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SCLM Société canadienne des leaders médicaux

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EDITORIAL

Engagement in the health system

Johny Van Aerde, MD, PhD

This issue of our *Canadian Journal of Physician Leadership* is about engagement. Physician engagement takes place at two levels: the independent, individual level and the interdependent, systemic level. At the independent level, physicians act as disease experts and as advocates for each patient, all on a one-to-one basis. In contrast, the interdependent level of engagement consists of two-way interactions, relationships if you will, with all the elements in the health care system: patients, physicians, health care workers, and all other stakeholders, each with their own needs and contributions.

The different types of relationships at these two levels require different mental models of health, wellness, and disease, as well as different sets of leadership skills. One important skill is the ability to zoom in and out: zoom into the detailed, individual elements and zoom out to see the overview and the connections between all those elements.

This issue of the *CJPL* offers material that deals with both levels of physician engagement. The book review – of three related books – gives us a glimpse into the one-on-one level, the relationship between the patient and the physician or the health care team. What is unusual about these books is the people who wrote them. They entered the health care system from different angles, as mothers, patient advocates, physicians. The physicians ended up as patients in their own units and disliked the world they themselves had helped create. All three books make us pause and reflect on our professional relationships, our understanding of how and what we communicate, our mental models, compassionate care and empathy, and what these constructs mean at the individual, independent level of engagement.

The seven articles in this issue apply mainly to the interdependent, systemic level, although some deal with both levels. Brian Goldman's writing on the mental model of "us and them" (pages 95-98) leans closely

toward the books reviewed, with an ER story that describes the empathy gap created by different social identities inside and outside our health care system. Duncan Rozario (pages 99-103) weaves Plato's seven virtues into both levels of engagement, starting with our own mental models and how they relate to the values we hold.

Tyrone Perreira and colleagues (pages 111-122) have developed a short, easy survey to measure physician engagement at the systemic level and describe how it can enable engagement in quality initiatives. Dawn Hartfield (pages 104-110) looked retrospectively at systemic engagement from a practical angle. A new physician leader, she structured the domains of the LEADS framework to guide a new quality management program. Figure 5 in her paper shows a new way to look at the LEADS framework within the context of the Stacey complexity model.

Malcolm Ogborn (pages 83-88) illustrates time management in a new light that can be used at all levels of engagement. The same applies to Nancy Merrow's third article in a series on coaching competencies (pages 90-94). This time she explains how to ask appropriate questions that turn a problem into a goal and move intentions into actions. David Mador (pages 123-127) shows us what else is possible as physician leaders transition through the phases of their professional life.

How do they re-engage with the system, and how do physicians who used to have leadership roles re-adjust when they rewire and re-engage differently?

We hope that this issue stimulates you to reflect on how best to engage in our health care system at all levels to make the world around us a better place for each (individual level) and for all (systemic level).

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PERSPECTIVE

Mastery of time: a challenge for physician leaders

Malcolm Ogborn, MBBS

Dealing with time demands is an ongoing challenge for physician leaders and a significant reason for the reluctance of physicians to accept leadership roles. Mastering time involves more than just maintaining a structured calendar; it requires understanding the bias our own perception places on time choices, understanding how we assign priority, and developing and maintaining good, consistent habits of time allocation. Time perception falls into five main frames: Past-Negative, Past-Positive, Present-Fatalistic, Present-Hedonistic, and Future. How we balance our focus between them has a significant influence on our time-allocation choices. Understanding urgency requires vigilance for decisions being driven by impatience. Understanding importance requires careful reflection on personal mission, values, and goals. Email is often cited as a unique challenge to effective use of time, but is really just a slightly special case of the consequences of not having a firm paradigm for making decisions about use of time. These concepts can be applied in concert through frameworks, such as the Eisenhower box. Effective time management is not a simple trick; it is the product of good habits of thought, appropriate organizational skill, and clear communication to those with whom we work. Commitment and practice in this area can be life changing.

KEY WORDS: time management, time perception, physician leadership, Eisenhower box

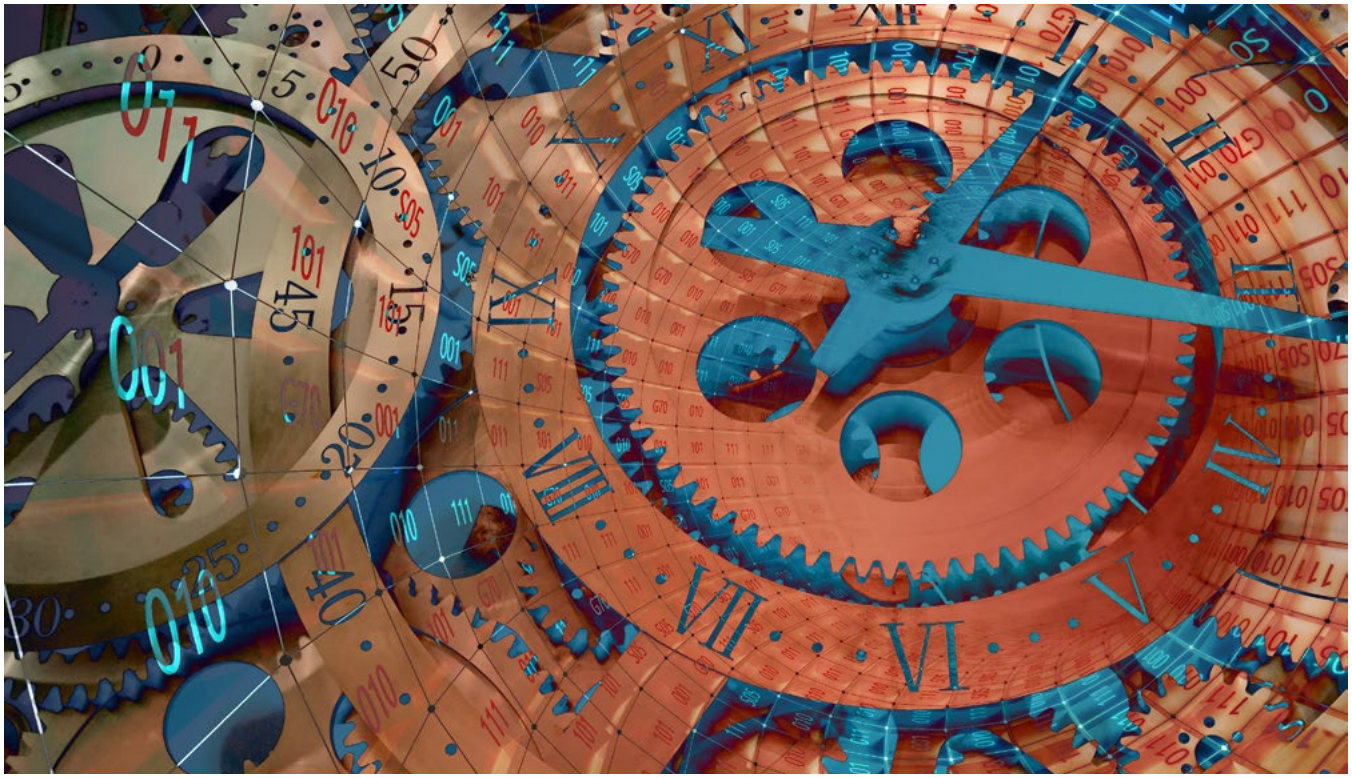
"How did it get so late so soon? It's night before it's afternoon. December is here before it's June. My goodness how the time has flewn. How did it get so late so soon?" – Dr. Seuss

Better time management is an almost universal wish of physician leaders. Taking control of our time is essential for our own effectiveness and well-being. Also, one of the most common responses of potential leaders is, "I am not sure if I can find the time." To attract other physicians to leadership, leaders must demonstrate, by example, that the demands of leadership can be managed within a reasonable lifestyle.

Mastery of time occurs in three steps: understanding our own individual perception of time; achieving insight into what is truly urgent and truly important; and applying those insights to allocate time.

Understanding perception of time

"You can't have a better tomorrow if you are thinking about yesterday all the time." – Charles F. Kettering



Nor can you effectively manage the challenges of today if your head is perpetually lost in the infinite possibilities of the future. Dr. Philip Zimbardo, over decades of research into how we perceive time, has identified five "temporal frames" that capture how we cluster our time perceptions.[1] These are Past-Negative, which views past experience with negativity and pessimism; Past-Positive, which is the reverse; Present-Fatalistic, where we see ourselves at the mercy of current events; Present-Hedonistic, where we seek pleasure and gratification in the moment; and Future, where we plan and consider diverging possibilities. The tendency to use each of these frames can be measured by an online inventory tool.[2]

Based on accumulated data from this inventory and studies correlating it with other psychological measures, the researchers have proposed an ideal balance between frames – not just for time issues but for balancing affect.[3] Predominant foci in Past-Negative, Present-Fatalistic, or Future have been associated with negative affect, whereas Past-Positive or Present-Hedonistic foci are correlated with positive affect. To be productive in the present and organized for the future, we must accept what is beyond our control in the present, while making room in the moment for our happiness, well-being, and celebration of achievement. We also need forward-thinking plans without being paralyzed by consideration of an infinity of possible outcomes. If we lean excessively to past or future, we risk not allocating enough time to present events.

Conversely, if we fill every minute of our formal schedule with present concerns, we set ourselves up to fail when we inevitably drift for some time into reminiscence or speculation. In balanced time perception, making allowance for time spent in past, present, and future is essential. Achieving this balance in perception is amenable to a range of coaching or self-change approaches, discussion of which is beyond the scope of this article.[4] Without such balance, we may pay lip service to managing time in a logical way, but our preferred time focus will act to sabotage our best efforts by leading us away into past or future, or allowing to us to abdicate responsibility for our fate by wallowing in fatalism.

Deciding urgency and importance

"Your time is limited, so don't waste it living someone else's life."
– Steve Jobs

Urgency is an important influence in time-related decisions, and complex mathematical models compete to quantify its impact.[5] But while we measure urgency, defining the source is much more elusive. Jon Elster, a political and social theorist working from a more philosophical viewpoint, hypothesizes that we tend to be "intolerant of inaction."[6] He then draws a distinction between two states that form that intolerance: impatience and urgency. In impatience, we are unable to defer gratification and will accept smaller gains for immediate reward. Urgency is more complicated; it leaves space for recalculation of the benefits of delay and the urge to act may be tempered by other concerns.

In both cases, our judgement is likely being influenced by how acting will reward us. How many of the things that hit your urgent list will have serious consequences for you and others if delayed, meaning they are truly urgent? Here the reward is achievement of a goal or avoidance of catastrophe. Alternatively, how many things on that list will have irritating consequences or require some effort to defer or refuse, but their delay will not contribute to the end of life as we know it? Here the reinforcement is often no more than avoiding or deferring something undesirable, or requiring more immediate effort to secure a longer-term gain. Such immediate gratifications can unfortunately still be powerful rewards.

Do you ever accept a task that is really a distraction, but it is easier to get it out of the way than deal with a nagging requester or have a learning conversation about whether the request is appropriate? Do you find yourself saying, "It's just easier to do it myself"? If you answered "yes" to either question, you may be confusing impatience with urgency. We are busy people; as a result, many of our urgency rankings risk being relegated to Daniel Kahneman's[7] largely subconscious System 1 thinking, which supports quick decision based on unconsciously recognizing patterns of inputs. This instant decision-making, while economical of effort in the moment, creates the risk of being seduced into short-term expediency at long-term cost. Mastering time requires using Kahneman's more objective, intentional, and reflective System 2 to make conscious decisions about what issues truly merit the designation *urgent*.

The issue of importance also has layers of nuance. To quote Stephen Covey,[8] "If something is important, it contributes to your mission, your values and your high priority goals." It follows logically that, to identify something as important, you must be able to identify your mission, articulate your values, and set your high-priority goals.

Mission may be something imposed by organizational practice or business, although often such statements lack the precision required to inform choices among individual scheduling demands. Leadership literature stresses the value of personal mission statements as the "how" of achieving our vision, which in turn is the "what," a describable and achievable state of the future. Time aligned with mission is time spent in a role or behaviour that contributes to what we seek to achieve.

Values shape the choices we make in our mission. However, we often only become aware of our values when something arises that conflicts with them. More commonly, we must make a choice about best fit with our values, and this requires conscious reflection. The free online Barrett Personal Values Assessment (PVA) can help start this process.[9] The PVA is useful for articulating values, but it also maps them onto psychological drives. Time aligned with values is time aligned with meeting the underlying needs those values support.

Goal setting – Many organizations have embraced the SMART goal concept: Specific, Measurable, Achievable, Realistic, Timely. However, in my experience, many people do not routinely use such goals much beyond annual performance evaluations, let alone in daily scheduling decisions. Even simple steps in this direction, such as maintaining an up-to-date "to do" list can be very helpful. Time aligned with goals results in completion of objectives and milestones that you have set for yourself.

It is worth noting what research says about how we perceive time well spent. Dr. Ilona Boniwell[3] found that time well spent is associated with doing things we like, that serve balance in our lives,

work well with our organizational systems, and do not leave us with a sense of time running away from us or out of our control. She describes a cycle, which might be seen to reward some choices and discourage others. It does hinge on the starting point of doing things we like, or things that give us satisfaction.

Dr. Kennon Sheldon[10] found that events contributing to self-esteem, such as autonomy, relatedness, and competence, tended to be seen as the most satisfying and were consistently ahead of those contributing to self-actualization or meaning, physical thriving, and popularity. Events associated with the acquisition of money and luxury were seen as an even less satisfying use of time. The hierarchy that puts status and achievement ahead of well-being may well be relevant to the discussion of burnout among physicians and other high-achieving professionals. Even the concept that we find enhanced self-esteem more satisfying than self-actualization suggests a risk of making time choices to look good rather than pursuing personal goals.

Making accountable decisions about time allocation

"The key is in not spending time, but in investing it." – Stephen R. Covey

The core issue in mastering time is having a clear decision-making paradigm about allocating time and a clear action pathway arising from that paradigm. A simple and effective model, described in detail under the third of Stephen Covey's[8] "seven habits of highly effective people," is the Eisenhower box. This model was first described by President Eisenhower in a speech to the World Council of Churches in 1954. The box is a simple two by two grid with columns labeled "Urgent" and "Not urgent," and rows labeled "Important" and "Not important" (Figure 1). The simplest application suggests that tasks in quadrant 1, *urgent–important*, be done immediately. Tasks in quadrant 2 (*not urgent–important*), while important, can be scheduled to a convenient time. Tasks in quadrant 3 (*urgent–not important*) may be urgent for someone other than you or, even if urgent, the penalty for not putting them ahead of other priorities may be acceptable. These may be deferred, delegated, or discarded. Tasks in the final *not urgent–not important quadrant* may be nice to do but not essential, or may often be tasks continued out of tradition or habit. These may be safely discarded.

Covey makes some further telling observations about the "highly effective" people he studied. First, they anticipate the demands of the *urgent–important* quadrant. They pre-emptively allocate time for these tasks, knowing they will happen, even if they do not know what they will be. This is analogous to an office medical practice reserving a couple of appointments each day for urgent patients. Second, and most striking, highly effective people simply do not do quadrant 3 and 4 tasks. In Covey's view, highly effective people focus exclusively on what is important. It also follows that they must be skilled at turning down requests for their time.

