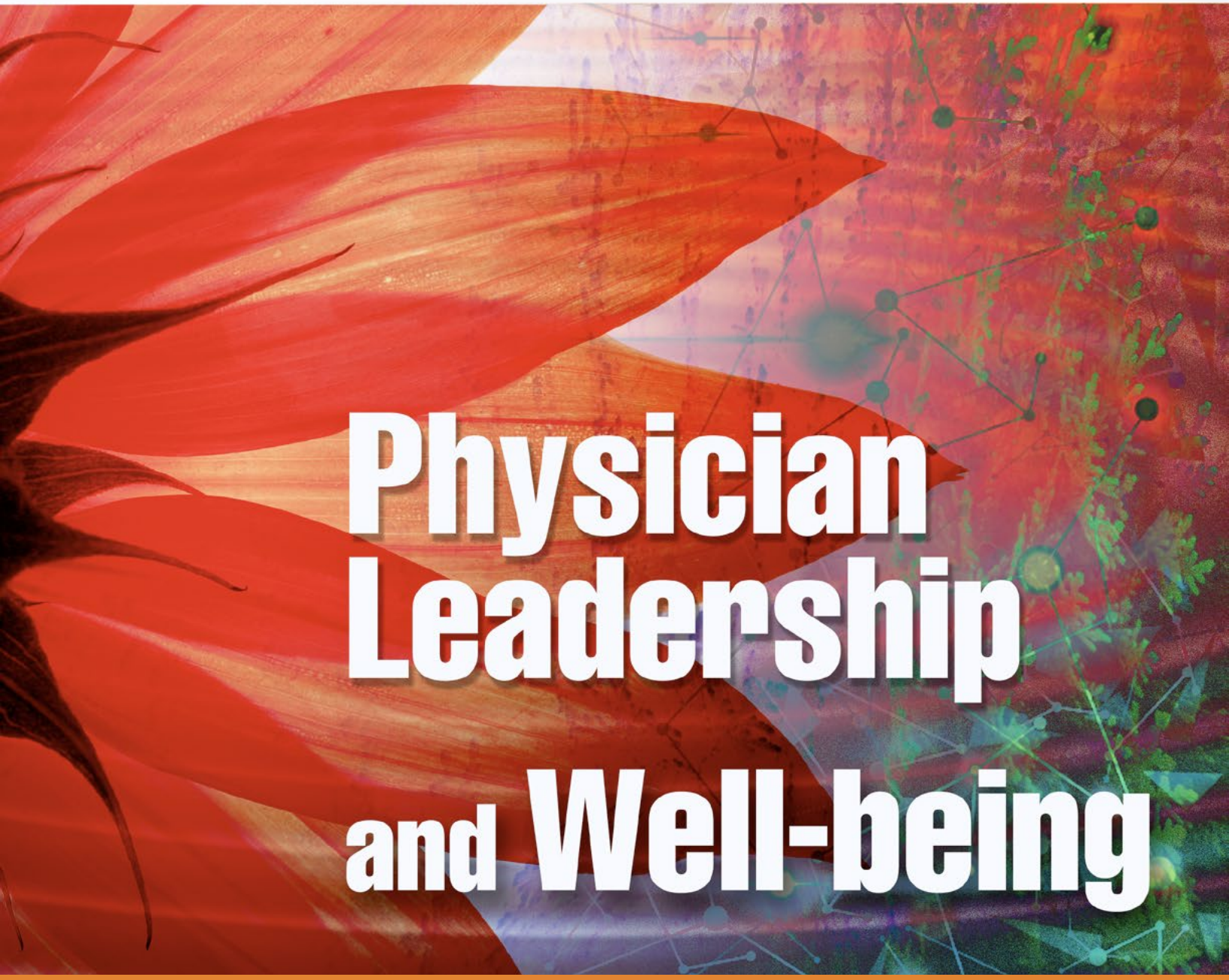
CANADIAN JOURNAL OF
Volume 6 Number 2
2019

Physician Leadership

THE OFFICIAL JOURNAL OF THE CANADIAN SOCIETY OF PHYSICIAN LEADERS



In this issue

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

Contents

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ISSN 2369-8322

EDITORIAL

Addressing wellness

Johny Van Aerde, MD, PhD

Although the World Health Organization has a clear definition of wellness, the term might have a slightly different meaning for each physician and physician leader, depending on where they function in the health care system. It is also important to make the distinction between the tools and skills needed to address burnout versus what is needed to maintain wellness at the personal, interpersonal, organizational, and systemic levels of health and health care in Canada.

Many elements affect physician wellness. The articles in this issue of the *Canadian Journal of Physician Leadership* address some features of wellness to improve day-to-day life for physicians and physician leaders. Other aspects will be addressed in upcoming issues.

As we come to the end of 2019, the staff of the Canadian Society of Physician Leadership and *CJPL* wish you and your loved ones health, prosperity, and happiness for the new decade. Happy 2020, and we look forward to seeing you in Vancouver at the 2020 Canadian Conference on Physician Leadership!

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CSPL SCLM

Natural justice and alternative dispute resolution: their importance in managing physician performance

Daniel Boivin, LLB, Guylaine Lefebvre, MD, Steven Bellemare, MD

The formal complaint and discipline processes set out in hospital bylaws and provincial legislation and regulations play an important role in providing fair and predictable forums for resolving disputes. However, these mechanisms address a limited range of issues, with respect to only one party. Approaching budding disputes earlier and allowing the individuals involved to disclose the true interests underlying their behaviour can provide opportunities for all parties to identify lasting solutions. As such, good knowledge of the principles of natural justice and the potential advantages of alternative dispute resolution mechanisms are invaluable tools for the physician leader.

KEY WORDS: dispute resolution, disruptive behaviour, natural justice, just culture

Vignette

Dr. Richards is a highly regarded thoracic surgeon at a large teaching hospital. His recruitment was seen as a major win for both the hospital and the university, given his stellar reputation as a clinician, teacher, and researcher. Lately, however, there have been concerns about Dr. Richards' performance. He is late or absent from academic rounds, he snaps at personnel, staff have complained that he has yelled at them, and he is late in his record-keeping. He has stopped attending departmental meetings but is highly critical of decisions and communicates this disagreement in "reply all" email communications.

In the operating room, many nurses now refuse to work with Dr. Richards. The atmosphere in the department has become toxic. A formal complaint was lodged when Dr. Richards aggressively threw a clipboard on a ward clerk's desk. He faced a disciplinary hearing before the Medical Advisory Committee, where his disruptive behaviour and record-keeping deficiencies were flagged as issues. As a result, his privileges were suspended for two months.

The disciplinary process was in line with standards and Dr. Richards will not appeal the decision. His suspension will affect his colleagues and his patients. During the two months, booked surgeries will be rescheduled and patients will be added to his colleagues' already long lists. The suspension will give Dr. Richards an opportunity for reflection about his behaviour and will serve as a message to the rest of the staff that the hospital does not tolerate disruptive behaviour.

Will the atmosphere and interpersonal relationships in the department be any better when Dr. Richards returns? Will the suspension truly fix the issues? Could we have done better?

The pillars of natural justice

The principles of natural justice are well recognized in law as rules to apply to fulfill a duty to provide procedural fairness. Developed by decades of jurisprudence, they generally require judicial, quasi-judicial, and administrative decision-makers to arrive at an unbiased decision after providing the parties with a fair opportunity to make representations. Judges in Canada's Supreme Court wrote,

> I emphasize that underlying all these factors is the notion that the purpose of the participatory rights contained within the duty of procedural fairness is to ensure that administrative decisions are made using a fair and open procedure, appropriate to the decision being made and its statutory, institutional, and social context, with an opportunity for those affected by the decision to put forward their views and evidence fully and have them considered by the decision-maker.[1]

The jurisprudence is clear that natural justice is "flexible and variable, and depends on an appreciation of the context of the particular statute and the rights affected."[1] Whether the obligation of natural justice applies to a particular context and, if so, to what extent, is a complex matter that is best discussed with hospital legal counsel. However, it is helpful to be cognizant of the three major aspects of natural justice and to apply these principles in the decision-making that is part of health care management, as these principles are simply full of common sense. Understanding and applying the three major aspects of natural justice in health care management can be valuable in helping build a positive workplace culture.

The right to know the nature of the complaint

Any person against whom a complaint has been made ought to know the nature of that complaint. Not making a physician aware of a complaint against them until many complaints have accumulated and a decision has been made to treat all complaints "en bloc" deprives them, with the passage of time, of opportunities to address older complaints and assess whether any potential remedies might have been effective. This can affect the fairness of the resolution process.

An opportunity to respond

The person against whom a complaint is made should have an opportunity to respond to that complaint. Physicians who are presented with a complaint and

with management's decision about that complaint at the same time are typically left with a feeling of dissatisfaction and injustice. The lack of a true opportunity to respond to a complaint is often the reason why a court overturns a management decision.

Unbiased decision-making

An unbiased decision-maker must make the decision. Although this principle ensures that the decision is legally valid, its greatest benefit stems from the creation of buy-in by the person who may be negatively affected by the decision. One can imagine that a surgeon whose operating schedule is cut as a result of a discipline process may not accept the decision if it is made by the chief of surgery who then personally uses the freed up operating room time. Quite apart from the legal requirements, biased decision-making is not conducive to healthy work environments nor to the creation of mutual trust.

The value of alternative dispute resolution

Most hospitals provide a formal, well-established process for the prosecution of complaints against professionals. Although these processes are fair and have survived the test of time, they are limited in what they can achieve. In such hearings, the focus is on the conduct of the professional facing discipline. There are few opportunities to examine the conduct of others involved in the dispute or other factors in the work environment. Because they are designed to judge the conduct of one individual, such hearings are not conducive to identification of the underlying dysfunction in a work unit and the repair of a broken work environment. Parties often spend valuable resources on a discipline process only to eventually return a professional to a dysfunctional work environment.

Three ADR mechanisms exist: negotiation, mediation, and arbitration.

Alternative dispute resolution (ADR) mechanisms are much more flexible. They can be designed to respond to the specific requirements of a situation. There is no limit to the number of parties who can be involved in the process or to the nature of the issues that can be discussed. ADR mechanisms allow great flexibility in the design of a solution that is best adapted to the issues at hand; they allow solutions to be applied to the root problem, whereas discipline processes are often limited to applying set consequences to an individual whose behaviour is often just a symptom of more significant systemic issues.

Three ADR mechanisms exist: negotiation, mediation, and arbitration.

Negotiation

Physician leaders are frequently called on to take part in negotiations, and the approach they adopt in dealing with a matter can drastically affect the result. Many negotiations are conducted using a positional approach. The best example of such an approach is the traditional way to negotiate the purchase of a car or house. Parties typically adopt an exaggerated initial position, which often plays to the other side's weakness. When adopting such a strategy, parties usually make unreasonably high demands that leave room for concessions on issues they do not care deeply about, all the while obtaining concessions they desire from the other party, in the hope of eventually reaching a point of mutual agreement.

In addition to being draining and time consuming for all parties, positional bargaining can produce suboptimal outcomes: bluffs, misrepresentations, threats, and promises all contribute to mistrust or serve to poison the long-term relationship. Although the difficulties of positional bargaining may be tolerated in some circumstances, they can lead to negative results in the context of resolution of workplace difficulties.

Interest-based bargaining presents a better approach to workplace negotiations by focusing not on the parties' positions, but rather their interests. The difference is well illustrated by the often-cited example of two children fighting for the last orange in a fruit basket. Each wants the orange. They provide arguments as to why they should have the orange and the likely result of this negotiation is that they would each settle for half the orange. Each will have obtained half of their wish: not bad, but not optimal. If, instead of focusing on their positions, each had focused on their interests – one child stating that they wish to

eat the pulp and the other stating that they need the zest to bake a cake – they could have each gotten 100% of their wishes.

