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# Physician Leadership

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## Happy people work better

### In this issue

Turning burnout into joy

Five fundamentals of civility for physicians: Part 2

The continuing challenge of patient-centred care

Could Saskatchewan become the best place in the world to practise medicine?

Accountability and trust: sitting on a three-legged stool

Physician leadership development through the lens of LEADS and competency-based education



# Contents

- 67** **EDITORIAL: Achieving joy in Canada's health care system: what can we do today?**  
Johny Van Aerde, MD, PhD
- 70** **Turning burnout into joy**  
Mamta Gautam, MD
- 74** **Transforming health care through systems and stories**  
Cheryl Heykoop, DSocSci, and  
Guy Nasmyth, PhD
- 80** **Five fundamentals of civility for physicians: Part 2**  
Michael Kaufmann, MD
- 87** **The continuing challenge of patient-centred care**  
Michael Gardam, MD, and  
Judith John, BA
- 92** **Could Saskatchewan become the best place in the world to practise medicine?**  
Susan Shaw, MD, and Ivan Muzychka
- 97** **Accountability and trust: sitting on a three-legged stool**  
Darren Larsen, MD
- 102** **Physician leadership development through the lens of LEADS and competency-based education**  
Ming-Ka Chan, MD, Celia Rodd, MD, Elisabete Doyle, MD, Eleanor MacDougall, MD, Jenette Hayward, MD, and Karen Gripp, MD
- 109** **STORIES FROM OUR CCPES: Journey into the unknown**  
Gary Ing, MD
- 110** **STORIES FROM OUR CCPES: My leadership journey**  
William Sischek, MD



**Book Review: The Future of the Professions How Technology Will Transform the Work of Human Experts**

Reviewed by Johny Van Aerde

**112**

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EDITORIAL

# Achieving joy in Canada's health care system: what can we do today?



Johny Van Aerde, MD, PhD

"We have chosen a profession that invites those who are ill to share their suffering, stories and worries, and that gives us the privilege to serve and help in removing or preventing

some of the burden(s)" (p. 4).<sup>1</sup> This touches on the highest aspirations any profession can wish for in a society. Yet, although such professional purpose should lead to a high level of satisfaction, we hear and read much more about burnout, distrust, and lack of engagement than we do about joy.

People used to believe that you don't have to be happy at work to succeed, that work is not personal. That thinking has been debunked, and the research is clear that happy people work better.<sup>2</sup> Science is on our side: there are clear neurological links between feelings, thoughts, and actions.<sup>3,4</sup> Why then are 50% of people not engaged emotionally or intellectually in their organization, and why are another 20% actively disengaged, leaving less than one-in-three engaged

systemically?<sup>2</sup> For physicians, increasing demands on time and resources, poorly designed systems to do the daily work, and attacks by politicians in some provinces have resulted in alarming levels of systemic disengagement and burnout.<sup>5</sup>

When leaders, physicians, and others are disengaged, they infect others with their attitude, negatively affecting outcomes and quality of care. Joy in work is not only a core part of Deming's<sup>6</sup> theory of improvement, but he also argues that it is a fundamental right and, as leaders, we have a responsibility to ensure that workers and co-workers enjoy that right.

A recent white paper from the Institute for Healthcare Improvement<sup>1</sup> (IHI) provides an evidence-based framework to improve morale and work satisfaction among individuals and teams and in the system. It describes how we, who provide services in the health system, can go from the current state to enjoyment in our work.

There are four steps, each leading to the next according to IHI.<sup>1</sup> However, it is clear that the four steps are more closely integrated (Table 1).

**1. Ask staff and team members, "What matters to you?"**  
This step is about asking the right questions and really listening; it is about doing something with, not for others. It helps to identify what contributes to or distracts from enjoyment in work. This type of "appreciative inquiry" taps into strengths and highlights what is

	<b>Local</b>	<b>System</b>
<b>Action</b>	Ask staff, "What matters to you?" (step 1)	Use improvement science to test approaches for improving joy in work in your organization (step 4)
<b>Conversation</b>	Identify unique impediments to joy in work in the local context (step 2)	Commit to a systems approach to make joy in work a shared responsibility at all organizational levels (step 3)
<b>Source: Based on Perlo et al.<sup>1</sup></b>		

**Figure 1. Quadruple aim.**



**Source: Modified from Langley et al.<sup>8</sup>**

already working. For example, ask What makes a good day for you? What makes you proud to work here? When we are at our best, what does that look like?