Totally ignoring the tasks allocated to quadrant 3 may be a luxury

Figure 1. The Eisenhower box

not all can afford, but this area is prime for developing delegation skills.[11] There is a trade-off here: in exchange for gaining back time that would otherwise be spent on the task, the leader must intentionally allocate a share of quadrant 2 time to provide clarity about the task to the delegate, make a commitment to follow up, provide thoughtful and constructive feedback, and celebrate success. By so doing, they convert a distracting task to a capacity-building exercise for members of their team, which will reduce their own workload in the long term. Delegation is also a valuable tool in deriving the most benefit from personal time.

A number of studies have shown that people who use their wealth to buy time for desired pursuits are happier than those who accumulate "stuff,"[12] making this the exception to the old saw of money not buying happiness.

Time spent in maintaining social relationships, fitness, and health should clearly be quadrant 2 activities. If you are deferring these during your precious off time to cut grass or clean bathrooms, you might want to explore buying those services.

Email is not above the law

"Any email that contains the words 'important' or 'urgent' never are, and annoy me to the point of not replying out of principle." – Markus Persson

Email gets a special mention, because it is frequently identified as one of the major time stresses in many environments. It is recognized as a driver in many workplace distraction scenarios and maladaptive behaviours. Some companies and European countries have gone as far as regulation and legislation to limit off-hours access to and use of work email as a workplace health and safety concern.[13] Despite this imposition, these countries and companies seem to be doing fine, perhaps proving that there is life beyond email.

If you sit at your screen, waiting to pounce on and respond to messages at any time of the day and night, you are the one training people to send you those emails. Instead, you could set aside specific time for email processing in your schedule. It is possible to construct filters to align incoming messages with your urgent and important criteria. If you do so, you will find that people will pick up the phone if it really is urgent (it usually is not). They may conclude that, if there will not be an instant response, maybe the issue is not important enough to

waste time typing. Email survival, detox, and rehab is a big topic that is well covered in *The Hamster Revolution*.[14]

Summary

To master time,

1. Understand how you perceive time and strive to develop a balanced perspective of past, present, and future.
2. Develop explicit criteria for what you can truly accept as urgent.
3. Develop and continuously update criteria for what is important. Intentionally weigh demands on your time against your mission, values, and goals. Do not forget those things that are important to your well-being and humanity.
4. Create and implement a decision-making paradigm to apply the axioms you adopt. Put the commitments involving your life balance and well-being into the calendar first. Apply the paradigm to everything, including email.
5. Practice ways to say no to demands outside your priorities. Look for opportunities to delegate while allowing adequate time to follow up and support the delegation.
6. Consider coaching to support you. This could be informal, working with friends, family, or colleagues who are striving to or have achieved similar results, or engagement with a professional coach.

There is no instant panacea for time management. Each of these steps requires reflection, development of a process that works for you, commitment to apply that process, and re-evaluation of your results. It involves discarding old habits and developing new ones, with all the neuropsychological complexity that we now understand comes with such changes. This is challenging work, but success, or even progress, can be life changing. Do you dare try?

"If we take care of the moments, the years will take care of themselves."
– Maria Edgeworth

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ADVICE

Coaching competencies for physicians: the artful question

Nancy M. Merrow, MD

In this series of articles on coaching competencies, we have been exploring how the coach approach fits into medical practice and leadership. Whenever you are faced with a person or group of people who want things to change, there is an opportunity for coaching. In coaching, artful questions and deep listening skills are used to identify the person's goals, intentions, and inner resources that will be drawn upon to move forward. We propose that the coaching style of conversation is one tool that can be very useful once the physician has explored the utility and circumstances that make it powerful.

KEY WORDS: coaching competencies, questioning, deep listening

When using the coach approach, we co-create a relationship within which questions can be asked that provoke the person into new insights about an issue, the options, and their willingness to act. The coach holds the person 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 person and may be holding them back from committing to what they say they want.

In our first article,[1] we introduced the parallels between a traditional medical encounter and one using a coach approach. We adapted the SOAP model (subjective, objective, assessment, plan) and switched the physician role from the expert providing the right answer, to a coach asking the right question that unlocks the person's expertise in their own life. The coach approach shifts the responsibility for insight and action to the person with the issue. The coach holds the person accountable for their intentions.

The first specific competency we looked at was listening.[2] Whatever kind of helping encounter you may be in – whether you are treating patients, teaching, mentoring, or leading – better listening can be expected to lead to better understanding. When we are listening well with intent and purpose, we start to design questions from what we hear. The more deeply and deliberately we listen, the more incisive the questions become. Truly artful questions arise from what the other person is saying, and from what you hear. Using your careful and fulsome attention and observations, you will pick up nuances that bring the next great question to your mind. You will know that your question is sparking an insight when the person reacts with a pause and a comment, such as, "What a great question" or "Let me think about that for a bit" or "I am not sure how to answer that."

When your listening skills are attuned, when you suspend your judgement, when you hold the person completely capable of getting to their own solution, the questions will flow.

Practice sitting quietly with your full attention on the person while they process your question. Resist peppering them with another question. Manage your own feelings of curiosity or impatience and notice when you are getting

ahead of the person with a pre-judged notion of what they will think or say. The best next question can only come from what you hear from the other person. When your listening skills are attuned, when you suspend your judgement, when you hold the person completely capable of getting to their own solution, the questions will flow.

Artful questions are open ended. In general, we start with "what" or "how" and, rarely, "why." A question beginning with "what" or "how" opens possibilities. A "why" question can sound challenging or judgemental, as it may require the person to justify something they think or do. "When" questions are useful for helping the person formulate their next steps and to hold them accountable for moving their intention into an action. Using a coach approach will be most useful when helping an individual or a group to change their issue into a goal and to decide about steps to take. A coaching encounter will generally not be effective if the person cannot get to the point of putting a goal into words. If they can, the coach's questions will start to pull out what they want, what is getting in the way, what strengths they can draw upon, and what they are prepared to do by when to move toward their goal.

If you have a relationship of trust with the person being coached, questions can become deeper and more challenging. Always remember that many issues are intensely personal for the person, and they may feel vulnerable opening up to you, even though they have sought your help. Where there is a power differential between you and the coachee or where you may be responsible for their performance review, you may not be the best coach, although you can listen to them and help them consider options for support. In any event, kindness and compassion are well placed in these situations.

The artful question in practice

Let's look at a scenario I have anonymized from one of my coaching encounters.

I was approached by a colleague (C) who was facing some conflict in the workplace. He was frustrated and had started to think about leaving the hospital he had been at for many years. He had heard that I was doing some coaching and was curious about the approach. He called me and, after a brief chat, we booked an hour together and met near his office. After a brief introduction to the process, I asked him what he hoped our conversation would achieve.

"If we spend an hour talking about this, what will have made it a good use of your time?" He was a bit stumped at first, and this is a key point. Sometimes, we invest a lot of time thinking and talking about our issues, without any plan or idea about whether the time was well spent. We go around and around on the vexing parts of the problem without formulating any specific goal or action. This is where using a coach approach can get people unstuck or help shift their perspective and open new options to move forward.

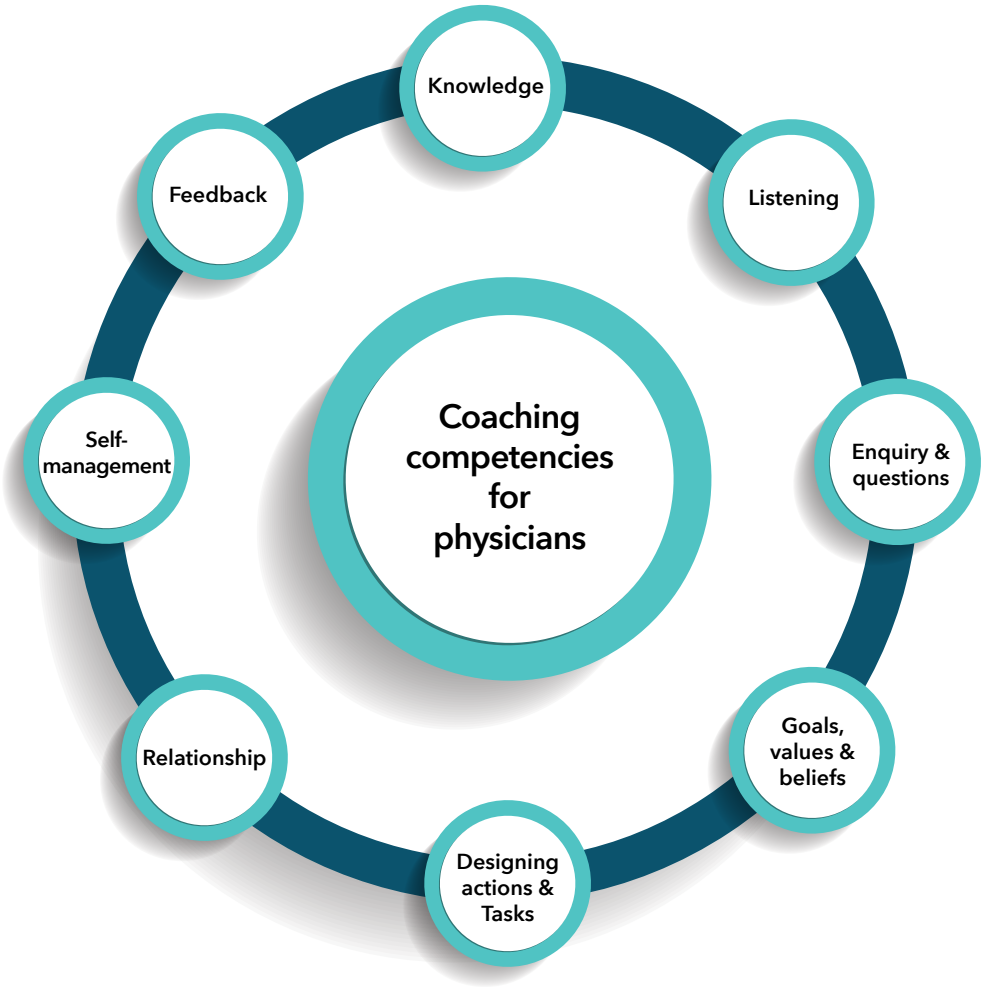
I nudged him a bit: "When you were making your way over here just now, what were you hoping would come out of the conversation?"

C: "I need to decide whether I can stay at my current hospital."
M: "So, the goal of our coaching session is for you to make a decision about where to work?" I asked, seeking clarity.
C: "Uh, no I don't really want to leave where I am now."
M: "Okay, what would you say is really the decision you are trying to make?"
C: "I just can't stay there the way things are."
M: "You need something to change so that you can keep practising where you are." I paraphrased. He nodded. "All right, so we are going to talk about changing something about your current work that would make it possible for you to stay there." I thought this was about as close to a goal as we could get for the moment.
C: "Yes, that's it."

Until there is a goal for the conversation, you may be listening and trying to help, but you are not coaching. It can take several minutes to get clear on what to spend the rest of the time talking about, so stay with it.

The next challenge when using the coach approach is to manage your own curiosity and need to know what the situation is. What needs to emerge is what is making the situation so difficult for the

Core competencies for the coach approach

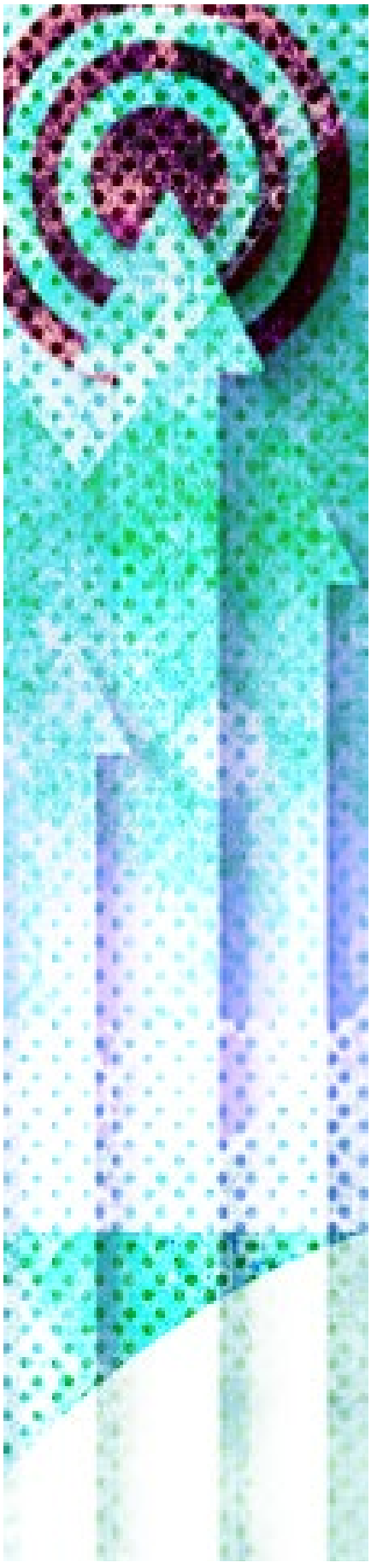


person. In coach mode, you are not problem solving and you do not "need to know" the details of the experience they are having. Subject matter expertise is not necessarily part of what the coach brings to the relationship.

Remember, the core tenet of coaching is that the coach believes that the person is competent in their own life and can make decisions and act on their own behalf. When you step into advice giving and problem solving, there is a risk that their capacity for managing themselves and their life is diminished rather than expanded. We all know of people who are overly dependent on others for various reasons. When the situation is such that you are faced with a competent person who is asking for help, and they agree to have some coaching about the issue, the opportunity is there to reinforce and build their skills to be better at turning a problem into a goal, moving intentions into actions, and being held accountable to their stated next steps.

The conversation with my colleague about his work went on.
M: "What would make the biggest difference for you at work right now?" Note, I did not ask him what the problem was.
C: "I feel like I am doing more than my fair share of the work and the call, and I'm fed up."
M: "How could you go about asking for fairness?" I did not ask how much call he was doing, how many in the group, etc. As much as I might like to form my own opinion about what he is doing and whether it is appropriate in a group, those details are not relevant to what he can do about the problem. I picked up on his use of the word "fair" which may be related to his sense of values and principles, not necessarily an amount or number, and used it in my question.
C: "I can't ask the chief; we don't see eye to eye." I'm super curious now, but I hold it. He did not

answer my question, so I simply acknowledge that I heard him, and ask it again.
M: "You don't feel you can go to the chief, so how could you go about asking for fairness?"
C: "I guess I could meet with the scheduler. She is working on the next block this week."
M: "How could you get ready for that conversation?" In a higher stakes conversation this might lead to a role play and prep session.
C: "I have the schedules for the last three-month block. It shows how many clinics and call days we each have."
M: "What other information might be helpful about the fairness of the schedule?"
C: "I think there is something in our division rules about it, but I'm not sure." He hasn't done all his homework yet for a successful conversation about how work is shared in the group.
M: "When do you think you could be ready for this conversation with the scheduler?"
C: "I could review the rules tonight and give her a call tomorrow." He is not committed with "I could."
M: "So what is your plan?" I could assume that he will do what he says, or restate what he told me, but he will own the plan if he puts it together himself in a statement back to me.
C: "Tonight, I'm pulling out the last three months of schedules and reviewing the division rules. Tomorrow, I will call the scheduler and ask for a meeting."
M: "How does that feel for an action plan?"
C: "Better. I was just so angry and tired that I couldn't get my next step straight. Thanks."
M: "Would you like to give me a call or text and let me know how it goes?" Offering to hold him accountable.
C: "Yeah, I will. That will close the loop for me."