The orange example is obviously simplistic, but it demonstrates that novel solutions are reached by going beyond positions and exploring interests. The real issues are brought forward and the parties can work on finding solutions to these issues rather than identifying a compromise that may not be a true solution to the underlying problems. Such compromises often leave some of the parties with a sense of injustice or incomplete justice.

Mediation

Disputes in health care environments are often based on a multitude of factors, and it may be very difficult to identify all relevant interests. In fact, it is unrealistic to think that a professional facing a complaint of disruptive behaviour will feel comfortable sharing their true interests when negotiating with a hospital administrator. This is where mediation is helpful.

In mediation, a neutral third party (an outside professional mediator or perhaps another trained hospital leader with no stake in the dispute) assists the parties in identifying the true underlying interests on both sides of an issue. Successive private caucuses with each party facilitate the process. Once the mediator establishes a level of comfort, allowing the parties to disclose their interests to him/her, the mediator can eventually guide the parties to a solution where the various interests intersect.

Arbitration

Arbitration involves a similar process, but one in which the neutral third party imposes a decision after exploring all the interests and discovering all the facts. As such, mediation emerges as a favoured method to resolve disputes in the health care environment, because it involves mutual agreement of the parties to settle their dispute.

The value of a staged approach

A workplace culture that promotes early management of conflicts within a just culture framework will likely permit identification of potential disruptive behaviour and reduce the risk of accumulated incidents that lead to no-win situations for both individuals and institutions.[2] The "just culture" approach provides guidance for decisions and actions from complaint to resolution. A just culture algorithm and method, if applied skillfully by physician leaders, might even obviate ADR.[3]

The Vanderbilt model for addressing disruptive behaviour proposes a tiered approach with four graduated interventions. Initially, an informal intervention, such as a "cup of coffee conversation," can suffice to foster awareness of the issue.[4] In most cases, this type of intervention creates enough insight on the part of the physician exhibiting disruptive behaviour to satisfactorily address the problem. Occasionally, when insight isn't sufficient to engender lasting change, such an early and timely discussion may provide enough information to allow the physician leader to conclude that underlying interests should be explored and, eventually, that the situation warrants mediation. Early and skillful ADR through mediation holds the promise of avoiding persistent problems because their underlying causes will have been addressed. As such, the need to escalate to other tiers of intervention (action planning and eventually disciplinary measures) is likely to decrease.

Vignette revisited

Dr. Richards' department head invited him to an informal discussion and quickly recognized that

many underlying issues were at play. With the hospital administration's permission, mediation was provided and, during that process, it soon became clear that Dr. Richards had behaved in a disruptive fashion because he was facing serious work–life balance issues. His new role as a single parent was interfering with his clinical, research, and teaching duties, and he was not getting appropriate support from colleagues who were envious of his stellar reputation.

With the assistance of the mediator, Dr. Richards started on a path of understanding that he could not do everything himself and agreed to consult a mental health professional for a suspected major depressive disorder. In parallel, an intervention with colleagues was also undertaken and the prevailing unhelpful attitude of ignoring work–life balance issues was addressed. Rounds and meeting times were revised to allow professionals with family obligations to participate. Over time, Dr. Richards' depression improved and the department head dedicated resources to the coaching of staff to foster a more collegial workplace. Department morale improved and numerous collaborations between Dr. Richards and colleagues ensued in the research sphere.

Although using the formal discipline process would have addressed Dr. Richards' behaviour, early mediation allowed for a multi-factorial, lasting solution geared to the underlying issues that gave rise to the tensions and focused on saving relationships.

Conclusion

Interest-based conflict resolution is a powerful, productive method for resolving conflicts in the health care environment, where many problems are multi-factorial. It affords physician leaders the flexibility to explore solutions that disciplinary processes mandated by legislation, regulations, and bylaws cannot provide, such as allowing all the relevant parties to participate in a resolution. ADR is one tool that can be part of a just culture algorithm and, if embedded in a hospital's rules and regulations, can enable positive solutions to challenging situations. ADR can be used in a variety of circumstances and allow rapid intervention and communication that is conducive to finding solutions geared to the underlying issues and not only to the symptoms.

References

1.Baker v. Canada (Minister of Citizenship and Immigration) [1999] 2 SCR 817 at par. 22. **https://tinyurl.com/yxqa7l7u**

2.The role of physician leaders in addressing physician disruptive behaviour in healthcare institutions. Discussion paper. Ottawa: Canadian Medical Protective Association; 2013. **https://tinyurl.com/tucbb8h**

3.Bellemare S. Leveraging the power of a just culture to promote accountability and inform system improvement. *Can J Physician Leadersh* 2019;5(3):160-2.

4.Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. *Acad Med* 2007;82(11):1040-8.

Author attestation

Daniel Boivin conceived the overall manuscript and prepared the first draft. Guylaine Lefebvre and Steven Bellemare helped develop the manuscript outline. All authors reviewed and approved the final version of the manuscript.

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This article has been peer reviewed.

What do we really mean by "physician engagement"?

Tyrone Perreira PhD, MEd, Melissa Prokopy, LLB, and Tamarah Harel

The concept of physician engagement is important to every hospital for a variety of reasons; however, a literature review revealed that no universal definition of the term exists. A conceptual analysis helped define the concept for further development and began to establish a common language. We clarify both what physician engagement means and how leaders can measure engagement. Establishing a common understanding will focus improvement efforts and allow organizations to compare their engagement results and strategies over time.

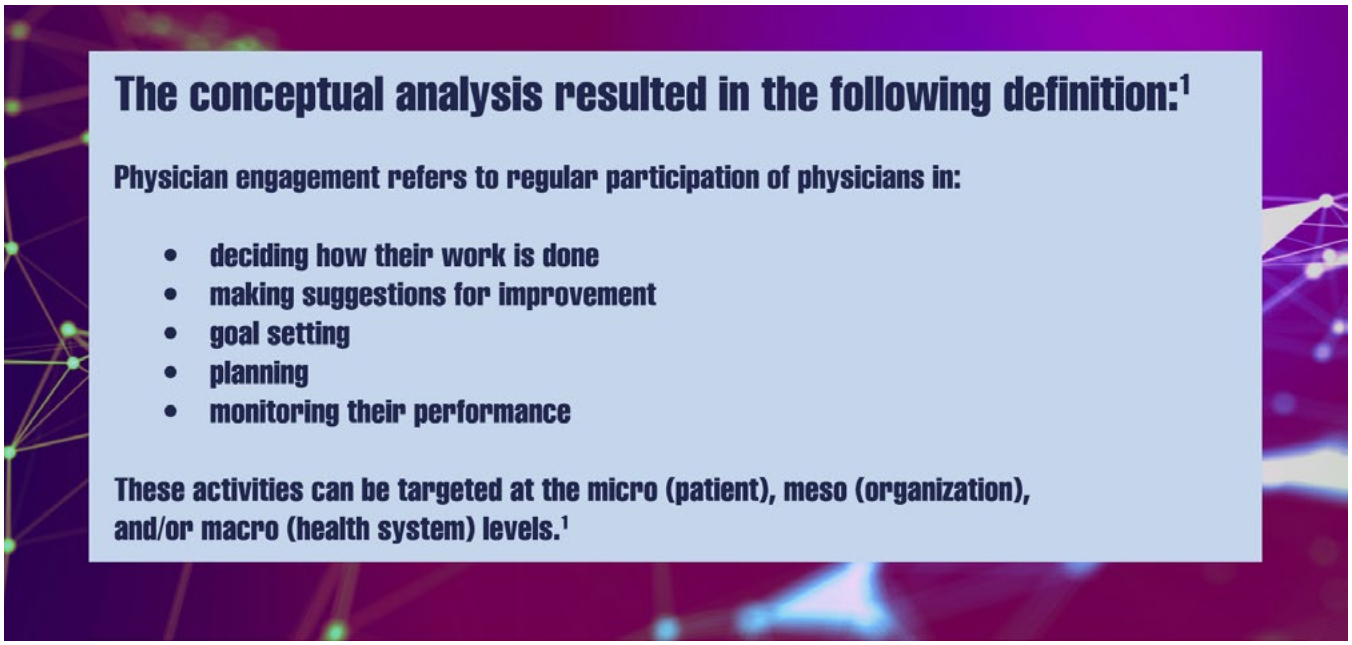
KEY WORDS: physician engagement, definition, measurement, common language

A recent conversation with a well-respected hospital physician leader revealed his frustration over effectively engaging physicians working at his hospital. Many of them struggle with burnout and transitions, such as the adoption of a new hospital electronic medical record system; an ever-increasing workload also adds to the burden. He knows these physicians are committed to providing the best possible patient care but cannot figure out how to boost engagement.

This conversation brought to light a bigger question: are these physicians truly unengaged, or does the term "engagement" need to be better understood and defined? Because "engagement" has often been applied to a variety of actions and behaviours, it is likely being used too broadly and inconsistently. Moreover, within Ontario's health care system, a multitude of surveys are currently used to measure physician engagement.

The concept of physician engagement is important to every hospital for a variety of reasons – statutory obligations, accreditation requirements, to improve culture and relationships – yet no one seems to be able to clearly articulate what it means or how to improve it. Most importantly, without a clear and shared understanding of what the term means, organizations cannot be certain that they are using the right tools to capture what they set out to achieve. In turn, efforts to improve engagement may often not succeed.

With this in mind, the Ontario Hospital Association and the University of Toronto conducted a robust literature review of the term "physician engagement," confirming that, currently, no universal definition or measurement exists.[1] "Engagement" has been applied to a variety of actions, such as support for projects,[2] motivation to take on leadership roles,[3] improving organizational performance,[4] participation in the appropriate and effective use of services,[5] and an ongoing two-way social process in which both the individual and organizational components are considered.[6] Physician engagement appears to be distinct from "work engagement," which refers to a positive psychological state of mind characterized by one's vigor, dedication, and absorption in overall work.[7] Physician engagement also appears to be distinct from "job satisfaction," a worker's positive feeling toward their job.[8] As such, one could potentially be engaged in certain aspects of work, organizational leadership for instance, but dissatisfied with other aspects, such as increasing documentation requirements. This is rarely unpacked in the literature.



The lack of a clear definition and understanding of engagement can result in vague survey questions. Leadership may misinterpret results, and dissatisfaction may manifest as a lack of engagement. The literature review plainly demonstrated that engagement can refer to a range of actions, attitudes, and behaviours.[1] It also revealed that a work environment that includes a culture of accountability, communication, incentives, good interpersonal relationships, and opportunity can enhance physician engagement and result in improved outcomes.[1]

A conceptual analysis of the term physician engagement was then conducted to address this ambiguity, help define the concept for further development, and begin to establish a common language.[9]

Defining physician engagement

Based on this conceptual definition, one can see that a physician might be highly engaged in one area, such as direct patient care, but may have little interest or involvement in another, such as health system improvement.

Clarifying the "what"

This working concept of physician engagement offers a valuable starting point for organizations and their leaders to begin thinking about what they are truly trying to measure: engagement, job satisfaction, level of involvement, commitment? At what level? Perhaps the focus is work engagement, which applies to the physician's state of mind and to their work overall, or it may be more about participation in specific activities. For the latter, it is vital to also determine the target of these activities: patients, the organization, or the health care system.

Homing in on what is being measured offers a clearer picture of how to begin the work of improvement by first choosing the right measurement tool. The appropriate tool should be valid and reliable. This can inform the development of a sound improvement strategy. Although this concept seems simple and straightforward, anecdotal evidence suggests otherwise. For example, a physician who attends leadership meetings is not necessarily engaged. In this case, it is more valuable to ask why that physician is in attendance and if they genuinely want to participate. More specifically, are they contributing to the discussion about how work should be done, suggesting improvements, helping set goals, and planning and subsequently monitoring performance?

Because no universal definition or measurement currently exists, even hospital leaders who are confident in their engagement data may benefit from taking a closer look at their organization's current assessment of physician engagement. Although a hospital

may have good baseline data and trends that show improvement over time – which is a great success on its own – having a clearer understanding of what is being measured can be useful in supporting the goals of the organization.

