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Steps to developing leadership talent

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Physician-led quality improvement: a blueprint for building capacity

ADVICE: Managing physician conflict

We have a great idea, now what? Using the Canadian Healthcare Lean Canvas for implementing innovation

ADVICE: The sweet space of executive coaching: when leadership gets messy

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

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EDITORIAL

The Staircase of Leadership

Sharron Spicer, MD, FRCPC, CCPE

We should all be grateful that medical leadership training has matured over the past decades. Gone – hopefully – are the days when physicians rose through clinical ranks to take on leadership roles without being selected for or trained in leadership skills. Many physician leaders of the not-so-distant past can recount early experiences when they were reluctantly or unexpectedly placed into leadership roles with inadequate training, scant orientation, unclear expectations, and lack of performance feedback. For many, it was leadership by intuition; worse, it sometimes made for leadership by (poor) example.

We now recognize that leadership involves learned skills and, therefore, we do a better job of training physician leaders. We also understand that leaders hold distinct but overlapping key functions of leadership, management, and facilitation. Frameworks such as LEADS create structure and context around key tasks of medical leadership: Lead self, Engage others, Achieve results, Develop coalitions and Systems transformation.[1]

The LEADS framework is not unidirectional, but there is a recognition of increasing leadership complexity and competency along its continuum. As leaders mature in skill and experience, they likely move along this trajectory in their degree of influence. At the same time, one never fully masters any one component. As one develops expertise in one area, they may come back and revisit skills in another. There is building, growing, and teaching in a tiered approach within each component, allowing novice, intermediate, and senior leaders to gain skills in each domain over time. The cycle is not linear, not necessarily even circular, but more of a spiral.

I suggest that we consider the spiral approach to teaching leadership skills. As we impart skills in each LEADS domain, we can use consistent building blocks and add detail and complexity for the more experienced learners. This may include workshops and mentoring for emerging leaders, perhaps more coaching for those already immersed in leadership roles.

This approach to learning is not unique to medical leadership training. The pedagogy of medical education recognizes the spiral nature of undergraduate clinical knowledge. The Cumming School of Medicine at the University of Calgary, where I teach, describes its initiative to implement a new pre-clerkship curriculum as focused on the *spiral delivery* of patient-centred clinical presentations, while providing opportunities for self-regulated learning and professional identity, including moral obligation and social accountability, to improve societal wellbeing.[2]

In the United Kingdom, the National Health Service even has a spiral leadership toolkit. Designed for health care learners, the toolkit aims to help clinicians develop and reflect on key leadership competencies. Similar to LEADS, it links theoretical and practical knowledge in multiple key domains: Managing self, Team and leadership, Managing others, Financial understanding, Risk and governance, Change management and improvement, Confidentiality and data protection, and Medico-legal issues.[3]

Curious about the concept of spiral delivery of education, I looked to literature in childhood

education pedagogy. The aptly named *Spiral Playbook*[4] puts forward a spiral of inquiry. While not intended as a leadership framework, it certainly lends itself to describing steps in innovation and change management.

> Once you have completed a full spiral, you are well-positioned to do it again with a different focus. Although the stages in the spiral overlap, it is critical that you linger long enough in each phase to do the work that will make the biggest difference for all learners. There can be quick gains along the way, but the enduring benefits accrue over time as you become more familiar with the spiral of inquiry and share your learning in a supportive network.[4] [page 22]

Furthermore, the playbook describes how the spiral of inquiry creates a growth mindset:

> Researchers… have revolutionized learning theory… with insightful work on motivation, resilience and mindset. Cultivating a *growth mindset* is key to learning at any age, and key to leading a team, a school or a whole system…. The opposite of a growth mindset is a *fixed mindset* – the self-limiting belief that we are only as good as our innate abilities, and that our failures are evidence of our limitations. Learners and leaders with a fixed mindset fear failure more than they love new learning. The good news is that a growth mindset can be learned. The spiral of inquiry offers a way to shift from the fixed mindset of sorting and ranking to a growth mindset for deep learning.[4] [page 11]

This image of the spiral reminds me of the magnificent spiral staircase in *Harry Potter and the Prisoner of Azkaban* – actually the Dean's Staircase in London's St. Paul's Cathedral. It is an emblem of potential. For medical leaders, learning the skills of leadership is like a spiral staircase. With basic building blocks of leadership components twisting around an axis, one can climb up or down the staircase to learn or refresh any component.

Like the spiral staircase, this issue of *CJPL* is sure to have something for everyone at all stages of leadership skill development. We have an interview with Dr. Bolu Ogunyemi, highlighting issues of equity, advocacy, and social justice for our colleagues and patients, as well as describing the importance for leaders of enhancing communication skills in writing and public speaking. Pamela Mathura and colleagues describe how engaging physicians in quality improvement leads to direct improvements in patient outcomes. Drs. Mamta Gautam and Scott Comber describe the Canadian Lean Healthcare Canvas, a tool to develop and communicate key messages about innovative ideas in health care. Dr. Malcolm Ogborn shares a condensed chapter from his new book *Sudden Leadership – A Survival Guide for Physicians*, describing how we can manage conflict without inducing shame. Dr. Debrah Wirtzfeld talks about how coaching can help leaders develop their own self-awareness about styles of conflict and apply that to the "messy" business of leadership. Finally, we have two book reviews by Dr. Johny Van Aerde: *Ducks in a Row* by Sue Robins and *The Premonition* by Michael Lewis. Reading these articles, I felt that each has a perspective to provide to the leader at every stage of development. I hope you enjoy this issue of *CJPL*.

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Physician-led quality improvement: a blueprint for building capacity

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Physicians have a vital role to play in health system transformation, and their committed involvement provides an opportunity for comprehensive improvement and change. Health care has been shifting to a team-based, integrated, and collaborative approach, with a greater expectation for physicians to engage and lead quality improvement (QI). However, there are many barriers to physician QI capability, participation, and leadership. A physician leader at a university and a provincial health care organization's executive director recognized this challenge and developed an innovative coalition, the Strategic Clinical Improvement Committee, to build organizational capacity for physician-led QI. Six key principles and approaches underpin the coalition: QI as inseparable from care, accountability, a team approach, organic growth through training, academic credibility, and return on investment, including 14 enabler strategies. To date, achievements include the completion of over 60 physician-led QI projects, development of a summer health care improvement elective course, receipt of grants totaling $250 000, 16 QI papers published in peer-reviewed journals, and numerous projects shared nationally and internationally at conferences. The coalition has propelled a shift toward a physician-led improvement culture at the direct care level. The criticality of sustaining this culture of physician QI engagement and leadership will require balancing competing priorities, limited resources, and various other health system influences.

KEY WORDS: health care, quality improvement, physician leadership, coalition

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In health systems studies, the evidence is clear about the importance of physician engagement and leadership to direct projects, initiatives, and transformation.[1] The role of physicians is evolving; they must demonstrate effective leadership qualities beyond those needed to treat patients and include all aspects of health system improvement.[2] Physician leadership in quality improvement (QI) is defined "as the active and willing participation of physicians in local and regional QI projects that develop a strategic partnership with healthcare operations to improve healthcare delivery."[3]

A western Canadian university (University of Alberta) department

of medicine (DoM), located in an urban provincial health zone, identified the need for health system transformation. The aim for the change was: QI education, physician engagement and leadership, innovation, and enhanced patient-centred care.[4] The challenges facing the DoM leaders were the need for large-scale QI education and participation and the planning, evaluation, and coordinated implementation of practice change interventions. Further, there was no formal way to facilitate the collaboration of medicine program physicians in the two local health organizations and associated hospitals, regarding clinical service enhancements. Each organization's hospital medicine program had varied QI strategic priorities, and there was minimal sharing of interventions, successes, and opportunities. Few DoM physicians, who have joint academic and organization appointments, participated in hospital-based QI initiatives. QI training was completed by a small number of DoM physicians and not included in the medical learner programs. Physician participation in QI initiatives was voluntary and often at the request of medical leadership. The DoM physicians had minimal desire to participate, and many did not view QI as academically creditable, without promotional or financial benefits.

The DoM leaders recognized the need to create networking and collaboration opportunities for physician QI engagement and leadership.[4] To address these challenges, in January 2015, an innovative physician-led coalition – the Strategic Clinical Improvement Committee (SCIC) – was developed. A coalition is defined as the joining of people and organizations and often involves existing leaders working in strategic pragmatic partnerships to influence outcomes on a particular problem.[5,6]

In this article, we describe the development of the SCIC and outline enabler strategies to address the identified challenges. Further, we present a physician-led QI leadership approach to engage physicians as leaders in health care QI.