It seemed to me that there were likely a lot of other issues for this physician in his group, but the one he brought to the coaching encounter was fairness of work assignments, so that is what we focused on. This conversation was very focused once we established his goal to get treated fairly in the clinic and call schedule.

I have simplified the scenario and the coaching process to introduce the rhythm of a coaching encounter. In a longer coaching engagement, it would be up to the coachee to open different and deeper conversations about his conflict with the chief of his department, whether it is difficult for him to stand up for himself, where his value of fairness is rooted, and how he let himself get so far down the road of considering a job change without taking some straightforward steps to improve his situation. Although this example may seem like a relatively simple issue to an experienced physician, for him it was weighing heavily, so I met him where he was at.

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 are dependent on the patient or person making choices, decisions, and changes. The defined questions, goals, and solutions are theirs. By acting as a coach when people bring you problems that are within their control, 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.

In upcoming issues of CJPL, I will continue to adapt the core competencies for the coach approach for physicians and medical leaders (see diagram) and discuss the specific skills that comprise each. My next article will be about "goals, values and beliefs." We will explore how listening skills and artful questions can be used to uncover what may be either empowering or getting in the way of a person's ability to move forward on important issues.

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PERSPECTIVE

“Us” and “them” in medical culture

Brian Goldman, MD

Empathy is the capacity to see things from another person’s point of view. In some health care settings, empathy and kindness are lacking. One factor in the lack of empathy toward both patients and colleagues is the tendency to see others as the enemy. Although humans are hard wired to be kind and empathic to one another, under conditions of stress, they are also hard wired to decide whether another individual is friend or foe. Some medical cultures are defined by conflicts between in-groups and out-groups and a resultant lack of empathy. One way to restore friendliness and empathy is to address the underlying sources of stress.

KEYWORDS: empathy, kindness, in-groups, out-groups, stress

“Sorry to intrude,” says Susan, a paramedic with 15 years of experience, as she approaches a triage nurse standing behind a counter in the emergency department. Her partner Jeff stands beside a stretcher bearing a young man whose shirt is covered in vomitus.

“John is a 22-year old male who got intoxicated with alcohol and did a face plant while attempting to hop three steps at a time down the concrete staircase just inside the entrance to the subway,” Susan tells a triage nurse named Fraser. The nurse stares for a moment at John and then Susan before glancing at the more than 60 patients, family members, friends, and bystanders who have crowded into the waiting room.

“You again?” Fraser asks sarcastically while motioning to the sea of impatient humanity on chairs, stretchers, or leaning against the walls. “This is your fifth drop off this evening. Are you telling me we’re the only emergency department that’s open in the entire city?”

Susan sighs as she slinks away to stand closer to John’s stretcher. She turns her head to meet the eyes of her partner, who nods his head in sympathy. He’s the only other person in the room who knows what it’s like to be blamed for doing their job.

Fraser retreats behind the counter at the triage desk and sits down to record vital signs on John’s ED chart.

“Glad you spoke up,” another triage nurse, Amanda, shoots Fraser an approving look. “Those paramedics know we don’t fight back when they keep bringing us patients. They get a much chillier reception at the ED across the street.”

This exchange is typical of a kind that occurs not infrequently at some hospitals. In this paradigm, the paramedics see themselves as members of what psychologists refer to as an in-group and the triage nurses as members of an out-group. Likewise, the triage nurses view themselves as the in-group and the paramedics as the out-group.

What’s striking about this encounter is that members of the in-group have abundant empathy for one another, but little if any empathy for their perceived opponents.

The empathy gap in health care

“Empathy is the feeling that ‘I might be you’ or ‘I am you,’ but it is more than just an intellectual identification; empathy must be accompanied by feeling. Sympathy

brings compassion, ‘I want to help you,’ but empathy brings emotion. Without feeling, there is no empathy.”[1] Empathy is defined as the ability to imagine what it’s like to stand in someone else’s shoes and see things from their perspective.

Evolution has equipped our brains with cells known as mirror neurons.[2] These cells are active, both when we are carrying out an action and when we are observing someone else carry out the same action. This enables humans to see things from both perspectives at the same time. Although it hasn’t been proven that mirror neurons are the seat of empathy, having these specialized brain cells most likely facilitates empathy for others.

Many experts in medicine and psychology have decried the lack of empathy in modern health care. System issues that may interfere with empathy include stress, time pressure, technology, fragmented care, and the increasingly complex needs of patients. These factors can overwhelm health professionals with competing priorities that distract them from empathizing with patients. Individual factors can also impair the capacity for empathy. One of these is compassion fatigue, a gradual lessening of concern for, or frank indifference to, the suffering of patients and others who need our help. Another is known as moral distress, which is defined as holding a moral obligation to act in a specific clinical situation, but feeling constrained from acting because rules, regulations, or customs make such action impossible without risking professional repercussions.

Moral distress and compassion fatigue are risk factors for burnout. The 2018 National Physician

Health Survey found that 30% of Canadian physicians had burnout.[3] High rates of burnout exist among nurses too.[4] Studies have shown a consistent negative association between burnout and empathy, although a causal link has not been established clearly.[5]

Another factor that impairs the capacity for empathy and is seldom noticed, let alone talked about, is the tendency to see working in health care as a battle between in-groups and out-groups. The basis for this behaviour is known as social identity theory, resulting in "us" versus "them" scenarios.

Us and them

In 1979, the Polish social psychologist, Henri Tajfel, proposed that the social groups to which people belong bestow upon them a sense of self-esteem and social identity.[6] The latter has been defined as a person's sense of who they are, based on the groups to which they belong. Surveys by social psychologists have shown that humans regard members of their in-group as loyal, industrious, generous, charitable, kind, and empathic. They regard members of out-groups as the polar opposite.

Many examples of social identity are at play in everyday life. Among social classes, these include designations, such as middle and working classes. In politics, Canadians identify with political parties, such as the Liberals, Conservatives, and the New Democratic Party. In sports, we have the Toronto Maple Leafs and the Montreal Canadiens or the New York Yankees and the Boston Red Sox. In the former Yugoslavia, there are Bosnians and Serbs; in Northern Ireland, Catholics and Protestants.

It's not a stretch of the imagination to suspect that such group distinctions exist in medical culture. At some hospitals, emergency physicians and consultants see themselves as opponents in a battle over patient referrals. In the operating room, surgeons and anesthesiologists may be in a perceived conflict over which profession controls time, the flow of patients, and income. Sometimes, internists and cardiologists disagree over which service should admit the elderly patient with congestive heart failure and dementia.

These dyads can shift depending on the circumstances. Physicians who typically see themselves as rivals may at times also see themselves as fellow members of a larger in-group in opposition to allied health professionals, such as nurses. Not infrequently, it's health professionals in general versus patients and families.

This may come as a surprise, but just as we are hard-wired to empathize with others, we are also hard-wired to categorize others as friend of foe.[7] In as little as 30 milliseconds, human beings distinguish between in-groups and out-groups. A photo of a member of an out-group activates the amygdala, which signifies an emotional response to the recognition of a potential enemy. In contrast, a photo of a member of an in-group does not lead to activation of the amygdala. This is tangible proof that human beings exhibit implicit racial bias. Thirty milliseconds is well below the 525-millisecond threshold required for conscious processing of images and activation of the frontal lobes. The latter executive function nullifies implicit racial bias; without it, the processing speed of the amygdala would allow its us-versus-them reaction to always win.

In the scenario above, Fraser and Amanda saw themselves as sticking up nobly for triage nurses. At the same time, they implied that paramedics, Susan and Jeff, took the easy way out of a potential conflict with staff at a nearby ED by overburdening the ED at which they worked. However, an instinctive survival strategy that is well-suited to the "kill or be killed" times of yesteryear is not particularly appropriate in modern life or, in particular, modern hospitals. So, why do some medical cultures spend a lot of time seemingly dividing colleagues into us and them? Although it hasn't been studied, we can make some educated guesses.

Hospital environments are stressful. Time and productivity pressures and scarcity of resources, such as beds, personnel, and operating room capacity, together with budgetary cutbacks exacerbate the situation. These circumstances likely put humans into "survival" mode. In the brain, they would be expected to activate primitive emotional centres, such as the amygdala,

thus fostering the tendency to divide the world into friends and enemies. Such conditions would also tend to deactivate the frontal lobes, thus depriving those affected with the capacity to reason past their primitive biases.[7]

Possible fixes

In a system in which us versus them predominates, there is little value in admonishing health professionals to be more empathic toward one another. It's probably more fruitful to address first the factors that have led to stress and scarcity.

It's important to remember that scarcity of time may not be improved by an increased financial budget. A better fix might be to address and remove unnecessary yet onerous responsibilities that make the work itself stressful.

The next step might be to encourage dyads of in-groups and out-groups to spend time together to find that what they have in common. That might entail meeting professionally or socially. Another way to address the gap in empathy would be to have members of in-groups and out-groups switch places with one another for a day or two to allow them to see the challenges of the opposite group from its point of view.

The idea behind all of this would be to diminish the role and perceived value of us and them and, in so doing, create one great big us.

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OPINION

How a throughline focused on virtue may be a key strategy for physician leaders to stay in the infinite game

Duncan Rozario, MD

We are at a tipping point in society, where income inequality, employment instability, and a fundamental lack of societal virtue are poisoning the well of happiness. In his seminal 1776 work, *An Inquiry into the Nature and Causes of the Wealth of Nations*, Adam Smith[1] said, "Consumption is the sole end and purpose of all production; and the interest of the producer ought to be attended to only so far as it may be necessary for promoting that of the consumer." He spoke of the importance of allowing just and balanced market forces to allow optimization of the interests of the consumer and business alike, leading to centuries of incremental growth in the wealth of nations.

However, 50 years ago, Milton Friedman's[2] treatise on shareholder primacy helped change the focus of business culture. He stated that the responsibility of business is to increase its profits and serve the interests of the shareholder; any focus on social responsibility was akin to socialism. He also said that business should, "Use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception or fraud."

How well has that focus served our societies? Have the largest, most successful corporations stayed within the rules of the game and avoided deception or fraud to provide fundamental value to society? Or have we incentivized the wrong behaviours? In August of this year, the Business Roundtable,[3] in its revised Statement on the Purpose of a Corporation, changed its focus from profit to, "delivering value to our customers, investing in our employees, dealing fairly and ethically with our suppliers, supporting the communities in which we work, and generating long-term value for shareholders." Will this happen without an existential pivot to focus on virtue instead of profit in all that we do in business and in health care?

In public speaking, a throughline is an idea, theme, or concept that unites or links all of the narrative elements. It "traces the path that the journey takes,"[4] so that leaders and followers end up at the same destination. As physician leaders, we share unique challenges as we fundamentally strive to change behaviours and beliefs in the delivery of health care with only the power of our actions and words. Coercion and use of authority will not produce the longstanding cultural changes we seek to improve the institutions we lead.

I propose that a leadership focus on the concept of virtue, and incentives that promote its value, will be the throughline that leads to success. We seek to motivate our staff and physicians to provide the best possible patient care and experiences, but have the mistaken belief that incentives and rules (otherwise known as carrots and sticks) are the key motivator. We institute more and more rules, but, at best, we

get a baseline of compliance that leads to mere mediocrity. In its 2017 report on the state of the American workplace, the Gallup organization[5] reported that only 33% of employees are engaged at work and demonstrate discretionary effort. Gallup's CEO, Jim Clifton, states, "The old ways – annual reviews, forced rankings, outdated competencies – no longer achieve the intended results."

In the truly infinite-minded book, *Exception to the Rule*, Rea and colleagues[6] state that a focus on a virtuous business culture benefits both the bottom line and society. Twenty-five centuries ago, Plato described the seven virtues of trust, compassion, courage, justice, wisdom, temperance, and hope. They appear to be a common denominator that spans diverse cultures, societies, and religions. How can an approach to leadership based on virtue succeed?

Trust

Trust makes your workforce more agile, ready to respond efficiently to uncertainty and more tolerant of risk and failure. In health care, "trusting and meaningful relationships are more important than extrinsic rewards and recognition."[6] Innovation is a common organizational priority in health care and, at its core, means "new action." This requires tolerance of risk, which speeds the decision-making process. This virtue is foundational to the patient–caregiver relationship and improves outcomes after care when treatment recommendations are embraced. It also improves resilience among our caregivers.

As leaders, we are often responsible for explaining "why" we are doing things, but we need to devolve the responsibility of "what and how" to our teams. The concept is simple but challenging: as leaders, we develop trust by being vulnerable and, first, trusting our followers by giving them the responsibility to implement that what and how. Increasing the portion of our workforce willing to demonstrate discretionary effort will require a focus on managers in our organizations. Gallup[5] reports that up to 70% of an employee's engagement depends on their supervisor, who must be empowered to build trust and relationships in the group. In a world filled with volatility, uncertainty, complexity, and ambiguity, a culture based on virtue, and the resulting reputation for integrity, has the best chance to succeed.

Compassion

Compassion improves customer and employee care and experiences and is one of the most important virtues in health care. It involves empathy, being able to feel the pain and suffering of others, but also requires instituting the actions needed to alleviate that suffering for our patients and colleagues. This is how compassion is superior to empathy and is a key strategy to build resilience and reduce burnout in our caregivers. "Empathy needs to be demonstrated throughout the entire continuum of health care, from patients to nurses to physicians and administrators. The institution of health care needs to understand that its very survival depends on an existential pivot to focus on the wellness of caregivers."[7]

In *Give and Take*, Adam Grant[8] divides people into givers, takers, and matchers. He demonstrates that givers, those who help unconditionally but are not doormats, are the key to successful long-term team performance. Compassion for colleagues and customers reduces risk, improves engagement and belonging, and changes culture. Health care has become a team undertaking, and one challenge has been melding a cohesive and successful team out of disparate individuals.

In Google's project Aristotle,[9] the researchers identified a consistent characteristic, "the good teams all had high 'average social sensitivity' – a fancy way of saying they were skilled at intuiting how others felt based on their tone of voice, their expressions and other nonverbal

cues."[10] In other words, empathy is a key aspect of psychological safety, which creates a safe environment for risk taking and collaboration. Although the focus on quality and efficiency in health care is necessary, we need to feel safe to develop the relationships that will lead to great work.[11]

Courage

Courage encourages tempered risk taking and promotes doing "the hard right," rather than the "easy wrong." We ask teams to innovate and produce exemplary care and experiences. Grit describes the learned determination that leads to the ability to weather multiple failures on the path to success. It allows us to manage ethical storms, de-escalate conflict, and maintain our work relationships.

Justice

Justice promotes equality, diversity, accountability, and discretionary effort. Politics is fundamentally about who gets what, and if we care about the distribution of resources and power at our institutions, we need to get involved in our local politics. Discretionary effort depends on our team members' perception of just and fair treatment and opportunities.

Rather than a sole focus on profits, Rosa Chun[12] wrote about corporate social responsibility, virtue, and business saying, "when customers perceive an organization to show strong empathy, it enhances their emotional attachment to the company. This leads to satisfaction and eventually differentiation."

The tides are turning among most large corporate shareholders and CEOs, who are now speaking up about the importance of environmental, social, and governance (ESG) issues. "In 2018, Bank of America Merrill Lynch found that firms with a better ESG record than their peers produced higher three-year returns, were more likely to become high-quality stocks, were less likely to have large price declines, and were less likely to go bankrupt."[13]

Forgiveness is also a key way to obtain justice. It reduces one's tendency to be consumed by hate and allows one to be free. A focus on self is a quick way to enhance suffering, whereas a focus on others before self allows one to act with justice and compassion.

