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# Physician Leadership

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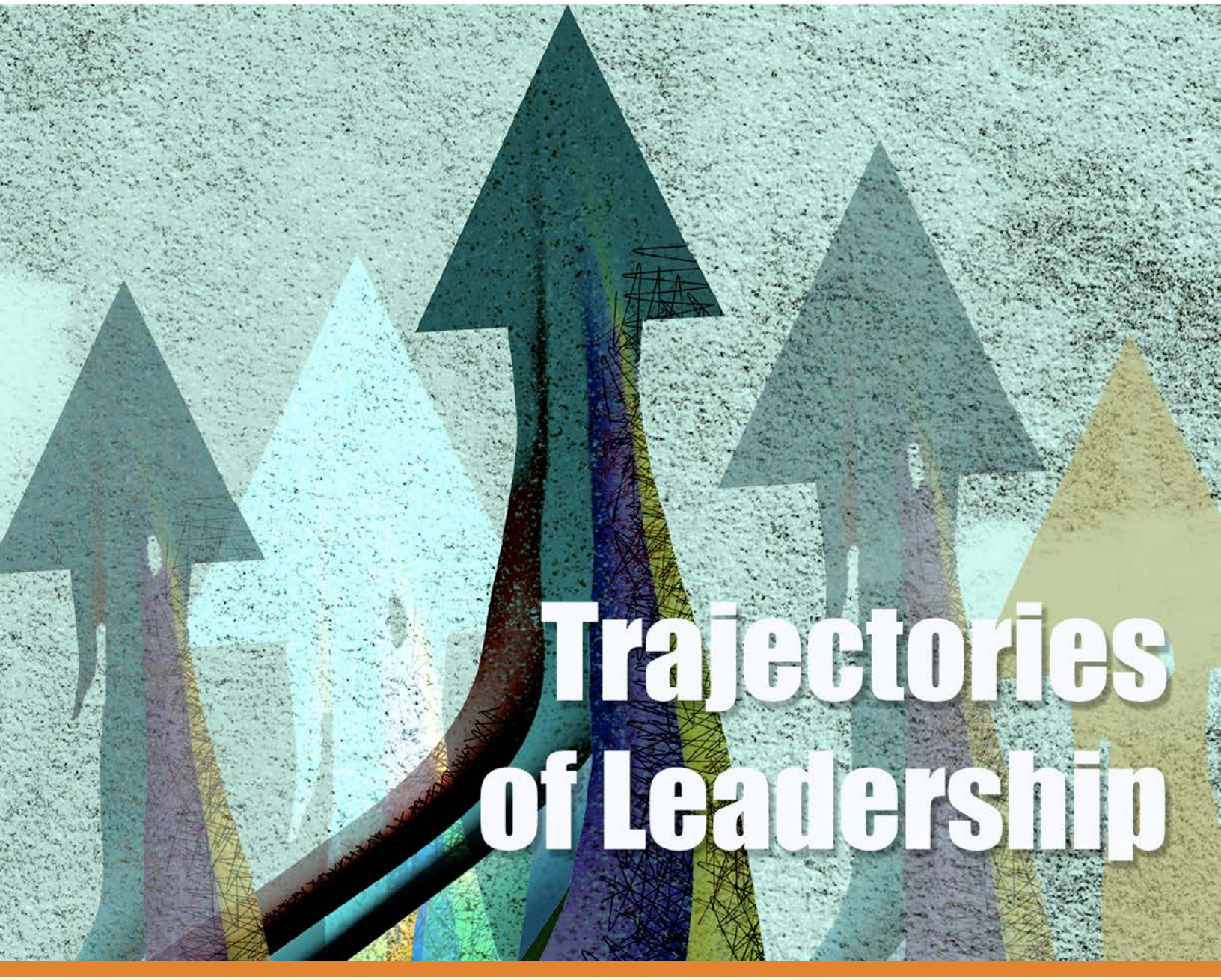


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CSPL Canadian Society of Physician Leaders
SCLM Société canadienne des leaders médicaux

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GUEST EDITORIAL

# Physician leadership needed now more than ever

Shannon Fraser, MD

Never has society needed physician leadership more, and never has it been so challenging for many of us to take on those roles – although take them on we must.

That was one of the main themes to come through from the Canadian Conference on Physician Leadership held in Toronto this year, as we gathered for the first time in-person in three years under the auspices of the Canadian Society of Physician Leaders. Those who attended took full advantage of the opportunity to network and catch up, while many Canadian physicians who still did not feel prepared for face-to-face interactions chimed in enthusiastically causing the meeting hashtag **#CCPL2022** to trend on Twitter.

The meeting demonstrated how far physician leadership has come in terms of diversity and representation in recent years, although speakers, such as Dr. Ivy Bourgeault, Canadian Institutes of Health Research Chair in Gender, Work and Health Human Resources, showed how far we still have to travel while suggesting the tools we can use to get there.

For many, a highlight of the meeting saw four women physician leaders under the moderation of another woman present their hopes and fears for the future of health care in Canada. To paraphrase a comment made on Twitter: "As medical students, we often hear that we will be the generation that needs to fix the system. However, to witness a panel of such successful female physician leaders today and hear them say that they will provide structure to guide us is so powerful."

The two opening speakers – former family physician, federal health minister, and now Queen's University dean of health sciences, Dr. Jane Philpott, and Canadian Medical Association president, Dr. Katharine Smart – set the stage for what was to come in the two-day meeting of plenaries and workshops.

Dr. Philpott reminded us that patients are why we do all that we do; she also spoke of how health care reform and transformation are far more effective when patients are part of the team. She then turned to the profession and argued strongly that physician leadership, as we enter the post-pandemic period, is critically important. But Dr. Philpott also acknowledged the toll the last two years have taken on physicians and urged people to take time to rest, recharge, and then re-enter the fray with a renewed sense of purpose.

Dr. Smart said physicians have to develop new skill sets to function as leaders, and these include being able to communicate effectively to serve as advocates for better care. "I would challenge us as physicians to feel comfortable and ready to have hard conversations about health care reform, even if they may not be easy or even if we may be going up against popular opinion," she said.

"Action feels better than anxiety," said Dr. Courtney Howard, Yellowknife emergency physician and past-president of the Canadian Association of Physicians for the Environment, as she and others spelled out the dire future for health and well-being if we fail to address climate change and other fundamental shifts in the ecological infrastructure.

The meeting made it clear that if physicians are willing to step up and take on leadership roles, then the will and resources exist for us to make a difference. Masking and responsible behaviour showed that, even during this sixth wave of the pandemic, it was possible to provide a useful forum to talk about the actions we can take to do better for ourselves and our colleagues.

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COMMENTARY

# "We're not better now": Canada's health care providers need well-being supports, stat

Andrea Lum, MD, and Laura Foxcroft, MD

Now, more than ever, robust well-being supports are needed for Canada's health care providers – especially as we prepare to exit the Omicron wave and build back a battered health care system. For two years since the World Health Organization declared a global pandemic, health care workers have been on the front lines burning the candle at both ends.

But the issue of burnout was already brewing well before the virus crisis brought hospitals to their knees. We went into the pandemic with a very high burnout rate, with evidence showing it affected a staggering half of practising physicians.

We're not better now. Our providers are exhausted, clinically, academically, and emotionally. More physicians are experiencing moral injury, compounded by a growing lack of institutional trust and, more recently, vitriol directed toward doctors, nurses, and health care professionals.

A recent study[1] showed that, among Ontario physicians, the annual rate of outpatient visits for mental health and substance use increased by 27% during the first year of the pandemic. The report also found physicians self-report high levels of symptoms of anxiety and depression, with surveys suggesting these symptoms have been worsened by the COVID-19 crisis.

As contractors – not hospital employees – doctors often aren't included in many organizational, hospital-based support networks, resources, or employee assistance programs. The figures are a stark sign of the need for greater mental health resources for physicians and highlight the need for programs that support physician well-being.

As we look toward an end to the pandemic, and a new normal for many, the health care system is faced with a daunting task: clinical backlogs, patients with long COVID, and a shrinking workforce of health care experts, to name a few.

Amid the COVID-19 crisis, the Ontario Medical Association issued a report[2] outlining five system-level solutions to physician burnout. Among ensuring fair and equitable compensation, increasing work-life balance, and streamlining administrative work, providing institutional supports for physician wellness was listed as a key priority. The OMA also calls for implementing proven, individual-level well-being interventions for physicians.