Collaborative sponsorship

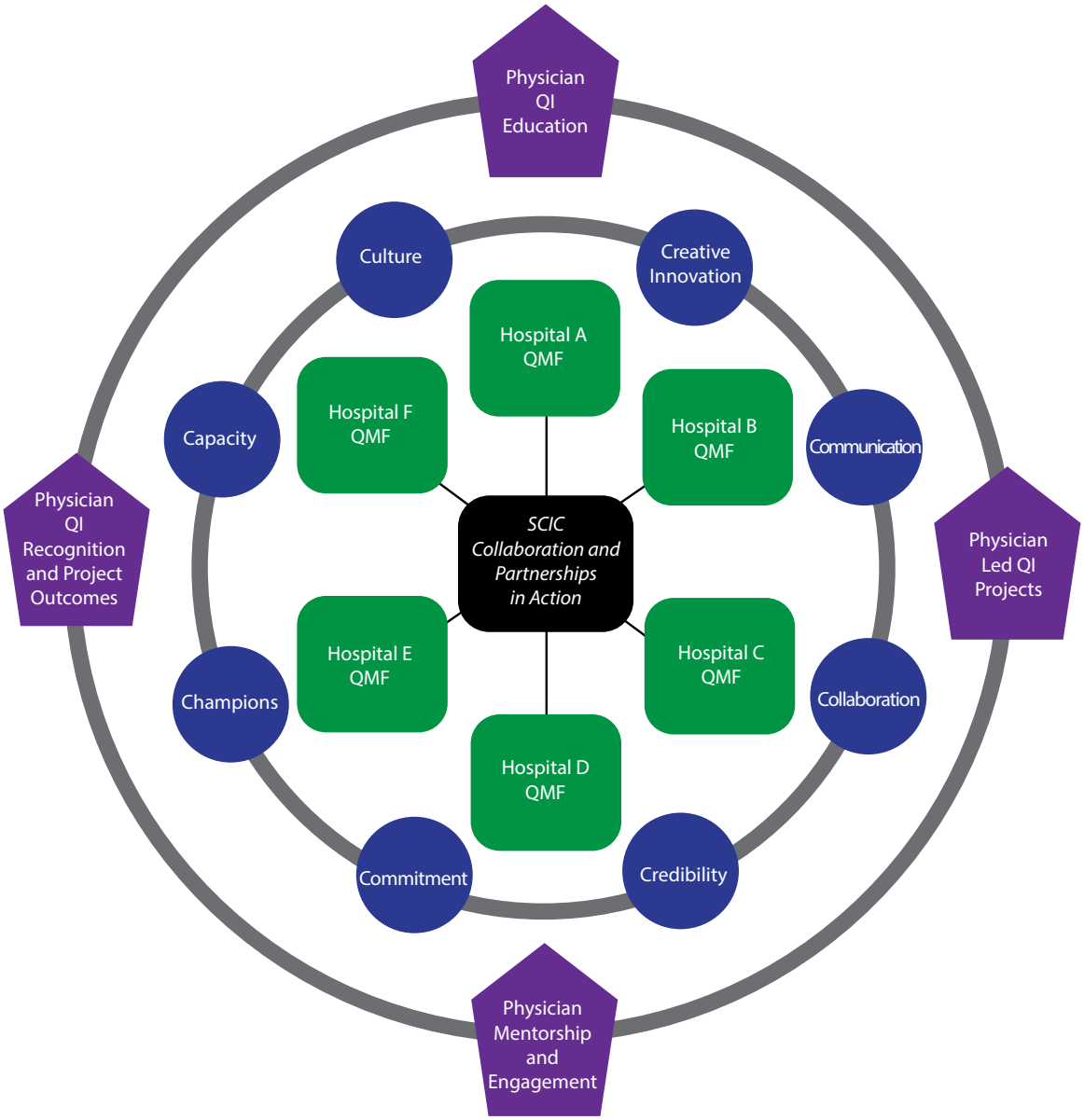
In 2015, two senior leaders, a university DoM deputy clinical department head, who had the authority for the academic medicine department, and a health organization (Alberta Health Services) executive director, who had oversight for the local health zone medicine program, sought to join program and strategic priorities through a new coalition, with each serving as co-chair. The focus of this initiative was to strengthen physician QI capability; participation in and leadership of improvement projects; medicine program collaboration; and patient outcomes and experiences. This strategic collaboration between the university's DoM, the two health organizations (Alberta Health Services and Covenant Health), and six zone hospitals provided the platform to build a shared vision and purpose for organizational clinical QI and to develop physician QI knowledge and skills.

Development of the Strategic Clinical Improvement Committee

Physician volunteers from each of the 15 DoM divisions and the health organization medicine programs were recruited. Junior (<5 years) faculty physicians and physicians with an interest in QI were encouraged to be part of the coalition. Beyond physician leaders, medicine program interdisciplinary operational leaders were invited to participate. The initial 20-member coalition (14 physicians and six executive directors representing each hospital) met in person monthly, developed terms of reference, and recognized physicians as QI leaders requiring a theoretical and practical understanding of the science of improvement so as to influence sustained organizational improvement.[7]

A QI specialist position was created with responsibility for infusing and facilitating improvement-science knowledge in collaborative partnerships among academic medicine speciality physicians, organizational leaders, and frontline clinical staff. This funded position is a joint contract, with accountability to both the university DoM and the health organization medicine program. In September 2016, the QI specialist joined the coalition and, shortly thereafter, a patient advisor and clinical informatics physician were also recruited.

Figure 1. A multilevel physician QI leadership coalition model



To support teamwork and collaboration among the coalition members and frontline clinicians, a slogan was developed: *Collaboration and Partnerships in Action*. It was used on all documents to express the willingness to collaborate with clinicians (interdisciplinary health care personnel) and health organizations to achieve optimal health care outcomes.

The coalition created eight committee values based on the Salas and Frush framework[8] for team performance. The shared values are creative innovation, communication, collaboration, credibility, commitment, champions, capacity, and culture.

Effectively leading change is increasingly identified as a critical success factor for improved health and organizational performance; this requires physician QI leaders to become change advocates.[9] The coalition used the LEADS framework to identify four priority topics for physician QI leadership: QI education, QI project leadership, mentorship and engagement, and QI recognition and project outcomes.[3,10] The priorities reflect supporting members to lead self, develop

hands-on QI skills, build QI teams to mobilize knowledge while mentoring and engaging frontline interdisciplinary clinicians, and support a culture of health system improvement.

As a result of this initiative, a framework for a physician-led QI leadership coalition was developed (Figure 1). The framework comprises three rings. The inner ring reflects the partnerships developed among six hospitals in the health zone, where each hospital's quality management framework (QMF) is collaboratively linked for the zone medicine program. The middle ring is the shared values of the SCIC and its partners. The outer ring reflects the priority topics, guided by the LEADS framework, to support physician QI capability, participation, and leadership.

Aim of the SCIC

The aim of the coalition was to build organizational capacity for physician-led QI. The membership addressed this through improved science education, hands-on training, and mentorship. Further, it also served as a forum for sharing information about QI initiatives; showcased individual and team successes; created a platform for QI dialogue about physician-led initiatives; and recommended improvement opportunities for implementation within the medicine program. In the first two years, the goal was to provide physician members with foundational QI literacy and experiential project opportunities with a multidisciplinary frontline team. To aid with the development of long-term goals, an internal coalition evaluation was planned.

Strategies to enable the SCIC

To achieve the goal and address the challenges identified by the co-chairs, six key approaches were developed: QI as inseparable from care, accountability, a team endeavour, organic growth through training, academic credibility, and return on investment. They included 14 enabler strategies (Table 1).

QI as inseparable from care

To prevent competing priorities between the health care organizations and the DoM, the co-chairs acknowledged the need to ensure alignment between academic and clinical medicine. The health organization developed a quality management framework (QMF), to "provide vision, leadership and direction for quality planning, quality monitoring and QI within [the health organization]."[11]

Despite the QMF, physician QI participation and leadership remained limited and varied with projects and membership on quality councils. Many physicians were unaware of why they should engage and what would be gained from their participation. To address these challenges, the co-chairs developed a governance structure that linked coalition physicians to the QMF quality councils and aligned coalition and organizational QI priorities. This allowed QI information to flow within and across the DoM and the health organizations. It also provided member physicians with the opportunity to join quality councils and collaborate with multidisciplinary clinicians as active participants and leaders of clinical innovation.

Accountability

Before the coalition was established, minimal physician-led QI projects were completed, and only a few medicine physicians modeled QI leadership. Thus, coalition physicians were encouraged to complete a QI project of their choice in collaboration with interdisciplinary clinicians and medical learners (residents and medical students). The physician coalition member was a QI mentor, educating medical learners and colleagues about QI and implementation approaches. In addition, that physician was accountable for the project timeline and championed the improvement at their local hospital.

Team endeavoured

Collaboration among the DoM divisions and within the zone medicine program was infrequent; thus, an interdisciplinary QI team approach was established. The coalition QI specialist recruited interdisciplinary frontline clinicians along with skilled health organization personnel, such as data analysts, QI and patient engagement consultants, and patient safety advisors. Quarterly, the QI specialist and the hospital-based medicine program QI consultants met to share and develop strategies for expanding

Table 1. Key approaches and strategies used to enable the Strategic Clinical Improvement Committee, a coalition to promote physician leader participation in quality improvement (QI)

Key approach	Strategy
QI as inseparable from care	1. Establish co-chairs: physician leader from university's department of medicine and executive director of the health zone organization's medicine program. 2. Align governance structure with health organization's quality framework. Ensure that strategic priorities are physician-led and accomplished collectively and that physician coalition members are aware of and assigned to either hospital or program quality committees.
Accountability	3. Physician coalition members serve as mentors influencing residents, medical students, and frontline physicians. 4. Physician coalition members lead implementation of interventions at their local hospitals and are accountable for project timeline.
A team endeavour	5. QI projects are led by physicians, supported by residents and a coalition QI specialist and, when appropriate, assisted by other health organization skilled staff, such as data analyst, patient experience, and QI consultants. 6. Link health zone medicine program QI consultants. Coalition QI specialist and health organization medicine program QI consultants meet quarterly to share, collaborate, and develop spread strategies. 7. Establish formal linkage to the health organization's Patient Engagement Department and recruit a patient advisor as a member of the coalition.
Organic growth through training	8. Train faculty physicians, residents, and undergraduate medical students using a QI workshop called Evidence-based Practice for Improving Quality (EPIQ).[13] Develop a Summer Healthcare Improvement Program for undergraduate medical students to learn improvement science while assisting physician coalition members and residents with QI projects. Link the health organization QI educational program to the EPIQ workshop to avoid duplication. 9. Encourage physicians to complete formal training in improvement science (master's, certificate, or PhD). Support coalition QI specialist to obtain advanced QI training (PhD in health quality).
Academic credibility	10. Support scholarly outcomes, such as peer-reviewed manuscripts and conference posters. 11. Acknowledge physician-led QI activities during the annual DoM faculty physician performance review process. 12. Include QI in the annual university research day, welcoming both university and health organization staff. Invite QI experts as plenary speakers to present and judge abstracts/posters.
Return on investment	13. Establish joint funding arrangements between the university and health organization for dedicated QI specialist personnel to sustain coalition QI support. 14. Track QI project outcomes, complete cost calculations to demonstrate intervention effect and financial impact. Secure grants to fund QI projects and to support knowledge dissemination.

interventions. Where applicable, the patient advisor, informatics physician lead, and other colleague physicians from different DoM specialities were encouraged to collaborate by participating in QI project teams.

Organic growth through training

Because improvement-science knowledge was lacking, an Evidence-based Practice for Improving Quality (EPIQ) workshop, offered by the university's life-long learning for physicians department, was selected as the training platform.[12] To advance medical learner QI knowledge and experience, the coalition developed a summer health care improvement elective course for undergraduate medical students. These students directly supported the physician member and resident in completing project tasks. The coalition perceived this continuum of QI learning across all levels of medical learners as promoting and building a physician QI culture.

Academic credibility and return on investment

QI was viewed as not academically creditable and without physician recognition, peer support, or funding. To support knowledge dissemination via published manuscripts, physician members were encouraged to complete advanced QI training (i.e., master's), moving beyond foundational QI knowledge, and the QI specialist was also supported to complete a PhD in health quality. To motivate physicians to participate and lead QI activities, the co-chairs added QI to the DoM's annual research day. DoM leaders acknowledged QI, added it to the faculty physician annual review process, and encouraged physician-peer QI mentorship. All QI project outcomes were tracked, and, when appropriate, cost calculations were included to demonstrate intervention effect and financial impact. For some projects, grant funding was obtained to offset associated costs (i.e., publication costs).