Former United States President Barack Obama[14] emphasized the importance of diversity in the workplace saying, "Diversity is not charity. It is not something you do to be nice. If you don't have diversity around that table, you are missing a market. You are misunderstanding how your message is being received. Organizations that have a bunch of women on their boards do better. They make more money, they get in less trouble, they're more successful."

Wisdom

Wisdom promotes common sense and foresight and requires us to learn from our experiences or those of others. As Ray Dalio[15] describes, "the satisfaction of success doesn't come from achieving your goals, but from struggling well."

As leaders, we have a long list of deliverables and goals in our programs, and to maximize our potential we need to be willing to push our limits, and fail at times. At times, our cognitive bias will prevent us from seeing the truth and, if we completely disagree with our colleagues, then someone must be wrong – could it be you? We need to move out of the "it's this or that" mindset to get "this *and* that" accomplished.

Temperance

Temperance allows balance and discipline in the workplace. Recognizing that our perception of reality is individually flawed, we must understand the importance of learning what we do not know and being open minded. Considering opposing views has the remarkable effect of showing us the distortions in our own reality.

As leaders, we need to learn how to balance competing interests simultaneously. Habits such as meditation, morning exercise, and gratitude journals can change one's mindset for the day and beyond.[16] Benjamin Franklin, who could be considered the father of temperance, was noted to meticulously plan his day, with the morning question, "What good shall I do today," followed by his evening question, "What good have I done today?"[17]

Hope

Hope leads to an optimistic, future vision. Robert Waldinger of Harvard's 75-year longitudinal Grant and Glueck study said, "You could have all the money you've ever wanted, a successful career, and be in good physical health, but without meaningful relationships, you won't be happy."[15]

Pursuing our collective interests will almost always win out over an individual focus. Talking about virtue moments at the beginning of our meetings is one key way to practise optimism and can set the tone. Gratitude journals, gratitude letters or walls, and a conscious focus on optimism can help us focus on a better future.

Virtue

These are all learned traits, and if they don't exist in our business culture, they can be taught. We need to incentivize the right behaviours that will lead to more virtuous actions that benefit the entire system.

In health care, we have a deficit-based approach to our work. What is the problem (disease) and how do I resolve it (surgery or medication)? In the management of groups, however, an appreciative-based approach has proven to be superior. How many times in meetings do we start by asking, "What great work are we doing here, and how do we do more of that?" Instead, most of us are constantly engaged in a perpetual loop of "whack-a-mole" going after problems reactively as they appear. While values are beliefs, virtue is fundamentally demonstrated by actions, and we need to see that discussed and incentives provided at all levels of our organization.

Discussion

As a physician leader, what will be your throughline? How will your leadership fundamentally alter the culture of your organization to produce sustainable improvement? The CMA Code of Ethics and Professionalism[18] provides great leadership and inspiration as we struggle with these existential challenges. It emphasizes the importance of civil and respectful communication, justice, and treating our colleagues with dignity and compassion. As leaders, we must understand that, in a debate, more important than who is right or wrong, is what is true.

Leadership is a learned skill, and one should not underestimate the importance of developing local talent though rounds, journal clubs, management training, and mentoring (and a subscription to the *Harvard Business Review*!). Fundamental health care system reform will only happen when physicians get involved and embrace politics, which is fundamentally about who gets what.

We must mentor and foster our successors and understand that there are limits to the effectiveness and term of our leadership. Joseph Simone[19] states that the maximum term for a physician leader should be 10 ± 3 years. Fresh ideas and renewal are essential, and we need to understand that, once we accomplish 80% of our objectives, it may be time to go. Find people

who are better than you and retain them. What you do is noble, and despite the immense challenges, medical leadership is immensely fulfilling and rewarding when you take a moment to reflect.

We must have an understanding of how any business is fundamentally an infinite game and, to stay in the game, our vision must drive all decisions and actions.[20] A vision based on virtue is one that focuses on excellence, promotes engagement in both employees and customers, and simultaneously creates economic value. For this to happen, we need to lead a cultural change – to focus on our planet, our employees, our customers, and our community. Virtue is a skill that can be taught and strengthened like any other.

A focus on profit or other short-term goals may be successful in the short term. However, as physician leaders, if we want to create an environment of psychological safety where passionate colleagues and staff feel inspired to display discretionary effort and innovate, an infinite-minded focus on virtue has the potential to engage your entire workforce and lead to the type of innovative culture that will allow our health care system to aspire to excellence in the years to come.

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The LEADS framework as a roadmap for implementing quality management

Dawn S. Hartfield, MPH, MD

Large-scale implementation is a significant leadership challenge. The task can seem overwhelming, but a structured approach can transform what seems to be an impossible problem into a solvable one. When implementing our quality management framework, our team used the LEADS framework as a roadmap. As a physician new to a senior leadership role, using LEADS, along with other tools, bolstered my skills, ability, and confidence and those of the team to carry out a significant, large systems change. This journey demonstrates a unique use of LEADS and other tools that medical leaders may find of value in their daily practice.

KEY WORDS: quality-management framework, LEADS framework, quality-improvement systems, implementation, system transformation, physician leadership

Establishing a framework for managing quality in health care systems is a challenge, and one that requires physician leadership and buy-in to be successful and sustainable. For medical leaders, knowledge of the concepts of quality and safety is important, and additional leadership skills are critical for success. This paper describes a case study in implementation using LEADS[1] within Alberta Health Services (AHS), a provincial health authority in Alberta, Canada.

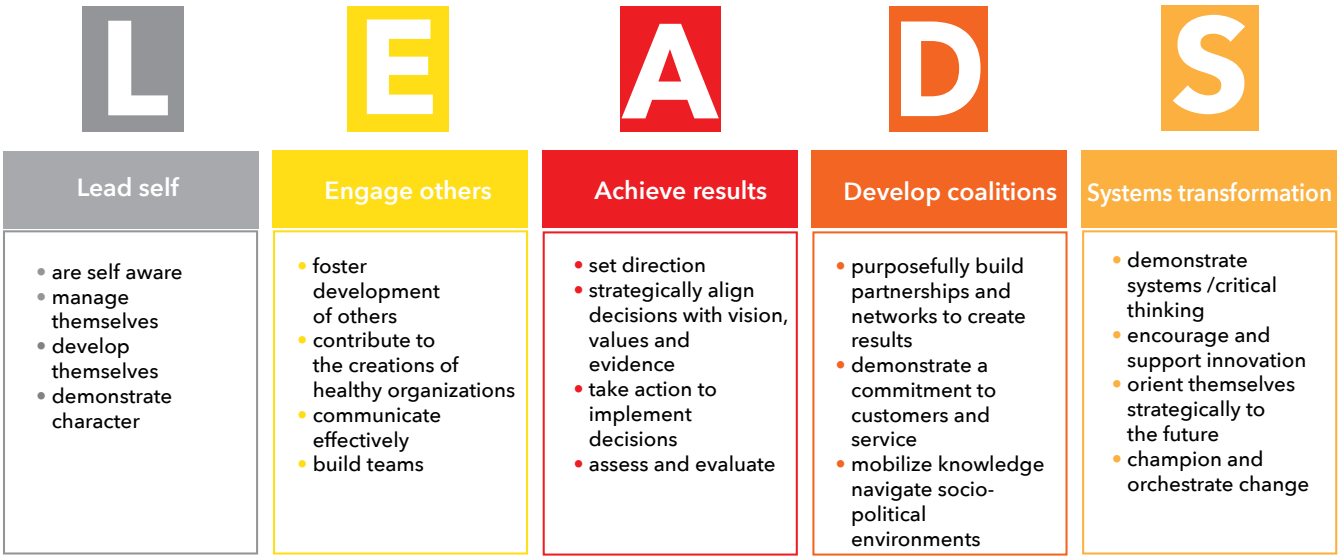
The LEADS framework (Figure 1) describes five core leadership domains (Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation), and each domain is supported by four capabilities. This practical framework is used nationally, is readily accessible, and provides an evidence-based model for health care leadership development.[2] Using LEADS as a guide, as well as other tools borrowed from industry and the business world, we established a quality-management framework that is embedded in the work that we do in our complex system. This implementation journey demonstrates a unique use of LEADS and other tools that medical leaders may find of value in their daily practice.

Establishing a framework for managing quality in health care systems is a challenge, and one that requires physician leadership and buy-in to be successful and sustainable.

The journey began in 2013 in the Edmonton Zone (EZ) of AHS when it was determined that a framework for quality improvement, distinct but supportive of our patient safety system, was required. This direction came from our parent organization, the senior leadership team in the EZ, but was also a requirement to meet the standards of the Health Services Organization (formerly Accreditation Canada). The goal was to establish a system that would provide vision, leadership, and direction for quality planning, monitoring, and improvement; to enhance an integrated approach to quality; and, ultimately, to develop a structure that connects the frontline provider to senior administration. The vision was to deliver better quality, in the form of better outcomes, experience, and value to our population.

I was hired as the "medical director for quality and safety," and my primary task was leading the

Figure 1. The LEADS framework



team that would establish this new system. I am an academic pediatrician and, at the time, had nine years of experience in quality and safety, had established a quality-management system at our children's hospital, and was involved nationally with organizations where I taught quality and safety. I felt confident in my quality and safety knowledge and skills; however, I had little experience outside child health and was unfamiliar with the operational structures and leadership teams that worked across the EZ. I understood the importance of the task and the difference that could be made to the system, providers, and patients, but needed to expand my network.

I was excited about the new challenge, but many questions swirled in my mind. How does one engage others on a zonal or provincial scale, to participate in establishing a new quality system that comes with no resources? How could I provide a compelling story to encourage others to embark on this new quality journey? I clearly needed a strategy to approach this work.

I had recently been introduced to the LEADS framework through the AHS Executive Leadership Program.[3] This program, developed by University of Alberta School of Business, Haskayne School of Business (University of Calgary), and AHS, is based around the LEADS framework and provides emerging health care leaders with fundamental leadership skills to enable success in their roles. On reflection, I determined that using the LEADS framework as a guide to establishing the quality-management framework would help break down what seemed like an impossible task into a series of logical progressive steps. If LEADS was designed to facilitate leadership development, why not use LEADS as a structure to develop a quality-management system?

I began the journey with Lead self, which involved significant self-reflection.[1] As mentioned, I was comfortable with my knowledge, skills, and ability in quality and safety. I had established programs in the past and could lean on some of the same skills, but this work was at a completely different scale. I had recently completed the LEADS 360 assessment and again reviewed the feedback along with my executive coach results to look for pearls of wisdom from those who I had worked with.

I realized that relationship building was going to be critical for me, and personally challenging. I am an introvert who tends to be quite private and prefers not to "overshare"; therefore, I avoid asking colleagues a lot of personal questions as I fear being too intrusive. I was surprised to learn

from the LEADS 360 assessment that people needed this from me as a leader, to take relationships with team members to a different level. People I worked with wanted to know how I thought and felt about things. This was clearly important information I would need to use as I was building relationships. In addition, it was apparent that given the scope of the work, project management would be important, as would a very structured process to change management.

A second domain of LEADS is Engage others.[1] In this project, engaging others included a multi-faceted approach. Most immediately, I sought to establish relationships with the new project team I was leading. This involved many coffee conversations, learning about their incredible skills and abilities, as well as about their lives outside of work. (I found a comfortable balance!)

We took a change-management course together (ProSci, Halifax, Nova Scotia), which was extremely helpful and resulted in great team bonding. We reached out to local leadership teams to learn about their current resources in terms of quality and what was important to them, as well as our provincial quality team. It was extremely important to ensure that our approach aligned with the province's direction and to avoid any duplication of efforts. We also reached out to external organizations to learn from others (the Develop coalitions domain of LEADS[1]) and completed a literature search.

Figure 2. Edmonton Zone quality management framework

The information gathered from the engagement exercises allowed us to establish our structure, which is very simple (Figure 2). The frontline unit quality councils are the heart of the system — at the interface of care. These are multidisciplinary teams whose membership mirrors that of the care team, supported by improvement experts, whose role is to identify and solve problems in their environment.

The unit quality councils are supported and guided by the site/program quality councils in their area. The zone quality council provides support and guidance for the quality management framework in the EZ by helping to guide priorities, remove barriers, and provide education and other support. They link directly with the provincial teams to ensure alignment of priorities. The system is the ultimate responsibility of the Senior Leadership Team in the zone which includes the operational leaders (the executive directors) and their physician dyad partners (LEADS Systems transformation: demonstrates systems and critical thinking[1]).

We developed coalitions with the program and site leadership teams and used a structured process to support the establishment of their quality councils.

Once the structure was defined, we moved on to establishing an implementation plan. Thus, achieving results[1] involved establishing a clear project management plan, including a change-management strategy. Our team used our newly acquired skills from the ProSci course (Systems transformation: champion and orchestrate change). We set goals and established measurements that we could use to define success. As part of this, we set up a reporting system for the quality councils, so that we could understand the work they were doing, and the enablers and facilitators needed to complete quality work. We also used the Institute for Healthcare

Improvement's (IHI) capability self-assessment tool, to track the progress of our system over time.[4]

We developed coalitions with the program and site leadership teams and used a structured process to support the establishment of their quality councils. This was an iterative process that we adjusted as we learned by bringing on board teams across the EZ. Included in this structured process were tools for our teams to use, as well as guiding documents for the quality councils. One of these was a standard terms of reference based on Juran's trilogy of quality planning, monitoring, and improvement[5] so that the teams understood the work to be done.

One year after we began our work, we began to see system transformation[1] (Figure 3). Eighteen of 23 targeted quality councils were established. By the fall of 2016, after nearly two years, the number of councils in the EZ had stabilized and, to date, remains just over 100.

Our reporting system has provided some interesting results. Quality councils have regular multi-disciplinary participants and reflect care team membership. Over half of the quality councils have regular physician attendance. Of note, councils with physicians involved were more successful in achieving their goals. Over time our system became more transparent; from inception, the number of teams with quality boards in public facing areas had doubled to 70%. The councils had work plans in place, these teams were completing quality-improvement projects successfully, and these were having a positive impact on outcomes. Only 9% had a patient advisor, identifying an area for focused system improvement.

Most important, we could see that organizational culture with respect to quality improvement was changing. Early on, a common "barrier" to success identified by quality councils was not having adequate access to a quality consultant to do project work for the team. As time passed, the most common barrier shifted to the team having insufficient time to complete the work themselves. The teams were engaged and were hands-on, rather than having someone else do improvement to them. In addition, teams were learning basic concepts and realizing the importance of change management and the need to invest training and thought in this part of the process. Indeed, the structure was in place, and we were seeing a shift in culture: system transformation.