Western University's Schulich School of Medicine & Dentistry in London, Ontario, is answering that call with the implementation of the Peers for Peers program to better support our clinical faculty members' mental health. The first program of its kind in Canada, Peers for Peers provides one-on-one support for clinical faculty, allowing us to provide guidance in moments of need. Well-being leads offer emotional support and resources, recognizing that it is important for professionals to access supports they need but at a distance from their leaders or employers.

Think of it like roadside assistance – if your car breaks down at the side of the road, we're there to help. We can tow you back home, safe and sound, but there's more that needs to be examined to

determine why the car broke down in the first place. Was there a problem with the engine? Were you driving down the wrong road? Peers for Peers allows clinical faculty members in challenging situations to get the support they need, and to be guided to resources. It's these kinds of quick interventions that are needed to prevent trauma and for people to look after their own emotional well-being.

Our well-being program provides fast, accessible support, but we are not the permanent infrastructure or systemic solutions required for long-term change. There are no maximum hours physicians can work in a week. Our medical culture is often to continue working and serving our patients, sometimes without paying attention to our own wellness, resulting in burnout. That needs to change.

Proactive efforts to streamline physician training – targeting budding doctors to certain fields, whether it be primary or speciality care, based on population needs to better serve our various communities – is also essential. And we must acknowledge that the hardest hit population of health care workers throughout the pandemic is women. We must provide extra resources to this group, who often bear the brunt of childcare and family needs, which have been greatly disrupted by COVID-19.

But well-being initiatives are still a place to start, and programs targeted for providers must become more common nationally. We have developed a Peers for Peers training curriculum accredited by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada that covers a range of topics, from empathetic listening to recognizing peers in distress to implicit bias.

There has been uptake across Ontario, with both the Northern Ontario School of Medicine in Sudbury and the Richmond Physicians Society adopting the program's framework. Growing interest in the program across Canada also tells us why such well-being initiatives are important and needed so urgently.

Because the program is customizable to the unique needs of various health care groups, educational institutions, and communities, it becomes intensely local. That grassroots aspect is apparent, and we're starting to see the culture shift here in London's health care network to one where physicians and providers prioritize their mental health.

It has been a challenging two years for our southwestern Ontario community and Canada at large. Against the backdrop of a global pandemic, we've gone through unprecedented social, political, and racial reckonings, we collectively began to reconcile the trauma of Canada's residential school system, and we've experienced alarming climate events from coast to coast. That's on top of the emergencies and crises doctors combat in our local communities daily.

Through all of this, care providers have continued to fight to improve the health – and mental health – of Canadians. Now, it's time we heal the healers.

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OPINION

# What health care leaders can learn from Volodymyr Zelensky

Nick Paterson, MD, and Jhase Sniderman, MD

Ukraine's President Volodymyr Zelensky modeled crisis leadership in the early stages of the Russian invasion of Ukraine. In this article, we reflect on Zelensky's attributes of relatability, clear communication, and servant leadership as characteristics that health care leaders can also use to lead organizations through crises such as the COVID-19 pandemic response.

**KEYWORDS:** health care leadership, crisis, communication, servant leadership, Zelensky

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The rise of any conflict inevitably brings with it new characters, both heroes and villains. The crisis that ensues can forge or fracture new leaders. Still reeling from the most recent COVID-19 wave, the world has shifted its gaze to the Russian military invasion of Ukraine. In the early days of the war, one new character has emerged as an inspirational leader: Ukraine's President Volodymyr Zelensky.

With millions of others, we have been transfixed by Zelensky's fortitude and resolve. His words and actions have helped to rally his fellow Ukrainians and much of the world. Given ample opportunity to be extracted from the country to a safer location, he firmly planted himself at the centre of the crisis in Kyiv to lead his troops from the frontline.

Over the course of the COVID-19 pandemic, many military comparisons have been applied to the response. Terms such as "battle," "frontlines," and "troops" have been used both literally and figuratively. Although the toll of war-time conflict and hospital pandemic leadership can hardly be compared, elements of the success of Zelensky's leadership can be extended across a broad range of health care crisis situations. Here, we reflect on some of the ways health care leaders can adapt and implement qualities that have made President Zelensky successful throughout the early stages of this conflict.

## Relatability

In unpredictable and high-stakes situations, a leader's authenticity and relatability are paramount. The leaders we admire in these situations are honest and forthcoming, quick to admit their vulnerabilities and fears of what lies ahead.[1]

Wharton School professor and author, Adam Grant,[2] described the importance of relatability, explaining that what makes leaders great is not just their internal characteristics, but also their ability to understand and reflect the values and identity of those they lead. He goes on to note that "we're drawn to leaders who represent our group. The people we elevate into positions of authority aren't typical members of our group – they're prototypical members of our group. They're the people we see as exemplifying the ideals of the group and acting in the best interests of the group."

President Zelensky is often pictured in plain green military clothes, mingling with soldiers and civilians in streets throughout the nation's capital, inspiring

his people from among them. This cannot be overstated: as leaders, we should never forget the importance of jumping into the trenches from time to time and using that opportunity to genuinely connect with our front-line staff.

## Clear communication

As we reflect on the challenges of communicating essential information to our colleagues, a focus on clear and concise language is imperative. Leadership development researcher Ruth Gotian has analyzed Zelensky's crisis response and explains that his speeches resonate because they are "simple, plain-spoken, commanding and emotional."[1]

Although Zelensky's on-point messaging is critical, Wharton's Michael Useem[3] also notes that he sets the stage by standing in the street to show the landscape of war behind him rather than taking a formal pose behind a lectern during press conferences. In doing so, he helps people focus not on him but on the messages he is trying to deliver.

Similarly, Dr. Craig Smith, the chair of surgery at NYU Presbyterian, was made famous during the crippling first COVID-19 wave in New York City when internal memos he was sending to front-line staff were published.[4] These correspondences were short, clear, brutally honest, and yet full of resolve. In his words, they were a balance of "freighting facts and sunny-day optimism."[5]

When the fog of the pandemic lifts, we will still be left to pick through the rubble of the health care challenges that lie ahead: elective surgery backlogs, long-term care overhauls, pressured emergency departments, and so on. A focus on clear and poignant communication will help us and our organizations frame the important issues and unite in the messaging.

## Servant leadership

Paul Tesluk,[6] dean of the School of Management at the University of Buffalo, has written about President Zelensky's masterclass

of servant leadership. This is based on the idea that leaders are most capable of galvanizing people to accomplish herculean challenges when they focus least on satisfying their own personal needs and most on the fulfillment of their followers' needs. These leaders achieve commitment to a set of collective goals by displaying attributes of humility and commitment.

**Although servant leadership is a natural fit in medicine, its true power is unlocked with a top-down approach. This helps foster a culture of norms and expectations for behaviour among followers.**

He goes on to explain how "his frequent videos and social media posts continuously emphasize the importance of the cause, express confidence in his fellow Ukrainians. …. That commitment, confidence and demonstrated willingness to keep himself in harm's way has done more than earn him the admiration of Ukrainian citizens – it has inspired their loyalty and willingness to make sacrifices of their own."

Although servant leadership is a natural fit in medicine, its true power is unlocked with a top-down approach. This helps foster a culture of norms and expectations for behaviour among followers. In turn, servant leaders can articulate a path forward by advocating shared moral values, integrity, and stewardship that helps serve not only their followers but a broader society. Health care leaders have the opportunity to establish the foundation and culture of their organization, ensuring that not only patients, but also employees, are held in the highest regard.

The COVID-19 pandemic has forced a spotlight on leadership in health care. The continued crisis in health care may not build character, but it does expose it. Although formal avenues, from continued education to physician leadership development programs, exist to hone these skills, we would do well to remember that much can be learned and modeled from successes in the world around us.

## Conclusion

President Zelensky's authenticity, clear communication, and servant leadership have been inspiring and can serve as examples of attributes that are useful for health care leaders, especially in times of crisis.