Impact of the SCIC

The coalition has achieved its aim and actively demonstrated the expansion of physician QI leadership. From January 2015 to December 2021, the coalition grew to 35 members (27 physicians) who currently meet quarterly, with a 70% meeting attendance rate. Almost all (80%) coalition physicians are active members of the QMF quality councils, and most (11/15, 73%) DoM divisional meetings share QI endeavours and establish annual QI priorities. Of the 27 physician members, 22 (81%) have completed at least one QI project, and seven (26%) have completed more than two projects. Approximately 650 physicians and learners are EPIQ trained, and four physician members and two residents have completed advanced QI training (i.e., master's degree or certificate). Over 60 physician-led projects have been completed, and almost all have resulted in a conference abstract and/or poster. Sixteen QI manuscripts have been published, and numerous projects have been shared nationally and internationally.

In 2019, the coalition was awarded a prestigious university DoM collaboration award, and, in 2018, the QI specialist received a preclinical mentorship excellence award from the Undergraduate Medical Student Association for outstanding teaching contribution. The Royal College accreditation team recognized the integration of QI learning into the internal medicine residency-training program. Demonstrating the DoM academic QI commitment, a formal QI career pathway was established for faculty physicians, and several coalition physicians have been recognized for their QI efforts in the annual faculty physician review process, which supports academic advancement. Grants totaling $250 000 have been awarded, and coalition-supported QI project interventions have resulted in an accumulated cost avoidance of over $300,000. Three annual research and QI events have been held, with 120–300 clinicians and academic staff in attendance, highlighting and recognizing resident and physician-led QI. To increase transparency and to encourage physician-led QI, a public facing webpage was developed that houses all completed project posters, manuscripts, and includes information about the annual QI event, and coalition contact information.[13]

Discussion

Given the ongoing health system evolution, establishing

a physician-led QI coalition was a novel approach to support physician engagement and leadership in QI. Physicians are well positioned to lead and implement improvement, as they are aware of and have experience in the various clinical care pathways.[14] Moreover, physicians have a unique perspective, the skillset, and the ability to focus on patient outcomes while inspiring colleagues to improve care.[15] The SCIC is a supportive coalition for physicians to enhance their leadership while leveraging improvement science and mentoring colleague physicians, interdisciplinary clinicians, and medical learners.

In this coalition approach, we emphasized key enabler strategies to support physician-led QI similar to those identified by Goitein and others.[14,16-18] The strategies include: sponsorship by a university and health organization initiating coalition infrastructure; strategic priority setting; multidisciplinary membership; financial investment for a QI specialist; QI education and experiential training that includes medical learners; enhanced understanding of clinical multidisciplinary processes; links to health organizations[14,16]; networking and collaboration[17]; physician project choice[14]; informal physician-peer mentoring; a forum to recognize and share[14]; and academic credibility[16] and integration into the annual faculty physician performance review.[18] Most important, coalition physicians work in direct collaboration with academics and other health system partners to form interdisciplinary frontline teams leveraging evidence-informed practices to develop sustainable interventions.[14]

The coalition supports the scale and spread of interventions across the health zone and province by positioning physicians as change champions and leaders, strengthening intervention reach, change acceptance, and clinical impact. The coalition is a forum for sharing QI projects, highlighting team successes, and, most important, creating improvement dialogue among the physician members to co-create additional interventions and identify further improvement opportunities.

Barriers that were not addressed by this coalition that impact physician QI leadership include the need for protected time to focus on QI work[15] and remuneration[16], which is linked to a formalized physician QI role with a job title, description, and recruitment process for long-term sustainment of the coalition.[19,20] Further, there is the need to develop a formalized physician QI mentorship program that links experienced physicians with physicians attempting a QI project for the first time.[21,22] Finally, having only one QI specialist supporting the coalition infrastructure, physician members, projects, training and medical learners is not sustainable. To support coalition growth, formal links and collaboration across the health organizations' existing quality departments are needed to ensure access to skilled QI, patient safety, and data analyst personnel.

Future direction and conclusions

The next step is to explore the perceptions of physician members to determine areas of strength, the effectiveness of enabler strategies, and areas for advancement. The formation of this physician-led QI coalition has illuminated its substantive potential; it has been a lived example of *what is* and *what can be*. Physicians and learners feel empowered and want to engage in improvement that affects patient outcomes and experiences and supports the goals of the provincial health organizations. The combination of basic QI training, frontline QI project completion, and a forum for sharing and learning gave physicians the confidence to take steps toward improvement leadership. This physician QI leadership coalition started the shift toward a physician-led improvement culture at the direct care level. Sustaining the improvement culture will require balancing competing priorities, limited resources, and various other health system influences.

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ADVICE

Managing physician conflict

Malcolm Ogborn, MBBS

Conflict is an intrinsic part of human experience. This article explores the distinction between cognitive disagreement and the emotional experience of conflict. It discusses the sensitivity of physicians to the perception of shame and the impact that shame can have on conflict behaviour. It offers a framework for conversations to navigate conflict and a number of simple strategies physician leaders may employ to work through conflict themselves and within their teams. Although some conflicts require the help of a skilled specialist, most can be facilitated with thoughtful and courageous leadership.

KEY WORDS: conflict, physician, physician leadership, physician coaching

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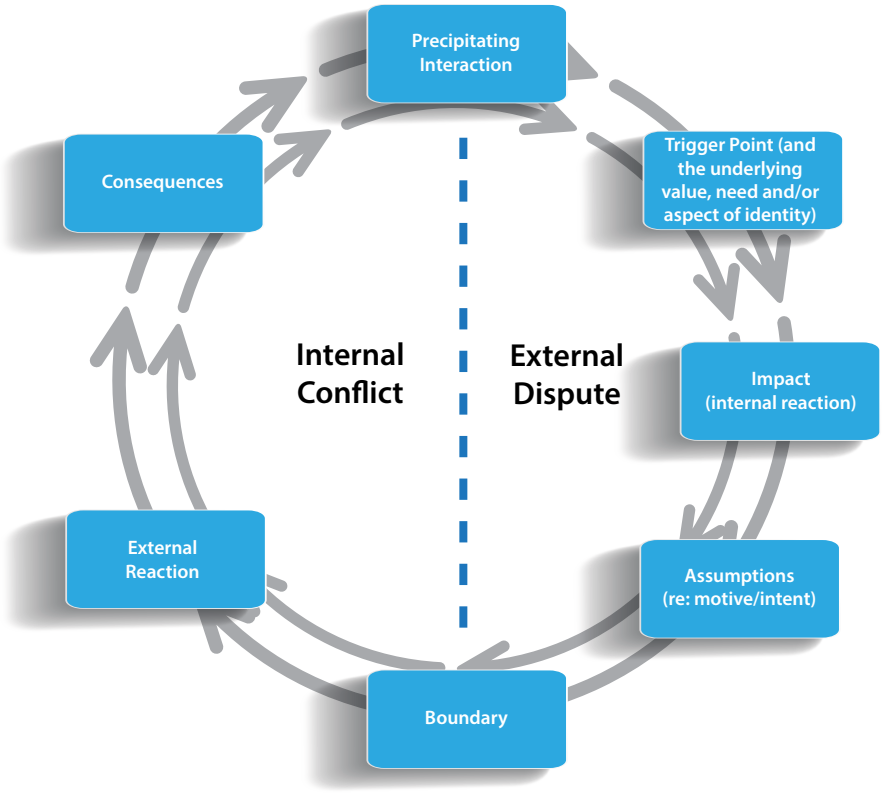
The nature of conflict

Conflict is part of the landscape of human experience. However, in my experience, managing conflict among their peers is a major source of anxiety for physician leaders and is often cited as a reason for reluctance to take on a leadership role.

Conflict is more than disagreement. Disagreement is cognitive; conflict is emotional. Conflict coach, Cinnie Noble, has a useful model that captures the emotional nature of conflict, the (Not So) Merry Go Round of Conflict (Figure 1).[1] A precipitating interaction triggers a limbic system response. This perception of threat may be a transgression of a personal value, a physical or emotional need, or an aspect of identity. An internal reaction follows, feeding story-making and building assumptions. Pressure increases until a boundary is crossed and an external reaction manifests, which might be verbal or behavioural. The consequences of these reactions create new

Figure 1. The (Not So) Merry Go Round of Conflict (adapted with permission from Cinnie Noble, CINERGY Coaching[1])