**2. Identify unique impediments to joy in work in the local context**

What processes, issues, or circumstances are keeping people from meeting professional, social, and psychological needs. This second step allows leaders to address the psychological needs of humans, not unlike Maslow's hierarchy of needs.<sup>7</sup>

Steps 1 and 2 take place in the same conversation and continue over time. These conversations about what really matters build the trust needed to identify frustrations during the workday. They allow people to address the impediments

together and set priorities for when and how to deal with them. Everyone must feel that they have been listened to before they can be open and honest. Respecting all voices also builds camaraderie and equity.

**3. Commit to a systems approach to make joy in work a shared responsibility at all levels in the organization**

Although making a workplace joyful is a leader's job, everyone from executive to clinical administrative staff also has a role to play. As partners, multidisciplinary teams share responsibilities to remove impediments and improve and sustain joy. From creating effective systems, to building teams, to bolstering one's own resilience, each person contributes to supporting a positive culture.

Like Maslow's pyramid,<sup>7</sup> the IHI paper<sup>1</sup> identifies five levels of fundamental human needs that play a central role in improving joy in work: physical and psychological safety; meaning and purpose; choice and autonomy; camaraderie and teamwork; and fairness and equity. Although all five of these human needs will not be resolved before addressing local impediments to joy in work, actions and a commitment to address all five will ensure lasting results.

**4. Use improvement science to test approaches for increasing joy in work in your organization**

This step allows leaders to determine whether changes are leading to improvement, and whether they are effective and sustainable in different groups, teams, departments, and clinics. Key elements of improvement science include: making the aim clear and numerical (how much, by whom, by when); starting small and using measurements to refine successive steps; launching a pilot before expanding the change idea into different settings and conditions; tracking and sharing the results; involving each person and all people.<sup>8</sup>

These four steps, some with short-term outcomes, others with a longer time line, are also an essential part of the fourth component of the quadruple aim,<sup>9</sup> i.e., care for providers. Indeed, "joy in work" is an important element of improved clinician experience for both the individual and the team (Figure 1). Although the four steps do not ignore larger organizational issues, such as staffing pressure or the



impact of electronic health records on clinicians' daily work, they empower local teams to identify and address impediments that they can change. They help everyone see the organization as "us" not "them."

In the context of today's stresses in the health care system, let us as physicians take the lead and show how this framework can change the conversations from "If only they would" to "What can we do today?"

### References

1. Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. IHI framework for improving joy in work. Cambridge, Mass: Institute for Healthcare Improvement; 2017. Available: <https://tinyurl.com/jdkc999> (accessed 19 Dec. 2017).

2. McKee A. Being happy at work matters. In: *Happiness*. Boston: Harvard Business Review Press; 2017.

3. Boyatzis RE, Passarelli AM, Koenig K, Lowe M, Mathew B, Stoller JK, et al. Examination of the neural substrates activated in memories of experiences with resonant and dissonant leaders. *Leadersh Q* 2012;23(2):259-72.

4. Goleman D, Boyatzis R, McKee A. *Primal leadership: unleashing the power of emotional intelligence*. Boston: Harvard Business Review Press; 2013.

5. Gandhi S. Burnt-out doctors are facing a health-care crisis of their own. *HuffPost* 2017;23 Aug. Available: <https://tinyurl.com/y8ye6xsm> (accessed 19 Dec. 2017).

6. Deming WE. *Out of the crisis*. Cambridge, Mass.: Massachusetts Institute of Technology; 1986.

7. Maslow A. A theory of human motivation. *Psychol Rev* 1943;50(4):370-96.

8. Langley G, Nolan K, Nolan T, Norman

C, Provost L. *The improvement guide: a practical approach to enhancing organizational performance*. San Francisco: Jossey-Bass; 2009.

9. Bodemheimer T, Sinsky C. Form triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med* 2014; 2(6):573-6. Available: <https://tinyurl.com/yb5wptc5> (accessed 19 Dec. 2017).