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# Development of a provincial medical affairs community of practice

Daniel P. Edgcumbe, MB BChir, and Lisa Harper

The term "medical affairs" describes functions undertaken by health care organizations in Canada in support of their relations with credentialed staff, such as physicians, dentists, midwives, and certain extended-class nurses. These credentialed staff are generally appointed by the board of directors of their organizations and operate under their own bylaws, rules, and regulations. Despite the importance of medical affairs, in Ontario, little has been done to connect these functions across health care organizations, even though there are significant potential benefits from doing so. In this paper, we describe the development of a provincial community of practice (CoP) for medical affairs. We briefly review fundamental concepts relating to CoPs, consider their relevance to health care and medical affairs in particular, and discuss the use of technology to support CoP development. The intention is to share our learning with others, so that they might consider establishing their own CoP, as well as to offer some practical advice on the implementation of virtual CoPs.

**KEYWORDS:** community of practice, medical affairs, medical administration, virtual, technology

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Communities of practice (CoPs) are "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis."[1] According to Wenger,[2] there are three fundamental elements of a CoP: the domain ("the area of knowledge that brings the community together"), the community ("the group of people for whom the domain is relevant"), and the practice ("the body of knowledge, methods, tools, stories, cases, documents, which members share and develop together"). For any CoP, there is an emphasis on practical application in the real world.[2]

Key characteristics shared by CoPs include: a purpose to develop members' capabilities and to build or exchange knowledge; a self-selected membership group, who are bound together by passion, commitment, and identification with the group's expertise; and an indefinite timescale that lasts as long as there is interest in maintaining the group.[3] These features distinguish them from other forms of organizing work, such as formal work groups, project teams, and informal networks.

In health care there is significant variation in how and why CoPs are established. However, their common goals can be considered in terms of exchanging learning, information, and knowledge or

sharing and promoting good practice-/evidence-based procedures.[4] CoPs can use technology in support of these goals, to "create a sense of togetherness over time and across distances."[5] Although technology can be an enabler, its use alone does not create a CoP. As Smith et al.[6] point out, although current advances in technology are an asset to the endeavour, "merely establishing an electronic site to host distributed members of an existing or aspiring CoP to engage with each is no guarantee of its success." Nevertheless, certain features, such as enabling asynchronous discussion through online forums, can support reflective practice, problematizing, and the generation of communal knowledge and resources.[6]

The ability to create a virtual CoP is particularly valuable in circumstances where potential members are geographically distant from each other, where competing priorities mean that synchronous collaboration is challenging, or where there are restrictions limiting face-to-face meetings (such as during the COVID-19 pandemic). All of these are relevant to the province of Ontario.

## The Ontario context

In Ontario, formal responsibility for the quality of care in hospitals rests with hospital boards.[7] Hospital care is delivered by hospital corporations, which, according to Tenbensel et al.,[8] remain as "private, albeit mostly not-for-profit entities with their own independent board." The same authors argue that Ontario has historically had a "highly disaggregated structure of Local Health Integration Networks, independent hospitals, multiple organisational and funding models of primary care." As of 2014, there were 155 public, private, and psychiatric hospital corporations in Ontario operating on 238 sites.[9] Corporations range in size and scope from large, multi-site academic hospitals to single, small rural sites.

Within these corporations, physicians (along with dentists, midwives, and certain extended-class nursing staff) usually form a group of "credentialed staff", who are given privileges to use hospital resources in return for providing care to hospital patients.[10] Credentialed staff are not typically employees of the hospital but are appointed by the board of directors. Appointment processes operate in accordance with the Public Hospitals Act[11] as well as each corporation's bylaws, rules, and regulations. Following initial appointment, credentialed staff are subject to an annual reappointment process. In contrast, other members of the staff are employed by the hospital and managerial control is exercised through organizational policies and procedures, under the umbrella of broader employment legislation. Because credentialed staff typically operate under an entirely different framework from other staff associated with the hospital, they require a specialized management function, commonly termed "medical affairs" or "medical administration".

As care providers, credentialed staff are critical to the delivery of patient care. It is increasingly recognized that their experience as care providers is also important to ensure that they can provide high-quality care. The Triple Aim concept proposed that, for health systems to be effective, they need to improve patient experience of

care, the health of populations, and reduce the per capita cost of health care.[12] Sikka and colleagues[13] contend that unless care providers experience joy and meaning at work, the objectives of the Triple Aim can be undermined; this led them to formulate a Quadruple Aim, incorporating the additional concept of provider well-being.

Despite the importance of medical affairs functions and the clear relationship between credentialed staff and the delivery of patient care, in Ontario, there is a paucity of opportunities for medical affairs departments to learn from each other. Despite the similar nature of the work they do, they often function in isolation. This can lead to departments spending time accomplishing tasks without the benefit of prior learning or experience. It can also result in unnecessary redundancy and duplication of well-worn processes. Such inefficiency can detract from the core business of supporting credentialed staff, with consequent impairment of patient care.

Therefore, establishing a CoP can bring value to those working in medical affairs and improve the care provided to patients and their families. Through participation in a CoP, organizations will be well placed to provide the best possible support to credentialed staff, which, in turn, will enable them to deliver safe, high-quality care. It is in this context and with these objectives in mind that we sought to establish a CoP to connect those working in medical affairs in the numerous hospital corporations throughout the province.

## Conception of a medical affairs community of practice

LH began working in medical affairs in 2017. She had a background in research and was surprised to find that the interconnectivity and sharing that characterize academia were largely absent in medical affairs. She created a shared list of contacts in Ontario to help medical affairs professionals reach out to one another when they had a question or wanted to know how other organizations addressed a variety of topics. Although this was useful, she concluded that it did not fully meet the needs of medical affairs professionals, particularly with respect to broader sharing of ideas and resources or providing opportunities for collaboration.

During recent work on medical leadership development at Halton Healthcare, DE undertook an environmental scan of hospital organizations in Ontario. In conversations with partner hospitals, he soon realized that individual organizations were often left to their own devices, despite a clear appetite on the part of those working in medical affairs to be more connected.

Based on LH's conclusions regarding the contrast with her academic experience and DE's findings of the views of medical affairs departments, we determined that there could be utility in establishing a CoP for medical affairs. Following discussion with medical affairs leaders at other hospital organizations (Providence, the Ottawa Hospital, Oak Valley Health, and Humber River Hospital), the Ontario Medical Affairs Community of Practice (OMACOP) was conceived.

OMACOP has become a network for professionals who are responsible for the administrative management of credentialed staff. In keeping with the principles defining a CoP, it is a grassroots initiative, with no hidden agendas. It was established solely for the benefit of the community and to give members a place to connect, learn together, share resources, ask questions, and explore solutions to challenges. Membership is free and open to anyone working in medical affairs across Canada. Members have access to a lively and active online forum, as well as the opportunity to participate in regular OMACOP meetings. Although the community began with a focus on Ontario, it may be of interest to those in other provinces and territories as well.

## Development of the community of practice

In October 2021, we created a public-facing website and discussion board. The inaugural virtual meeting of OMACOP took place in November 2021, with more than 40 participants from a range of organizations across the province. The director of medical affairs from the Ottawa Hospital presented an approach to medical human resources

planning. Breakout sessions on various topics were facilitated by OMACOP members, including hospital on-call coverage, contract management, disruptive physician behaviour, and mandatory education for physicians. In March 2022, a second virtual meeting included presentations on the Ontario Hospital Association's Credentialing Toolkit, as well as lessons from medical affairs in Alberta. Slide decks from meetings are posted on the discussion board and remain available as a resource to members.

Virtual meetings are evaluated using a survey. Participants are asked to provide feedback on meeting duration, time allotted for discussion, quality of discussion, topic coverage and scope, presentations, and documents provided. Participants are also encouraged to suggest other potential topics for future meetings and to provide comments. This process creates a continuous feedback loop, ensuring that future meetings include topics that are timely and relevant to the community.

The online discussion forum is evaluated using analytics features built into the forum software. This provides several metrics of engagement, including new user signups, number of discussion topics, number of posts, and number of daily engaged users. Activity metrics include page views, user visits, and time to first response to posted questions. We currently have 56 members from across the province. In a 30-day period between February and April 2022, there were 128 user visits, 1400 page views, and a time to first response of one hour.

Feedback has been positive to date, confirming the value of the CoP. The evaluation approach will continue to evolve to best determine how well the CoP approach is working to build relationships and foster collaborative work between its members.