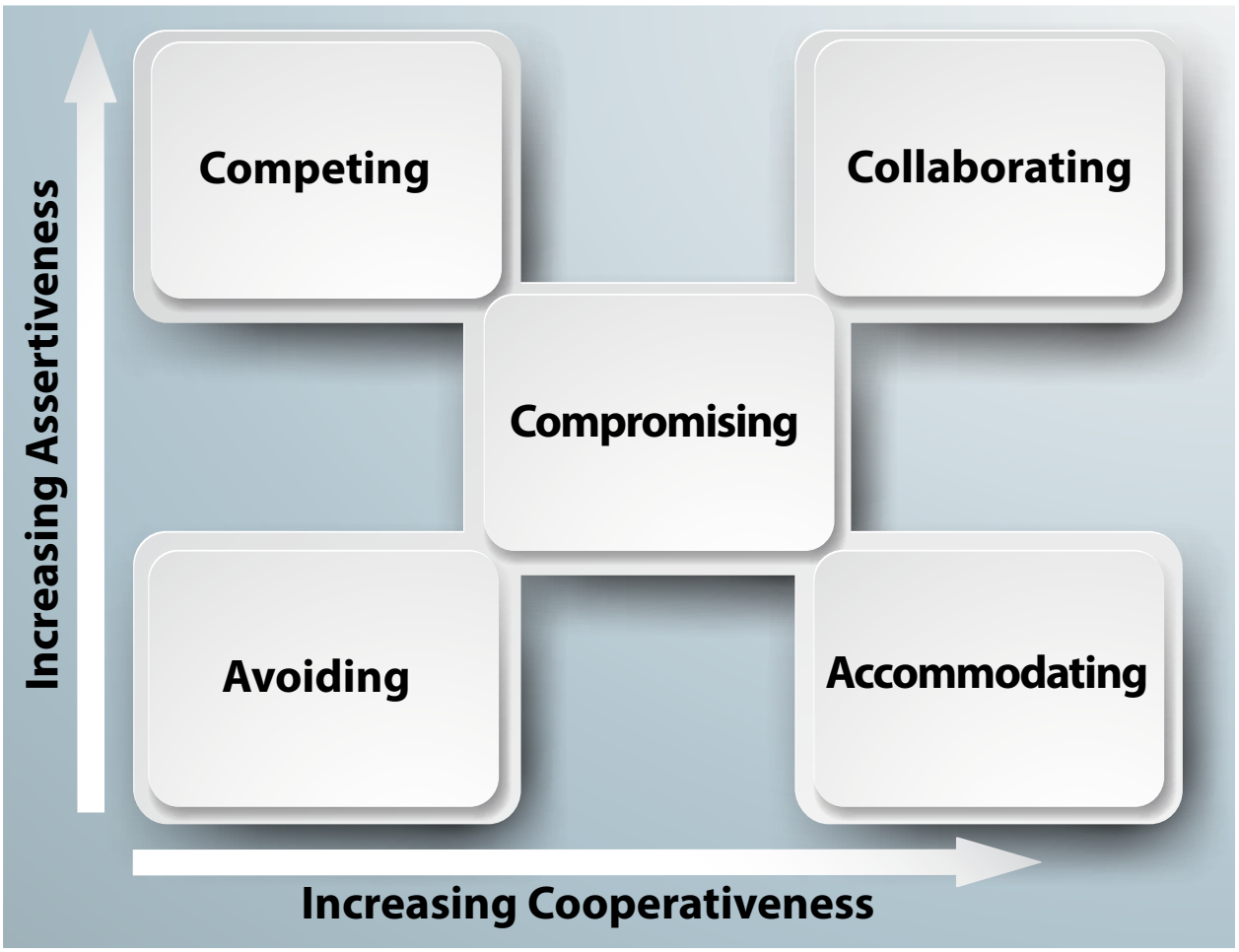


triggers that escalate the cycle. This pathway resembles Argyris's Ladder of Inference of how we build beliefs about the world.[2] The more cycles of the loop, the more confirmation bias develops and the greater the distance between belief and objective truth. The conflict becomes the lens through which all incoming information is viewed and subconsciously selected. An important implication of this model is that the external reaction, which may be the first sign of conflict the leader sees in their team, is not where the conflict starts. It may have been preceded by many rounds of precipitating interactions that fell just short of crossing the boundary into behaviour. Such interactions may have been shaping thinking and belief for months or years. They may be happening in the head of one person with the other antagonist(s) unaware of the impact of their actions. Not seeing conflict is very different from absence of conflict.

Once the boundary has been crossed, bystanders often withdraw in silence, a common behaviour among physicians. Sometimes, those on the sidelines are drawn in and pick a side. They, too, are triggered by the process or by the misinformation that often develops around conflicts. The saying "In war, truth is the first casualty" (Aeschylus 525–456 BC) can be applied here. Bystanders need to belong and not separate from their peers. At a brain level, exclusion generates similar patterns of neural activation as physical pain; thus, consequences of joining the fray may seem less than the perceived pain of exclusion.

Once the emotions of conflict are established, the "facts" play an exceedingly small role. The

Figure 2. The Thomas-Kilmann[3] model of approaches to conflict by levels of assertiveness and cooperativeness



experiences of those involved are now in the past. Everyone's version of them, shaped by their own cognitive filters, is immutable. Managing conflict by arguing about past "facts" is futile, yet it consumes vast amounts of time and energy. Conflict stories are valuable in understanding what triggered a disagreement to become conflict, but they should not be considered objective truth. Conflict management is about managing emotion in the present and designing actions in the future, not rewriting the past.

Knowing your own conflict preference

As conflict is a ubiquitous part of our experience, we develop preferred approaches to it. A useful model is that of Thomas and Kilmann.[3] It classifies conflict style by level of assertiveness and cooperativeness (Figure 2). *Avoiding* sidesteps conflict and maintains a situation where no one's needs are met. *Accommodating* satisfies the other party without regard for your own needs. *Competing* secures your wants without regard to those of the other party. *Collaborating* attempts to obtain a result that meets the most needs of all parties. *Compromising* incompletely meets the wants or needs of all parties.

This type preference can be measured with a validated instrument, the Thomas-Kilmann Conflict Mode Instrument.[3] Knowing your preference tells you where your natural inclination in responding to conflict lies. It does not tell you of which approaches you are capable. We can use a style other than our preference; it just takes more effort. Neither does the instrument tell you which approaches are correct. Sometimes, conflicts are "not the hill to die on!" In these cases, avoiding or accommodating may be wise strategies. A decision to sidestep the conflict or merely cave in to the wishes of another party should be made carefully, however. Davey[4] has a useful concept to consider in these situations, the notion of conflict debt. This is "the sum of all contentious issues that need to be addressed to move forward but instead remain undiscussed and unresolved." Any avoided, accommodated, compromised, or competed conflict will generate debt. Sometimes an absolute standard must be upheld. For example, a conflict with a surgeon who refuses to use the pre-operative checklist is a situation for competing. Collaborating is the best approach where there is hope that all interests can be met and compromising where some sharing of pain is inevitable. No one has all these style preferences but knowing your preference will inform the level of effort and support required to use the best approach.

Conflict and shame

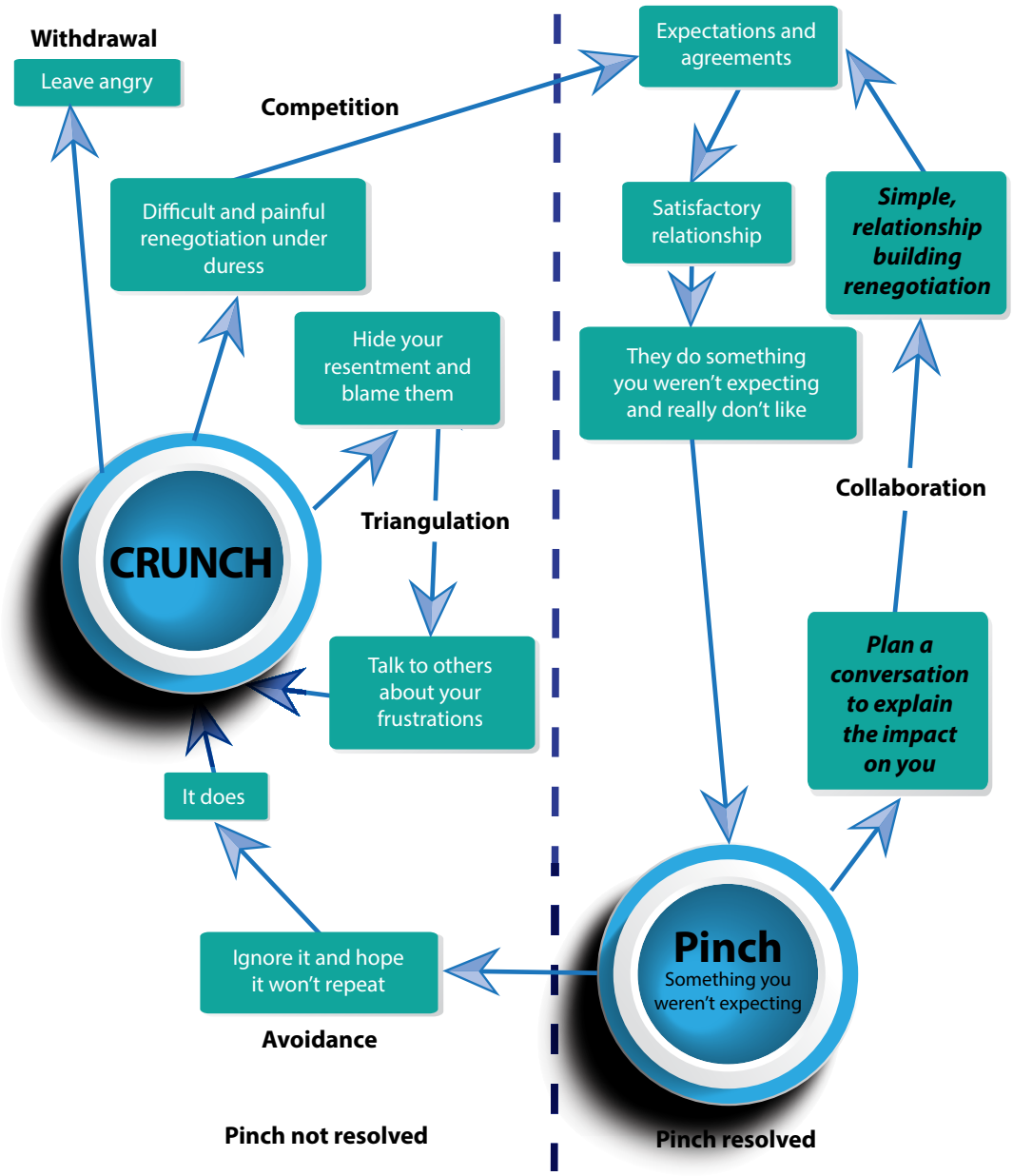
Shame happens when we confront an undesirable image of ourselves. Physicians are really good at creating shame. A vision of excellence to which one aspires and against which one measures career progress can be very helpful. However, the study of physician burnout has emphasized that physicians often develop an unachievable self-image of unfailing perfection.[5] They do this in part by themselves, but are often aided by well-meaning teachers and family. Anything that casts a negative light on a physician's performance or behaviour may be interpreted as a failure to be this imagined paragon. If this happens, shame is triggered.

Shame happens when we confront an undesirable image of ourselves. Physicians are really good at creating shame.

Sadly, many physicians are also trained in systems that use shaming as a pedagogical tool.[6] Even if a dispute did not start with shaming, or shaming was completely unintentional, shame may be weaponized as the dispute escalates. Antagonists search for examples of their colleagues' or organization's failings to shame opponents. Physicians' responses in conflict situations often align with predicted patterns of shame defense.

Author and researcher Brené Brown[7] identifies a long list of workplace behaviours that are associated with shame. A number that are commonly seen in the landscape of physician leaders, particularly in conflict, include perfectionism, gossiping, back channeling, power over (a

Figure 3. The pinch theory of conflict management (adapted from Robertson and Long[6])



particularly noxious behaviour around trainees), withdrawal, blaming, and weaponized humour. All these behaviours make excellent "precipitating Interactions" in driving a cycle of conflict. A physician leader dealing with conflict needs to recognize them and call them out.

Every effort should be made to keep shame off the agenda. Where there is contention, framing the topic by focusing on the issue and not the person is vital. Encourage, or perhaps require, that people restrict their comments to their own experience. This prohibits hearsay, speculation about other people's thoughts and motives, and commentary on actions, events, or behaviours that were not witnessed. Almost all that is inflammatory is removed by these sanctions.

Personal experiences may still be reported that generate guilt in the

listening party. Guilt is a negative emotional response to something we have done, as distinct from shame, which is a negative emotional response to who we perceive we are. Recognition of harmful actions moves toward accepting vulnerability, a necessary precursor to developing trust in any relationship. Admitting responsibility and making amends are important trust-building exercises in the passage through conflict.