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## Turning burnout into joy



Mamta Gautam, MD

Burnout is reaching epidemic proportions. Although it's important to identify burnout and understand the causes, we have to stop blaming doctors for becoming burned out and recognize it as a systems issue. There is a growing trend among health systems and other employers of physicians to adopt both individual and system-level interventions and develop a model of shared responsibility.

**KEY WORDS:** burnout, physicians, systems approach, scope, drivers, consequences, prevention, joy

Burnout appears to have become a mass phenomenon, receiving a high degree of media attention. This is probably for a good reason – we are measuring burnout in physician populations more now and finding concerning results. Some studies report that close to one in two physicians is suffering



from burnout.<sup>1</sup> Burnout is an epidemic hiding in plain sight! We need to understand it better, so that we can best decide how to address and manage it effectively.

### What is burnout?

Burnout is a psychological term that refers to long-term exhaustion and diminished interest in work. The term was first coined in the 1970s by the American psychologist, Herbert Freudenberger, who used it to describe the consequences of severe stress and high ideals experienced by people working in “helping” professions.<sup>2</sup>

Burnout is a state of chronic stress, characterized by a triad of symptoms of mental exhaustion and physical fatigue, detachment from work, and feelings of diminished competence. The Maslach burnout inventory (MBI) has been recognized for more than a decade as the leading measure of burnout, incorporating the extensive research that has been conducted in the more than 25 years since its initial publication.<sup>3</sup> MBI surveys use three general scales to assess the main symptoms:

- **Emotional exhaustion scale** – measures feelings of

emotional overextension and exhaustion from one's work

- **Depersonalization scale** – measures an unfeeling and impersonal response toward recipients of one's service, care, treatment, or instruction
- **Personal accomplishment scale** – measures feelings of competence and achievement in one's work

## What is the scope of the problem?

In 2006, two surveys<sup>4</sup> were conducted in Canada to examine the prevalence and severity of burnout in physicians. In the first, Alberta physicians responded to a series of demographic questions and four burnout measures, including a modified MBI. In the second survey, Canadian physicians completed the Boudreau burnout questionnaire as part of the Canadian Medical Association Physician Resource Questionnaire. Overall, 45.7% of Canadian physicians and 48.6–55.5% of Alberta physicians were classified as being in the advanced phases of burnout.

In 2008, a survey of Canadian physicians showed lower rates of burnout, but confirmed that in addition to workload, value congruence also contributed to predicting burnout among physicians.<sup>5</sup>

The 2017 CMA survey results are pending. In May 2017, Doctors Nova Scotia partnered with Michael Leiter and the Centre for Organizational Research and Development at Acadia University

to conduct a survey studying the work-life issues facing Nova Scotia's physicians and found burnout to be a serious problem.<sup>6</sup>

## Looking at physician satisfaction and burnout at different career stages, Drybye<sup>8</sup> found that early-career physicians (0–10 years out of residency) had the lowest satisfaction with career choice and highest frequency of at-home conflicts.

In the United States, a 2011 Medscape report revealed burnout in 45.5% of physicians. In 2014, it was present in 54.5% of physicians.<sup>7</sup>

Looking at physician satisfaction and burnout at different career stages, Drybye<sup>8</sup> found that early-career physicians (0–10 years out of residency) had the lowest satisfaction with career choice and highest frequency of at-home conflicts. Mid-career physicians (11–20 years out of residency) worked more hours, took more overnight call, had the lowest level of satisfaction with specialty choice, and the highest rate of burnout.

An examination of the burnout literature reveals that it is prevalent in medical students (28%–45%) and residents (27%–75%, depending on specialty), as well as practising physicians.<sup>9</sup> A 2017 Canadian Federation of Medical Students survey sent to medical students across the country

showed that around 37% met the criteria for burnout.<sup>10</sup>

The highest rate of burnout has been reported among the "frontline" specialties: family medicine, general internal medicine, and emergency medicine.<sup>1,11</sup>

## What are the drivers of burnout?

The causes of burnout can be intrinsic, extrinsic, and related to the culture of medicine.