In early 2017, we completed a comprehensive review of the quality management framework including a SWOT (strengths, weaknesses, opportunities, and threats)[6] analysis, repeat application of the IHI capacity

Figure 3. Increase in the number of quality councils in the Edmonton Zone during transformation, to a plateau in October 2016

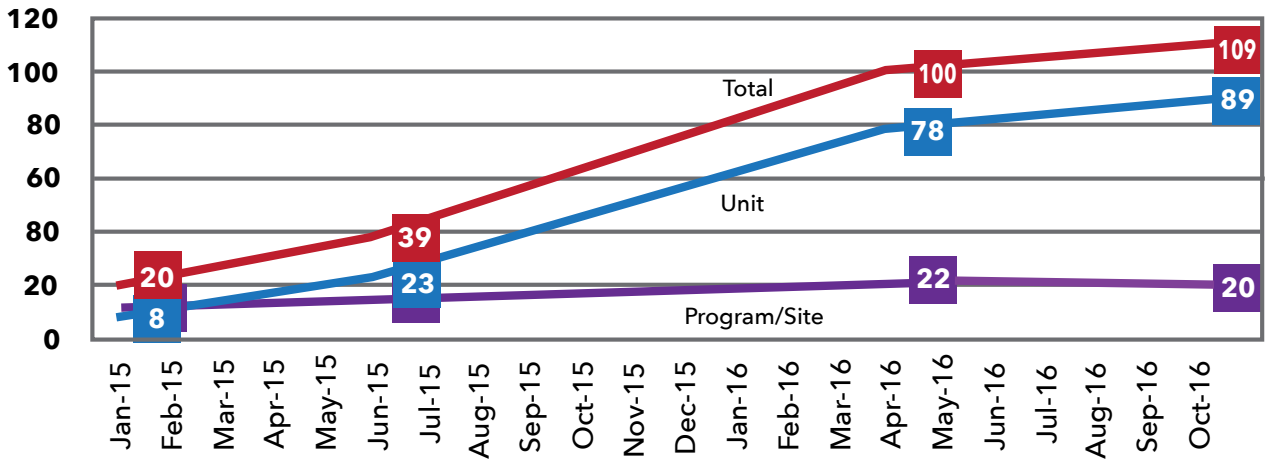
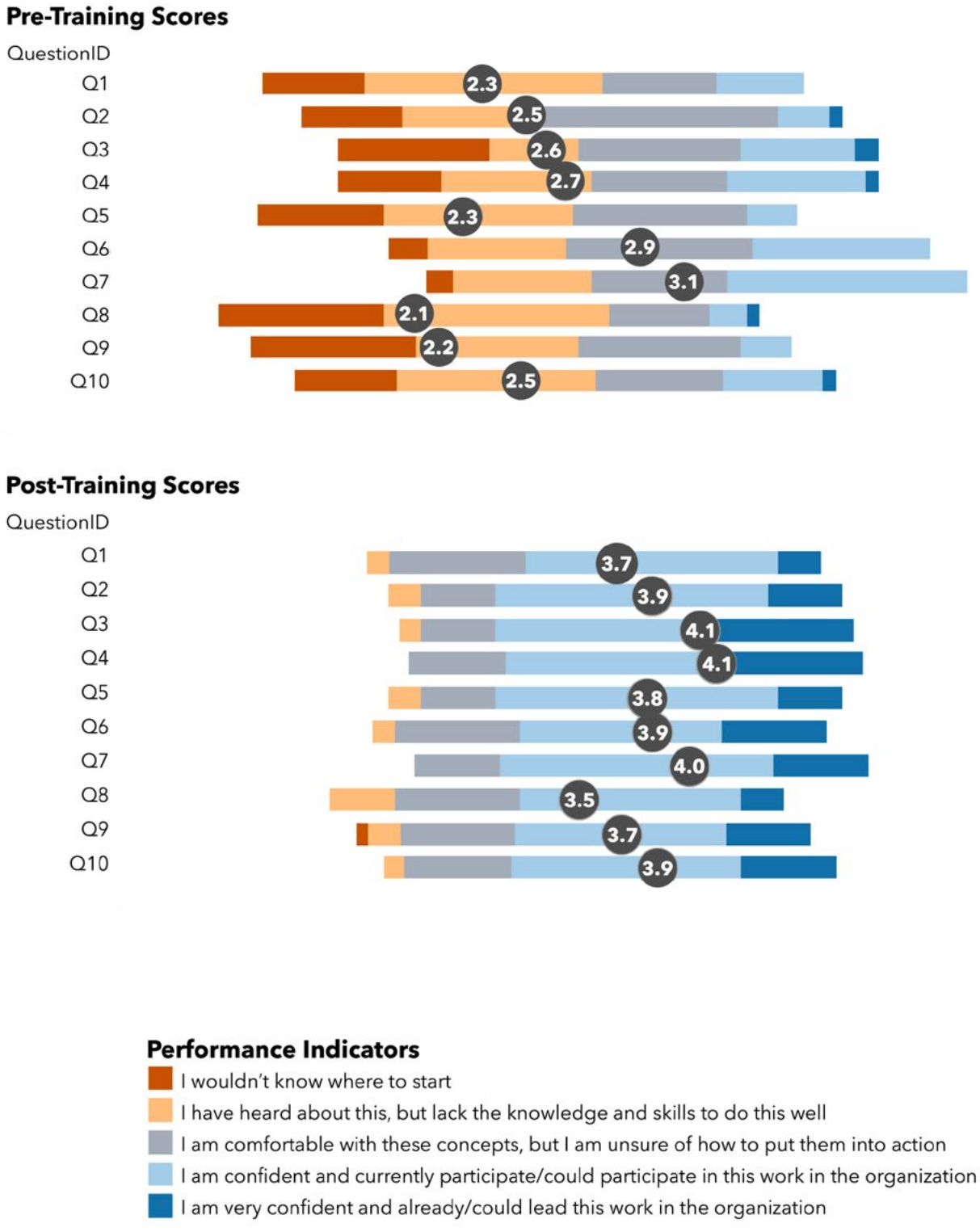


Figure 4. Pre- and post-training test results show a significant improvement in knowledge of participants (n = 190)



self-assessment tool,[4] extensive internal consultation (within the zone and province), and a follow-up literature review culminating in a five-year strategic plan[7] (AHS, internal communication) to continue to foster the development of the system. Our findings aligned with Frankel's white paper, "A framework for safe, reliable, and effective care,"[8] which validated our approach.

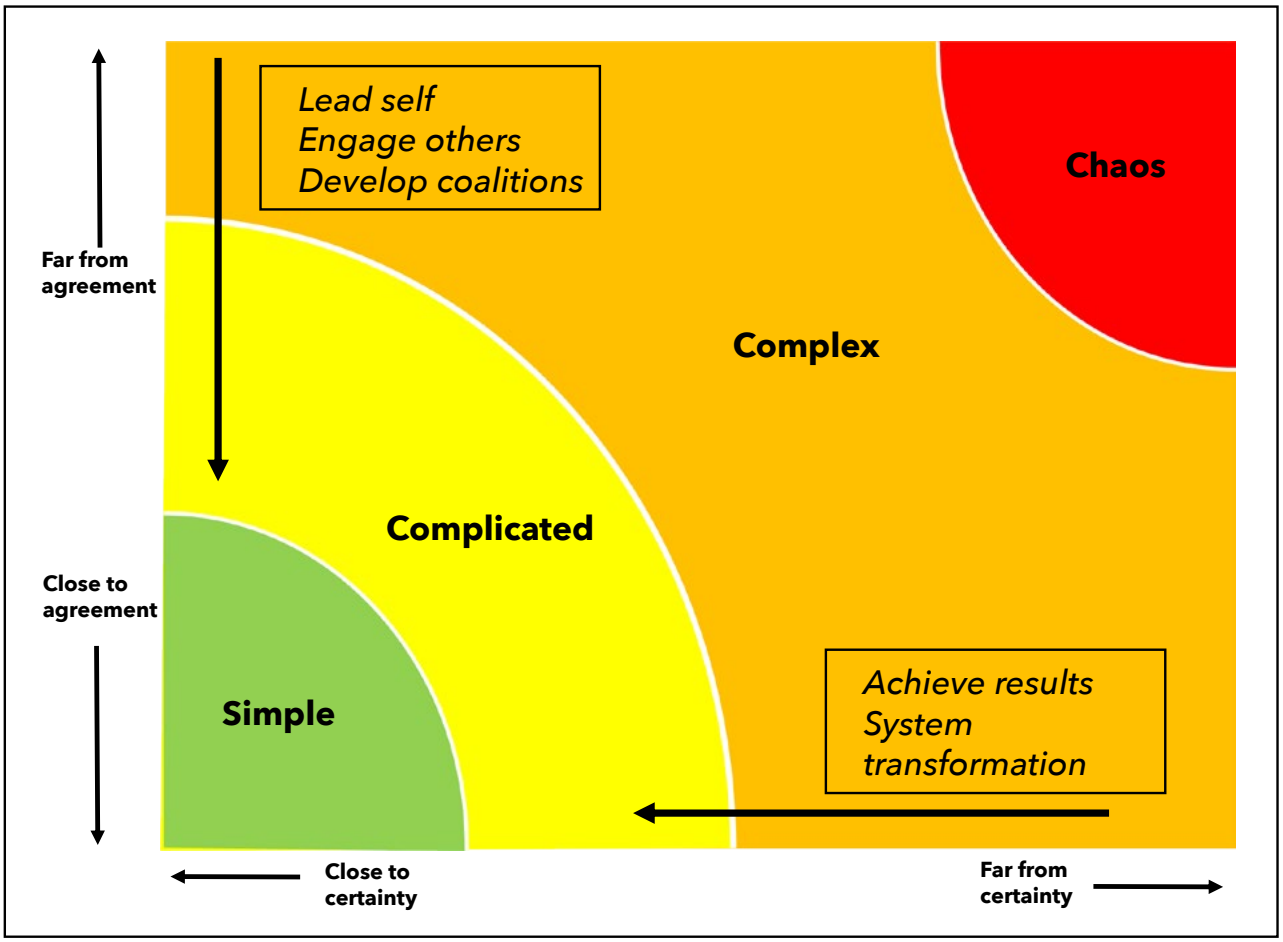
This work is part of our ongoing quality journey and includes the following elements:

1. Improving safety culture
2. Building quality and safety literature
3. Establishing a leadership management system
4. Enhancing use of quality indicators to drive improvement

One highlight of this part of the journey is establishment of a full-day improvement course that tackles all four pillars of work. It is targeted at quality council members and has them complete the day with a "straw-dog" of a project that they can take back to their quality council to refine and implement. We have assessed this process using the Kirkpatrick Model,[9] as we wanted to be sure that the day was a worthwhile investment for participants and the organization alike. We have demonstrated significant improvements in knowledge of participants through the use of a pre/post-test (Figure 4). We are aware of teams that have completed the projects they developed at this session and received grant funding to support the work. A formal assessment of the longer-term impact is currently underway.

Now, over five years into our quality journey, our framework is seemingly entrenched in the system, but, as with all organic systems, will require ongoing nurturing. It is, of course, not perfect. On reflection, the decision to use the LEADS framework to guide our early actions was a sound one. LEADS is a flexible model that can be used at a

Figure 5. Modified Stacey matrix and LEADS domains



personal level for leadership development and, as we did, to structure an approach to a large leadership challenge. This ensured that we used a comprehensive approach and were intentional in our actions each step of the way.

As an industry health care has much to learn from other disciplines, such as business, the social sciences, and manufacturing, to improve our ability to both lead and manage.

When one considers complexity and the Stacey matrix (Figure 5), this approach enabled us to transform a complex implementation challenge into one that was complicated and manageable.[10] The domains Lead self, Engage others, and Develop coalitions fostered a shift toward "agreement"; the domains Achieve results and Systems transformation supported a shift towards "certainty" as theories were discovered and tested in the innovative and iterative processes that we used. To take the small steps required to move from complex to complicated required patience and time, trust, creativity, and the ability of our team and senior leadership alike to tolerate risk of failure.

As an industry health care has much to learn from other disciplines, such as business, the social sciences, and manufacturing, to improve our ability to both lead and manage. In addition to the LEADS framework, our team used many valuable tools to facilitate our work toward systems transformation, which I have shared as part of our journey. Education in leadership and management, change management, project management, team building, executive coaching, just culture, quality and safety are invaluable for physicians leading both small and large teams. Having tools in an easily accessible toolbox is invaluable in navigating through the complex leadership challenges one can face in health care.

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Measuring physician engagement in quality improvement: a pilot study

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The term "physician engagement" is overused and often misunderstood. It is believed that system transformation requires physician engagement in quality improvement (QI); however, no tool exists to accurately measure this. The purpose of this study was to develop an instrument that could be used to evaluate physician engagement in QI and then pilot it with a small sample of physicians and physician leaders. An electronic survey was developed using a series of focused literature searches and a modified Delphi panel of QI experts. Cognitive debriefing was performed with a group of physicians and physician leaders. The survey was then administered to 37 physicians working in Ontario hospitals. Descriptive analyses were carried out. This short, easy to administer survey allows for the collection of baseline data on facilitators of physician engagement, as well as training and participation in QI. Construct reliabilities are promising with Cronbach's alphas between 0.75 and 0.96.

KEY WORDS: physician engagement, quality improvement, hospitals, evaluation, survey

Despite the notion that physician engagement in quality improvement (QI) is critical to health system transformation, the concept remains poorly defined, measured, and researched.[1] The Ontario Hospital Association's (OHA's) Physician Provincial Leadership Council (PPLC), which comprises senior physician leaders from across the province, identified an important need for additional work in this area and supporting evidence identifying facilitators of physician engagement.[1]

The health care literature suggests that the following antecedents are necessary to enhance physician engagement: accountability[2-8]; communication[2,5-29]; incentives[30] (both financial[3,31,32] and non-financial[33]); and good interpersonal relations between physicians and administrators, with alignment of goals,[34-37] values,[7,37-40] and beliefs.[41] There must be trust[14,15,27,40,41] and respect,[6,8,38] such that physicians feel supported by their organizations.[2,42] The work environment must promote teamwork,[14,17,38,43-45] relationship building,[46,47] and the development of strategic partnerships,[48] whether intergroup[18] or peer.[47] The environment must provide opportunities to partake in and be involved in leadership[8,9,47,49] and decision-making,[2,6,8,15,22,46,50-53] and allow for assessment and suggestions for possible improvements[12] and improvement projects.[54] Finally, there must be opportunities for education, training, and support,[3,6,10,22,26,42,54-66] including training in how to use data effectively.[67] Vital to all of this is protected time to participate in these activities.[49,68-72]

No data currently exist with respect to the number of Ontario physicians formally trained or participating in QI. There is a need

to better understand facilitators and barriers to involvement as well as perceptions of significance. Thus, this study had three objectives: to develop an instrument that could be used to evaluate physician engagement in QI; to pilot the instrument with a small sample of physicians and physician leaders; and to identify facilitators and barriers to physician engagement in QI.

Methods

Part 1. Survey development

No single tool examined all of the facilitators of engagement identified in the literature. Instruments, such as the Well-being Index[73] and Culture of Care Barometer,[74] include only select components. Others, such as the Medical Engagement Survey,[75] are broken down into other well-established, distinct constructs, such as "empowerment" and "satisfaction," perhaps contributing to the ambiguity of the term, engagement.

Response burden was also a concern. Instruments were quite lengthy, even though the literature suggested that fewer questions would suffice. For example, two single-item questions to represent depersonalization (I have become more callous) and emotional exhaustion (I feel burned out) demonstrated results consistent with those based on the 22-item Maslach Burnout Inventory.[76]

As a result, two robust, comprehensive literature reviews were conducted and published.[1,77,78] The first was a scoping review to identify factors associated with, and tools used to measure, physician engagement.[1,78] The second was a conceptual analysis to study and clarify the term "physician engagement."[77] Based on these exhaustive reviews, five key constructs were identified that enhance physician engagement: well-being, interpersonal relationships, opportunities, work environment, and incentives.[1,77] A modified Delphi technique was then used to finalize key areas of focus and corresponding questions.[79-81]

Sample: Convenience sampling was used to recruit participants from Ontario, Canada, for the modified Delphi technique. The panel consisted of senior leaders from the Ontario Hospital Association (2), the Ontario Medical Association (3), Ontario Health (formerly Health Quality Ontario) (2), and faculty at the Dalla Lana School of Public Health (4), two of whom are quality improvement experts. Each of these organizations works closely with, and obtains feedback from, a pool of frontline physicians from a variety of clinical settings.