Conflict management techniques

The availability of conflict professionals has certainly increased in recent years. However, as conflict is ubiquitous, outsourcing its management in all or most cases would be time consuming and expensive. Few conflicts require external intervention. Many of those only reach that point because the opportunity for thoughtful people to use simple and early interventions was missed.

The simple act of not ignoring a conflict is a highly effective step. Using effective conversation techniques to engage individuals or groups that are in conflict, have them civilly describe how things are landing for them, and express their desires will probably allow forward movement on most conflicts. The (Not So) Merry Go Round of Conflict[1] is used by conflict coaches to create insight about the experience of conflict. It is also useful to help parties in the conflict to imagine how the other party or parties are experiencing the situation. Exploring what precipitated a conflict, the responses that were generated, and questioning the mental models formed creates a space to explore alternative assumptions that may inform new approaches. Conflict management requires being curious in a search for understanding, rather than just trying to see who is right.

Awareness of a trigger for conflict, however small, creates the opportunity for early intervention. In 1972, Sherwood and Glidewell[8] observed that, over time, we experience triggers or "pinches" in a relationship that build to conflict (Figure 3). We tend to ignore these small provocations. At some point, the pressure to react becomes too much. We then have a "crunch" where the conflict surfaces in our behaviour. Common but ineffective organization behaviours that may arise include withdrawing, triangulating by expressing our frustrations to others, or entering a challenging negotiation to try to restore the relationship. The alternative strategy is to have a collaborative discussion as soon as there is a pinch, to "nip it in the bud." Dealing with pinches as soon as they occur is a significant and effective personal or organizational cultural shift.

Davey[4] has also proposed "conflict strategies for nice people." Three strategies – *two truths*, question the impact, and common criteria – can be particularly effectively applied by physician leaders. Two truths has parties to the conflict validate each other's perspective. They repeat the other's position, asking clarifying questions as needed. They may find ways to strengthen the other's case. The conversation assumes that both proposals are meritorious. The challenge is now a shared one of finding the best solution. This

approach is a good prelude to using integrative thinking to build novel options out of the best components of each position.[9]

Question the impact is a good approach when one side has serious concerns about what is being presented by the other side. These concerns are too commonly expressed as attacks on competence or character. A neutral and inviting response is: "I think I understand what you are saying. I have some concerns. How would you see this working with…" or "What would the effect on X be...?" "How" or "what" questions are asked until either the fears are allayed or the other party finds a way to adjust their idea to fit the new dimensions. This approach invites the other party to problem-solve rather than defend.

Common criteria is a good approach for complex and nuanced situations. The parties list all the issues that need to be addressed and then discuss priorities. This creates a situation where all parties see what has brought them into conflict. This can also work into an integrative thinking approach to novel solutions as you drill down into the thinking behind each listed issue.[8] This process is helpful at teasing out mutual or complementary interests around which negotiation can occur.

External intervention for conflict

External intervention for conflict can take the form of conflict coaching, negotiation, mediation, or arbitration. Conflict coaching uses inquiry techniques to develop insight and new perspectives on conflict and supports the choice and design of action to move through conflict. It can take the form of coaching a leader to manage conflict in their team, a useful pre-emptive strategy. It can also support one, some or all parties in a conflict. Conflict coaching does not presume a specific solution; that is for the parties being coached to decide. This is the strategy of choice where emotional issues are the dominant feature of the conflict.

Complex situations may benefit from conflict coaching to support constructive engagement in mediation.

Negotiation, and its specialized partners, mediation and arbitration, are particularly good at dealing with specific issues rather than the emotional landscape. Before choosing an issues-based strategy, careful exploration of the timeline of the conflict is valuable in discriminating between an issue that has led to conflict and a conflict that has adopted an issue as a justification. If the latter case, a coaching approach may be more productive.

Arguably, the most popular reference on negotiation is *Getting to Yes*.[10] Among its many practical tips on negotiation, a couple are worth highlighting. The first is to focus on interests, not people, as described in the section on shame. Another important concept is best alternative to a negotiated agreement or BATNA. This means having a plan for what to do if you are unable to negotiate a solution. At an emotional level, having at least one other option reduces the fight or flight response.

Mediation is a term that comes up often. Mediators are skilled people who work with individual parties to understand their experience, then work between the parties to lay the groundwork for options, and finally work with all parties present. Complex situations may benefit from conflict coaching to support constructive engagement in mediation. Physician leaders often need to be part coach, part mediator.

Arbitration is where a third party will decide the outcome based on what the parties to a conflict submit to the process. This can be a reasonable approach for a leader, for example, on a time-sensitive issue that is stuck between parties. Before choosing arbitration as a solution, thought must be given to balancing the benefit of a clear result against the risk of creating a win–lose dynamic that may foster ongoing resentment between the parties. The leader must also weigh the impact on future relations and the impact of taking autonomy from their followers.

Neither mediation nor arbitration is a strategy for well-meaning amateurs; both require specific skills and the ability to maintain trust in challenging situations. Leaders should be circumspect about taking on these roles themselves.

Conflict and psychological safety

A full discussion of psychological safety, conflict, and the work environment is beyond the scope of this article, but parties in conflict now commonly raise concerns about psychological safety. Psychological safety is most emphatically not the absence of conflict; environments where conflict is kept invisible may be among the most psychologically dysfunctional. Rather, psychologically safe environments are ones in which people can be open about their vulnerabilities and expect reasonable support; expectations, processes, and policies are clear and open to civil discourse. They proscribe malicious and hurtful behaviour. They are not, however, democracies or zones where people can fail to meet their work and behavioural obligations without consequence. If these are issues in your workplace, they may have to be addressed in parallel or before conflict intervention if protracted litigation is to be avoided. Useful concepts in this area can be found in recent publications by Clark.[11,12]

Key learning points for physician leaders approaching conflict

- Recognize that conflict is a normal part of human relationships.
- Be aware of your own preferred conflict style; practice or find support to work in other styles where they are more appropriate.
- Understand your shame triggers and those of the people with whom you work. Be sensitive to shame behaviours as a source of conflict.
- Act sooner in conflict rather than later; do not let small issues become large ones.
- Use good conversation techniques to share and understand individual experiences in a conflict; this is often enough to resolve most interpersonal conflicts.
- If you cannot work through a conflict that is affecting you or your work, seek skilled help rather than giving up.
- Where conflict involves a specific issue external to people's feelings about each other, consider mediation or arbitration.
- Do not try to create psychological safety by avoiding or suppressing conflict; instead, work to reveal conflict and work through it constructively.

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This article is a condensed chapter from Dr. Ogborn's recently published book *Sudden Leadership – A Survival Guide for Physicians*. Information on the book and suppliers can be found at **https://tinyurl.com/bdfcnsa4**. The book explores practical, field-tested approaches for physician leaders to common conundrums through episodes in the experience of two new physician leaders.

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We have a great idea, now what? Using the Canadian Healthcare Lean Canvas for implementing innovation

Mamta Gautam, MD, MBA, and Scott Comber, PhD, MBA

The Canadian Healthcare Lean Canvas has successfully provided a manageable and actionable innovation framework with which to capture the key aspects of proposed health care innovation projects as used by participants in a physician leadership development program to address large-scale complex issues in health care.

KEY WORDS: innovation, framework, lean canvas, health care, tool, problem-solving

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A dilemma in Canadian health care innovation occurs when excellent ideas and good science fail to reach the bedside.[1] Physician leaders know that innovation can improve patient outcomes; however, it continues to be difficult to enact. Although innovation is often supported in theory, it can be difficult to go from ideation to execution. This requires physician leaders to adopt a new way of thinking, to identify and address a different approach to creating solutions. An innovation framework that helps physicians describe the rationale of how their new idea creates, delivers, and captures value in economic, social, cultural, or other contexts can be of help.

Such frameworks are not usually part of a medical school curriculum, and yet we know that physician leaders need innovation processes and tools to move their ideas to solutions. There is a whole field of implementation science dedicated to this concept.[2,3] In this article we present the one-page Canadian Healthcare Lean Canvas, a practical tool that reflects many of the concepts implicit in implementation science and that can be used by physician leaders to outline and implement innovation.

The Lean Canvas

The Lean Canvas, in its original iteration, is a one-page business model template that summarizes a proposed solution for a defined problem. It was created by Ash Maurya to assist in deconstructing an idea into its key assumptions and is widely used in business and entrepreneurship.[4] It is adapted from Alex Osterwalder's Business Model Canvas and optimized for lean startups. Similar to a startup, it is quick, easy, effective, and concise. Unlike elaborate business plans, which can take too long to write, are seldom updated, and are almost never fully read by anyone other than the authors, consider the Lean Canvas as a fancier way to sketch out an idea for a project on a napkin over a lunch meeting. Ideally, it should be quick to create, adaptable, and easily read and understood.

Maurya describes four key aspects and benefits of a Lean Canvas.[4]

1. Fast: While writing a business plan can take weeks or months to complete, one can easily outline multiple possible business models on a canvas in an afternoon.
2. Portable: Captured on a single page, this business model is much easier to share, revise, and update.
3. Concise: The Lean Canvas

Figure 1: The Canadian Healthcare Lean Canvas

template forces one to distill the essence of your product from which you can easily create your elevator pitch.

4. Effective: This is a great tool that allows one to effectively document and communicate progress, whether it is to an investor, a project sponsor, a board, or your team.

Adapting the Lean Canvas for health care

When we were asked to design and develop a longitudinal physician leadership development program (PLDP) in partnership with Doctors Nova Scotia and CMA Joule, it was agreed that one of the goals would be to help participants develop skills in leading change and innovation in medicine. Within the PLDP, participants are presented with action learning challenges where teams work to propose solutions for current, real challenges facing health care. This provides an opportunity for applied innovation, working and learning as a collaborative team through deliberate practice.

We introduced the participants to the Lean Canvas template as a way to map their innovative ideas. The original Learn Canvas model was geared mostly to for-profit organizations and did not entirely meet the social aspects and culture of health care. We searched the Internet for other versions that were more applicable to social entrepreneurships such as health care.[5] We found templates that were better, but still not ideal. Finally, we modified the Lean Canvas to suit the needs of health care specifically and designed the first Canadian Healthcare Lean Canvas (Fig. 1).

Using the Canadian Healthcare Lean Canvas

The Canadian Healthcare Lean Canvas consists of 11 elements, with specific questions posed for each element. It is designed to help you consider and complete each aspect of your idea. First, you are encouraged to take time to reflect, define, and articulate your overall

- Purpose: What is your reason for creating this product/ service/process, clearly defined in terms of the health care problem you want to solve?
- Impact: If your project were successful, what would be the intended health care impact?