Clarifying the "how"

Improving engagement over time requires a concerted effort by health care leaders to evaluate their objectives and the methods used to achieve them. Those in leadership positions should consider the language used, the extent to which they want their physicians involved at each level (micro, meso, and macro), and how they measure engagement. Talking to physicians and gathering qualitative input is critical. Some leaders believe that physicians who don't complete surveys are often the least engaged; however, these physicians may be convinced that their participation will not bring about any positive changes. Success will only be achieved if organizations commit to working together with physicians.

Hospital leaders can begin their improvement efforts by taking steps to set up their organizations for success, namely:

- Define your objectives – What do you want physicians to be engaged in? At what level?
- Be explicit – If you are only interested in participation in a specific activity, then clearly state that.
- If conducting a survey, use a tool that is valid and reliable.
- Work with peer hospitals to use a common tool – This allows for comparisons and sharing of improvement strategies among sites and jurisdictions.
- Do more than surveying – Qualitative data are equally important in clarifying the "why," i.e., the facilitators and barriers to engagement.
- Consider a physician compact – A joint agreement between your organization and its physicians can explicitly outline what physicians may expect from you and, in turn, what you may expect from your physicians.
- Encourage and create a work environment that includes a culture of accountability, communication, incentives, good interpersonal relationships, and opportunity.

The next time you hear the term physician engagement, reflect on how it is being used. As most health care leaders use the term engagement to denote action, a consistent approach offers an opportunity to realign and implement standardized language across the sector. Agreeing on a common approach is ideal to enable a more comprehensive investigation and understanding of physician engagement. Moreover, establishing a common "what" will assist organizations by focusing improvement efforts in a targeted way and allow organizations to compare their engagement results and strategies over time.

References

1.Perreira TA, Perrier L, Prokopy M, Neves-Mera L, Persaud DD. Physician engagement: a concept analysis. *J Healthc Leadersh* 2019;11:101-13. doi: 10.2147/JHL.S214765

2.Skillman M, Cross-Barnet C, Singer RF, Ruiz S, Rotondo C, Ahn R, et al. Physician engagement strategies in care coordination: findings from the Centers for Medicare & Medicaid Services' Health Care Innovation Awards Program. *Health Serv Res* 2017;52:291-312. doi: 10.1111/1475-6773.12622

3.Snell AJ, Briscoe D, Dickson G. From the inside out: the engagement of physicians as leaders in health care settings. *Qual Health Res* 2011;21(7):952-67. doi: 10.1177/1049732311399780

4.Spurgeon P, Mazelan PM, Barwell F. Medical engagement: a crucial underpinning to organizational performance. *Health Serv Manage Res* 2011;24(3):114-20. doi: 10.1258/hsmr.2011.011006

5.Spaulding A, Gamm L, Menser T. Physician engagement: strategic considerations among leaders at a major health system. *Hosp Top* 2014;92(3):66-73. doi: 10.1080/00185868.2014.937970

6.Kaissi A. Enhancing physician engagement: an international perspective. *Int J Health Serv* 2014;44(3):567-92. DOI: 10.2190/HS.44.3.h

7.Schaufeli WB, Salanova M, González-Romá V, Bakker AB. The measurement of engagement and burnout: a two sample confirmatory factor analytic approach. *J Happiness Stud* 2002;3:71-92.

8.Bowling NA, Hammond GD. A meta-analytic examination of the construct validity of the Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale. *J Vocat Behav* 2008;73(1):63-77.

9.Chinn PL, Kramer MK. *Theory and nursing: a systematic approach*. Maryland Heights, Mo: Mosby; 1983.

Author attestation

Melissa Prokopy and Tyrone Perreira both participated in the conceptualization of this article and revisions.

Tamarah Harel assisted with revisions and organization of the article. All authors approved the final version. Conflict of interest: The authors declare no conflict of interest. No funding was received for this work.

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This article has been peer reviewed.

Cognitive Coaching: a leadership essential?

Margie Sills-Maerov, MBA, with contributions from John Clarke, MEd

The roles that physicians play in the health care system — as leaders, mentors, providers, and colleagues — require not only the technical skills taught in medical school, but also the adaptive skills of communicating and engaging and fostering others' thinking in a psychologically safe way. Adaptive leadership requires that leaders help guide others through problem-solving, rather than providing the answer. As part of continuing professional development, health care improvement facilitators and administrative leaders in Alberta were trained in the skills of adaptive leadership using a model called Cognitive Coaching. Participants noted a qualitative shift in the culture of teams toward greater collaboration and better quality of conversation. Lessons from the health care experience to date and from the education sector indicate a benefit to physicians from building this intention and skill base.

KEY WORDS: Cognitive Coaching, adaptive leadership, complexity, mentorship, coaching

Physicians play many roles: mentor, partner in health, skilled clinician, colleague, and leader. As a result, they must be attuned to both the complex and complicated aspects of health care. Complicated environments require technical skills. Complex environments require adaptive skills. Complicated issues require a high degree of expertise in protocols, formulas, and knowledge. Goals are clear, and outcomes — the results of imaging or a simple surgical procedure — can be managed. Complex issues fail with rigid protocols, outcomes are uncertain, and resolution will vary from person to person; an example is helping a patient manage their blood sugar level.[1] Complex issues require the ability to surface and "upend longstanding traditions and deeply held beliefs,"[2] using the skills of listening, inquiring, and responding, and helping a person shift from where they are to where they want to be. A leader must be able to "guide others through problem solving, rather than dictating a solution."[3]

CanMEDS recognizes this need for physicians to possess both technical and adaptive skills, not only as medical expert, but also as communicator, collaborator, and leader. However, medical training is focused on the role of the medical expert and reinforced in hierarchical expert-driven structures in practice.[1,4] As a result, the default leadership role is that of a technical leader using a "teaching" or "expert" approach to engagement, which does not tackle the complex issues fully.[5] In contrast, adaptive leadership means that leaders are not necessarily responsible for having the answers, but rather for finding the answers in others with whom they work and fostering the most supportive interactions possible.[1]

Adaptive leadership skills are difficult to attain, and it has been suggested that there is a need to purposefully and systematically support the development of such skills in a manner replicating the rigours of the medical expert.[6] To help build awareness of these skills, the Canadian Society of Physician Leaders (CSPL) has adopted LEADS in a Caring Environment as a guiding

framework for physician leaders in addition to the CanMEDS framework. Frameworks help guide but not implement skill development and growth, and, in Canada, the health care system does not always support the ongoing training of the physicians who are needed to be leaders in the system.[7] Thus, the system is perfectly designed to get the results it gets.

Why are adaptive skills important? At the most basic functional level, our brains are wired to detect a threat. The amygdala can be triggered by any hint of a threat – stress, fear, aggression.[8] This was needed when we were hunters and gatherers, but is less functional in today's world. Managing a threat can be countered by keeping the more rational prefrontal cortex engaged, and appealing to the cortex is at the heart of "psychological safety." Thanks to Paul Gilbert's research[9] and advances in Compassion Focused Therapy, we also know that mirror neurons in the frontal lobe play a role in how we "feel safe." Looking at attachment theory and neurology, Gilbert noted that activation of the areas of the brain that promoted "the social safeness system" was linked to non-verbal behaviour, tone, and touch, which indicated caring. Activation of those areas promoted the ability to explore and learn with a greater sense of confidence. The mirror neurons help us understand others through the "feelings" we get from others and are the link between sciences and humanities.[10] In addition, when we feel connected to others, oxytocin and serotonin are released and contribute to creating long-lasting psychological safety in a working environment.[11]

We know that adaptive skills are important, and we know why they impact others positively. However, what *specific* behaviours and mindsets are needed in leaders to support change and for others to thrive in an adaptive manner? Three years ago, I did some research on this question. Coaching in general seemed to be a common theme, but in many models, "executive leadership" focused or was entrenched in expensive for-profit models of training. A colleague pointed me in the direction of Cognitive Coaching (a service marked body of work).[12]

This coaching model is a skill development program that has been used for 35 years in education. It is designed to facilitate conversations that invite others to share, explore, and deepen their own thinking in a safe environment. It focuses on creating a learning environment versus embedding external coaching practices – it is about culture change. The premise behind it challenged some of my own

thinking on change management. Rather than targeting behaviour, the intention is to support the thinking that preceded any behaviour. It ticked many of the boxes I needed: it came from an entity focused on improvement in education; it was rooted in skill development not just a framework; it was theoretically sound, well researched, and studied for over 35 years; it was not a "rote" set of tools; and it was quite cost-effective as it emerged out of another "cash-strapped" human services delivery sector – education. In considering the "teaching" aspect of health care, it also made intuitive sense. Good teachers foster a sense of curiosity, make you feel that you can figure things out, help refine your thinking, and likely make you think and reflect on your thinking years later. In many ways, good leaders have similar traits.

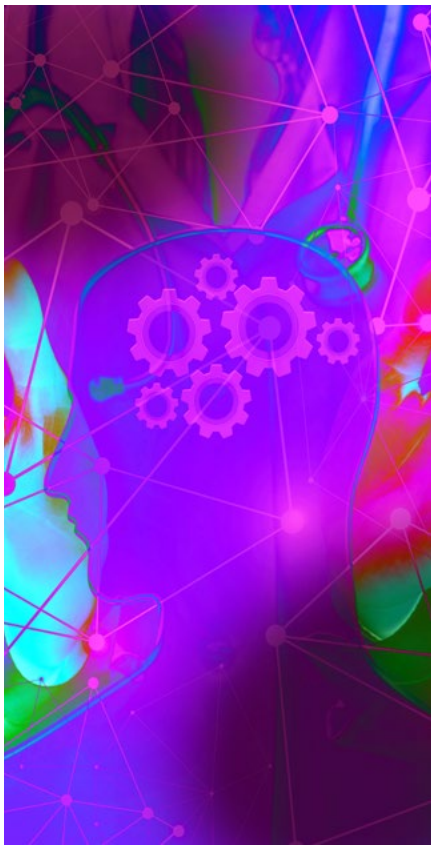
As part of continuing professional development, a number of health service agencies in Alberta pooled resources to fund training for improvement professionals and change leaders in the province and test the effectiveness of Cognitive Coaching. We tested the training with two cohorts of 40 improvement professionals and health care leaders. We were quite hesitant at first, as the training required eight six-hour days over the course of eight months or so. However, once we all completed the first two days, we quickly realized why it would take eight days: it consisted of skill building, not teaching. It was about learning, testing, practising, and internalizing. The way it was structured allowed for thinking to be shifted, and then behaviour followed.

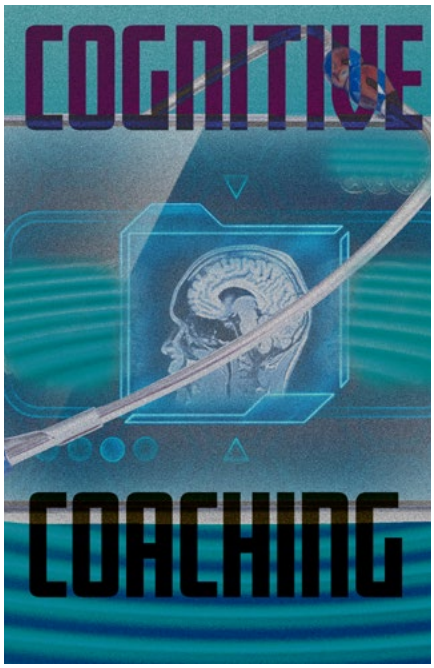
We completed qualitative and quantitative evaluations of the participants, looking at self-efficacy, skill acquisition, and application and practicality in the health care environment. Participants experienced a shift in how they looked at their role: they found that they used the skills in high-stress or conflictual situations with success, and it changed the way team members interacted and worked with each other. They had a greater sense of being effective in helping others with change. Instead of having to have the answers about a change, they were instead getting the answers out of the teams that they were supporting and had a greater impact. They moved away from being "problem solvers" to acting as coaches who enhanced the thinking of others and grew teams and collaborative partnerships (M. Sills-Maerov, unpublished action research, 2015–2018).