- **Intrinsic drivers** include the typical personality traits of physicians, which reveal us to be perfectionistic, responsible, conscientious professionals who have high expectations of ourselves.
- **Extrinsic factors** are related to the practice of medicine, such as long hours, frequent call, and frustration with administrative burden; feeling undervalued; frustrations with referral networks; difficult patients; medicolegal issues; and challenges in finding work-life balance. There is often a marked sense of lack of control.<sup>12</sup> One study showed that the highest burnout rate was associated with spending less than 20% of one's time doing the aspect of work that was most enjoyed.<sup>13</sup>
- Finally, **the culture of medicine** reinforces highly perfectionistic and responsible behaviour as ideal. It strives for perfection and encourages self-denial. The patient must come first, and the physician

must be strong and invincible and never show weakness.

The American Medical Association has defined seven drivers of burnout: workload and job demands, efficiency and resources, meaning in work, culture and values, control and flexibility, social support and community at work, and work-life integration.<sup>14</sup>

## What are the consequences of burnout?

Although burnout is not a psychiatric diagnosis, it can lead to serious consequences, with impacts on the physician, patients, and the system.

### The physician

- Although appearing similar to depression, burnout differs in that it primarily impacts a person's relation to their work. However, some of these effects can affect one's personal life too.
- Physicians can develop serious chronic physical problems, problems with relationships, and psychiatric problems including anxiety, depression, and substance abuse, which can lead to suicide.

### The patient

- In terms of level of care, burnout can lead to increased rates of medical errors, riskier prescribing patterns, and lesser patient adherence to chronic disease management plans.<sup>15,16</sup>
- In terms of level of caring, it can negatively affect communication, reduce

empathy, and lead to lower patient satisfaction.

### The system

- Dissatisfaction makes physicians more likely to leave clinical practice or retire early.
- Physicians' ability or interest in leading changes in practice or the health care system may decline. This is of concern, as we need to increase physicians' interest and competencies in leadership roles.

## How can we prevent burnout?

Historically, most programs to address burnout have focused on treatment of individual physicians, offering stress management, resiliency training, mindfulness meditation training, and encouraging doctors to take care of their own health and have their own family doctor.<sup>17</sup> Studies have found that self-awareness and mindfulness training can reduce physician burnout and increase both physician well-being and patient-centred qualities. Training physicians to enhance their personal resilience using the 5Cs framework (control/confidence, commitment, connections, calming, care for self) has been successful.<sup>18</sup> This is important as it helps physicians maintain a sense of control.

However, the results have been limited, as physicians may become healthier but still have to return to work in an unhealthy medical workplace. We have to stop blaming doctors for becoming burned out and recognize it as a systems issue.

There is a growing trend among health systems and other employers of physicians to adopt both individual and system-level interventions and develop a model of shared responsibility.<sup>19</sup> In such a model, we would need to create processes to:

- Trust physicians again. Eliminate intrusive regulations and metrics without clear value.
- Develop practice models that preserve the decision-making autonomy of physicians.
- Adopt realistic work expectations.
- Allow physician autonomy, the ability to influence work environment and schedule control.
- Provide adequate support services: nursing, secretarial, administrative, social work, ancillary services.
- Let doctors do the doctoring. Identify, reduce, and delegate clerical work to others, e.g., use of medical scribes.
- Create a collegial work environment, healthy relationships, and common goals.
- Be value oriented; include medical profession core values as part of the mission.
- Minimize work-home interference by providing flexibility in child care and scheduling.
- Promote work-life balance, ensuring vacation time, limiting overtime, establishing mentoring, considering periodic sabbaticals.
- Measure, track, and benchmark physician satisfaction and well-being as a key institutional



success metric. What gets measured gets done.

- Coordinate with medical schools, regulatory bodies, physician health programs, health care organizations, insurers, and government to create a healthy medical culture.



## From burnout to joy

In 2000, Myers conducted a review of 115 years of medical literature and illustrated a clear dichotomy with regard to publications with regard to publications focused on “physician distress” versus “physician wellness.” There were 70 000 articles on depression and 57 000 on anxiety; but only 5700 focused on life satisfaction, 2958 on happiness, and 851 on joy. What if we focused on creating more of the positive?

The Institute for Healthcare Improvement recently published a white paper on improving joy in the workplace for all health care professionals.<sup>20</sup> They suggest that instead of framing the challenge as “reducing burnout,” we should focus on “enhancing joy.” “Joy, not burnout, ought to rule the day.” I couldn’t agree more.