You are then ready to move on to the other boxes.

1. Problem: This is the first and most important box to complete. What specific problems are you trying to solve? List the problems being experienced.
   - As Charles Kettering, head of research at General Motors from 1920 to 1947, stated, "A problem well stated is a problem half-solved."
   - Most projects fail, not because they do not build what they set out to build, but because they waste time, money, and effort building the wrong product. A significant contributor to this failure is a lack of proper "problem understanding" from the start. Before one invests months developing something, it is critical to determine if it is worth doing.[6] It can help to decouple the problem from the solution and test through customer interviews to validate its worth.
2. Stakeholders: Who do you need to have on your team? For whom are you creating value? Who are your internal and external stakeholders?
   - There are two main groups of people interested in or impacted by your idea. Inside, or internal stakeholders, are those who are closest to or have the strongest influence within an organization. Outside, or external stakeholders, are those who do not own, nor are employed by the organization, yet have some basic interest in its activities.
   - It helps to identify for whom you are creating value and to create a typical "customer" profile so that you can best develop and sustain these relationships.
3. Unique value proposition: How does this product/service/process meet the identified needs? How is it better or different than what currently exists?
   - Here, you can identify what value you plan to deliver to the customer, which one of your customer's problems you are helping to solve, or which customer needs you are satisfying.
   - There may already be some other solutions, so you will need to demonstrate how what you are proposing will be different and better than what already exists, including in what way, for whom, and why you believe this.
4. Solution: How do you solve the problem? Define the top three features of the proposed product/service/process.
   - This box essentially outlines the features that correspond to the specific problem your customer wants to solve. Ideally, it consists of must-have features, performance enhancers, and delighters.
   - Start by identifying the top three features that you want in your solution.
   - In health care, you can consider the Quadruple Aim of patient experience, population health, cost of care, cost to caregiver. Which of these are you enhancing, and how?
5. Success factors: Why do you think this will succeed?
   - Here, you can add any details that highlight what is different about this idea and if it has an advantage that cannot easily be copied or bought.
   - These can include factors, such as inside information, in-depth knowledge that is critical to the problem/domain, a single-minded focus on one domain, personal authority resulting from experience and expertise, a community of network and partners, or the culture in which you are introducing this idea.
6. Sustainability: What resources (financial, human, support) do you need to sustain this project once it is implemented?
   - In this and the next box, you will address the key resources and financial aspects of the proposal.
   - Take time to consider which key resources and key activities will be the most expensive, what resources you will need to keep it going, whether there is a revenue model, and if so, what that might look like. Consider whether any of your customers need to, or may be willing to, pay for any of the services.
7. Feasibility: What are the

major costs (financial and other resources) associated with running this project.
- Many solutions are too costly, extensively use resources, or are not sustainable. You will need to understand and develop feasibility criteria to ensure that the solution is "doable" within the constraints of your organization.
- Can you identify in advance any major costs or resources that may render this project unfeasible?

8. Key metrics: How will you know you are successful? Identify key metrics you will measure.
- It is important to identify the right balanced set of key metrics/measures for the project.
- In this box, add things that you can easily measure: SMART (specific, measurable, achievable, relevant, time bound) goals that will best capture the strength of your proposal. The metrics can become your research objects, the measures for which you gather and plot data over time, and the evidence of efficiency and success that you will show to your stakeholders.

9. Pathways: How will your product/service/process reach your target group? How will they access it?
- Once you create your innovative idea, you need to ensure that people will know about it and be able to use it to solve their problem.
- Here, consider through which channels your customers want to be reached, how do other companies/organizations reach them now, and which channels work best and are more cost-efficient.
- Define how customers will learn about this offering, how they can access it, and how it can be integrated with their routines.

The Canadian Healthcare Lean Canvas template can be used in various formats depending on the project group. In a small group, each member can have a full page-size copy of the template to write down ideas and thoughts. In larger groups, the template can be drawn on a white board and members can place Post-It notes in each box. The goal is to be flexible and easily adaptable as you move through the process. Once the items in each box are agreed on, details can be written concisely and shared with everyone.

The idea is to be messy, flexible, adaptable, and fluid with your thinking. For example, thinking your way through an element

in one box can often lead to a change in a previous box. We are often asked by physicians why the boxes are not numbered in logical order. The Canadian Healthcare Lean Canvas follows the structure of the original Lean Canvas which presented the boxes in a similar fashion. It was intentionally designed to stimulate original and innovative thinking by moving away from a linear model of thought.

Proven value

We have used the Canadian Healthcare Lean Canvas for the past two cohorts of the year-long PLDP offered by Doctors Nova Scotia.[7] It has been easily introduced to and understood by physician leaders. Although the impact of using this tool has not yet been formally investigated, anecdotally, the template has served program participants well, as they design and complete their action learning challenges and consider and propose solutions to actual challenges in health care in Nova Scotia. Examples of some of these completed projects, which provide recommendations on real-life health care issues, resulting from the use of the Canadian Healthcare Lean Canvas, can be found on the Doctors Nova Scotia website.[8]

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ADVICE

The sweet space of executive coaching: when leadership gets messy

Debrah Wirtzfeld, MD, CEC

The basis of successful leadership rests in leading and developing your people, not in maintaining the status quo. In transition to a new leadership role, medical leaders will often try to mend historical conflicts and build new and trusting relationships. However, about six months in, old patterns begin to surface and the messiness of leadership rears its ugly head. Leaders must recognize that this is where their leadership begins – with growing their people and leading their teams through the inevitable messiness of leadership. To meet this challenge, leaders must understand the reason they have come to leadership. To enhance team function, they must work to develop their internal self-awareness, an understanding of their own beliefs, values, and emotions, and external self-awareness, an appreciation of the impact of their words and actions on others. This can be amplified by understanding the value of "thinking slow" or looking at problems intentionally, without an automatic or intuitive response. The key is developing a deeper understanding of yourself and what you bring to leadership to support sustainable change in the health care system, and this is where executive coaching can assist medical leaders – to limit the messiness and create a supportive environment for self-reflection and personal development.

Keywords: executive coaching, leadership development, leading self

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As an executive leadership coach, I never cease to be impressed by the dedication and regard medical leaders have for the people on their teams. The vulnerability a leader shares when confronted with the realization that they can make or break their team, regardless of external factors, is very powerful. However, one of the most difficult concepts that a new leader, or even a seasoned leader in a new role, must grasp is that managers manage things and leaders lead people. This is often misinterpreted because people are messy.

During the early days in your new role, you are busy meeting people, forming strategic alliances, and assessing the match between people and priorities. People are watching as you set goals and define your vision for the position. Your team is excited by the idea of what is possible, and they should be as this is the time when it seems as if the world is your oyster. However, about six months in, give or take, you are hit with a

cold dose of reality. No matter who you are, what you are trying to accomplish, or where you are positioned in an organization, the same old problems start to raise their ugly heads. Although, at first, it may have seemed as if the road was smooth and you were on your way to making a long-lasting and defining change, it now seems like your efforts were all for naught. What you might fail to recognize is that you have entered the space where true leadership lives and where you can actually make the most significant change – where the bright and shiny is wearing off and the messiness returns! This is when you go from a manager of things to a leader of people, and your people need you!

This view of leadership is elegantly summarized in a 2016 interview with Ed Catmull, co-founder of Pixar and former president of Walt Disney Animation Studios.[1] In his reflections on leadership during times of transformation, he states:

> The fundamental tension is that people want clear leadership, but what we're doing is inherently messy. We know, intellectually, that if we want to do something new, there will be some unpredictable problems. But if it gets too messy, it actually does fall apart. And adhering to the pure, original plan falls apart, too, because it doesn't represent reality. So you are always in this balance between clear leadership and chaos; in fact that's where you're supposed to be. Rather than thinking, "OK, my job is to prevent or avoid all the messes," I just try to say, "well, let's make sure it doesn't get too messy."

Both leaders and their people want leadership to be clear and decisive. Leaders are expected to know the policies, procedures, and rules. Historically, they have been expected to be able to apply them in an effective and efficient manner that will lead to peaceful restoration of the status quo. However, what we now recognize is that leaders have failed to take into consideration that their own biases and prejudices can often result in a failure to provide the

psychological safety necessary for resolution. This adds to the mess and is often a blind spot for many leaders.

As a leader, what are some of the important issues you must consider to ensure that things don't get too messy? What skills will you require to lead your team through these times of uncertainty?

Your first inclination might be to dive right in and try to fix things. If your team is going to survive, you must address issues as quickly as possible and set things right. However, leadership is not often quick, and it involves not only the content of the issues you are facing, it demands that you think about the relationships you are building and how these will be navigated and strengthened during your term. It requires that you get clear about what you bring to leadership and why you have chosen to lead.

Your why of leadership

Most of the time, leaders are caught in an endless cycle of *what* they need to do and *how* they need to do it, leaving little time to ponder the why of your leadership. The "Golden Circle," as espoused by Simon Sinek,[2] puts the why at the centre of the circle, with the what and the how encircling it and dependent on its definition. If you are not aware of why you are in leadership, the difficult times when things get messy will force you to question your role and even your ability as a leader.

About a year into a senior leadership position, "Dr. Smith" approached me about executive coaching. The issue their team was facing was around equity in the call schedule, which was causing tension among team members. Dr. Smith was concerned as this was the first major issue they had been forced to address during their tenure, and historical lines of allegiance were once again beginning to emerge. Dr. Smith felt that they would have been able to prevent the discontent among team members, if only they had been a better leader. What they failed to realize was that conflict prevention is not the work of a leader, but rather managing relationships during times of tension. We began the coaching relationship by exploring their why of leadership.

As a leader, what are some of the important issues you must consider to ensure that things don't get too messy? What skills will you require to lead your team through these times of uncertainty?

As might have been expected, this was not as easy as it seemed. Dr. Smith wanted to focus on the what and the how of the call schedule. However, by considering what they wanted to accomplish for their team members, the organization, and themselves, they were able to identify that their why of leadership was to develop team members, be seen as a transparent and authentic leader, and provide a safe place for open dialogue. Each time conflict arose, they were able to remind themselves and others of their why of leadership. This allowed the members to regroup and focus their activities on the task at hand.

Look internally to lead your team

Knowing your why of leadership is an important first step; however, effectively leading a team will require you to reflect more deeply. Self-awareness is an essential component of leading self. It is often one of the most difficult elements for leaders to tackle, as it demands an objective assessment of what you are contributing to a dysfunctional situation. You must turn the focus on yourself instead of looking for the answer in the "problems others are creating for you" or "the dysfunctions inherent in your team".