The learning design of the course broke down key components and built skills over time in ways that allowed changes in thought and behaviour. At its base, the coaching training taught a core pattern of "pausing, paraphrasing and posing questions," that

- Supported mirror neuron function in paced conversations and non-verbal alignment to match the thinking of the person being coached, resulting in a high degree of rapport
- Reduced the level of perceived threat by using artful ways to paraphrase, indicating deep listening and understanding
- Fostered new patterns of thinking with thought-provoking questions

The course focused on how to apply that core pattern based on the needs of the individual. It helped shape the flow of a conversation based on the type of issue: to reflect on something that went well or did not, to plan something coming up, or to resolve a problem. Through their coaching skills, the facilitators were able to help the coachees identify, name, and articulate their issue(s) and then strategically reorient them to a more resourceful state through the questions asked. This method can be used both formally and informally. A structured conversation could be held or the skills applied in everyday situations.





We also learned that coaching is not always the answer. At times a leader needs to be an expert, or an evaluator, or a collaborator.[11] However, in coaching, it is the purposeful application of skills designed to help others build their capacity as self-directed individuals that sets it apart from other models. The premise is that the greater the cognitive resourcefulness of a team, the better its members can adapt and change within a changing landscape. Fostering the development of autonomous, self-directed learners on our teams means they recognize their actions and the impact of those actions within the larger system — a key function of a leader in the LEADS framework.

Although coaching has not been fully studied in health care or with physicians, it has been well researched in education, and a number of lessons may apply to physicians in their practice. For example, Joyce and Showers[13] seminal work in 1980 affected how professional development was delivered and shed light on how to increase teachers' ability to put new ideas and approaches into practice in the classroom. Simple professional development outside the context of work resulted in about 20% uptake of new practices. When individuals received professional development and coaching, implementation increased to 80–90%.[13] In what ways might coaching change the impact of continuing medical education or best practice guidelines?

The results of research specific to Cognitive Coaching have been collected over the past 35 years. Some of the themes may also be applicable to physicians and translate well into health care.[14]

Finding 1: Teachers and mentors who were coached or received specific Cognitive Coaching training were better able to improve the performance of their students and teacher mentees.

This appeared to be linked to several areas: the ability to more thoughtfully reflect on their own learning, a greater emphasis on the needs of others, their ability to ask questions to stimulate thinking of others, as well as a fundamental shift away from "creating clones" in thinking to fostering the development of others and focusing on their success. Those who were coached consistently demonstrated improvements in their ability to reflect and learn and become critical thinkers.[15-19]

Questions for health care: Like teachers, physicians are in the business of human services. Physicians support co-designed health care with patients, in particular for chronic condition management. Adaptive leadership skills supported by training in coaching might improve those interactions, as in the case of teachers and students. As physicians are also teachers to residents and students, their ability to support learning might be aided by coaching. Competence by design, as set out by the Royal College of Physicians and Surgeons of Canada,[20] is already focusing on the role of the preceptor as coach. How might the skills developed through Cognitive Coaching affect these interactions?

Finding 2: Culture in the classroom with students and between teachers improved.

Teachers who had been teaching for years found that using Cognitive Coaching resulted in a "calmer" classroom with fewer (problematic) student behaviours. They found the culture of the classes to be "more friendly" and open, which affected student achievement. The skills can be used both formally in structured conversations and informally in everyday interactions, thus the impact on culture.[21,22]

Questions for health care: Like teachers, physicians are often put in the role of being an "expert" and part of a hierarchy, both formal and informal. Their

interactions with colleagues, professions, and patients are all affected by people's sense of safety and connectedness and can be enhanced with greater skills and abilities in conversations. If coaching promotes a "social safeness system" resulting in a shift in the culture, what might be some of the impacts on health care? Could it decrease the level of burnout seen in health care providers? How might physicians, as key leaders in the health care system, have an impact by leading with adaptive skills versus technical skills, when appropriate?

Finding 3: Teachers who were coached had a greater degree of self-reflection supporting their own professional development.

The studies highlighted the impact of an increased emotional intelligence rating of teachers by others and a greater awareness of their own metacognition. Teachers who were coached were better able to reflect on their own practice in a more balanced way and became more flexible and adaptable in their teaching style. Administrators also noted that teachers who received coaching training had an increased desire to grow and learn professionally. Some of the flexibility was attributed to a greater use of both sides of the brain, engaging both the analytic and intuitive functions.[23-26]

Questions for health care: Emotional intelligence is the ability of people to recognize, discern, label, and manage their own emotions and the emotions of others. This is quite similar to the Leads self domain in the LEADS framework. Given the finding above, how might Cognitive Coaching skills increase the ability of a provider be more self-aware, manage self, develop self, and demonstrate character? As medicine moves to a competency-based learning model, in what ways might the skills of coaching affect the mentor–mentee relationship? How might they affect a mentor's own self-reflection?

Finding 4: Coaching is a practical leadership tool to foster a positive culture.

Alberta-based education studies looked at the impact of Cognitive Coaching on leadership development.[27] Before training, the sense of efficacy as tested with a validated educational tool showed that newly appointed school principals were markedly lower in efficacy compared with more experienced principals. After two years of collegial support through coaching and mentorship from the experienced principals, the level of efficacy between the two was equal. Adopting Cognitive Coaching as a tool and a way of interacting among principals resulted in improvements in school climates in terms of professionalism, leadership, engagement, and academic results. Other studies demonstrated more positive attitudes as a result of a greater sense of trust, community, collaboration, and networking. Teachers and leaders felt less isolated and, as a result, a greater ability to have a positive impact in the workplace. Over time, any concerns about the extra time needed for coaching fell away.

Questions for health care: Learning adaptive leadership skills is not easy. However, if physician leaders purposefully focused on building adaptive leadership skills, as proposed by Schwartz and Pogge,[6] how might they affect mindsets and long-term change? What skills could foster Developing coalitions (mobilize knowledge) and Systems transformation (critical thinking, support innovation, and orchestrate change) as defined in LEADS?

Adaptive leadership is a necessary skill in health care, as underlined by CanMEDS and LEADS. Adaptive leadership skills are not taught, nor reinforced in health care structures. The adaptive skills needed to guide teams through problem solving are aligned with those educators need to develop self-resourced children and learning environments, and they hold potential in health care. As an example, the faculty of medicine and dentistry at the University of Alberta will be offering Cognitive Coaching as part of continuing medical education starting in 2020. We hope to learn more about the impact of training providers purposefully in the "soft skills" of leadership. As in any skill building exercise, incorporating the skills into a person's approach takes time, reflection, and personal growth. If we want physicians to be the leaders we expect them to be, we need to afford them that opportunity.

References

1.Haeusler, JM. Medicine needs adaptive leadership. *Physician Exec* 2010;36(2):12-5.
2.Kornacki MJ. Three starting points for physician leadership. *N Engl J Med Catalyst* 2017;7 Aug. https://tinyurl.com/wayenkz
3.Chaudry J, Jain A, McKenzie S, Schwartz RW. Physician leadership: the competencies of change. *J Surg Educ* 2008:65(3):213-20. doi: 10.1016/j.jsurg.2007.11.014
4.Vildbrad MD, Lyhne JM. Improvements in CanMEDS competencies for medical students in an interdisciplinary and voluntary setting. *Adv Med Educ Pract* 2014;5:499-505. doi: 10.2147/AMEP.S74876
5.Parrish S. The path to perpetual progress: my interview with Atul. Knowledge Project Ep. 42. Farnam Street Media Inc. https://fs.blog/atul-gawande/ (accessed 13 Sept. 2019).
6.Schwartz RW, Pogge C. Physician leadership: essential skills in a changing environment. *Am J Surg* 2000;180(3):187-92. DOI: 10.1016/s0002-9610(00)00481-5
7.Kendal D. Challenges and opportunities to ensure effective physician leadership in *Canada. Can J Physician Leadersh* 2014;1(2):8-9.
8.Rock D. *Your brain at work: strategies for overcoming distraction, regaining focus, and working smarter all day long.* New York: Harper Collins; 2009.
9.Gilbert P. Introducing compassion-focused therapy. *Adv Psychiatr Treat* 2009;15(3):199-208. DOI: 10.1192/apt.bp.107.005264
10.Ramachandran V. The neurons that shaped civilization. TEDIndia; 2009. https://tinyurl.com/hxw8qb7
11.Sinek S. *Leaders eat last: why some teams pull together and others don't.* New York: Penguin; 2017.
12.Costa AL, Garmston RJ. *Cognitive Coaching: developing self-directed leaders and learners.* Lanham, Md.: Rowman & Littlefield; 2016.
13.Joyce BR, Showers B. Transfer of training: the contribution of "coaching." *J Educ* 1981;163(2):163-72.
14.Edwards J. Cognitive coaching: a synthesis of the research. Highlands Ranch, Colo.: Thinking Collaborative; 2016. https://tinyurl.com/rrbu9yd
15.Garmston R, Hyerle D. Professor's peer coaching program: report on a 1987–88 pilot project to develop and test a staff development model for improving instruction at California State University. Sacramento, Calif.: California State University; 1988.
16.Gonzalez Del Castillo A. Cognitive coaching as a form of professional development in a linguistically diverse school. PhD dissertation. St. Louis, Mo.: University of Missouri; 2015.
17.Jaede M, Brosnan P, Leigh K, Stroot S. Teaching to transgress: how cognitive coaching influences the apprenticeship model in pre-service urban teacher education. Presented at the annual meeting of the American Educational Research Association, Philadelphia. Washington: American Educational Research Association; 2014.
18.Rennick LW. The relationship between staff development in balanced literacy instruction for kindergarten teachers and student literacy achievement. PhD dissertation. Saint Louis, Mo.: Saint Louis University; 2002.
19.Batt EG. Cognitive coaching: a critical phase in professional development to implement sheltered instruction. *Teach Teach Educ* 2010;26(4):997-1005. DOI: 10.1016/j.tate.2009.10.042
20.Competence by design. Ottawa: Royal College of Physicians and Surgeons of Canada; 2019. https://tinyurl.com/y7y45y6f
21.Eger KA. Teachers' perception of the impact of cognitive coaching on their teacher thinking and behaviors. PhD dissertation. Urbana, Ill.: University of Illinois; 2006.
22.Saphier J. The school culture survey. Acton, Mass.: Research for Better Teaching; 1989.
23.Smith MC. Self-reflection as a means of increasing teacher efficacy through cognitive coaching. Master's thesis. Fullerton, Calif.: California State University; 1997.
24.Burk J, Ford MB, Guffy T, Mann G. Reconceptualizing student teaching: a STEP forward. Presented at the annual meeting of the American Association of Colleges for Teacher Education, Chicago. Washington: American Association of Colleges for Teacher Education; 1996.
25.Edwards JL, Newton RR. The effects of cognitive coaching on teacher efficacy and empowerment. Presented at the annual meeting of the American Educational Research Association, San Francisco. Washington: American Educational Research Association; 1995.
26.Garmston R, Linder C, Whitaker J. Reflections on cognitive coaching. *Educ Leadersh* 1993;51(2):57-61.
27.Rogers WT, Hauserman CP, Skytt J. Using cognitive coaching to build school leadership capacity: a case study in Alberta. *Can J Educ* 2016;39:3. https://files.eric.ed.gov/fulltext/EJ1114119.pdf

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This article has been peer reviewed.

ADVICE

Coaching competencies for physicians: listening at the next level

Nancy M. Merrow, MD

In this second of a series of articles on coaching competencies, the focus is on developing the skill of listening. Most physicians have been trained in "active listening," using brief encouraging sounds and gestures, paraphrasing, summarizing, reflecting, and probing for additional detail. However, by looking further into the com-position of a powerful and trans-formative listening encounter, we can learn to listen at the next level.