## Lessons learned

As in the case of any collective, it is helpful to establish a small coalition of those who are willing to work at getting the CoP up and running. Having a shared sense of purpose and vision is essential. Ensuring that the coalition has members who can contribute in diverse ways will also increase the chance of success. For example, LH already had an extensive network of contacts in medical affairs throughout the province, which enabled a fast call out for potential members of the CoP. DE contributed technical expertise, including setting up the online discussion forum and website. All members of the coalition provided unique perspectives, which were essential in considering topics for discussion and in contributing to the broader development of the CoP, including planning and reviewing evaluations and identifying potential speakers for the virtual meetings.

The use of technology allows for the creation of a virtual CoP that can overcome geographic barriers. With only modest technical expertise, it is possible to use open-source software to establish a virtual platform for a CoP at very low cost. In our case, Wordpress (an open-source content management system) was used to quickly create a public-facing website using existing webhosting. The online discussion forum for members uses Discourse (open-source software), which was deployed on a cloud-based server through DigitalOcean (DigitalOcean, Inc., New York, USA). Discourse provides a secure, user-friendly, and easily administered forum, which has now largely replaced the unwieldy emails with large numbers of copied recipients. It permits the sharing of documents, so that members can exchange policies, procedures, and terms of references with ease. Feedback surveys are created using REDCap (developed at Vanderbilt

University), which is available free of charge to institutions for non-commercial research purposes and is widely used in academic centres around the world.

Providing a variety of opportunities for engagement can also strengthen a CoP by allowing community members to contribute in the way that best meets their needs. Virtual meetings are helpful in providing a focus for discussion and information-sharing and fostering a sense of community. Many CoP members also benefit from asynchronous discussion through the online forum, which allows them to quickly get answers to questions that arise in their day-to-day work. The online site provides archival value giving members access to thematic data. This is important because members can search previously discussed topics online, eliminating the need to send out large group emails to ask questions that may have been previously answered.

It is also important to choose appropriate evaluation techniques for the engagement approaches. Although more traditional methods, such as formal feedback surveys, work well for in-person meetings, a different approach is needed to evaluate the utility of online discussion forums.

## Conclusion

Although a CoP is ultimately dependent on the participation and engagement of its members, it also requires at least some dedicated leadership to get established. The use of technology can facilitate connections between community members, transcending geographic and other barriers. Evaluation metrics should be chosen to reflect the engagement approaches. We hope that others will be able to learn from our experience and consider establishing their own CoPs in areas of common interest.

Finally, we invite all medical affairs professionals across Canada to join our community and become active members of OMACOP. In sharing knowledge, expertise, and best practice, we can support the transformation of health care. Interested individuals can learn more and join through the website at **https://omacop.ca/**

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ADVICE

# Optimizing meetings: a critical post-pandemic task for physician leaders

Aaron Johnston, MD

Meetings and committees occupy a significant amount of the working time of physician leaders and their teams. The amount of time spent in meetings has grown over decades and that growth has rapidly accelerated over the COVID-19 pandemic. The return to in-person work offers physician leaders the opportunity to optimize their meetings by thinking about the entire suite of meetings they and their teams are involved in. Creating a meeting inventory and evaluating it can reveal patterns, inefficiencies, and redundancies that can become targets for optimization. Effective meetings can create a competitive advantage for leaders, teams, and organizations and can support productivity and job satisfaction. Meeting optimization should be a high priority for physician leaders.

**KEY WORDS**: physician leaders, meeting inventory, virtual meetings

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Physician leaders spend a significant amount of their working time in committees and meetings. The frequency and length of meetings have been increasing steadily in industry over decades,[1] and have rapidly accelerated over the course of the COVID-19 pandemic.[2] Among senior managers, 65% said meetings kept them from completing their own work while 64% felt that meetings came at the expense of deep thinking.[1]

The option of virtual meetings has moved meeting culture outside of the office and, where many physician leaders were previously able to confine meetings to certain times or days of the week, many now stretch into early mornings and evenings or occur alongside clinical duties. New committees formed to address challenges arising from the COVID-19 pandemic, as well as existing committees, often increased their meeting frequency to address new and emerging challenges related to the pandemic. Virtual meetings were initially a way to keep teams engaged and connected, but, over time, issues of Zoom fatigue, technical factors, and engagement issues have become important themes.[3]

In the literature, a focus has been on making individual meetings effective, but relatively little attention has been given to understanding the suite of meetings that occur within organizations as a whole and how they fit together and connect to the purpose, principles, and production of an organization. The first step in creating a successful meeting is determining whether it is necessary and then defining its purpose and the participants required to ensure success.[4] As a return to the physical workspace occurs, leaders can evaluate the meeting landscape for themselves and their teams and make improvements that can

**Table 1. Example of a meeting inventory table**

| Meeting | Frequency | Duration | Timing | Control | Importance /effectiveness | Category |
|---|---|---|---|---|---|---|
| Leadership team meeting | Weekly | 2 h | Monday a.m. | No | High/medium | Strategic |
| Meeting with direct report | Weekly | 1 h | Monday p.m. | Yes | Medium/medium | One-on-one, info sharing |
| Process X meeting | Monthly | 1 h | Thursday a.m. | Yes | Medium/low | Standing meeting |
| Weekly team check-in | Weekly | 30 min | Monday a.m. | Yes | High/high | Workflow planning Operations |

support both productivity and job satisfaction.

## Creating a meeting inventory

The first step in optimizing meetings is creating a detailed inventory for yourself and your team. Include all types of meetings in this inventory. For each meeting, record the frequency, duration, and timing. Consider whether the meeting is under your control. Do you run the meeting? Do you set the timing and agenda or are you there to inform others of their schedule? Do you decide when to attend the meeting? Consider your importance to the meeting: how often is your presence critical to the meeting's success? How effective is the meeting in achieving its goals? Finally, categorize the meetings into types, such as information sharing, strategic meetings, decision meetings, etc. Collect all the data from your inventory and from your team's inventories into a table for further analysis (Table 1).

## Evaluating your meeting inventory

As you create an inventory for your department, patterns, inefficiencies, and redundancies may begin to emerge. Perhaps you are spending the same amount of time meeting with an experienced direct report who needs little guidance as you are with a new hire who needs significant support and direction. Perhaps your schedule is dominated by low-effectiveness meetings or meetings are stacked heavily into certain workdays creating meeting fatigue and limiting effectiveness.

The frequency of meetings impacts value, and optimizing meeting frequency is a key step in managing the meeting suite of your team. Meetings that are too frequent can lose sight of the big picture and get lost in detail as a way of filling up the meeting space. For example, a weekly one-on-one meeting with a highly productive direct report may focus too much on the details of that person's work. Less frequent meetings could lead to more meaningful updates and focus on important bigger picture issues. On the other hand, infrequent meetings can be problematic, as the team may struggle to maintain the work without direction. Consider whether the work done at infrequent meetings can be combined into an aligned work stream or if it needs to take place at all.

You may identify meetings where the original task of the group has been completed or is no longer relevant to the team or organization. A common phenomenon is a highly effective team that accomplishes its goal

but continues to meet because they have enjoyed working together. Remember, the fifth stage of Tuckman's small-group development is adjournment.[5] Even great teams and great meetings can come to a natural end.

Identifying inefficiencies and redundancies is critical in optimizing the meeting suite of your team. You will likely find meetings with overlap that may be combined, meetings that are too frequent or run too long, and meetings or committees that have more members than required.

External meetings, meetings that you or your team are a part of but do not control, deserve special attention. Where the role of your team in these meetings is to bring its perspective, a single representative from your team is desirable. Where the purpose of the meeting is purely informational or where there is rare overlap with your team's core work, consider being a communicating member, receiving minutes and communications but not attending every meeting.

Every committee and meeting should be able to articulate its own purpose and how it connects to the overall purpose, principles, and production of the team and organization. Making this connection clear and apparent supports the success of meetings. Where there is no clear connection to the overall goals, cancellation of the meeting or committee should be considered.

## Optimizing meetings

Optimizing your team's suite of meetings can create a competitive advantage for your team and your organization. Meetings are expensive, and unnecessary meetings can distract from the core work and purpose of your team. Reviewing the entire suite of committees and meetings your team is involved in will allow you to make changes that will support productivity and job satisfaction.

Each meeting should be optimized in terms of frequency, duration, timing, and modality (e.g., in person or virtual). The frequency and duration of many meetings increased during the last two years, but the status quo should not be assumed. For each meeting, consider the work that it supports and whether less frequent or shorter meetings could accomplish that. Consider the timing, not only of individual meetings but also of the suite of meetings as a whole, so that they are spread out over the work week and time for focused work and deep thinking is maintained.