Self-awareness has two crucial elements: internal and external.[3] Internal self-awareness is an extension of knowing your why; it is awareness of your values, beliefs, and emotions, and how these relate to team function.[3] As a leader, it is important that you understand that these elements of your internal awareness represent who you are and what you have experienced, rather than the indisputable truth. Failure to understand yourself in relation to others can lead to attributing the behaviours of team members to negative intent or faulty character, while thinking that your contribution is a product of your circumstances or a fault of the environment. Internal self-awareness can deepen

appreciation of the possible motives of others beyond negative attributions that can disrupt the functions of the team.

Over the last several years, the ability to assess how your message is being received has been seriously impacted by COVID-19 and a shift to a virtual meeting environment.

Internal self-awareness is found in the ability to reflect on what an appropriate response might look like and in an understanding of how your own values, beliefs, and especially emotions are contributing to the situation.[3] As a leader, it rests in your ability to separate the facts from the story you are telling yourself and negative assumptions you are making about the other person(s).[4] It helps to remember that, in any situation, there are generally few facts and most of what you are basing your response on is your interpretation, an assessment that is biased by past experience and an impression of how things should be.

External self-awareness refers to an understanding of how your words and actions affect others on the team.[3] Without this knowledge and a curiosity around how you are perceived by others and the impact you have on them as a leader, it will not be possible to provide the psychological safety your team needs to function effectively.[4] External self-awareness comes with an acceptance that your intentions might not always align with your impact and that a significant contribution to the dysfunction of your team might lie in your inability to decipher how you are being perceived as a leader. It also requires self-compassion and a strong desire to improve, as this is where most of the hard work around self-awareness happens.

It is not uncommon for leaders to ponder how they can assess the impact that their words and actions have on others. Short of providing a psychologically safe environment where feedback is encouraged, leaders want to know if there are any other clues about how their message is landing. The art of communication is found in leaders who pay attention, not only to what is being said, but also what is not being said.[3,4] As a leader, you can build on your external self-awareness by paying attention to how your message is received. A change in body language, demeanor, or a pause in the conversation by the recipient could signal that your message has not landed in the way you intended. You might ignore these important signals as you do not want to wander in the direction of a difficult conversation. However, it is precisely in these moments that you will come to understand your people, the strengths they bring to the team, and what they need to be successful.

Over the last several years, the ability to assess how your message is being received has been seriously impacted by COVID-19 and a shift to a virtual meeting environment. Access to nonverbal cues has become limited. We see most people from the chest or neck up, and some may even have their cameras off. However, there is a science to reading people, and, if you remain focused on identifying what is behind the words, you can still have an impact.

Look for signs of agreement and understanding, specifically participants nodding or maintaining eye contact with you when you speak.[5] Frustration can be seen in someone raising their shoulders or eyebrows. Disagreement can be revealed by a look of concern, someone wrinkling their forehead, crossing their arms, or diverting their eyes away from the camera. Obviously, you cannot be looking for these somewhat subtle cues in all participants at the same time. As with an in-person meeting, you will need to be selective about whom you are paying attention to during any discussion given your previous understanding of where people tend to sit on various issues. You will need to be more astute in your attempts to be inclusive, perhaps even letting people you wish to speak to about a subject know beforehand that you will be calling on them during the meeting. Be transparent by acknowledging that recognizing cues in a virtual world is difficult and that you want to be inclusive of all voices. Invite people to raise their hands and to enter comments in the chat box. Your focus must be on recognizing what cues you have available to you, being open to the possibility that there may be misinterpretation, and ensuring that all voices are heard.

There are also nonverbal cues that are not visual.[6] Before the onset of COVID-19, the practice of coaching often involved telephone-based interactions. This might seem counterintuitive as one of the tenets of coaching is being able to assess nonverbal signals and how these relate to what might not be said or what a client is truly passionate about. There is a lot to be found in the tone, pitch, and cadence of speech.[6] The same is true for virtual meetings. If someone increases the cadence of their speech, it could signal excitement or passion. A change to a more silent tone might signal a lack of confidence in what is being said. It is not important that you be able to recognize exactly what the other person is thinking or feeling; rather, it is important that you notice the change. Based on the situation, you might choose to bring attention to it during the meeting or you might make a mental note that you need to speak with someone later. As with visual cues, these cues have always been there. It is up to you to sharpen your focus and be courageous in speaking with them.

The value of slow thinking in leadership

Understanding your why and working on yourself first are important in all aspects of leadership, but they are of particular significance in situations where you will benefit from thinking slow.[7] As defined by Kahneman in *Thinking, Fast and Slow*,[7] slow thinking refers to a more deliberate type of thinking, often surrounding complex systems. Involved in problem-solving and requiring you to monitor and control your emotions and behaviour, slow thinking can lead to strengthened relationships and sustainable outcomes. This is not, however, the type of thinking that most physicians, especially seasoned practitioners, engage in daily during clinical interactions with patients. You are more likely to engage in fast thinking, which is automatic, intuitive, and seeks to assimilate what you see with previously held beliefs.[7] This type of thinking leads you to confirm what you already know rather than considering novel information or ideas, especially when faced with difficult leadership issues.

In the fast-paced world of medical leadership where there seems to be a constant need to answer urgent concerns in rapid sequence or fast thinking, leaders must be deliberate about finding the space for slow thinking. First, leaders must acknowledge that fast thinking is emotional and prone to confirmation bias.[8] It does not consider diverse opinions and may negate important information. Understanding that this can lead to uninformed decisions should alert leaders to the value of finding the time for reflection.[9] It can even make you more productive.[10] The way to approach this in a fast-paced world is to recognize when you do your best work and set aside 20–30 minutes several times a week to dedicate to slowing down the speed of your thoughts and becoming more intentional. Knowing the space that works best

for you, whether while sitting or walking, and what the background is like will also be important. Finally, know what you want to think about. Many great questions will streamline your workflow and define your accountabilities to long-term outcomes.[10] Coaching is a valuable space to consider some of these questions in more depth with a reflective partner.[11]

As an executive coach, when I suggest to medical leaders that "solving" leadership problems might require them to engage in thinking slow and that not all leadership problems are urgent, this often gives them the mental space they need to think about building for sustainable success with their teams. That inequity in the call schedule has existed for a decade or longer and does not need to get solved by the end of next week using an automatic or intuitive approach. In fact, that type of thinking can lead to a failure to consider all options and all voices – it misses valuable information. The problem can be addressed over a period of, say, six months or a year, in a logical and deliberate way that seeks input from all, identifies and minimizes risk, and celebrates successes. This type of thinking is necessary to support your teams in sustainable transformation of our complex health care system.

The value of executive coaching in messy leadership

Executive coaching has been defined by the International Coaching Federation as "partnering with clients in a thought provoking and creative process that inspires them to maximize their personal and professional potential. The process of coaching often unlocks previously untapped sources of imagination, productivity, and leadership."[11] As such, it is well positioned to assist in the messiness that is medical leadership. Understanding your why of leadership, building your self-awareness, and thinking slowly are not solo activities, and they are difficult to achieve during the routine hustle and bustle of the packed daily agenda that most medical leaders face. Coaching accepts that you hold the answers to your leadership challenges and that these can be discovered through a relationship with your coach that is centred on self-discovery and growth.

The Canadian Society of Physician Leaders supports coaching as a valuable asset in the development of medical leaders.[12] It is aligned with the LEADS framework, most significantly Leading self, and can assist with mitigating the messiness of human relationships that are at the centre of all successful leadership initiatives.

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INTERVIEW

Physicians as advocates

This article has been adapted from an interview in the Canadian Society of Physician Leaders' *Leading the Way* podcast series.* In this episode, aired on 1 Sept. 2021, Dr. Johny Van Aerde (executive medical director of CSPL) spoke with Dr. Bolu Ogunyemi.

Boluwaji Ogunyemi, MD, FRCPC is an early career physician who is assistant dean for social accountability and clinical assistant professor of medicine at Memorial University in St. John's, Newfoundland. His writing has appeared in a number of prominent publications, including the *New York Times* and the *Globe and Mail*. In this interview, Dr. Ogunyemi talks about his clinical and advocacy work with marginalized populations and

reflects on his own development as a leader.

Congratulations on receiving the Early Career Volunteer Award from the Canadian Dermatology Association for your work in social justice and health advocacy in downtown Vancouver's Eastside. Tell us a bit about the work that you did there.

It began as part of an elective rotation at the Pender Clinic. I was drawn to the way the clinic functions; it focuses on equity and meeting people where they are. Once I finished the four-week elective in dermatology, I kept working even though I wasn't getting academic credit for it. For me, that clinic was very important because that was one of the first times that I really saw dermatologists' role in providing equitable care to a marginalized and underserved population.

You have also done work for the Equity in Medicine leadership team, Black Physicians of Canada, and Canadian Doctors for Medicare. How do you link your work in dermatology with equity?

Dermatology is actually closely linked with equity. For example, atopic dermatitis is rampant in many First Nations' communities. It is undertreated and can be associated with cutaneous viral and bacterial infections that are also undertreated. Part of the cause is crowded housing, especially on reserves. First Nations' housing has been neglected by the federal government for decades. Poor housing quality and mould can contribute to an increased prevalence of cutaneous infections. Children often need oral therapy, sometimes intravenous, and have to be flown to major centres to receive care. This is really a preventable problem.

We can provide equitable care by meeting folks where they are. Teaching the people who regularly provide care in these communities how to deal with the medical side of these infections is important, but a lot of the work is based on culturally safe care. For example, it's important to have material translated into their mother tongue, because family members may not speak or read English.

It's important to treat them as people. When I gave a talk to the

community about what they can do about atopic dermatitis, I gave it in their healing lodge. For many members of this First Nation, this was a place where they were more comfortable than in a clinic, which can be associated with "white coat" doctors. I think it's important to meet folks where they are.

Some people say, "I don't see skin colour; I see people" or "I see humans." How do you respond to a statement like that?

I realize that a lot of folk are well-meaning when they say that. One thing that frames equity is intention, but so is impact. When you're on the receiving end, the impact kind of renders the experiences that racialized folk have as unimportant. Every human is shaped largely by our experiences; we all do see race and ethnicity, and it affects the way that everyone perceives us in the world. So many folk who are marginalized have, unfortunately, suffered – some more than others – because of their race, their skin colour, even their hairstyle. When folk say they don't see colour, those experiences are made invisible or negated in a way. So, while the intention is good, the impact also has to be considered.

If we look at determinants of health, what is the role for physicians to play as advocates?