KEY WORDS: coaching competencies, communication, change, listening

When using the coach approach, we co-create a relationship within which questions can be asked that provoke the coachee into new insights about the issue, their options, and their willingness to act.[1] The coach holds the coachee accountable for their stated intentions. The coach uses deep listening skills to formulate the questions that move the conversation into action. By listening with intent and purpose, the coach will identify beliefs, thought patterns, and assumptions that are held by the coachee, which may be holding them back from committing to what they say they want.

The most basic of all human needs is the need to understand and be understood. The best way to understand people is to listen to them."
Ralph G. Nichols[2]

Listening as a specific skill

Levels of listening have been described by various authors. One influential writer is Ralph G. Nichols, PhD, who famously said, "The most basic of all human needs is the need to understand and be understood. The best way to understand people is to listen to them."[2] Before his death at age 96, Dr. Nichols was recognized with the Lifetime Achievement Award by the International Listening Society. The art and science of listening has flourished since he published his studies as a professor of psychology at the University of Minnesota over his 40-year career.

Traditional medical training has included basic training in "active listening" and most physicians are familiar with how to demonstrate it by using brief encouraging sounds and gestures, paraphrasing, summarizing, reflecting, and probing for additional detail. By looking further into the composition of a powerful and transformative listening encounter, we can learn to listen at the next level.

Modes and levels of listening

Note: The following material has been adapted from E. Cox,[3] Kimsey-House et al.,[4] pp 34-9, and Hawkins and Schwenk.[5]

Internal listening – Internal listening is about what is going on for the listener. We have a need for information or understanding about how a situation may affect us or decisions we must make. When listening internally, we are trying to figure out things: Am I ready for this? How long might this take? Where do I have to be next? Will we need to follow up on this? What needs to happen next? When listening internally, we are not yet working on what matters to the person who is trying to communicate with us. Most conversations begin with a brief period of internal listening so that we can set our own goals and boundaries on the rest of the encounter.

If internal listening identifies critical issues and the opportunity for a good conversation is limited, the encounter may have to start with planning a better time to talk. For example, if, as the conversation starts, you are feeling some urgency to reach a conclusion because of competing priorities, your ability to listen effectively may be limited.

Focused listening – When we shift our focus from what we need to what is going on for the other person, more noticing occurs. We start making observations about the other person's posture, gestures, energy level, tone, and pace of speech. The content of the conversation is attended to, as well as the emotions. We start using techniques, such as paraphrasing, reflecting, summarizing, and probing. Generally, a person will feel well heard during and after a focused listening experience.

At some point in a productive relationship that involves listening, we begin to consider what is going on between and around the listener and the speaker.

Global listening – At some point in a productive relationship that involves listening, we begin to consider what is going on between and around the listener and the speaker. Global listening considers the quality of the relationship between the parties and the circumstances that impact the progress of their communication. This is how we identify and manage differentials in authority, power, culture, knowledge, beliefs, and assumptions to understand the challenges in communication. The more complex the issues and the higher the stakes, the more global listening will help to remove barriers to progress. When listening at this level, we explore how the people and the situation came to the place we are at. We go beyond what we think to why and how we think.

Generative listening – At this level, we achieve fascinating, fun, and unexpected insights in conversation. Suddenly, we both know something neither of us knew before. It results from the genuine non-judgemental and curious stance taken by people who are committed to hearing each other and moving forward in a positive direction. Generative listening leads to creative partnerships and initiatives with deep understanding of unique perspectives.

Authentic listening – Calling out the multiple factors that affect how well we can listen to each other is an advanced technique in listening. When we enter the mode of authentic listening, we openly explore and have a dialogue about what is making it difficult to listen. There may be unresolved issues, prejudices, biases, confusion, or values conflict within or between the parties that must be recognized and processed if they are barriers to listening. When the relationship has not matured to this point, the listener may discuss the barriers identified during authentic listening with a trusted colleague.

The role of the listener (physician, teacher, supervisor, mentor, leader) and the relationship with the person being listened to (hierarchical, peer, direct report) help to define the level and mode of listening that will be most impactful in a positive way. We offer this discussion to invite reflection on how and when you need to listen and what benefit enhanced listening skills might offer.

Components of the listening competency: quick reference tool

AWARENESS

Prepare for impactful conversations by bringing your awareness to the present moment. Focus on your breath for a minute. Move around to release some kinetic energy before you begin. Notice when your awareness is drifting, and use subtle tactics to draw yourself back to the present moment. Quietly tap your toe, touch your tongue to the roof of your mouth, or otherwise silently and invisibly signal to yourself that you are back.

ATTENTION

Find an appropriate setting for the encounter. Silence any devices and set them aside. Give the person your full attention by using body language, eye contact, and brief, timely verbal responses and gestures. If you lose attention, ask a clarifying question to get back on track. People know when you are not paying attention. You are human, so just admit that you lost focus and ask them to back up the discussion a bit. Your clarifying question tells them you were with them up until that point.

PRESENCE

Who you are speaking with and your roles and the relationship frame the conversation. How you look, talk, smile, move, shake hands, and occupy space has an impact on the other person. Your choice of language and use of humour, as well as the pace, tone, volume, and habits of speech that you use all reveal how committed you are to hearing and understanding. Manage your presence with intent and purpose.

CURIOSITY

Suspending judgement and using open-ended questions demonstrate genuine curiosity about the other person's issues and views. Hold your opinions, values, experiences, history, and advice aside unless the person asks for your perspective. The person will feel more deeply listened to when you ask questions to clarify what is happening for them, not what you would like to know.

AUTHENTICITY

Authentic listening goes beyond non-judgemental curiosity and allows biases and lack of understanding to surface. When you are reacting to a person in a way that is interrupting your ability to listen, call it out and talk about it. Explore your assumptions and any differences in values, perspectives, and beliefs for greater understanding.

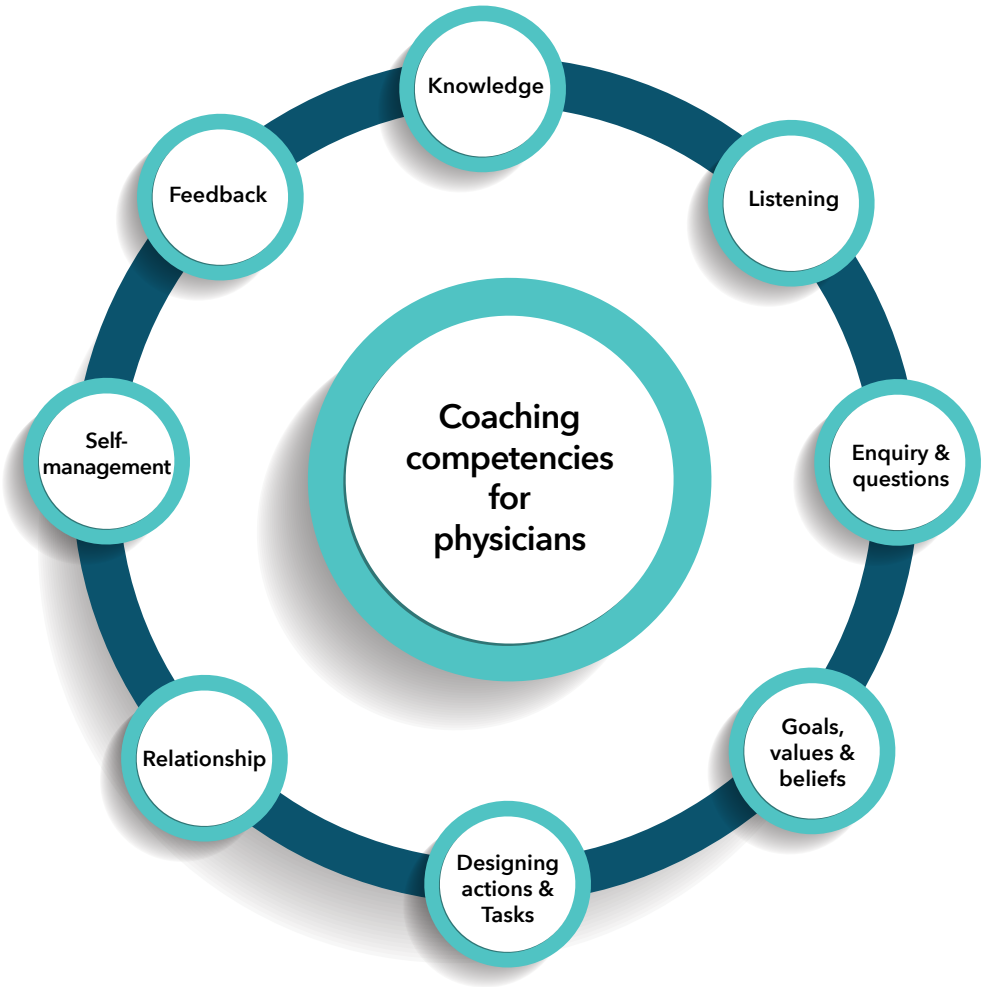
REFLECTION

Use paraphrasing and reflection to check understanding. Acknowledge feelings that surface during the conversation. Offer and accept feedback on how the encounter unfolded. Have a trusted mentor or coach to debrief intense interactions for ongoing learning and development.

More on core competencies for using the coach approach

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

Core competencies for the coach approach



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 upcoming issues of *CJPL*, I will adapt the core competencies of the coach approach for physicians and medical leaders and discuss the specific skills that comprise each. My next article will be about enquiry. We will examine the art of the open-ended question and how to choose exactly the right next question that moves the conversation forward in an impactful way.

References

1.Merrow N. Coaching competencies for physicians. *Can J Physician Leadersh* 2019;6(1):19-23. **https://cjpl.ca/coachingcomp.html**
2.Nichols RG. The struggle to be human. Presented at the ILA Convention, Atlanta, Ga., 17 Feb. 1980. **https://tinyurl.com/v3d3fvm**
3.Cox E. *Coaching understood: a pragmatic inquiry into the coaching process*. Los Angeles: Sage Publications; 2013.
4.Kimsey-House H, Kimsey-House K, Sandahl P, Whitworth L. *Co-active coaching: changing business transforming lives* (2nd ed.). Boston: Nicholas Brealey Publishing; 2007.
5.Hawkins P, Schwenk G. The interpersonal relationship in the training and supervision of coaches. In Palmer S, Mcdowall A (editors). *The coaching relationship: putting people first*. London: Routledge; 2010. pp. 203-21.

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This article has been peer reviewed.

Physician engagement, leadership, and wellness

Johny Van Aerde, MD, PhD, and Graham Dickson, PhD

Physician wellness is a pre-requisite for engaging physicians in shaping health systems of the future. Before reform can occur, physician leaders must address issues of wellness. In this article, we outline steps leaders can take to reduce physician burnout, to grow and sustain physician engagement, and to move to a place of wellness where other physicians can and will take on both formal and informal leadership roles. We also describe how use of the LEADS framework can generate leadership practices that increase wellness and reduce burnout at all levels of the health care system.

KEY WORDS: physician engagement, LEADS framework, health system change, physician leadership, burnout, wellness, psychological safety

Health care systems worldwide and in Canada are facing significant reform, and physician leadership is key in that reform.[1] Yet evidence shows that a critical proportion of physicians are suffering from low engagement and burnout, factors that limit their ability to be healthy receptors of change or to engage as partners in that change.[2-4] Indeed, the collective state of physician health has become a significant threat to the viability of the Canadian health care system.[3] Physician wellness is a prerequisite for any efforts to engage physicians in shaping health care systems of the future. Physician leadership must address issues of wellness before reform can happen.

The challenge is simple: the same physician leaders who would champion change must first address and mitigate conditions and circumstances that forestall physician wellness. To do so, they must recognize that, for many physicians, the path to wellness goes through three stages: diminishing and eliminating burnout, participating in activities and opportunities that enhance engagement, and taking the opportunity to become a physician leader in the cause of reform. This paper deals with how physician leaders, in partnership with other health system leaders, can introduce and take steps to address these concerns. The focus is on wellness, because the presence or absence of mental and social well-being of health care workers either enhances or limits health system performance.