The organization and running of meetings need not all fall on the

leader. Delegating leadership of some meetings can improve performance and support employee growth. Creating an optimized suite of meetings will allow the meetings themselves to be more effective and will also create space outside of meetings for deep thinking, creativity, and completion of day-to-day tasks of work.

Change can be hard, and leaders should approach optimizing meetings with change management in mind. Team members may feel loss as an ineffective but fun committee ends or may feel left out as meeting membership is streamlined. It is important to understand the psychology that supports the continuation of ineffective meeting patterns in organizations.[6] Leaders must be clear with their teams about the purpose and potential of optimizing meetings and be open to navigating the challenges that will arise as with any change.

## Summary

The return to in-person work provides a logical opportunity for physician leaders to optimize the committee and meeting involvement of their teams, and should be a high priority for physician leaders. Leaders can make improvements by considering the entire suite of meetings in which they and their team are involved and using an organized approach to eliminate redundancies and low-value meetings and to optimize the frequency, duration, timing, and modality of each meeting.

Optimizing meetings can create a competitive advantage for leaders, teams, and organizations and can support productivity and job satisfaction.

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# Model to improve charting performance for physicians

Maryna Mammoliti, MD, Adam Ly, MScOT, and Cindy Chen, BSc

Timely, accessible, and comprehensive charting of medical care is a complex issue that has clinical, legal, regulatory, and financial implications. Documentation, along with the rise in other administrative tasks, is a factor contributing to physician burnout. We posit that difficulties with charting are multifactorial and can stem from physician, patient, and environmental factors. Physician leaders have a responsibility to enforce charting standards and deadlines and are best positioned to lead charting-related solutions. To assist physician leaders, we propose a charting performance model as a tool to assess charting difficulties within their organizations.

**KEYWORDS:** physician health, charting, documentation, workplace health, leadership

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## Charting — the bane of our existence?

The documentation of medical care is required by medical boards and regulatory bodies to ensure continuity of care, quality improvement, and service reimbursement. Despite general guidelines, the format and details may vary among physician practice areas and institutions, even within specialties. Different institutions and regulatory bodies may set a mandatory timeline for documentation. For instance, in Ontario, the most responsible physician must complete a discharge summary for all inpatients within 48 hours of discharge.[1] From a medicolegal perspective, documentation of the events of a medical visit or procedure can be used as evidence in criminal and civil lawsuits.[2]

A medical leader may be alerted by the records department about outstanding documentation or a physician with repeat documentation deficiencies. Physician leaders may be more involved than ever before in issues related to outstanding documentation because of the ease of tracking deficiencies with the implementation of electronic medical records (EMRs). Penalties for delayed charting can include, but are not limited to, informal performance management, suspension of hospital privileges, restrictions of a medical license, job loss, and lawsuits.

Physicians now spend about two hours on documentation for every hour they devote to patient care,[3,4] and an average of 16 minutes is spent on the EMR for each patient encounter.[5] This means that physicians spend an average of 5.9 hours of an 11.4-hour workday on the EMR, and 1.4 hours after clinic hours.[6]

Resident physicians also struggle with charting. One study found that first-year residents spent an average of 112 hours a month charting 206 patient encounters. Although these residents became more efficient over time, the number of hours continued to be significant, as it merely decreased from 7 to 5 hours a day over a 6-month period.[7]

Burnout has been defined as an occupational and workplace issue by the World Health

Organization.[8] Burnout refers specifically to phenomena in the occupational context. In 2017, 43.9% of physicians in the United States were suffering from this syndrome.[9-10] Clerical tasks, such as charting, are predictors of physician stress leading to burnout.[11] Administrative obligations, including charting, were ranked second among the top 10 burnout contributors by the Ontario Medical Association's Burnout Task Force in 2021.[12] Streamlining and reducing documentation and administrative work ranked number 1 in its top 10 solutions to physician burnout.

Physicians who did not have time for EMR documentation were 2.8 times more likely to show symptoms of burnout than those who reported having sufficient time.[13] Physicians who spent moderately high or excessive amounts of time on their EMR at home were 1.9 times more likely to show burnout symptoms than those who spent minimal or no time on the EMR at home. Physicians who agreed that EMRs add to the frustration of the day were 2.4 times more likely to show burnout symptoms than those who disagreed.

A survey of 25,018 physicians in the United States[14] found that physicians doing ≥ 6 hours a week of charting after hours were twice as likely to report higher burnout scores compared with those charting ≤ 5 hours. The same study also found that physicians who believed that their organizations had done a great job in implementing, training, and supporting the EMR system were half as likely to report higher scores of burnout compared with those who disagreed.

In this article, we propose a charting performance model (CPM) as a tool for physician leaders to assess and apply interventions to various domains affecting charting performance, thereby potentially mitigating one factor that can contribute to physician burnout.

## The charting performance model

In developing our model in the context of charting, we applied fundamental theories and models

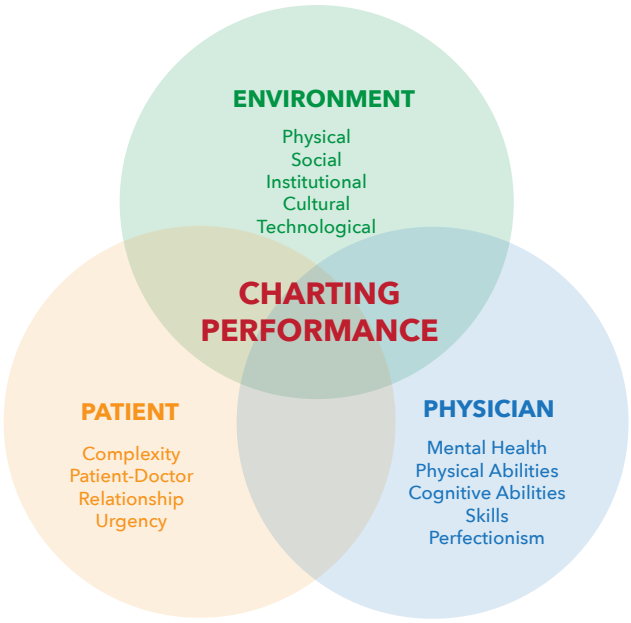


**Figure 1. Model depicting charting performance as a combination of physician, environment, and patient factors**

used in occupational therapy. The Canadian Model of Occupational Performance and Engagement (CMOP-E) theorizes that a person's ability to perform their life's occupations depends on the interplay between the person and their environment.[15]

In our CPM (Figure 1), charting performance depends in part on the physician's characteristics in the areas of mental health, physical and cognitive abilities, skills in using the EMR, and traits, such as perfectionism. Environmental factors, such as physical, social, institutional, and cultural aspects, also play a role. We extend the scope of the environment by adding technology. In further expanding the CMOP-E, we add patient factors, including patient complexity, the patient–physician relationship, and urgency. We further propose applying interventions to each domain to optimize occupational performance in the realm of charting.[16]

## Physician factors

**1-Mental health** – Untreated or unrecognized mental health conditions, such as depression, attention deficit hyperactivity disorder, substance use, or anxiety, can impact one's ability to chart. For example, depressive symptoms can contribute to poor concentration and cognitive slowing. Anxiety can cause physicians to be preoccupied, delaying chart completion. Even without a psychiatric diagnosis, emotions (e.g., fear, guilt, or stress) may impact charting behaviour. Understanding mental health in the workplace and redirecting to the appropriate medical care can help. Coaching and therapy in this area may also be helpful.

**2-Physical abilities** – Physical states can include fatigue, hunger, pain, and various medical conditions, such as poorly controlled diabetes, migraines, and chronic pain. These states may impair physical functioning and can further impact emotional and cognitive states, thus distracting from charting. Support from leaders to treat or accommodate the medical condition itself may help improve charting

**3-Cognitive abilities** – Charting requires cognitive functions, such as working memory, concentration, and prioritizing. Some of these functions may decrease with age, distraction, or medical conditions. Appropriate workplace accommodations, such as a quiet or private space may be helpful.

**4-Skills** – Skills such as time management, organization, and technological skills develop through prior life experiences and/or on-the-job. One study[17] of physicians completing a physician enhancement program consisted of a monthly chart audit, telephone follow-up with a faculty monitor, and regular practice visits. It found that participants significantly improved their charting skills and maintained them 24 months later. The EMR has become a presence in many facilities, yet physician skill level and understanding of the full EMR potential may be lagging. Instruction in the use of shortcuts, smart phrases, and templates may be helpful.