Data collection: Potential Delphi participants (n = 11) were contacted via email and in person. All agreed to participate. The panel was then sent an email that contained an Excel file (Microsoft, Redmond, Wash., USA) with constructs and sample questions. Participants were asked to rank questions on a Likert scale from one (not at all important) to five (very important) and to suggest additional indicators. Items included in a second round were determined by the first round.[82] The questions were then revised and recirculated to the team via email and an Excel spreadsheet. Questions with an average score of less than 3 were removed. Questions were then distributed to the PPLC, and feedback was obtained in person at its quarterly meeting. Cognitive debriefing was conducted with this group of physicians and physician leaders to ensure that the questions resonated with them, were actionable, were worded appropriately (e.g., not too negative or abrasive), and that respondent burden was minimized.

The survey was constructed using Checkbox 7 (Checkbox 7, Watertown, Mass., USA) online survey platform.

Part 2. Pilot study

The study design was cross-sectional. The rationale for a pilot study can be grouped into several broad classifications: process (e.g., assess feasibility of steps required), resources (e.g., assess time and budget), management (e.g., human and data optimization/management), and scientific (e.g., assessment of treatments).[83] The purpose of this pilot study was to assess feasibility of the email distribution method, assess the amount of time it takes to complete the survey, and assess data management.

Sample: Convenience sampling was used to recruit physicians from across Ontario, who were representative of the physician population at which the survey was

aimed. An email invitation was sent from the OHA to members of their PPLC to ensure variety in hospital type (i.e., community, small/rural, academic teaching, mental health, and complex continuing care/rehabilitation). Those interested in providing feedback were asked to contact the research team. Respondents were also asked to forward the link to individuals on their medical advisory committee who would complete the survey, critically assess the instrument, and provide feedback. In total, the link was distributed to 49 physicians. Based on the Canadian 2014 National Physician Survey, a 16% response rate was expected.[84]

Data collection: Potential participants were sent an information email containing a link to the online survey. This afforded an inexpensive method that allowed for rapid surveying of a large, geographically distributed sample across the province.[85] The survey was administered through Checkbox. Once participants clicked on the link, they were directed to an introduction page, which explicitly stated that by completing and submitting the survey, they were consenting to participate in this study. Following the initial invitation, participants were sent two follow-up reminders at 1-week intervals. All questions on the survey were mandatory; thus, participants were required to answer all questions on each page before proceeding to the next page of questions. Once the survey was completed, participants had the opportunity to provide additional free text and general comments.

Data: All data were categorical. They were imported from Checkbox into Excel and then directly into SPSS v. 23.

Analysis: Descriptive analyses were performed to generate frequency distributions for each variable. Negative survey items were reverse-coded and included as new variables in the data set. Cronbach's alphas were calculated for each construct to test reliability. In the literature, the ratio of sample size to number of free parameters ranges from as low as five participants per observed variable to 10-20:1.[86,87]

Ethics: Approval was obtained from the Research Ethics Board at the University of Toronto.

Table 1. Characteristics of survey respondents (*n* = 37)

Characteristic	No.	%
Sex		
Female	15	40.5
Male	22	59.5
Year of birth		
1946–1964	9	24.3
1965–1976	15	40.5
1977–1995	12	32.4
1996+	1	2.7
Formal leadership role		
No	9	24.3
Yes	28	75.7
Years practising medicine		
≤ 2	3	8.1
3–5	4	10.8
6–10	7	18.9
11–20	11	29.7
21+	12	32.4
Years in same organization		
≤ 2	6	16.2
3–5	8	21.6
6–10	7	18.9
11–20	10	27.0
21+	6	16.2

Table 2. Survey respondents' perceptions of well-being (*n* = 37)

Statement/question	No.	%
I feel I am having positive impact on people's lives through my work		
Strongly disagree	0	0.0
Disagree	1	2.7
Neutral	2	5.4
Agree	18	48.6
Strongly agree	16	43.2
The work I do is meaningful to me		
Strongly disagree	0	0.0
Disagree	1	2.7
Neutral	1	2.7
Agree	11	29.7
Strongly agree	24	64.9
I've become more callous towards people since I've started this job		
Strongly disagree	14	37.8
Disagree	9	24.3
Neutral	9	24.3
Agree	5	13.5
Strongly agree	0	0.0
I feel burned out from work		
Strongly disagree	5	13.5
Disagree	10	27.0
Neutral	13	35.1
Agree	5	13.5
Strongly agree	4	10.8
My work schedule leaves me enough time for my personal life		
Strongly disagree	2	5.4
Disagree	5	13.5
Neutral	13	35.1
Agree	15	40.5
Strongly agree	2	5.4
This organization has a positive workplace culture		
Strongly disagree	1	2.7
Disagree	2	5.4
Neutral	9	24.3
Agree	16	43.2
Strongly agree	9	24.3

Results

Characteristics of respondents

Of the 49 physicians contacted, 37 completed the survey for a response rate of 75.5%. This sample included 15 specialties from seven sites, with variation in hospital type. To avoid potential identification of participants, details related to hospital type and specialty are not reported. On average, it took five minutes and 43 seconds to complete the survey.

Respondents were 59% (*n* = 22) male, with 73% (*n* = 27) born between 1965 and 1995 (Table 1). Over 76% (*n* = 28) were in formal leadership roles, and 62% (*n* = 23) had been practising medicine for over 10 years and had been with their organizations longer than five years.

Constructs

Well-being: Over 91% (*n* = 34) of respondents agreed and strongly agreed that they felt they were having a positive impact on people's lives through their work, and 95% (*n* = 35) felt the work they do is meaningful to them (Table 2). Five (13%) felt they had become more callous toward people since they started their current job, with nine (24%) unable to decide. Nine (24%) agreed or strongly agreed that they felt burned out, with 13 (35%) unable to decide. Almost 46% (*n* = 17) felt their schedules afforded them enough time for their personal life and families, and 68% (*n* = 25) felt their organization had a positive workplace culture.

Perceptions of senior leadership and co-workers: With 76% of respondents holding formal leadership roles, it was not unexpected to find that over 73% agreed or strongly agreed that they trusted their senior leadership and that their senior leadership listened to their views, took their concerns seriously, supported and respected them (Table 3).

Table 3. Survey respondents' perceptions of senior leadership and co-workers (*n* = 37)

Statement/question	No.	%
SENIOR LEADERSHIP		
There is strong senior leadership in this organization		
Strongly disagree	0	0.0
Disagree	3	8.1
Neutral	4	10.8
Agree	10	27.0
Strongly agree	20	54.1
Senior leadership within this organization listen to my views		
Strongly disagree	1	2.7
Disagree	0	0.0
Neutral	8	21.6
Agree	13	35.1
Strongly agree	15	40.5
I feel well supported by senior leadership in this organization		
Strongly disagree	0	0.0
Disagree	2	5.4
Neutral	7	18.9
Agree	15	40.5
Strongly agree	13	35.1
I trust this organization's senior leadership		
Strongly disagree	0	0.0
Disagree	3	8.1
Neutral	7	18.9
Agree	16	43.2
Strongly agree	11	29.7
I feel senior leadership treat me with respect		
Strongly disagree	0	0.0
Disagree	3	8.1
Neutral	4	10.8
Agree	12	32.4
Strongly agree	18	48.6
I receive constructive feedback from senior leadership		
Strongly disagree	0	0.0
Disagree	3	8.1
Neutral	12	32.4
Agree	12	32.4
Strongly agree	10	27.0
My concerns are taken seriously by senior leadership		
Strongly disagree	1	2.7
Disagree	1	2.7
Neutral	4	10.8
Agree	18	48.6
Strongly agree	13	35.1
CO-WORKERS		
I feel respected by my co-workers		
Strongly disagree	0	0.0
Disagree	0	0.0
Neutral	3	8.1
Agree	12	32.4
Strongly agree	22	59.5
My interprofessional team functions well together		
Strongly disagree	0	0.0
Disagree	0	0.0
Neutral	4	10.8
Agree	13	35.1
Strongly agree	20	54.1

However, only 59% (*n* = 22) agreed or strongly agreed that senior leadership provided constructive feedback. Regarding co-workers, 92% (*n* = 34) agreed or strongly agreed that they felt respected, and 89% (*n* = 33) felt their interprofessional teams functioned well together.

Opportunities and work environment: Just over 80% (*n* = 30) of respondents agreed or strongly agreed that they have opportunities to be involved in decision-making and opportunities for leadership (Table 4). Almost 90% (n = 33) felt they had opportunities to suggest improvements; however, only 62% (*n* = 23) felt they had opportunities for training and education.

Approximately 65% (*n* = 24) agreed or strongly agreed that they had the resources they needed to do a good job. Only about 60% (*n* = 22) felt that unacceptable behaviour was consistently tackled. Over 80% (*n* = 30) of respondents felt well informed about what was happening in their organization, that two-way communication existed with the organization's administration, and that there was alignment between their goals and those of the organization. Only 62% (*n* = 23) agreed or strongly disagreed that they were held accountable for achieving results.

Scale reliabilities

All Cronbach's alphas were greater than 0.7 and were considered acceptable (Table 5).[88]

Incentives

Approximately 84% (*n* = 31) of

Table 4. Survey respondents' perceptions regarding opportunities and work environment (*n* = 37)

Statement/question	No.	%
OPPORTUNITY		
To be involved in decision-making that impacts the organization		
Strongly disagree	1	2.7
Disagree	1	2.7
Neutral	5	13.5
Agree	16	43.2
Strongly agree	14	37.8
To suggest improvements in the way things are done		
Strongly disagree	1	2.7
Disagree	1	2.7
Neutral	2	5.4
Agree	17	45.9
Strongly agree	16	43.2
Leadership opportunities are available to me		
Strongly disagree	0	0.0
Disagree	1	2.7
Neutral	6	16.2
Agree	15	40.5
Strongly agree	15	40.5
I have education and training opportunities at this organization		
Strongly disagree	0	0.0
Disagree	3	8.1
Neutral	11	29.7
Agree	13	35.1
Strongly agree	10	27.0
WORK ENVIRONMENT		
I have the resources I need to do a good jobs		
Strongly disagree	0	0.0
Disagree	4	10.8
Neutral	9	24.3
Agree	16	43.2
Strongly agree	8	21.6
Unacceptable behaviour is consistently tackled		
Strongly disagree	1	2.7
Disagree	5	13.5
Neutral	9	24.3
Agree	14	37.8
Strongly agree	8	21.6
I feel well informed about what is happening in the organization		
Strongly disagree	1	2.7
Disagree	0	0.0
Neutral	6	16.2
Agree	20	54.1
Strongly agree	10	27.0
Two-way communication exists with organization's administration		
Strongly disagree	2	5.4
Disagree	3	8.1
Neutral	4	10.8
Agree	16	48.6
Strongly agree	12	32.4
There is alignment between my goals and the organization's goals		
Strongly disagree	0	0.0
Disagree	3	8.1
Neutral	4	10.8
Agree	18	48.6
Strongly agree	12	32.4
I am held accountable for achieving results at this organization		
Strongly disagree	1	2.7
Disagree	0	0.0
Neutral	13	35.1
Agree	18	48.6
Strongly agree	5	32.4

respondents reported that their organization did not use any form of incentive to obtain outcomes (Table 6).

Quality improvement

Fewer than 14% (*n* = 5) of respondents were formally trained in QI at their organization (Table 7). Of the five people trained, four received intermediate training (e.g., the application of basic tools in small projects) and the fifth received introductory training (e.g., basic concepts and tools). All five "agreed" that the training received prepared them to participate effectively in QI projects. Regardless of training, 57% (*n* = 21) of respondents had participated in QI projects: 49% (*n* = 18) at the organization level, 40.5% (*n* = 15) at the patient level, and only 19% (*n* = 7) at the system level. Approximately 70% (*n* = 26) "did not know" or "disagreed" that useful data on their own performance to support QI were available.

When asked if their organization made it easy to participate in QI, 68% (*n* = 25) responded "yes" and identified "provision of organizational support" (*n* = 17) and "making QI part of their job" (*n* = 14) as the main facilitators. The remaining 32% (*n* = 12) that felt their organization did not make it easy to participate and identified "no training offered" (*n* = 7), "never asked" (*n* = 6), and "not enough time" (*n* = 5) as the main barriers. Approximately 60% "don't know" (*n* = 21) or "disagree" (*n* = 1) when asked if resources dedicated to QI are producing positive results. Respondents felt that the

Table 5. Reliability of survey results by construct

Construct	No. of items	Scale	Cronbach's α
Well-being	6	5 point	0.772
Senior leadership	7	5 point	0.957
Co-workers	2	5 point	0.754
Opportunity	4	5 point	0.846
Work environment	6	5 point	0.831

Table 6. Characteristics of survey respondents (*n* = 37)

Statement/question	No.	%
My organization uses incentives to obtain outcomes		
No	31	83.8
Yes	6	16.2

QI projects their organization participates in result in services that are safe (*n* = 25), patient-centred (*n* = 25), effective (*n* = 13), efficient (*n* = 10), timely (*n* = 9), and equitable (*n* = 5).

Additional questions identified for inclusion

It was suggested that Schaufeli's nine-item work engagement scale,[89] which is valid and reliable, be added to determine the level of overall "work engagement" and to establish a baseline for physicians. It was also suggested that an additional single question be added to determine whether an individual received training in QI external to their organization.

Discussion

The purpose of this pilot study was to assess the feasibility of the email distribution method, the amount of time it takes to complete the survey, and data management. No concerns with our methods were identified. All participants were able to open the information email and use the link to the survey. Completion time was short, approximate five minutes. Finally, no concerns with our data management were identified; data were easily and securely transferred between Checkbox, Excel, and SPSS software.

This short survey identifies key facilitators of physician engagement and can quickly highlight opportunities for both senior leadership and policymakers. It is promising that all scale reliabilities were found to be acceptable. This level of psychometric and formative evaluation is not present with other surveys in the engagement literature.[1] This is important and one of the reasons that such a rigorous approach to the development of this survey was taken.

The literature suggests that a dedicated effort is required by all health care workers to achieve and sustain high performance.[90] This instrument helps to identify an opportunity for formal QI training. Only a small percentage of our participants were formally trained in QI at their organization; none received advanced training, an interesting finding considering that over half participated in QI projects.

This tool helped to reveal that approximately a third of the organizations made it challenging for physicians to participate in QI, the main barriers being no training offered, no formal invitation to participate, and lack of time. Given that Ontario's *Excellent Care For All Act* requires hospitals to link executive compensation to the achievement of targets set out in the QI plan,[91] it is interesting to see that only a small number of organizations used incentives to drive outcomes within their organizations.

Table 7. Survey respondents' training and participation in quality improvement (QI) (*n* = 37)

Statement/question	No.	%
Formal training received in QI at their organization		
No	32	86.5
Yes	5	13.5
In last year, participated in QI projects		
No	16	43.2
Yes	21	56.8
For those who participated in QI, the level of projects*		
Patient	15	40.5
Organization	18	48.6
System	7	18.9
I receive useful data on my performance to support QI		
Disagree	11	29.7
Don't know	15	40.5
Agree	6	16.2
Strongly agree	5	13.5
Organization makes it easy for you to participate in QI		
No	12	32.4
Yes	25	67.6
Organization makes it easy to participate in QI by*		
Protected time	1	2.7
It's part of my job	14	37.8
Organizational support	17	46.0
Ongoing education & training	5	13.5
It's not easy to participate in QI at organization because*		
Not enough time	5	13.5
I am never asked	6	16.2
No training offered	7	18.9
Organization does not support	1	2.7
Resources dedicated to QI, producing positive results		
Strongly agree	4	10.8
Agree	11	29.7
Don't know	21	56.8
Disagree	1	2.7
QI projects in organization result in services that are*		
Safe	25	67.6
Effective	13	35.1
Patient-centred	25	67.6
Efficient	10	27.0
Timely	9	24.3
Equitable	5	13.5

*Respondents could select multiple options; thus, totals will exceed 100%.