It's important for physicians to be humble, because we aren't the final arbiters of health. For example, in Newfoundland and Labrador, a health accord has been proposed. Many members of this accord are non-physicians because it's important to leverage virtual care; so, we need policymakers, those in economics, technology, etc. If you're a physician, you should be good at delivering culturally competent care, but you may not be an expert in policy, you may not be an expert in economics, you may not be an expert in technology or even in administration. We need to realize that we have some of the skills, but certainly not all. We have to find out who else we need on board.

I do think that there is a role for physician leaders as advocates. Many physicians assume leadership roles in health – not just medicine, but in health more broadly. Many leadership skills aren't taught in medical school or in residency: administration, managing a team, conflict resolution. These are all skills that aren't necessary to a practising physician, but are important in the broader way of organizing health and ensuring that we can have good health outcomes.

What is a leadership trait, skill, or style that has been most valuable for you up to this point in your career?

I've certainly been putting deliberate effort into communication. I don't think I was ever a gifted speaker, but I kept on practising and put myself in uncomfortable situations. I delivered a 16-minute TED talk from memory. That was important for me. I have given a number of keynote speeches since, so I think part of it is becoming comfortable in that realm.

I don't think I'm naturally gifted writer. Every time I submit an article, I know it might be rejected. Sometimes, I'll have major edits, but I just keep revising and revising. It's this growth mindset that has allowed me to develop my writing to the level that it has been published in the *New York Times* and most major Canadian newspapers.

Communication is something that everyone needs to practise; whether it's working with groups or chairing meetings, it's all about practising. One thing I've learned more recently is that it's a skill to make sure you can communicate with people whose voices may not otherwise be heard. It's not just the loudest voices that we need to value. It's all voices and learning how to get on the frequency of someone else and make them feel like they can contribute and have their contribution valued.

I'm so honoured that we had this time together. On behalf of the members of the Canadian Society of Physician Leaders, I thank you very much for giving us your time and your wisdom.

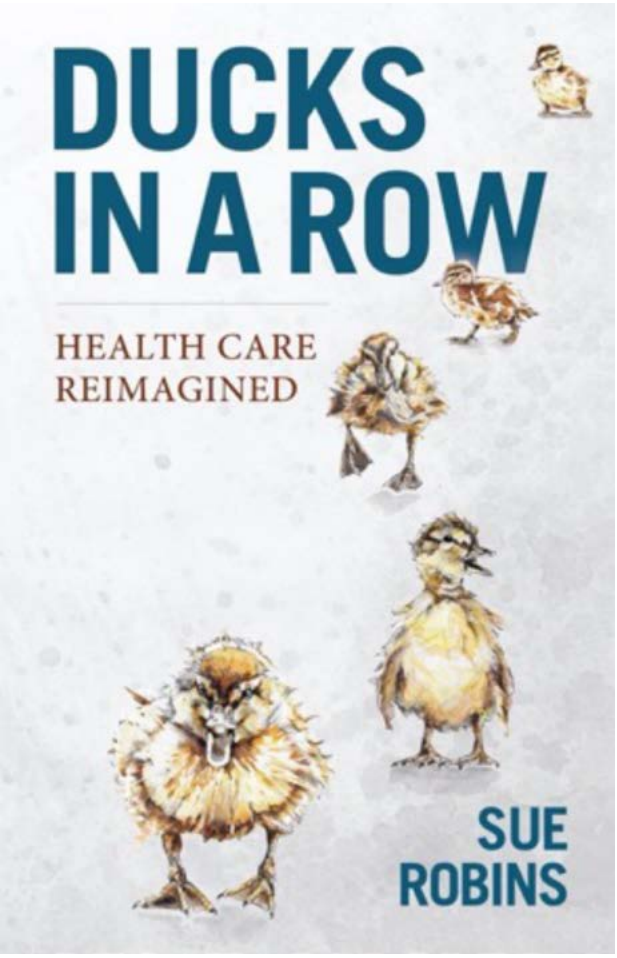
*To listen to the full interview with Dr. Ogunyemi, please visit **https://tinyurl.com/2p8bdv8r**. This podcast and others can be found online at physicianleaders.ca/podcasts.html.

BOOK REVIEW

Ducks in a Row: Health Care Reimagined

Sue Robins
Bird Communications; 2022

Reviewed by: Johny Van Aerde, MD, PhD



The ugly duckling of the health care system is the lack of relationship-centred care. In *Ducks in a Row: Health Care Reimagined*, Sue Robins masterfully exposes the mental models and assumptions in our health care system, demonstrates the need to create safe spaces, and shares how to hold truly engaging conversations among staff, patients, and families in the planning of care. Throughout the book, there are very practical suggestions for improvement. Acting on even one improvement adds a duck to your row, one duck at a time.

The book is split into three sections. Power to the People examines the power imbalances inherent in health care settings. Humanity in Health Care for All expresses hope by sharing stories and best practices for health professionals to engage with patients and families. Health Care Reimagined is the ideas section, putting forth many ducks. It outlines practical tips and stories about creating people-friendly health spaces and engaging patients and families at the organizational level – on councils, as teachers, as advisors, and in research.

Robins' rich experiences as a parent, cancer survivor, volunteer, health care worker, health activist, and communication expert inform her perspectives. Her work as a family engagement specialist in two children's hospitals adds to her understanding of health care systems. She shows how to bring together the relational needs of patients and families with the medical expertise of health care workers in ways that enhance care.

This book is about our health care system and our humanity as Canadians. Because each of us connects with the health care system at some point(s), we would all do well to take the advice offered in *Ducks in a Row*.

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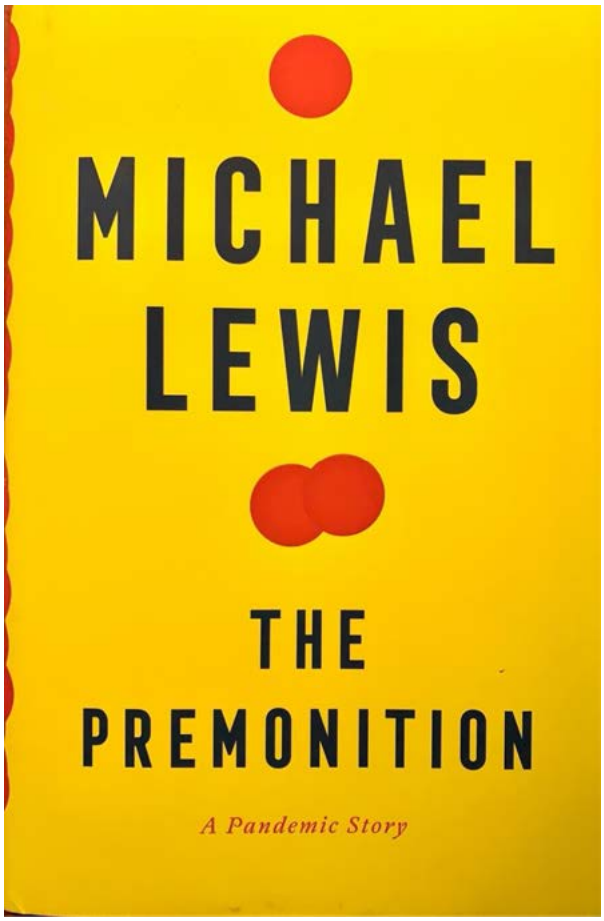
BOOK REVIEW

The Premonition: A Pandemic Story

Michael Lewis
W.W. Norton & Co., 2021

Reviewed by: Johny Van Aerde, MD, PhD

The Premonition by Michael Lewis has all the makings of a good thriller: a small group of rogue superheroes – scientists and doctors – who have never worked together join forces to fight a supervillain, the malevolent



force of institutional rigidity and arrogance. Tragically, this book is not a novel. Instead, in this non-fiction account, Lewis portrays the American government and public health systems as incredibly vast and insufficiently centralized, with "no one driving the bus". In fact, Lewis asserts, information about COVID-19 was known and ignored, and evidence about what public measures should have been taken while awaiting the arrival of a vaccine existed well before April 2020. In this account of COVID-19, institutional malaise contributed to the spread of the pandemic.

The main characters in *The Premonition* come from assorted backgrounds: Bob Glass, a father who helped his daughter create an infectivity model for a 2003 science fair project; Joe DeRisi, a biochemist who developed a useful technology for rapid viral testing; Charity Dean, a public health officer in California who began tracing transmission of resistant tuberculosis in her county; Carter Mecher, an epidemiologist with an almost clairvoyant mind, and Richard Hatchett, who plotted a national response to a deadly virus – in 2006. These unlikely collaborators somehow coalesce over time, banging their collective heads against institutional brick walls in their attempts to stop the spread of COVID-19. The institutional rigidity is mind-boggling, but perhaps not surprising.

The Centers for Disease Control and Prevention (CDC) emerges as the main antagonist. As America's public health agency, the CDC is, as its name suggests, technically responsible for preventing the spread of disease. But the book presents a damning portrayal of an organization in which no one is willing to risk getting fired by making a wrong move and in which an institutional abundance of caution amounts to a form of recklessness. The CDC pretended that the virus wasn't important until it was too late and, as a result, tens of thousands of Americans lost their lives. Even more mind-boggling is the complete absence of any coordination or integration of the public health system, with every county bumbling along on its own, making it so dysfunctional that one wonders whether there is a public health system at all.

Lewis focuses on the political conditions that existed before the pandemic and even before Donald Trump. The tragedy that became the American coronavirus pandemic was the perfect storm: the timing of the virus, the responses of then-President Donald Trump, the long history of politicization of the CDC, and the lack of a responsive and integrated public health care system.

The Premonition shows the damage done by institutional and bureaucratic malaise and rigidity to the lives of the US population in 2020. Could the same type of institutional, governmental, and bureaucratic rigidity inhibit physicians and physician leaders in overhauling what needs to be transformed urgently in the Canadian health care system?

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2022 Call for Nominations

Canadian Society of Physician Leaders (CSPL) Excellence in Medical Leadership Award (Chris Carruthers Award)

Nominations are being sought for the CSPL Excellence in Medical Leadership Award (Chris Carruthers Award). The Award shall be presented to a CSPL physician who has made an outstanding contribution to the development and mentorship of medical leaders in the field of health services leadership and management.

In a detailed letter qualifying the nominee, please describe in your letter of nomination how the nominee has demonstrated outstanding abilities in one or more of the following categories:

- *Commitment to enhancing the role of physicians in the management of health care delivery organizations*
- *Leadership in a hospital or health region management role*
- *Significant contribution to leadership development within CSPL or any related organization or program locally, provincially or nationally*

In addition to the nomination form, letter of nomination and curriculum vitae, please provide additional letters of support to the following email: carol@physicianleaders.ca.
Deadline for Submission: March 15, 2022
https://physicianleaders.ca/leadershipaward.html

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SCLM Société canadienne des leaders médicaux


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