**5-Perfectionism** – Perfectionism is a common attribute of physicians.[18-21] This quality can extend into writing the "perfect" chart note. Although perfectionism can be useful in other elements of training and practice, unhealthy perfectionism can lengthen charting time. Standards for charting should be made clear. These may be less rigorous than

other types of documentation and may include point form, lists, and pre-populated information to ease the burden of perfectionism.

## Environmental factors

**1-Physical** – The physical environment refers to the natural and built world around us.[22] The design of a building may cause distracting environments for physicians. For example, if charting is completed in a shared space without the ability to close a door or use dividers between computers, visual and noise stimuli can be a distraction. Open-concept spaces can invite interruption from other team members. A clinic may also be physically disorganized, which decreases workflow efficiency. Therefore, strategies such as providing distraction-free spaces, improving the workflow organization to save time, and using "do not disturb" signs can be helpful.

**2-Social** – The social environment refers to the people, organization, and society, and our relationships with them.[16] In a clinical setting, this includes the team of physicians, patients, nurses, medical learners, and administrative staff. Unreasonable workloads, unnecessary emails, communication issues, and boundary conflicts among the team can take time away from charting. Therefore, strategies such as defining the roles and responsibilities of each team member, delegation of tasks, and a "buddy system" for charting can be helpful.

**3-Institutional** – The institutional environment refers to policies, funding, regulations, and laws that govern an organization or society.[15] Institutional factors can have a significant impact on charting performance. For example, current funding models for particular specialties may force physicians to see more patients in less time to pay for overhead. Inadequate scheduled time, lack of training in using the EMR system, and lack of efficient templates can increase charting time. Therefore, strategies such as flexibility to work from home, scheduled time for administration and charting, funding for scribes, and a charting mentorship program can be helpful.

**4-Cultural** – In the context of charting, we refer to the cultural environment as the organizational and medical culture. A work culture that focuses on unreasonable productivity, lack of boundaries, and perfection can impact charting time. Leaders who promote a culture of work–life balance and provide support rather than punitive measures when mistakes are made can enhance performance.

**5-Technological** – Given the rapidly changing advances in information and medical technology, the technological environment evolves faster than physicians can keep up. One survey[3] found that excessive data entry requirements, "note bloat" (unnecessarily long cut-and-pasted progress notes), inaccessible information from other institutions, and notes geared toward billing rather than patient care were unhelpful factors in EMR design and use. On the other hand, participants found that the ability to message colleagues electronically, access the EMR from home, and share results with patients were helpful features.

## Patient factors

**1-Complexity of medical issues** – Patients with more complex medical conditions and psychosocial needs require involvement of multiple specialties and services and may have specific follow-up needs. Thus, documentation of several conditions at the same visit may be difficult and tedious.

**2-Patient–physician relationship** – The patient–physician relationship can impact the documentation. For instance, if a physician feels threatened by the patient or family, they could gravitate toward defensive and detailed documentation, resulting in longer charting times.

**3-Urgencies of patient care** – Patient urgencies can interrupt workflow and add to the administrative burden that may arise from documenting unscheduled services. Providing protected time for documentation may help to ensure timely completion.

## Conclusion

Charting is a required activity for patient care, legal and regulatory obligations, and remuneration. The demands of charting may contribute to higher levels of burnout. Using the CPM as a framework, physician leaders

can take a systematic approach to assess charting issues of physicians in their organization and implement practical solutions. Further research is required to test the efficacy of the suggested interventions.

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OPINION

# The resilience myth: is it just in our heads?

Peter Brindley, MD, and Steven Reynolds, MD

We recently finished weeks of service in different intensive care units (ICUs) on opposite sides of the Canadian Rockies. Neither of us had the most crushing of weeks, but we both experienced sadness and exhaustion in ways that come from long hours coupled with tragedy for many, and the end of life for some. For too long, we had avoided frank discussions about our work environment and what drives us to work in the place we do and in the way we do.

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Nowadays, we try to take stock the morning after we return to the real world, and this often leads to a quick chat on the phone. As self-admitted "failure friends," we do a quick mental pat down. We check our vulnerable bits first: that is to say, our emotional and mental health. Both of our thermometers suggested we were tired, mildly despondent, and bordering on listless. However, we both had administrative duties and research projects in teetering piles on our desks. We decided to sit in the rubble for a moment. After a few minutes, it was time to ask the question: are we resilient enough and, if not, are we to blame?

The physicians who we admired during training seemed imperturbable and made of steel. They would not be slowed down by a week in the ICU; after all, they had science to conquer and enemies to crush. We are now both mid-career physicians and like to tell each other that we are good at what we do. Surely, we should have ample skills to cope. If we can intubate and resuscitate, it should be as easy as ABC to manage our feral minds and sagging bodies.

Personal well-being matters. It is not only a matter of looking after ourselves so that we can look after our patients. After all, it is well recognized that fatigued, burnt out, and otherwise frazzled health care workers make more mistakes and cost the system more. In short, to do well you must be well. Ergo, a physician lacking resiliency could be a danger to patient care. If so, then physician, heal thyself.

Fortunately, there is no shortage of articles, committees, and workshops telling us how to grow our resilience. Unfortunately, who has the time? We have been told that resiliency is a muscle, so get out there and train. We are told that mindfulness starts with peace and quiet, so pretzel into that lotus position now. We know we need to exercise, ought to meditate, and need to rebuild the dam before the next storm. However, when exactly are we supposed to find the time, and how much of our hard-slogged money ought we to spend?

As cleverly summarized in the 2019 book, *McMindfulness: How Mindfulness Became the New Capitalist Spirituality*,[1] well-being has now become an industry with products to sell. It also has its high priests and lowly sinners. It has morphed into a moral requirement during off hours rather than a non-judgemental aid. No more eating ice cream in your underwear or drooling on the couch while snoozing to Netflix. No, dear Doctor, get out there and seize

some wellness – you owe it to your patients. Come on, be better!

Often things are best defined by what they are not. If so, then it is worth knowing that antonyms of resilience include fragility and weakness. However well intentioned, it now feels like not engaging in this resilience culture comes with a faint odour of failure. It also fuels a vicious cycle – "Oh no, now I also suck at meditation." For a profession already driven by insecurity and the imposter syndrome, we don't need further reminders of our shortcomings. We can even end up in an exhausting catch-22. In other words, we end up working on resiliency during time when we should really be working at nothing at all. The point is that, as a profession, we need to learn that you do not always have to "do"; sometimes you need to take time just to "be".

The resilience industry also distracts us from awkward but necessary questions. For example, why does this job require so much resilience in the first place? Have we set ourselves up for longevity and success, or have we merely undertaken a 30-year endurance test? Why does our lack of resilience feel like a personal failing akin to the 65% we got in chemistry? At the very time when we should be doing less, do we instead simply lean in ever harder, become ever grumpier, and leave the building with little left for our long-suffering spouses and bewildered kids?

Medicine is a challenging and wonderful career. Moreover, many other jobs are similarly challenging, but without our job security or societal prestige. As such, it is important not to moan. Regardless, one of the rarely spoken-about issues in health care is that, to be truly empathetic, we often take a small dose of the patient's distress on board. In other words, we need to let it in to understand it. Neuroscientists would explain this by talking about mirror neurons.[2] In simple terms, these neurons recreate a small copy of the sadness within ourselves, as the first part of fashioning a response. In other words, resilience is needed so that we can truly care for patients and not merely process them. Resilience is needed so that we do not lose the humanity that led us into this profession.

In closing, resilience ought not to be a buzzword, nor a product to buy, nor a personal failing, nor a booming industry. Just as with our patients, it should be led by the simple principle of "how can we all help". Instead, it feels too much like a crafty technique or cynical life hack so that we can endure crushing work hours or chase prestige and dollars. With a third of a career to go, we are eager to get it right, or simply just a little less wrong. It seems a shame to keep it between the two of us on a Monday post-call. Please excuse us if we have overshared. We will now get back to work. After all, there is a lot of work to do.