In the first part of the paper, we outline steps leaders can take to reduce physician burnout, to grow and sustain physician engagement, and move to a place of wellness where other physicians can and will take on both formal and informal leadership roles. In the second part of the paper, we describe how use of the Canadian LEADS framework (Table 1) can generate leadership practices that increase wellness and reduce burnout at all levels of the health care system.

Steps in addressing physician burnout

To generate wellness, we must first define it. The World Health Organization (WHO) describes wellness as a state of complete physical, mental, and social well-being.[5] In its recent survey on physician health, the Canadian Medical Association defined mental health as a combination of emotional, psychological, and social well-being. In that survey, overall state of mental health was good in 58% of respondents, while 30% were experiencing burnout.[3] WHO describes burnout in ICD-11 as "a syndrome conceptualized as resulting

Table 1. The LEADS framework: five domains, 20 capabilities[17]

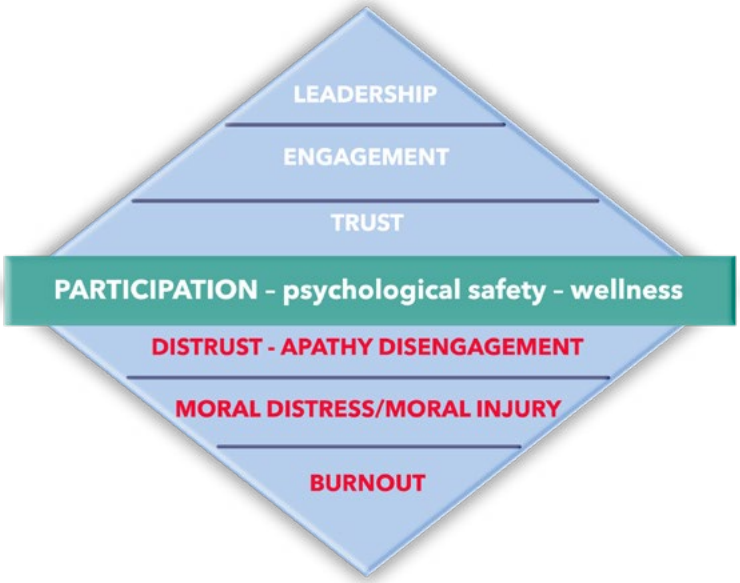
from chronic workplace stress that has not been successfully managed."[5] It is characterized by different ratios of Maslach's three dimensions: emotional exhaustion, increased distance from one's job with negativism or cynicism and depersonalization, and perceived or real reduction in professional efficacy.[5,6]

According to the Utrecht Work Engagement Scale,[6] vigour, dedication, and absorption result from engagement and are the assumed opposite poles of the three Maslach burnout characteristics: exhaustion, cynicism, and inefficacy.[7] Leadership and engagement are at the upper end of the engagement scale, burnout is at the opposite pole (Figure 1). The absence of trust and psychological safety – the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes[16] – can lead to apathy and disengagement, further descending to emotional fatigue, moral distress, and finally burnout. When trust and psychological safety are absent, leadership, engagement, and even simple participation are difficult if not impossible.

Wellness, engagement, and burnout are multi-level issues

There is debate about whether the lowest level of engagement is the same as burnout.[8] In a meta-analytic study, Goering et al.[9] found that "burnout and engagement predict a variety of behavioral and attitudinal outcomes differentially from one another," a sentiment shared by Sonnetag[10] and Prins et al.[11] In this context, it is likely better for leaders who wish to address both issues to see them as related but distinct; different strategies and tactics are required to ameliorate both. Whereas individual characteristics, such as perfectionism, used to be viewed as the main reason for burnout, organizational and systemic factors have come to the forefront more recently.[12] To generate wellness, offering only resilience programs to individual physicians is no longer sufficient, and leaders must address burnout prevention and wellness using a multi-level approach.

Figure 1. Degrees of individual engagement in the health care system.



Shanafelt and Noseworthy[12] identified drivers that determine interconnections between individual and systemic factors and that leadership can affect to improve wellness: workload and job demands, resources, meaning in work, organizational culture and values, control and flexibility, social support and community at work, and work–life integration. In other words, the main causes of burnout or the factors that could enable and maintain wellness are embedded in the structure and culture of organizations. In addition, there is a demoralizing misalignment between professional values and physicians' ability to meet each patient's needs for reasons that appear to be beyond a physician's control.[12]

Recently, new resources intended to improve health care, such as electronic health records (EHR), have actually reduced the quality of physician–patient interactions, resulting in even more fatigue and feelings of inefficacy, further decreasing the level of wellness and increasing the risk for burnout.[13,14] Stress caused by EHR design and use can be aggravated by chaotic clinical environments and lack of workload control.[15]

In short, increasing wellness requires formal and informal leadership at all levels — personal, interpersonal, organizational, and systemic — with nuanced strategies and tactics dependent on whether one is addressing burnout, as opposed to improving wellness or engagement.

Whereas Figure 1 illustrates the degrees of engagement for an individual physician, Table 2 reflects the range of organizational cultures of engagement and leadership with their various leadership types, mental models and cultures, relationships, and levels of engagement. The bottom three cultures — toxic at the bottom, moving up through dysfunctional to compliant — emerge from a hierarchical and mechanistic structure, where leadership resides only in formal authority. The top two cultures progress from sustainable, where leadership is distributed and embedded in organizational structures, to generative, an ideal state in which formal and informal leaders co-create the future. The organizational culture chasm implies a gap between compliant cultures (with formal leadership only and limited to no participation by physicians) to those where leadership, formal and informal, is shared by many, leading to trust, wellness, and engagement. Below the culture chasm, one cannot expect people to have the energy and mental fitness to become engaged and creatively participate in transformational changes.

Psychological safety and well-being

Based on two decades of research in organizations in the United States, Amy Edmondson[16] has developed frameworks and leadership toolkits that can be used to create psychological safety in the workplace surrounding learning, innovation, and growth. Without psychological safety and wellness the organizational culture chasm cannot be crossed (Table 2), and people will not be able to become engaged.

In Canada, the LEADS framework[17] has been mapped against the National Standard for Psychological Health and Safety in the Workplace,[18] demonstrating that LEADS can be used as a guide to improve psychological safety for all who work in the health care system. Research shows that

Table 2. Cultures of psychological safety and trust (above the culture chasm) lead to sustainable and generative organizations, while the absence of these characteristics leads to dysfunctional and toxic organizations.

Type of organization	Engagement level and leadership	Mental models, culture	Relationships
GENERATIVE	**Engagement level same as sustainable** ***Servant and co-creative leadership***	**Organizations are consciously evolving social systems**	**Co-creative and learning Evoking inspiration Mutually nourishing**
SUSTAINABLE	**Psychological safety Wellness, Trust Engagement** ***Compassionate and distributed leadership***	**Organizations are organic, living systems**	**Caring and safe learning Appreciative, trusting Honest, high integrity**
ORGANIZATIONAL CULTURE CHASM			
COMPLIANT	**Apathy** ***Formal leadership***	**Ideal organizations are machines or clocks**	**Respectful Purposeful**
DYSFUNCTIONAL	**Distrust Disengagement** ***Top-down leadership***	**People are the problem**	**Disrespectful Distrusting Dishonest, defensive**
TOXIC	**Moral distress Cynicism Burnout** ***Autocratic leadership***	**Those at the top are in power and always right**	**Attacking Blaming**

compassionate leadership is one of the primary factors needed to create a caring environment in healthy workplaces.[18] Health care leaders who employ the practices of LEADS will model behaviours that support the desired psychosocial factors of the national standard. In this respect, there is evidence that the leadership quality of immediate supervisors and executives can reduce burnout, improve satisfaction, and indirectly improve patient outcomes.[19,20] In one study,[19] every one-point increase in leadership score was associated with a 9% improvement in professional satisfaction and a 4% decrease in burnout among frontline doctors.

Evidence and return on investment in wellness programs for physicians

There are no longitudinal studies on the impact of interventions to prevent burnout or increase physician well-being, and studies on the effect of combinations of interventions at the individual, community, and system level are scarce. However, two articles provide evidence-based reviews and meta-analyses of both approaches.[21,22]

West et al.[21] looked at studies of interventions to prevent and reduce physician burnout, including single-arm, pre-post comparisons. Outcomes were changes in overall burnout rate, emotional exhaustion score, and depersonalization score. Of 15 randomized controlled trials, three involved structural intervention in the work environment and 12 were based on individual-focused interventions consisting of facilitated small group curricula, stress management and self-care training, communication skills, and community building. This review also looked at 37 cohort studies, 17 with structural and 20 with individual-focused interventions. Overall, the interventions decreased burnout rate (from 54% to 44%) and significantly reduced emotional exhaustion and depersonalization scores. Although both structural and individual-focused strategies resulted in clinically meaningful reductions in physician burnout, there was no information on a combination of these approaches and no long-term studies.

Panagioti et al.[22] also looked at individual- and organization-directed interventions in 19 studies with 1550 physicians. Overall, interventions were associated with small, significant reductions in burnout and emotional exhaustion. Subgroup analysis showed "significantly improved effects for organization-directed interventions

compared with physician-directed interventions," suggesting that burnout is more an organizational and systemic problem than individual. The organization-directed interventions that combined several elements, such as structural changes, fostering communication, cultivating a sense of control, and teamwork, tended to be the most effective in reducing burnout. Individual physician-directed interventions led to small but significant improvement, without evidence that content or intensity of the interventions further increased the benefits.

Based on these two reviews, Shanafelt at al.[23] made a business case for organizational interventions to invest in physician well-being. The authors demonstrated a positive economic effect, improved quality of care, and increased patient safety and satisfaction after changes were introduced to promote physician well-being. Many of these changes comprised elements of leadership and leadership development, as described in the five LEADS domains,[17] i.e., Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation.

In "Physician–organization collaboration reduces physician burnout and promotes engagement," Swensen[24] uses three principles to support the Mayo strategy against burnout: addressing people's psychological needs, developing constructive organization–physician relationships, and sponsoring physician leadership development. He writes, "The effectiveness of frontline physician leadership is one of the most critical ingredients for success. Medical centres need to develop physician leaders who can foster excellence, choice and camaraderie. Leadership development programs send a message that organization–physician partnerships are valued... they build social capital... accrued from trust, cooperation and connectedness of individuals and groups." These statements indicate that physician leadership development underlies the essence of Swensen's principles. Shanafelt et al.[23] further add that "Commitment from executive leadership is the prerequisite, assessment the first step, and frontline leadership a force multiplier." From the work of these frontrunners in the field of burnout, physician leadership and wellness seem to be going hand in hand.

In short, burnout reduction has been associated with organization-directed wellness initiatives, with weaker evidence for programs geared toward individual physicians.

Embedding physician engagement, leadership, and wellness in organizations

The articles discussed above focus primarily on addressing the challenges of burnout rather than generating higher levels of engagement, the next step in creating wellness. For this step, the Spurgeon model for engagement is helpful.

Spurgeon et al.[25,26] studied what engages physicians in leadership and later also reflected on the fourth of the Institute for Healthcare Improvement's quadruple aims (provider well-being)[27] and its effect on quality of care.[25,26] The Spurgeon model includes two dimensions: individual capacity, which reflects skills leading to increased self-efficacy and personal empowerment to tackle new challenges; and organizational opportunities reflecting structure and the cultural conditions that help physicians become more actively engaged in leadership activities (Figure 2).

While improving individuals' ability or capacity increases "can do," organizational opportunities increase personal motivation and "want to do." When some conditions are missing, physicians can feel powerless, frustrated, or challenged. Spurgeon showed that medical engagement is positively associated with organizational quality,[25,26,28] which has resulted in better outcomes, such as lower mortality rates and fewer patient safety incidents.[25,26] Once doctors become systematically engaged and take on leadership roles, the scores for patient experience also improve, as was seen at the Cleveland Clinic.[29]

Although the Spurgeon model[25,26] has been shown to improve physician engagement and leadership, organizational outcomes, quality of care, and patient satisfaction, it not yet been used for physician well-being. However, as leadership,

engagement, disengagement, and burnout are all part of one continuum (see Figure 1), the Spurgeon model could also be used to improve physician wellness for those who are not in the burnout space.