In conjunction with participation in QI, feedback[11] and assigned accountability have also been identified as important.[3,4] Feedback related to clinical performance is critical to QI.[92] This instrument helped to show that a large proportion of respondents were unaware or confirmed that they did not receive useful data on their own performance to support QI. Many respondents reported a lack of constructive feedback, which may relate to over a third of respondents undecided with respect to whether they were held accountable for achieving results. In addition, many respondents, almost two thirds, did not know whether resources dedicated to QI were producing positive results.

Using Health Quality Ontario's six defining elements of quality care,[93] our survey helped to show that there may be opportunities for greater promotion of project results and additional QI projects focused on equitable, timely, efficient, and/or effective services. To create a high-performing health care system, a system-wide perspective is needed.[94] This instrument helps to identify a potential need for, or lack of, system-level QI projects. This is the first time this type of data has been captured and examined in Ontario. Results clearly indicated that just over half of our sample group participated in QI projects, of which the majority were at the organization and patient levels, with only a few at the system level. Finally, the Canadian Medical Association recently released a report that one in four Canadian

physicians report burnout.[95] Based on a single question, our survey found that in this small Ontario sample, approximately one in four respondents expressed burnout, supporting the use of single-item questions when possible to reduce respondent burden.[76]

This work has the potential to create opportunities for future research that can substantiate or refute common organizational theories about motivation, culture, and performance in relation to physicians. By collecting accurate, valid, and reliable longitudinal data, we can move beyond the simple association of variables and start identifying causation, which could help health care leaders make evidence-informed decisions and focus resources in areas proven to have the greatest impact.

Limitations

Our survey population was small and made up, predominantly, of individuals in hospital leadership roles. However, the purpose was not to generalize results, but to develop and test an instrument that could be used by health care leadership in Ontario to quickly evaluate key areas, suggested in the literature to impact engagement in QI within their organizations.

Conclusion

A short, easy to administer survey was developed to help Ontario hospital leaders obtain baseline data on facilitators of physician engagement, participation, and training in QI. This instrument was able to help leaders quickly evaluate key actionable areas linked to physician engagement. A larger sample is warranted for accurate validity and reliability testing. This tool could prove extremely valuable in enhancing physician engagement in QI initiatives.

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Author attestation

In addition to participating in the research design and development of the survey instrument, all authors contributed significantly to article preparation. Tyrone Perreira and Melissa Prokopy conceptualized the article. Adalsteinn Brown, Anna Greenberg, James Wright, Christine Shea, and Julie Simard assisted with organization and revisions of the article. All authors approved the final version.

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PERSPECTIVE

The journey to retirement for physician leaders

David Mador, MD

You have risen to a senior medical leadership role – the culmination of your administrative career. You have decided that the time is right for full retirement in the next one to three years and that this "retirement" will not entail continued medical roles or activities. Your family is strongly supportive. You have an adequate financial plan and have developed or considered other interests to keep you occupied and stimulated in retirement.

KEY WORDS: physician leader, retirement, consultation, clinical practice, transition, opportunities, planning

What, then, are some of the aspects to be considered as you embark on this relatively short journey of transition? What are the unique qualities and competencies of medical leaders that will affect your route? In other words, how are you going to get from where you are today to where you want to be in the near future? A myriad of books and articles have been written about planning and considerations needed for a successful, rewarding retirement, but little specifically about how to deliberately plan the journey to retirement.

Based on my personal experience and observations of other colleagues, I would like to share some thoughts about the transition options available to physician leaders.

Unique competencies

Senior medical leaders come from academia, health care administration, the regulatory world, or medical politics. They have generally had interesting and varied careers that have enabled the development of a veritable potpourri of skill sets, depending, of course, on where their career took them. The opportunities to develop competencies in leadership far removed from traditional medicine are substantial and, by retirement, physician leaders may be expert in information management or technology, Quality, finances, capital management, research, teaching, etc. Some are acknowledged as exceptional leaders, something to which all physician leaders aspire, but may not have achieved.

In Canada, most physician leaders still have clinical roles, although these contract as their leadership roles expand over time. In some cases, they retire from active clinical practice to enable more focus on administrative work, as I have. However, generally, all medical leaders have a solid base of clinical competencies to add to their resume.

Whatever the acquired skills may be, their combination with a clinical background means that medical leaders contemplating retirement will have many options. In the vignettes that follow, I explore some of these options and what we might learn from them.

Options for retirement

Close the door and turn off the lights

Doctor Decisive had a wide variety of medical leadership roles, culminating in a major 0.8 FTE commitment. She retained a small clinical practice supported by her hospital, but is an avid baker, traveler, reader, and grandmother. She was content and felt fulfilled with her professional career and achievements. After much thought and reflection, she set a full retirement date about 1 year

ahead and continued to work full time until that date. She left on good terms with her team and her hospital. Now, several years later, she is happy in retirement and has no regrets nor does she miss professional life.

Learnings: Some leaders are quite comfortable with an abrupt transition to retirement, but even this example was a planned deliberate approach. Implicit in this approach is the need to have actively planned out what the retirement state will entail.

Return to clinical practice

Doctor Clinician had a varied administrative career as a medical leader. However, his work had become less engaging and more "same old." He had achieved most of the goals he set for himself several years ago and had developed a good succession plan that he has confidence will leave his organization in good shape.

He noticed that he continued to relish and enjoy his limited time in clinic, seeing and helping patients. He did not feel immediately ready for full retirement and, after discussion with his colleagues and a planned transition period, which included some clinical refresher courses, he returned to increased part-time clinical practice. He is currently enjoying both his work and partial retirement and plans to continue for a couple more years before full retirement.

Learnings: This might also be titled "back to our roots." For many physician leaders, part-time clinical practice can provide the adjustment period needed to transition to retirement from the high stress role of physician leader. Attention to clinical expertise/ competencies and collaboration with colleagues is key.

There is also mention here of succession planning as a fundamental and satisfying activity. Indeed, some would suggest this is the most important legacy piece of a senior Leader.

Something new

Doctor Academic was involved in the Faculty of Medicine in various leadership roles for over 20 years. She was thinking about retirement when she was approached by the CEO of her hospital to consider

a new 0.4 FTE role to establish and develop a formal Department of Quality and Innovation. The CEO was looking for a 3-year commitment and considered this an important initiative. Doctor Academic found herself stimulated by the potential of this new role and the aspect of creating something new both for the hospital as well as for herself. In addition, she realized that a 3-year commitment would probably provide a perfect time-frame in which to complete her career.

After a year in the new role, she is very happy and engaged with work. She has been developing new skills and expertise and finds this invigorating. She has almost completely tapered off her clinical practice and is learning to enjoy the additional time off. She has started to think about succession planning with the goal of complete retirement at the end of her term.

Learnings: New opportunities that may unexpectedly arise offer stimulating work, but at a different pace. For some, this combination may be a perfect fit. In this case, the opportunity arose because of general leadership skills and experience, not because of specific interests.

Becoming a consultant

Doctor Advisor had been involved in administrative roles at his hospital for many years in a variety of capacities. As he approached 60 years of age, he found that he was far busier than he wished to be. He found the ties of his remaining clinical practice burdensome and was not feeling stimulated by his administrative work. He wanted to have more time off for his personal life (including a new passion to learn to cook with a smoker grill).

Over his career, Doctor Advisor had been approached to provide advice on external projects, but had not been able to do so because of time constraints or a conflict of interest. Two years earlier, he was approached by a consultant group to participate in a request for proposal from another province. The bid was successful, and he found the work engaging and stimulating. Other organizations showed an interest in his consultant expertise. He decided that a part-time career for a few years as a consultant was appealing and that he wasn't really concerned about the uncertainty involved in such a career move. He was confident that there would be some work and that he would enjoy this. Over about a year, he retired from his administrative and clinical roles and subsequently pursued and developed his new contacts.

Two years later, he is as busy as he wants to be, working perhaps 12–15 weeks a year. He picks projects that he has a personal interest in and finds this very satisfying. The work blends easily with his personal life (he has become a good pitmaster). However, he has no desire to continue working indefinitely and has set age 67 as his final retirement goal.

Learnings: This is a common scenario that can go either way. Because of the limited project-orientated nature of the work, it can support a transition to full retirement or a longer term part-time retirement strategy.

Something new (again)

Doctor Builder is a senior physician leader who had a varied career. During the years spent working in a major academic hospital, he participated in a major hospital redevelopment. He interacted with planning consultants, architects, and construction companies and developed a passion for understanding how clinical need should drive the capital construction process, as well as a unique set of skills and expertise. One of the partners of the architectural firm that he had worked closely with went on to become the province's deputy minister of infrastructure and approached him about considering a role as clinical advisor in the department. He considered this a unique and exciting opportunity and did not hesitate to leave his current work and accept a three-year position at a 0.5 FTE with a firm intent to retire at the end of that term.

Learnings: In this scenario, a skill set and interest acquired during one's career develops into new interesting part-time work. Many such opportunities exist because of the varied careers that medical leaders experience.

Planned decompression

Doctor Deliberate achieved the role of vice-president of a large academic regional health authority – a high-intensity, high-stress job with a wide array of responsibilities. After several rewarding and stimulating years, he began to notice the toll this

was taking on his physical and mental health and started planning toward retirement. Believing that an abrupt full retirement would be a difficult adjustment, he chose to organize an orderly, planned, and gradual transition over a few years.

He analyzed his strengths and skills and cross-referenced them with his interests and passions. He looked at the needs of his organization and developed a role description for a new part-time position that would serve it well and keep him personally engaged and productive. This lower stress, part-time work would give him time and opportunity to ease up and achieve a better work–personal life balance. After significant discussions and negotiations with some of his colleagues, the role was created and the transition occurred.

A year later, the organization was finding great value in Doctor Deliberate's work, and he remained engaged and stimulated. Of equal significance, he started to develop some personal interests and enjoy time with his children and grandchildren. After year two, the work time commitment was further decreased with full retirement in the immediate future.

Learnings: Organizations are often too busy to proactively consider the creation of a new role that can be helpful to both the organization and to a leader in transition. However, it may not be difficult for a leader to take the initiative and "sell" a new role to their organization. This is a classic win–win scenario.

Informal leadership

Doctor Generous has decided not to renew her leadership position and is planning to retire fully in the next few months. However, she remains passionate about the importance of physician leadership to the Canadian health care system and wonders how to continue to promote it in an informal, unpaid way. For the last few years, she has been attending the Canadian Society of Physician Leaders' annual conference, which she has found very rewarding, and has developed a good network of contacts. She decides to maintain her membership even after retiring from active work and to continue to attend annually. She hopes that she may be able to contribute to CSPL by volunteering to be on the meeting planning committee or, perhaps, creating a workshop of interest to the members.

Learnings: This is another example of an activity that may be time-limited or more long-term. It might be more appropriately considered a retirement activity rather than transition.

Back to the drawing board

Doctor Tentative has "done it all" in a long and varied clinical and administrative career. About 2 years ago, he retired from his leadership role, but continued with a part-time consultative specialty practice. He developed several outside personal interests and, after reflection, convinced that he was ready, he finally retired fully. After 6 months, despite being quite active, he realized that he missed the social and intellectual stimulation of his previous work. He reached out and, in no small part because of his extensive and varied skills, his previous organization quickly re-engaged him in a consultative administrative role. He is working two days a week and is happy with this balance between work and partial retirement.

Learnings: Full-time retirement is not for everyone. For some leaders, continued work is integral to their sense of self and well-being, both intellectual and social aspects. However, the challenge is how to monitor the value of our work and our competencies as we get older. In addition, this is not an indefinite state and, at some future point, the journey to full retirement will occur and the challenge of transition remains.

Discussion

Personal finances, personal and family health, family support, and personal interests/activities are major factors in making the decision to retire. Although these factors are critically important in determining the approximate timing of retirement or indeed deciding whether we want to retire at all, the intent of this opinion piece was not to delve into them, but rather talk about the journey. This topic has been neglected in most discussions about retirement. However, for most of us, once we have decided that we are going to retire and have some ideas about timing, the challenge remains: how are we going to get there? How can we, at least in part, address the potential loss of meaning? As the above scenarios have illustrated, the journey to retirement is highly personal (like retirement itself) and may take place over a short timeframe or over many years.

I believe that personal engagement and buy-in is important for a transition to full retirement to be effective and gratifying. The L (Lead self) in the LEADS framework suggests that self-awareness and managing one's own performance and health are characteristics of a strong leader. I suggest that the retirement journey phase of leadership requires these same characteristics and that serious reflection and planning will be a rewarding activity.

If you believe that some sort of transition toward retirement is best for you, what are some possible considerations? Although some transitions may be quite obvious and require little active planning, others may need some degree of innovation. What are some aspects of your present or past work life that still interest and stimulate you? Analyze your strengths and the special, perhaps unique, skill sets that you have developed over the years and then consider whether any of these could fill a need for your organization or perhaps another group.

Is personal advocacy required? With whom do you need to discuss your thoughts, and do you need some personal support in your journey? Perhaps a mentor or friend could provide valuable advice and guidance. Not all of this planning has to be done alone. Have you been approached recently with opportunities (either internal or external) that you initially rejected, but might reconsider in the context of this transition.

In general, I believe that a slow-down or part-time role will likely be the most effective strategy leading to full retirement. Senior medical leadership roles are usually time intensive and quite stressful (whether we realize it or not); so a transition that involves fewer hours and less stress is likely to be effective. Most of the scenarios above highlight these types of transitions.

Conclusion

Retirement can and should be a rewarding part of our lives. However, getting to that retirement date does not necessarily happen automatically or organically. The rich and varied experience and competencies of physician leaders create the opportunity to organize and plan the journey to retirement, instead of taking a more passive approach. I believe that this deliberate approach will result in a smoother transition and, ultimately, improve our long-term satisfaction and contentment. For those of you considering retirement, I hope this discussion helps you approach the journey differently.

Disclaimer

The scenarios described above are mostly fictitious. They are based on my personal experience and observations of some of my colleagues as they proceeded along their own retirement journey.

Author

David Mador, MD, is a urologist, who had a successful 30-year clinical career centred at the Royal Alexandra Hospital. He has held a variety of senior medical leadership positions culminating in a four-year term on the executive of Alberta Health Services (AHS). Subsequently, he continued on a part-time basis with AHS as senior medical advisor with significant ongoing work in the development of the provincial clinical information system. He is now fully retired.