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NEWS

# Learning to lead – a simulation exercise

Pat Rich

Being a physician leader at whatever level is no game, and being a true leader cannot be simulated. But that doesn't mean learning to be an effective leader cannot be presented in a simulated format as an online game. That is exactly what the Canadian Society of Physician Leaders (CSPL) and the Royal College of Physicians and Surgeons of Canada in collaboration with Global LEADs have developed.

An interactive online module, called SimuLEADerShip, is available to CSPL members and Royal College fellows and resident affiliates. It helps participants develop leadership capabilities by working to improve patient and family-centred care in a fictious hospital setting of the future. As the skills learned can be applied in various settings, participating in the online simulation can be of value to family physicians as well as specialists.

Although this learning activity has been available only since the beginning of December, its development took two years and the involvement of several experts in simulation, gaming, and leadership. Dr. Johny Van Aerde, executive director of CSPL, who was directly involved in this process, described the genesis of SimuLEADerShip and the aims of the initiative in a recent interview.

The CSPL had been investigating easier ways for its members to develop leadership skills, because they are often working in environments where they face a number of pressures and have little time for personal skills development. At the same time, Dr. Van Aerde had been taking online courses and coming to appreciate commonalities between gamification and simulation theory. He noted that simulation is already used extensively in the health care system to teach many medical skills.

In 2019, the Royal College released an online video game as a learning module for quality improvement. According to Dr. Van Aerde, it used video clips to provide the participant with the perspectives of various stakeholders, such as the patient, resident, and physicians holding various positions. The initiative demonstrated the value of taking this approach to teaching fundamental organizational skills to physicians.

In January 2020, senior leadership at CSPL and the Royal College met and agreed to work together to develop a leadership training simulation module. To provide an evidence-based framework for the approach, Dr. Van Aerde said LEADS Global and Dr. Graham Dickson were engaged to participate in the project. Created with Dr. Dickson as principle investigator in 2006, the LEADS framework is a comprehensive approach to leadership development in health care.[1] It describes five core domains: Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation, which are each supported by four capabilities. It has been widely endorsed both in Canada and internationally.

SimuLEADerShip was developed around this framework, with a team under the direction of Dr. Anne Matlow, who had also led the development of the quality improvement simulation for the Royal College. The aim was to use the latest thinking in simulation theory to create an evidence-based experience that was both educational and fun.

As stated by the Royal College, the learning outcomes of SimuLEADerShip are to:


- Integrate the domains and capabilities of the LEADS in a Caring Environment capabilities framework into your leadership activities
- Reflect on the challenges of taking on a formal leadership role in a health care environment
- Assess and develop your personal leadership capabilities using the LEADS framework

A note in the module itself is more specific:

> The overall goal of the game is to successfully navigate change at Pondview Hospital. Ideally, the choices you make are aligned with the principles of effective leadership embodied by the LEADS framework and act to increase or decrease your Lead self, Engage others and Achieve results capabilities. Playing the game is intended to give a practical example of how the LEADS framework can be used to approach various leadership challenges. As a Royal College Section 3 simulation learning activity, it gives you some direct feedback on capabilities in the first 3 domains of LEADS while providing an opportunity for you to identify areas for improvement and plan for future learning about leadership.

Set in the children's hospital of Pondview in the near future (to allow the game designers to incorporate robotic elements that might not seem feasible at the current time), the scenario on which the module is based involves a young physician who is "tapped on the shoulder" to apply to lead the neonatal intensive care unit (NICU). The challenge is presented as follows:

> It's 2032 and guess what? Society and the environment haven't collapsed, humankind isn't at the cusp of extinction and we live in a time of equity, harmony and sustainable growth. The world truly is a magical place. Our story takes place at Pondview Hospital, where you have worked as a neonatologist for the last 11 years. Even though society has advanced tremendously, there are still challenges in your facility. Challenges that require the strength of a leader and you, Dr. X have always wanted to take on a formal leadership role. One day while on break you notice an internal job posting for an opening...

Starting with the interview process to apply for the position, the module works through a number of scenarios. The module allows

the participant to share their thoughts and reflections and listen to advice from online "coaches". Dr. Van Aerde said the initial plan had been to have video clips of various stakeholders in the scenarios, but this was not possible because of the isolation requirements at the start of the COVID-19 pandemic when the game was in development.

"It becomes obvious very fast that you have to engage others to improve the NICU," said Dr. Van Aerde. The simulation also extends outside the hospital environment as the participant engages with the community to find appropriate supports for patients as well as dealing with broader system issues, such as health equity.

Two CSPL members who are family physicians were also involved in the module's development to help make sure it was relevant to family physicians as well as specialists. "Leadership skills are leadership skills," said Dr. Van Aerde, and while the scenario in the game may not involve many elements common to family practice, the module focuses on learning skills that can be applied in a variety of settings.

As stated in the module itself: "While the game does try to reflect what it might be like to take on a leadership role in a neonatal intensive care unit at a community hospital, we consider most aspects of the story to be highly generalizable. We have made every effort possible to ensure the game is inclusive and can be enjoyed by physicians from any background."

Although it may seem that a module involving an online game and simulation might naturally attract younger physicians who grew up in a gaming culture, Dr. Van Aerde said the approach also appeals to older physicians. "Do you want to sit down with yet another book or another long course after a long day at work? Or do you want to have something where you can learn for 20 minutes, and then go back again and see if you can improve your score? In today's busy world, and being alone and not being able to learn in a team environment, I think [the module] serves all of us."

**Check it out. Exclusive access to CSPL members with Access code CSPL001**
**https://rc-prescience-test.firebaseapp.com/SIMULEAD/index-e.html**

By early April 2022, 520 physicians had registered for the game. A small number who were involved in evaluating the simulation before its release said they found the experience positive and noted the creativity in taking such an innovative approach to leadership training. The module does not always take itself too seriously; for example, the folder where you can store resources is called "dossier" because "we thought the word 'dossier' sounded more like something in an Ian Fleming novel and, therefore, much cooler." Another funny example is one of the possible answers, whether you should choose to rely on social media, "like the Kardashians," for seeking information on the posted position. The game quickly ends with the note that "communicating effectively is centre to your ability to influence others and express your authentic self. In this case using social media was not very effective. Live conversations are preferred for deep information." The module has been certified by the Royal College and the College of Family Physicians of Canada for up to 9 Mainpro+ credits as a 3-credit/h self-learning program.

## The SimuLEADerShip development team

**Anne Matlow, MD** – patient safety and system educator, RCPSC
**Graham Dickson, PhD** – CEO of LEADS Global
**John Van Aerde, MD** – executive medical director, CSPL
**Kirk DeRosier** – instructional designer/evaluator, Royal College
**Glenn Barton** – curriculum designer, Royal College
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**Constance LeBlanc, MD** – Board of Directors, CSPL
**Martin Vogel, MD** – Board of Directors, CSPL
**Carol Rochefort** – executive director, CSPL
**Susan Brien, MD** – former director, Practice and System Innovation (Royal College)

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**Dr. Jared Butler**

Medical Director Primary Care, Central Health / Founding Chair, Shalloway Family Practice Network
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**Dr. Mike Christian**

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Chief of Staff, Bluewater Health / Regional Academic Director, Lambton County, Schulich School of Medicine, Western University
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**Dr. James Jonasson**

Royal Canadian Navy Command Surgeon, Canadian Forces Health Services Group / Past Atlantic Regional Surgeon/ Maritime Component Command Surgeon
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**Dr. Winnie Lee**

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# 2022 CSPL Excellence in Medical Leadership Award
## (Chris Carruthers Award)

**Dr. John M. Tallon**

Co-Head, Department of Emergency Medicine, University of British Columbia

Dr. Tallon has been a pioneer in trauma care and prehospital medicine across Canada for over a quarter-century. He has not only advanced these fields by designing systems of care and conducting research, but he has also developed a long lineage of future leaders through his mentorship and coaching.

After graduating from the University of Toronto's medical school with honours, Dr. Tallon completed specialty training, becoming a Fellow of Emergency Medicine with the Royal College of Physicians and Surgeons of Canada after training in Calgary. He also earned a master's degree in epidemiology and community health from Dalhousie University. He has held numerous clinical, academic, and administrative positions, and is currently a clinical professor and co-head of the Department of Emergency Medicine at the University of British Columbia. He is also an adjunct professor in the Department of Emergency Medicine and holds cross appointments as an adjunct professor in the Departments of Surgery, Anaesthesia and Community Health and Epidemiology, all at Dalhousie University.