To operationalize the Spurgeon model, the Influencer model can also be applied to enable and maintain engagement at individual, interpersonal or social, and organizational levels.[30,31] The Influencer model has been suggested as a way to embed physician leadership development in the structure and culture of organizations,[31] but, so far, it has not been linked with physician wellness.

The Influencer framework encompasses six sources of influence, i.e., sources of motivation and ability in the personal, social, and structural spheres within organizations. Combining four or more sources of influence increases the chance of maintaining behavioural change tenfold.[30] When using this model, behavioural changes linked to the nine strategies delineated by Shanafelt and Noseworthy[12] have to be defined, and the six sources of influence have to be used to optimize the chance of improving wellness of physicians and other health care workers.[30,31]

Leadership and LEADS for physician wellness

Long-term solutions to improve the wellness of physicians must be implemented and maintained at all levels of health care delivery: individual, interpersonal, organizational, and systemic. A major premise of this paper

Figure 2. The medical engagement model (modified from Spurgeon et al.[25]) has two dimensions: individual capacity to tackle new challenges and organizational opportunities to become more actively engaged. The right upper quadrant represents optimal engagement by physicians and others.

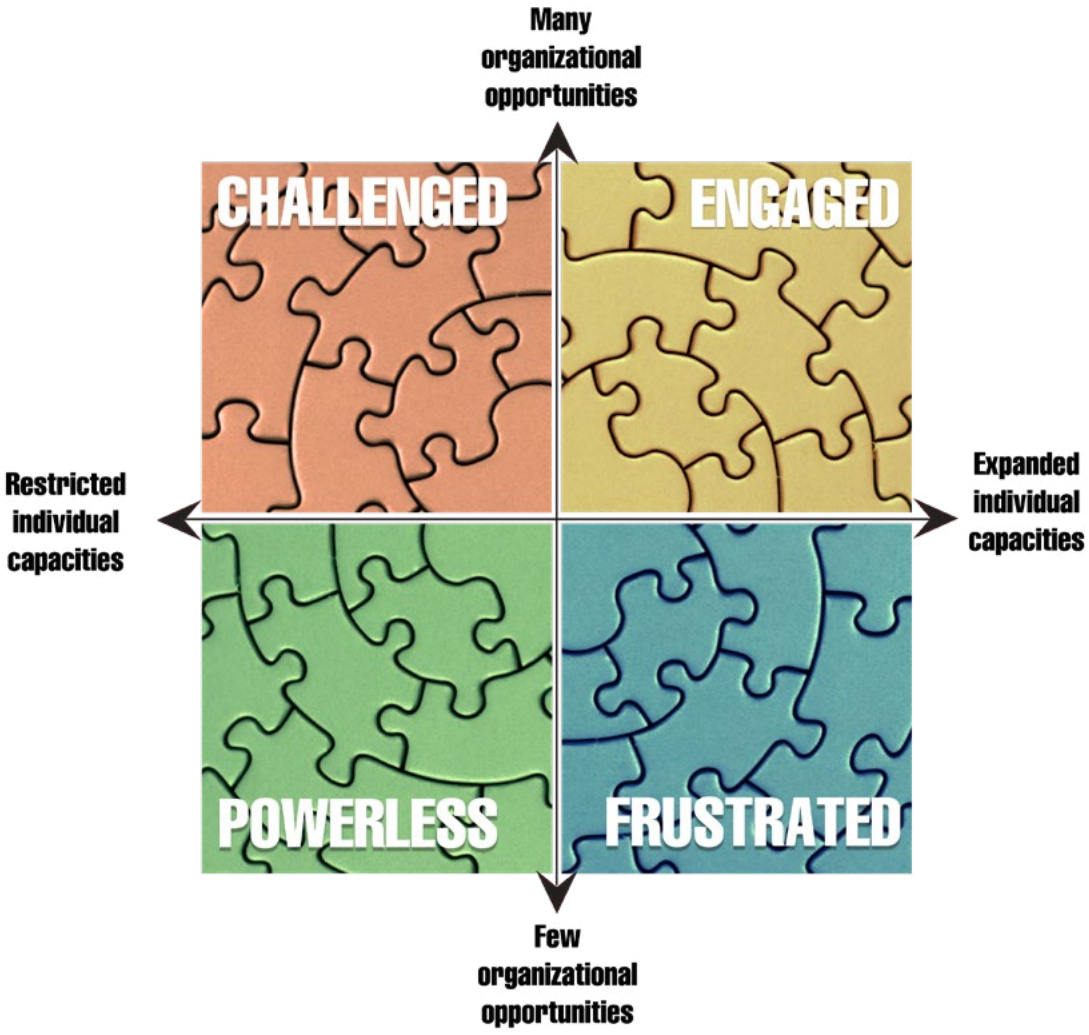


Table 3. Alignment of physician wellness with physician leadership

Mayo strategies[12]	LEADS capabilities[17]
1. Acknowledge and assess the problem	**LEAD SELF** • Are self-aware **ENGAGE OTHERS** • Contribute to creation of healthy organizations **ACHIEVE RESULTS** • Set direction • Asses and evaluate
2. Harness the power of leadership	**LEAD SELF** •Develop themselves • Demonstrate character **ENGAGE OTHERS** • Foster development of others • Contribute to creation of healthy organizations **DEVELOP COALITIONS** • Demonstrate commitment to customers/service • Navigate socio-political environments
3. Develop and implement targeted intervention	**ACHIEVE RESULTS** • Set direction • Strategically align decisions with vision, values, and evidence • Asses and evaluate
4. Cultivate community at work	**LEAD SELF** • Demonstrate character **ENGAGE OTHERS** • Foster development of others • Contribute to creation of healthy organizations • Communicate effectively • Build teams **ACHIEVE RESULTS** • Take action to implement decisions **SYSTEMS TRANSFORMATION** • Encourage and support innovation • Champion and orchestrate change
5. Use rewards and incentives wisely	**LEAD SELF** • Manage themselves ENGAGE OTHERS • Foster development of others • Contribute to creation of healthy organizations • Communicate effectively
6. Align values and strengthen culture	**LEAD SELF** • Are self-aware • Demonstrate character **ENGAGE OTHERS** • Forster development of others • Contribute to creation of healthy organizations **ACHIEVE RESULTS** • Strategically align decisions with vision, values, and evidence **SYSTEMS TRANSFORMATION** • Demonstrate systems and critical thinking • Encourage innovation • Champion and orchestrate change
7. Promote flexibility and work-life integration	**LEAD SELF** • Are self-aware • Manage themselves **ENGAGE OTHERS** • Contribute to creation of healthy organizations • Build themes **ACHIEVE RESULTS** • Strategically align decisions with vision, values, and evidence • Asses and evaluate **DEVELOP COALITIONS** • Purposefully build partnerships and networks to create results • Mobilize knowledge
8. Provide resources to promote resilience and self-care	**ACHIEVE RESULTS** •Take action to implement decisions • Asses and evaluate
9. Facilitate and fund organizational science	**ACHIEVE RESULTS** • Take action to implement decisions • Asses and evaluate **SYSTEMS TRANSFORMATION** • Demonstrate systems and critical thinking • Encourage and support innovation • Orient themselves strategically to the future • Champion and orchestrate change

is that leaders have both the responsibility and the skill set to create the conditions that will minimize burnout, improve engagement, and increase physician leadership. But, like our definition of wellness and our efforts to delineate what comprises burnout and engagement, leadership practice must also be defined. Earlier, the LEADS framework was introduced as a delineation of leadership practices with application at the individual, organizational, and systemic levels of the health care system. It also embraces leadership practices consistent with the Spurgeon[25] and the Influencer models.[30]

The LEADS framework provides a set of expectations and standards that can be used both to guide development of leadership skills for the individual physician's wellness (horizontal axis of Figure 2) and for organizational culture and structure (vertical axis) by embedding the framework systemically. Using practices guided by LEADS will enhance organizational opportunities for professionals to engage in quality for wellness, hopefully contributing to future health system transformation.

LEADS is a framework for leadership and leadership development, and its 20 capabilities can be integrated with actions to be taken for improving and maintaining physician wellness. In Table 3, the nine evidence-based strategies to improve physician wellness and reduce burnout described by Shanafelt and Noseworthy[12] and implemented

at the Mayo Clinic are aligned with the corresponding domains and capabilities of the LEADS leadership model.[17] Each strategy can be implemented using two to eight LEADS capabilities, and the capabilities together can fulfill the needs of the nine strategies. The term capability refers to the ability to work in a complex, multi-level, ever-changing environment, such as in the health care system, in the context of lifelong learning; the term competency refers to the skills and knowledge required to work in a predictable environment.

The LEADS framework can be used in three ways to embed physician well-being systemically. The first is for physicians, their peers, and coworkers to actually practise the behaviours implicit in the LEADS domains and capabilities. In doing so, they can model behaviours that support the workplace factors that lead to a culture of well-being and psychological safety. To that end, physicians, physician leaders, and their peers must truly concentrate on learning and demonstrating those capabilities, formally and informally.

Second, the LEADS framework can be used as a *disciplined approach* to change for creating psychologically healthy workplaces. Although the first use (above) benefits individual physicians and their teams, this second use is a change management process to support physician and non-physician leaders and help their organizations and the health care system cross the culture chasm into wellness, sustainability, and generative transformation. Although the theory behind each capability will show commonalities for each individual and organization, the practical behavioural implementation is likely to be different.

The third use is at the system level and consists in continuing to advance the use of LEADS as a *common vocabulary of leadership* throughout the health care system, such that practices, initiatives, and solutions based on LEADS can be understood and shared as they are refined for individual system contexts, including physicians.[32,33] LEADS can also be seen as a change approach that embraces the "caring" goal inherent in psychological health and safety.[34]

Conclusion

Leaders have the responsibility to create change within an environment of psychological health and safety. Physicians must provide the leadership required to generate psychological health and safe environments for their colleagues before such change can happen. For many physicians, the path to wellness goes through three stages: diminishing and eliminating burnout, participating in activities and opportunities that enhance engagement, and taking the opportunity to become a physician leader, formally and informally, in their own right.

If an organization is already experiencing psychological risks, any change process layered on top of day-to-day tasks can put additional stress on already strained staff, and individuals cannot contribute much if they live below the culture chasm. Achieving organizational wellness requires a sophisticated approach to the process of change management and distributed leadership. In organizations, leaders and physician leaders have the responsibility to steward the change.

LEADS can be used as a leadership development framework and as a change management tool to champion the practices that address burnout, as at the Mayo Clinic,[12,24] and improve engagement by using the sustainability model based on the Spurgeon[25] and Influencer[30] models. In doing so, physician leaders can generate wellness for physicians and all workers in the health care system. It behooves all physician leaders to acquaint themselves with the expectations of LEADS and embrace them in practice to create the healthy workplaces that our physicians need to be meaningful partners in health care reform.