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BOOK REVIEW

Humanity and relationships in health care

Reviewed by J. Van Aerde, MD, PhD

Bird's Eye View: Stories of a Life Lived in Health Care

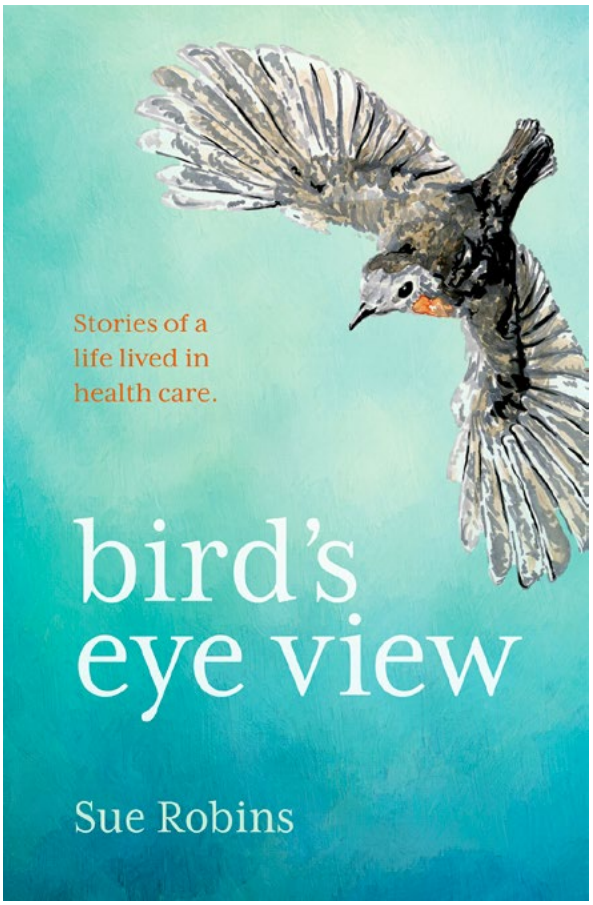
Sue Robins
Bird Communications, 2019

Breathe Baby Breathe! Neonatal Intensive Care, Prematurity, and Complicated Pregnancies

Annie Janvier, MD, PhD
University of Toronto Press, 2020

In Shock: My Journey from Death to Recovery and the Redemptive Power of Hope

Rana Awdish, MD
St. Martin's Press, 2017



These three books deal with relationships, perceptions, and suffering as perceived by people who have experienced the health care system from different angles. One author was a student nurse, an administrator, the mother of a child who needed help, an advocate for children and families in a children's hospital, and finally a patient. The other two authors are physicians. One is the mother of an extremely-low-birth-weight infant who was admitted to the neonatal intensive care unit (NICU) where she and her husband practise as academic neonatologists. The other is an intensivist who became a patient in her own ICU and nearly died, twice.

All three books are about mental models and culture, which, in turn, affect mutual understanding and misunderstanding in the health care system. They are about feelings and suffering, about empathy and compassion, and about how to communicate appropriately and effectively. They are about humanity and relationships.

In *Bird's Eye View*, Sue Robins weaves together anecdotes from a journey through the health care system in Edmonton and Vancouver. Each story contains a small lesson worth reflecting on. Robins is directive in some of her stories, but then, she has experienced the health care system from so many angles that she is entitled to give advice.

After two years as a nursing student, she left when she discovered it was not okay to experience feelings when you work in health care. That was three decades ago. Then, she spent a good amount of time as an administrator in several settings. When she became the mother of Aaron, her third child, she stepped out of the administrative world of health care and navigated the system from the outside, for and with Aaron, who was born with Down syndrome.

In the book, Aaron's journey reveals, not only the stigma language imposes on parents whose child falls outside society's "norm," but also the difficulty of trying to create a consistent plan for a child within a fragmented system. During this time, Sue becomes a volunteer advocate for family-centred care at the children's hospital Aaron frequents for medical and surgical care; later she is hired as a family-centred care consultant.

Finally, Sue plays yet another, very different role in our health care system when she becomes a patient with breast cancer needing surgical and post-surgical treatment. The stories in that section reveal what goes on in her mind while she continues to seek compassion and healing relationships. Here are a few pearls of wisdom that struck me. "The secret is to never assume how a person might feel. The other secret is that even if you have had cancer yourself, don't assume others experience it in the same way that you did." "It is easy to be kind, it does not take more time, kindness is up to individuals, and lack of kindness cannot be blamed on 'the system.' Never forget the system is made up of people."

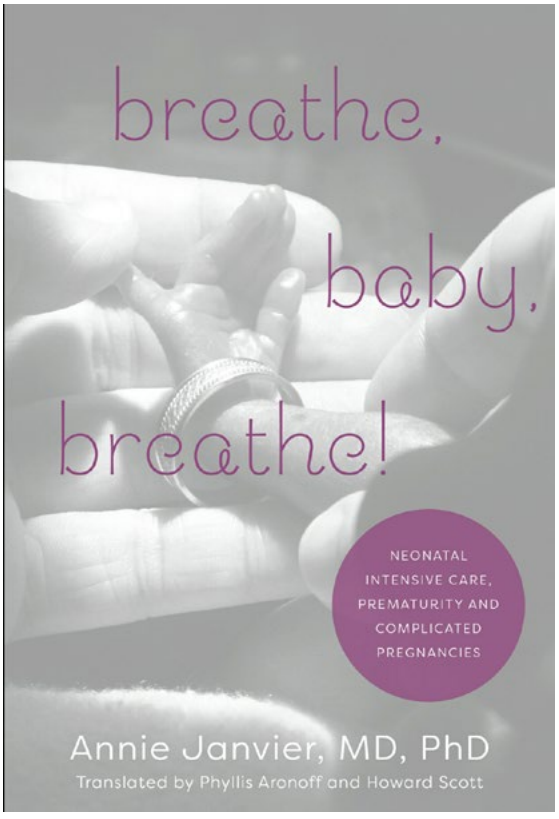
The book is about assumptions, perceptions, mental models, kindness, and empathy. It is about humanity and relationships, one at a time. This is not a book to be read all at once, but rather one or two anecdotes at a time, sometimes even skipping one, but making sure to leave time to think about what the stories might mean in your part of the health care system, today from your perspective as physician, perhaps tomorrow as patient.

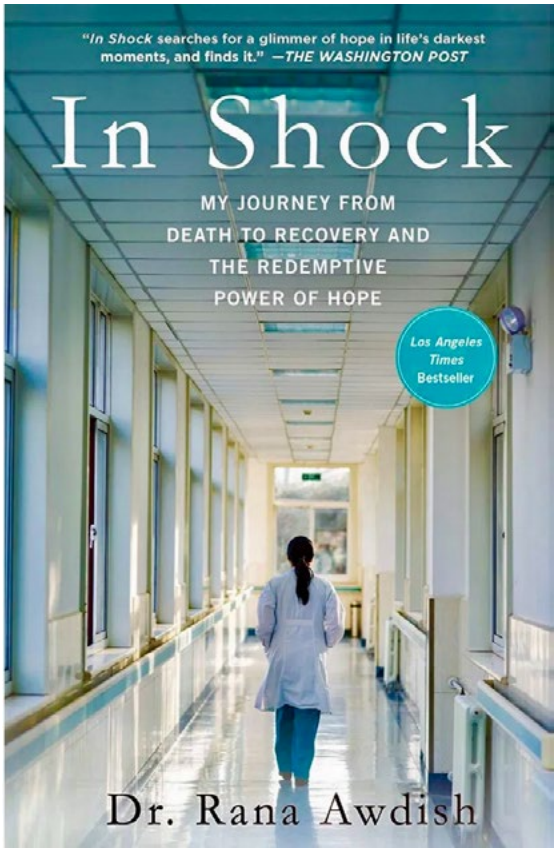
Breathe, Baby, Breathe! by Dr. Annie Janvier from Montréal tells the story of an extremely-low-birth-weight infant, born after 23–24 weeks of gestation to parents who are both academic neonatologists, the mother also with a PhD in ethics. Janvier is that mother.

This is not another textbook for parents of a preterm baby, explaining the many complications their baby might develop. In journal entries that are conversations with herself and her computer, Janvier tries to come to grips, not just with her baby's poor prognosis, but also with the chances of survival of herself as a mother and of her family unit. The reader feels the pain of a mother in despair, a mother who is convinced she is failing, of somebody who goes through a mental breakdown ultimately ending in post-traumatic growth.

Janvier knows the facts, the discouraging data: her child has about a one-in-three chance of surviving and a high probability of long-term difficulties. The outlook becomes more dismal when the infant develops overwhelming sepsis with multi-organ failure and the parents must decide whether to continue aggressive treatment. Although Janvier and her husband knew all the facts, they didn't understand how inadequate data and statistics would be in the face of overwhelming emotions. "Being a parent in the NICU changed me," she writes. "I hit bottom. I learned how easy it is to fall, and how fast it can happen."

Janvier came to understand how much she didn't know. As a neonatologist, she had written an information sheet for parents whose pre-term babies were admitted to the NICU. The information was mostly facts about the baby's chances of survival and about the possible long-term complications associated with prematurity. She once thought that such information was crucial, but as a parent, she saw how wrong she was. "My husband and I had all the necessary knowledge… but, in fact, we knew nothing, nothing at all."





The book recreates Janvier's experience in a very raw manner, as she describes her rage and sometimes chaotic thoughts. At times, I wanted to put down the book, because I no longer wanted to feel the suffering of a mother who had spiraled down into such dark places. However, Janvier also shares the lessons she learned. Her experience led her to change the way she interacts with parents and to improve doctor–patient communication to guide parents through the emotionally treacherous minefield of the NICU.

There are interesting similarities between *Breathe, Baby, Breathe!* and *Bird's Eye View*. In both, health care professionals are not communicating appropriately, don't acknowledge the suffering, and are perceived as lacking empathy and compassion. What struck me most were the almost identical quotes by Robins, "The secret is to never assume how a person might feel" and Janvier, "I have become intolerant of health professionals who presume to understand what parents need without asking them." Why do we, as physicians and health care professionals, assume to know our patients' needs, why do we base those assumed needs on data, and not on the emotions and feelings of those we care for? (BTW: Janvier's baby survived and, at the age of 16, is doing well, against all odds and statistics.)

Dr. Rana Awdish's experiences in the health care system go even deeper, as she ends up as a patient in the ICU where she is one of the intensivists. I read *In Shock* in two evenings, a dramatic, engaging, and instructive page-turner, not only because of the beautiful writing style, but also because the story and experiences are hair-raising, almost unbelievable. At the end of those two days, some of my thinking related to communication, presence, feelings, and compassion had changed. It made me rethink my own mortality, not in general, but in a hospital setting or an ICU, and how scary that would be.

Awdish survived two life-threatening events, one including an out-of-body experience that she doesn't belabour, and lived with chronic organ ailments for a few years. She was seven months pregnant when she experienced a massive bleed with hemorrhagic shock and hemoglobin concentration as low as 30 g/L, caused by what was thought to be severe HELP syndrome. She recovered over a few months, returned to work for a short time, and ended up in the ICU again, this time for what really caused her bleeding: hepatic adenomas. She then developed every possible complication in the textbook, including sepsis. She works and was a patient in a hospital that had researched sepsis in adults, she gave the pertinent information to the professionals, all the while feeling herself sink deeper and deeper into septic shock; no one listened, no one heard what she was saying.

As a patient in her own unit, this ICU doctor disliked what she heard, saw, felt, and experienced. In many instances, she perceived her peers as being unable to see human suffering as it is, often protecting themselves against the pain she says the profession doesn't allow us to feel. She felt disappointment in herself when she realized that she failed similarly as an intensivist on the other side of the equation.

Some of the insights she presents hit home and force you to challenge your own practice, assumptions, and mental models regarding feeling, emotions, and compassionate care. She finds that emotion is a common language through which patients can and

need to connect with physicians and the health care team.

As a result of her experiences, she not only formulated suggestions at the end of her book, but she also designed a full learning program on communication and empathy/compassion, which is used inside and outside her institution. A few quotes I remember: "Even when we intend to do no harm, it seems we lack the necessary tools to heal without layering some added suffering. Our greatest gift is our ability to absolutely be present with suffering." "How often does anyone listen generously, without their ears pre-tuned to what they hope the answer will be?" "Medicine cannot heal in a vacuum; it requires connection."

All three of these books make us pause and reflect on our professional relationships, our understanding of how and what we communicate, our mental models, empathy and compassionate care in the face of suffering, and what these constructs mean in our relationships. If I had to summarize the books in three words, it would look like this: medicine = humanity = relationships.

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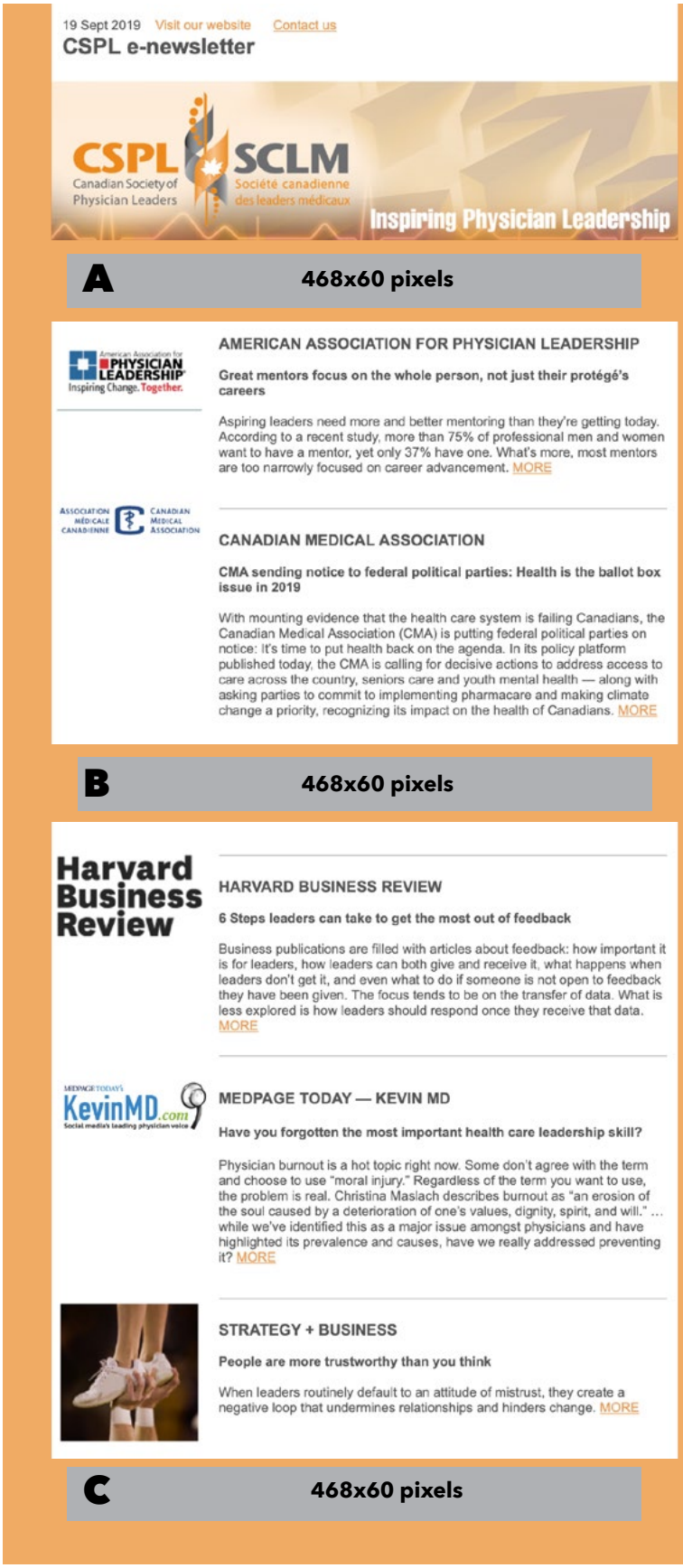

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