Dr. Tallon was an early advocate for advancing the specialty of emergency medicine in Canada. However, he did not limit his focus to emergency medicine or the interests of physicians. He has also been a strong proponent for developing the fields of prehospital medicine and trauma and the professional role of paramedics. Throughout his career, his research activities and publications have been multidisciplinary collaborations and stand as evidence of his engagement and approach to the practice of medicine. He has used his skills to enshrine a patient focus in both his research and administrative activities.

The trauma and prehospital care systems in Ontario, Nova Scotia, and British Columbia have all been significantly advanced through the leadership roles Dr. Tallon has played in them. For example, he was a crucial leader in developing the first organized trauma system in Nova Scotia. However, his influence extends beyond these provinces. As president of the Trauma Association of Canada, he provided advice and mentorship in developing both trauma systems and their leaders across the country. As an early medical director of BC Emergency Health Services (BCEHS) and its inaugural chief medical officer, Dr. Tallon was a driving force in its evolution from a public safety organization into an integrated component of the health care system. In guiding BCEHS through this transition, he adopted a panoramic view and a holistic approach, engaging people from all specialties and health care professions.

Dr. Tallon has been unfailing and unselfish in promoting those whom he has mentored, both locally and internationally. Several of his mentees have gone on to leadership roles, a testimony to his work. One of his mentees, Dr. Jan Trojanowski, recently wrote:

*"Through John's mentorship and observing his leadership style, I have learned the importance of listening and valuing team members' experience and input. He weighs these thoughtfully and, where needed, gets the group to come to a consensus either through acceptable compromise or overall agreement. He takes the time to get to know his team members, placing importance on those aspects of their lives that shape their abilities and purpose."*

BOOK REVIEW

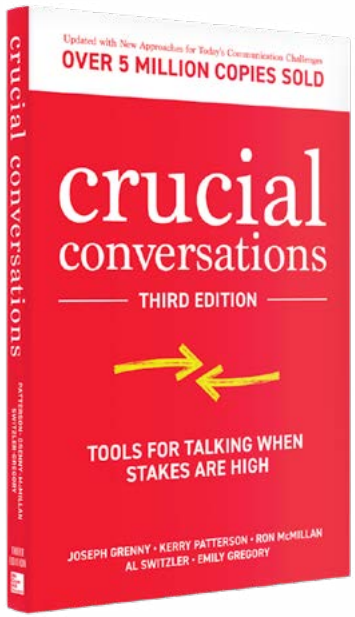
# Crucial Conversations: Tools for Talking when Stakes Are High

Third edition
Joseph Grenny, Kerry Patterson, Ron McMillan, Al Switzler, and Emily Gregory
McGraw-Hill; 2022

Reviewed by Johny Van Aerde, MD, PhD

*Crucial Conversations* by Grenny and colleagues might be known by many already, but the third edition released in October 2021 deserves a new review. A fifth author, Emily Gregory, who initially trained as a physician, has joined the four original authors, and the book now has sections on conversations in the virtual environment. Five million copies have been sold since the first edition almost 20 years ago, and, for the last 10 years, the related two-day course for learning and practising crucial conversations has been offered face-to-face and online by certified facilitators of the PLI/CSPL partnership.

A conversation turns crucial when the stakes are high, opinions vary, and emotions are strong. The book makes it clear that much of a conversation's outcome is determined inside our own mind, before even one word has been said. We should stay focused on what we really want for ourselves, for the other party, and the relationship, rather than lose ourselves in our emotions.




Clues are given on what to look for and how to listen when conversations turn crucial, and what signs and statements indicate that others feel unsafe. Simple but efficient skills allow us to step out of the original conversation and recreate safety, so that we can continue to talk about the issue at hand.

The model uses a number of mnemonics, which are easy to remember when a crucial conversation takes place. My favorite is STATE, where S stands for state the facts, T for tell your story, A for ask others to share their information and perception, all the while talking tentatively (T) and encouraging testing (E). Several others help us to remember steps that maximize the chance others will share their information, in particular when they are hesitant to do so. Ultimately, the intention of any conversation is to get all the necessary information into the shared pool of knowledge, safely and completely.

While the content of the book has changed little since the first edition, this third version has more practical examples and sections on virtual communication have been added to several chapters. The last two chapters – "Yeah, but: advice for tough cases" and "Putting it all together: tools for preparing and learning" – are particularly important as they give invaluable examples of real-life situations and how to deal with them.

This book makes it clear that self-awareness and self-management are foundational to a conversation, crucial or not. The tools used in crucial conversations contribute to creating an environment of psychological safety, constructive solutions, and the prevention of negative conflicts. Some health organizations in Canada have embedded the philosophy of, and skill development for, crucial conversations throughout their system, from the board level to that of frontline providers. This book should be on everyone's bookshelf.

## Author

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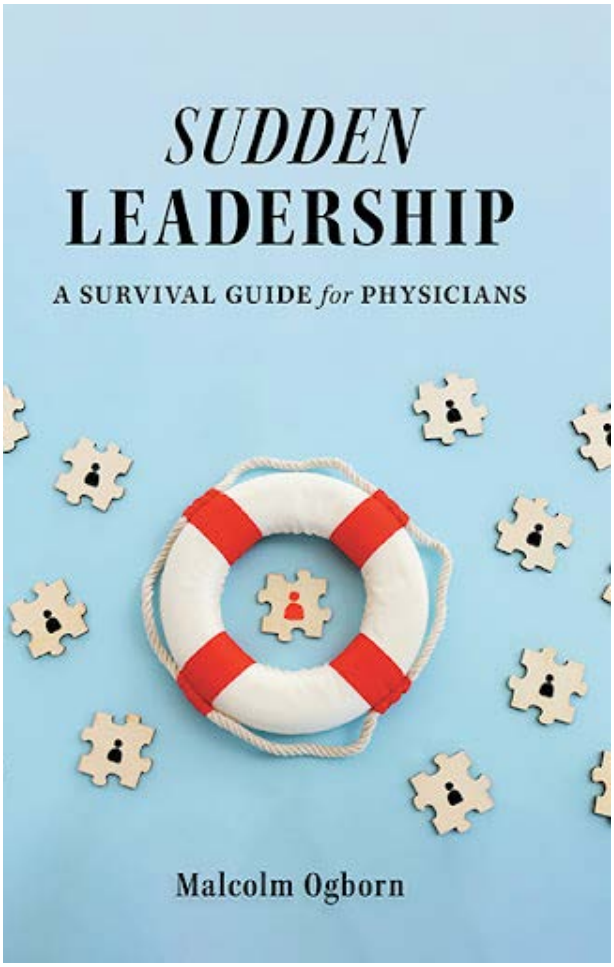
BOOK REVIEW

# Sudden Leadership: A Survival Guide for Physicians

Malcolm Ogborn, MD
Friesen Press; Spring 2022

Reviewed by Johny Van Aerde, MD, PhD




If you are an up-and-coming or mid-career physician thrown into a leadership role, you want this book on your bookshelf immediately. *Sudden Leadership* by Dr. Malcolm Ogborn is a survival guide that gives a quick and practical overview of ten topics needed at all stages of a physician's leadership journey. As Ogborn writes in the introduction, the book is not intended to be an extensive textbook on leadership development, rather it is a book "where introductory physician leader stuff is all in one place".

The book is based on the learning and experiences of the author as a physician leader in the academic and health care system environment, including the past few years as a coach of physician leaders. It presents narratives about two emerging physician leaders who encounter various situations, such as chairing meetings, communicating in writing and orally, building and engaging successful and efficient teams, dealing with conflict, handling wellness and burnout, and more.

The chapters don't need to be read in sequence. The book is written in such a way that one can read about a specific issue when it presents itself. The chapter on time management and changing time perception in the context of crisis is one of the better pieces of writing this reviewer has read in the last few years. Only the second chapter of the book, on followership and engagement, is a little less practical, although it deserves reading sometime during the study of the book. Every topic in the book is based on good evidence. The lists of resources and references at the end of each chapter are well stocked and merit exploration. The summaries of key take-aways for each chapter are excellent.

In short, this book fills a niche that has been left mostly empty until now. The practical and evidence-based content, the narratives, and the entertaining writing style make this a useful, easy to understand resource for the up-and-coming physician leader. As a matter of fact, this book is useful and practical for all physicians and physician leaders, no matter what the stage of their career.

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