## References

1. Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med* 2012;172(18):1377-85. DOI: 10.1001/archinternmed.2012.3199
2. Freudenberger HJ, Richelson G. *Burnout: the high cost of high achievement*. Toronto: Anchor; 1980.
3. Maslach C, Jackson SE, Leiter MP. *Maslach burnout inventory* (3rd ed.). Palo Alto, Calif.: Consulting Psychologists Press; 1996.
4. Boudreau RA, Grieco RL, Cahoon SL, Robertson RC, Wedel RJ. The pandemic from within: two surveys of physician burnout in Canada. *Can J Community Mental Health* 2006;25:71-88. <https://doi.org/10.7870/cjcmh-2006-0014>
5. Leiter M, Frank E, Matheson TJ. Demands, values, and burnout: relevance for physicians. *Can Fam Physician* 2009;55(12):1224-5. Available: <http://www.cfp.ca/content/55/12/1224>
6. Leiter MP. Survey report. Halifax: Doctors Nova Scotia; 2017. Available: <https://tinyurl.com/yd6hvxxk>
7. Health, wealth, weed, burnout: physician lifestyle report 2015. New York: Medscape; 2015.
8. Dyrbye LN, Varkey P, Boone SL, Satele DV, Sloan JA, Shanafelt TD. Physician satisfaction and burnout at different career stages. *Mayo Clin Proc* 88(12):1358-67. doi: 10.1016/j.mayocp.2013.07.016
9. Waguih WI, Lederer S, Mandili C, Nikravesh R, Seligman L, Vasa M, et al. J Burnout during residency training: a literature review. *J Grad Med Educ* 2009;1(2):236-42. doi: 10.4300/JGME-D-09-00054.1
10. Glauser W. Medical schools addressing student anxiety, burnout and depression. *CMAJ* 2017;189(50):E1569-70. DOI: <https://doi.org/10.1503/cmaj.109-5516>. Available: <https://tinyurl.com/ya79dbdo>
11. Peckham C. Physician burnout: it just keeps getting worse. New York: Medscape; 2015. Available: <https://tinyurl.com/ya6onpr4>
12. Koven S. Is burnout a real problem? *Boston Globe* 2014;26 May.
13. Shanafelt TD, West CP, Sloan JA, Novotny PJ, Poland GA, Menaker R, et al. Career fit and burnout among academic faculty. *Arch Intern Med* 2009;169(10):990-5. doi: 10.1001/archinternmed.2009.70
14. Shanafelt TD, Noseworthy JH. Drivers of burnout and engagement in physicians. In Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc* 2017;92(1):129-46. Available: <https://tinyurl.com/y9rj9tec>
15. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 2002;136(5):358-67.
16. Shanafelt TD, Balch CM, Bechamps G, Russell T, Dyrbye L, Satele D, et al. Burnout and medical errors among American surgeons. *Ann Surg* 2010;251(6):995-1000. doi: 10.1097/SLA.0b013e3181bfdab3
17. Gautam M. *Irondoc: practical stress management tools for physicians* (2nd ed). Ottawa: Book Coach Press; 2011.
18. Gautam M. The 5 Cs of physician resilience. *Can J Physician Leadersh* 2015;1(3):24-7.
19. Shanafelt T, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc* 2017;92(1):129-46.
20. Perlo J, Balik B, Swensen S, Kabacene A, Lansman J, Feeley D. IHI framework for improving joy in work. White paper. Cambridge, Mass.: Institute for Healthcare Improvement; 2017. Available: <https://tinyurl.com/yaf7zm87>

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*This article has been peer reviewed.*

Join Dr. Gautam at her workshop for seasoned physician leaders, **Sustaining Joy as Experienced Leaders**, at the 2018 Canadian Conference on Physician Leadership, April 20–21, 2018, in Vancouver. Learn to identify and address the challenges faced by experienced leaders and then focus on the joy in medicine, recall our passion, and inspire other physicians to take on leadership roles.

## Transforming health care through systems and stories



Cheryl Heykoop, DSocSci, and Guy Nasmyth, PhD

To address challenges in Canada's health care system, change is required. Systems thinking, including an awareness of interconnectivity, system boundaries, and the influence of perspectives, can help us to be prepared for change; yet it must also inform effective action. Taking action, or intervening in a system, requires a focus on letting go of ineffective attitudes, processes, hierarchies, policies, and paradigms. Stories and storytelling are ubiquitous in human experience and influence how we

understand our systems and intervene. Stories can also help us see what we must let go of and, at the same time, connect the system more effectively to itself. Specifically, a focus on the diverse stories of actors across the health care system has the potential to bring about systems change by helping us better understand the health care system and how we can intervene effectively. To highlight the value of stories and storytelling, one of the authors shares her own story of being diagnosed with non-Hodgkin lymphoma. Reflecting on this story and the process of storytelling more generally, we highlight how the collaborative process of sharing and hearing stories could facilitate systems change in health care.