References

1.Van Aerde J, Dickson G. Accepting our responsibility: a blueprint for physician leadership in transforming Canada's health care system. White paper. Ottawa: Canadian Society of Physician Leaders; 2017. Available: **https://bit.ly/20fUlj0**

2.Shanafelt T, Boone S, Tan L, Dyrbye L, Sotile W, Satele D, West C, Sloan J, Oreskovich M. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med* 2012;172(18):1377-85. DOI: 10.1001/archinternmed.2012.3199

3.CMA national physician health survey. Ottawa: Canadian Medical Association; 2018. Available: **https://**

tinyurl.com/ubtd4s3
4.Boudreau R, Grieco R, Cahoon S, Robertson R, Wedel RJ. The pandemic from within: two surveys of physician burnout in Canada. *Can J Commun Mental Health* 2006;25(2):71-88. DOI: 10.7870/cjcmh-2006-0014
5.Burn-out an "occupational phenomenon": International Classification of Diseases. Geneva: World Health Organization; 2019. Available: **https://tinyurl.com/y3mr2gq9**
6.Schaufeli W, Bakker. UWES: Utrecht Work Engagement Scale. Version 1.1. Utrecht: Occupational Health Psychology Unit, Utrecht University; 2004. Available: **https://tinyurl.com/thby5nx**
7.Leiter M, Maslach C. Latent burnout profiles: a new approach to understanding the burnout profile. Burn Res 2016:3(4):89-100. DOI: 10.1016/j.burn.2016.09.001
8.Taris T, Ybema JF, Beek I. Burnout and engagement: identical twins or just close relatives? *Burn Res* 2017;5:3-11. DOI: 10.1016/j.burn.2017.05.002
9.Goering DD, Shimazu A, Zhou F, Wada T, Sakai R. Not if, but how they differ: a meta-analytic test of the nomological networks of burnout and engagement. *Burn Res* 2017;5:21-34. DOI: 10.1016/j.burn.2017.05.003
10.Sonnetag S. A task-level perspective on work engagement: a new approach that helps to differentiate the concepts of engagement and burnout. *Burn Res* 2017;5:12-20. DOI: 10.1016/j.burn.2017.04.001
11.Prins JT, Hoekstra-Weebers JE, Gazendam-Donofrio SM, Dillingh GS, Bakker AB, Huisman M, et al. Burnout and engagement among resident doctors in the Netherlands: a national study. *Med Educ* 2010;44(3);236-47. DOI: 10.1111/j.1365-2923.2009.03590.x
12.Shanafelt T, Noseworthy J. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc* 2017;92(1):129-46. DOI: 10.1016/j.mayocp.2016.10.004
13.Shanafelt T, Dyrbye L, Sinsky C, Hasan O, Satele D, Sloan J, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc* 2016; 91(7):836-48. DOI: 10.1016/j.mayocp.2016.05.007
14. Gardner RL, Cooper E, Haskell J, Harris DA, Poplau S, Kroth PJ, et al. Physician stress and burnout: impact of health information technology. *J Am Med Inform Assoc* 2019;26(2):106-14. DOI: 10.1093/jamia/ocy145
15.Kroth PJ, Moriaka-Douglas N, Veres S, Bobbott S, Poplau S, Qeadan F, et al. Association of electronic health record design and use factors with clinician stress and burnout. *JAMA Netw Open* 2019;2(8):e1999609. DOI: 10.1001/jamanetworkopen.2019.9609
16.Edmondson A. *The fearless organization: creating psychological safety in the workplace for learning, innovation, and growth*. Hoboken, NJ: John Wiley & Sons; 2019.
17.Dickson G, Tholl B. *Bringing leadership to life in health: LEADS in a caring environment: a new perspective*. London: Springer; 2014.
18.Dickson G. Transforming healthcare organizations. Healthier workers. Healthier leaders. Healthier organizations. Ottawa: Mental Health Commission of Canada; 2018.
19.Shanafelt T, Gorringe G, Menaker R, Storz K, Reeves D, Buskirk S, et al. Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clin Proc* 2015;90(4):432-40. DOI: 10.1016/j.mayocp.2015.01.012
20.Shanafelt T, Lightner D, Conley C, Petrou S, Richardson J, Schroeder P, et al. An organization model to assist individual physicians, scientists, and senior health care administrators with personal and professional needs. *Mayo Clin Proc* 2017;92(11):1688-96. DOI: 10.1016/j.mayocp.2017.08.020
21.West C, Dyrbye L, Erwin P, Shanafelt T. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet* 2016;388:2272-80. DOI: 10.1016/S0140-6736(16)31279-X
22.Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. *JAMA Intern Med* 2017;177(2):195-205. DOI: 10.1001/jamainternmed.2016.7674
23.Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. JAMA Intern Med 2017;177(12):1826-32. DOI: 10.1001/jamainternmed.2017.4340
24.Swensen S, Kabcenell A, Shanafelt T. Physician–organization collaboration reduces physician burnout and promotes engagement: the Mayo experience. *J Healthc Manag* 2016;61(2):105-27.
25.Spurgeon P, Barwell F, Mazelan P. Developing a medical engagement scale (MES). *Int J Clin Leadersh* 2008;16:213-23.
26.Spurgeon P, Mazelan PM, Barwell F. Medical engagement: a crucial underpinning to organizational performance. *Health Serv Manage Res* 2011;24(3):114-20. DOI: 10.1258/hsmr.2011.011006
27.Feeley D. The triple aim or the quadruple aim? Four points to help set your strategy. Boston: Institute for Healthcare Improvement; 2017. Available: **https://tinyurl.com/sv2a267**
28.Spurgeon P, Clark J. *Medical leadership: the key to medical engagement and effective organisations*. London: CRC Press; 2018.
29.Merlino J, Raman A. Health care's fanatics. *Harv Bus Rev* 2013;91(5):108-16.
30.Grenny J, Patterson K, Maxfield D, McMillan R, Switzler A. *Influencer: the new science of leading change*. New York; McGraw Hill; 2013.
31.Snell AJ, Eagle C, Van Aerde JE. Embedding physician leadership development within health organizations. *Leadersh Health Serv* 2014;27(4):330-42. DOI: 10.1108/LHS-04-2014-0033
32.Van Aerde, J. Putting LEADS to work in the health professions. In Dickson G, Tholl B. (editors). *Bringing leadership to life in health: LEADS in a caring environment* (2nd ed.). London: Springer; 2020. In press.
33.Dickson G, Van Aerde J. Enabling physicians to lead: Canada's LEADS framework. *Leadersh Health Serv* 2018;31(2):183-94. DOI: 10.1108/LHS-12-2017-0077
34.Dickson G, Tholl B. (editors). *Bringing leadership to life in health: LEADS in a caring environment* (2nd ed.). London: Springer; 2020. In press.

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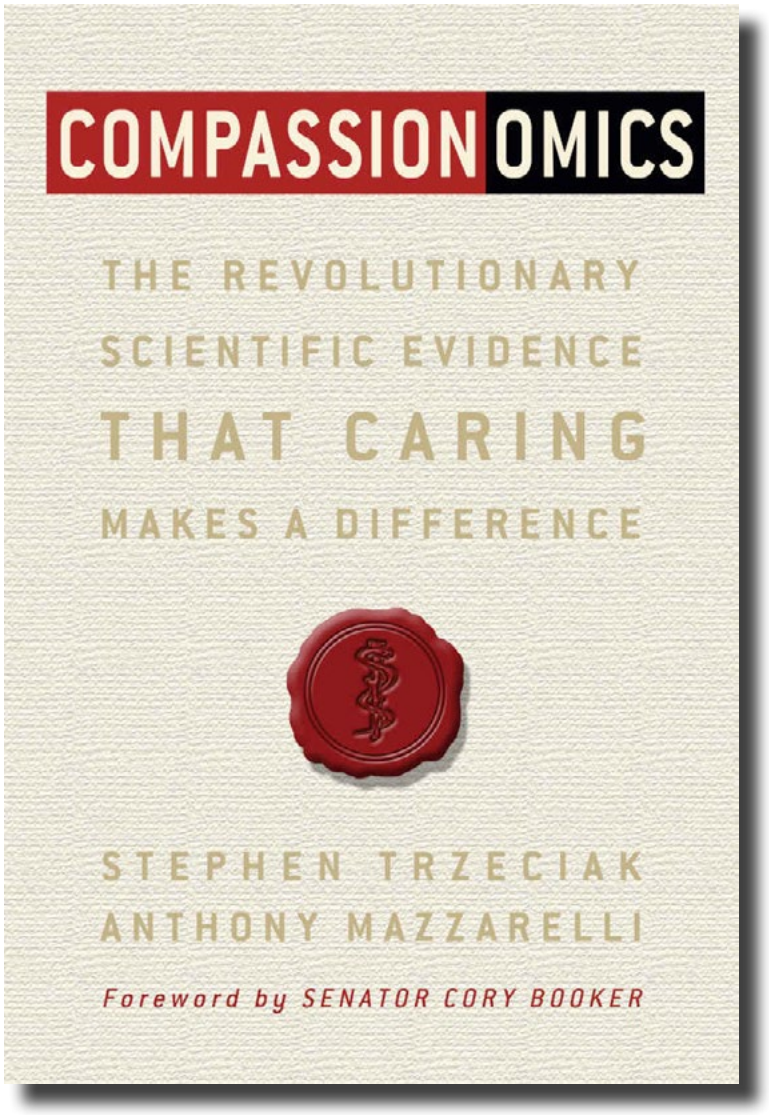
This article has been peer reviewed.

BOOK REVIEW

Compassion-omics: The Revolutionary Scientific Evidence that Caring Makes a Difference



Stephen Trzeciak and Antony Mazzarelli
Studer Group, 2019

Reviewed by J. Van Aerde, MD, PhD

No matter how much virtual care and artificial intelligence become part of health care, compassion remains a fundamental element in the relationship between helper and receiver. Compassionate care used to be an artful skill in the days when the "science of medicine" didn't have much to offer. Rapidly increasing scientific knowledge and technology have resulted in a compassion crisis in medicine, further aggravated by the current level of burnout among health care workers.

In Compassionomics – a term reflecting the combination of the art and the science of compassion – Drs. Stephen Trzeciak and Antony Mazzarelli ask whether compassionate care in medicine has made a reasonable difference in the well-being of patients and doctors. Trzeciak is an intensivist and clinical scientist with extensive experience in biomedical systematic reviews, and Mazzarelli is an ER physician, lawyer, and ethicist.

To their surprise, they found decades of evidence with hundreds of studies that had never been synthesized using a vigorous scientific approach. After reviewing more than 1000 abstracts and over 250 peer-reviewed research papers from the biomedical literature, they found that evidence pointed in one direction: compassion in medical and clinical relationships leads to better patient outcomes, lower health care resource use, and reduced medical costs. The authors provide solid evidence that compassion improves many health outcomes, including headache and migraine, back pain, diabetes, HIV, anxiety, depression, and even the common cold.

One explanation might be better patient self-care and improved adherence to prescribed therapy. However, the authors dig deeper for explanations and make connections with physiological and psychological processes. Although compassionate relationships result in better health care quality,

the opposite is also true: lack of compassion among health care providers can be a serious patient safety risk.

The book counters five reasons why physicians might miss why compassion is important:

1."I don't see it; it does not apply to me" – The book provides evidence that many who think they are providing compassionate care actually have a blind spot, a cognitive bias.
2. "I don't have time" – No less than five studies show that it takes, on average, less than 40 seconds to make a meaningful difference to a patient, and such opportunities occur 2.5 times per visit.
3. "I don't care" – Compassion benefits both the receiver and the helper in the caring relationship by reducing the sense of disconnect and burnout. Compassion differs from empathy in that it includes action. That action, to relieve suffering, activates the brain's "reward" pathways as seen on fMRI. More compassion is associated with less depression, a greater sense of personal accomplishment, and enhanced quality of life. Physicians who are most dissatisfied with the quality of their relationships with patients have a 22-fold higher risk of burnout.
4. "I don't know how" – Like any leadership skill, empathy and compassion can be learned without investment of a lot of personal time or organizational money.
5. "I don't believe it really matters" – That argument will not hold when you have read this book, which offers plenty of evidence that compassion does matter for the receiver, the helper, and organizations in the health care system.

Trzeciak put his findings into practice when, after 20 years in the ICU, he was burned out. He applied the techniques he had been studying, including spending at least 40 seconds during an appointment practising compassion toward patients. Once he connected more, cared more, leaned in rather than withdrawing, the fog of burnout started to lift and changed into what he calls "helper's high."

No matter how much technology tries to take away from our humanity, this book proves the importance of compassion and brings us back to what has been the essence of medicine since the days of Hippocrates: relationship-centred care.

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