**KEY WORDS:** storytelling, systems thinking, systems change, health care, organizational change

Although Canada's health care system is considered a source of national pride, we are hearing

increasingly that it is breaking and is rife with complex challenges.<sup>1,2</sup> Canada is losing ground; according to the Commonwealth Fund International Health Policy Survey, the Canadian health care system's performance ranks 9 out of 11 industrialized countries.<sup>3</sup> Prominent health economist and former CEO of the Canadian Medical Association, Bill Tholl, said, "Canada's decentralized set of health care systems continue to struggle to address the formidable challenges of growing health disparities among and between our indigenous peoples, the global threat of cybersecurity, an unprecedented scourge in terms of the opioid crisis, and the growing needs of an aging population" (personal communication, 20 Oct. 2017).

Although Tholl went on to say that a great deal of good work is being done, given that health care is a complex, adaptive social system,\* there is likely no one quick fix. Rather, more holistic approaches exploring interconnectivities and interdependencies among resources, stakeholders, and technology in response to increasing demands for high-quality, accessible, and timely health care are required.<sup>4</sup>

Reflecting on the words of Lewis Thomas,<sup>5</sup> a medical essayist:

When you are confronted by any complex social system... with things about it that you are dissatisfied with and anxious to fix, you cannot just step in

\*A complex adaptive social system is considered here to be a collective human endeavour in which the agents are interdependent and continually responding to ill-defined and constantly shifting requirements and expectations.



and set about fixing with much hope of helping. This is one of the sore discouragements of our time.... If you want to fix something you are first obliged to understand... the whole system.

Thus, in the context of health care, how can we understand the system to support its transformation, and what role can each of us play as agents of change? In this article, in an effort to begin answering these questions, we explore the potential power of stories and storytelling to catalyze systemic change. We also highlight the importance of multiple stories to adopt a systems lens and propel action to help the health care system adapt to and meet the challenges we face today and into the future.

### **Systems thinking and systems change**

To assist in understanding and making changes to complex, adaptive, social systems like health care, systems thinking is often considered critical. Although there is no one unifying definition to encapsulate systems and systems thinking, systems are generally thought to comprise a number of facets: *elements*, the parts that make up or constitute the whole; *links between the parts*, the processes and interrelations that hold the parts together; *boundaries*, the limits that determine what is inside or outside of the system; and the *perspectives* each of us holds.<sup>6</sup>

Furthermore, Meadows<sup>7</sup> brought our attention to the outcomes of a system, stating that “a system

is a set of elements or parts that is coherently organized and interconnected in a pattern or structure that produces a characteristic set of behaviors, often classified as its ‘function’ or ‘purpose’” (p. 188). However, as Meadows’ work suggests, how one views or defines the system will also shape the interactions and outcomes. In our health care system, something more is required beyond how we view the situation, and the reasoning behind any actions we take, to bring about positive change.

Systems thinking offers ways to view a situation through a more holistic lens. It is an orientation that supports us to understand more deeply the linkages, relationships, interactions, interdependencies, and behaviours among the elements of which the system

is comprised. According to Senge,<sup>8</sup> systems thinking is a “conceptual framework, a body of knowledge and tools..., to make the full patterns clearer and to help us see how to change them effectively” (p. 7). Building from Meadows’ articulation of systems, Stroh<sup>9</sup> refers to systems thinking as the ability to understand interconnections in a system “in such a way as to achieve a desired purpose” (p. 16).

However, a systems thinking orientation also requires us to be aware of how our own perspectives and interpretations may differ from those of others in different contexts and the actions, results, and consequences that arise from our framing and sense making.<sup>6</sup> In essence, to approach complex challenges like health care with a systems orientation requires that we work together to understand the multiple ways we comprehend and make sense of the system to develop a more holistic understanding of what works, for whom, and under what circumstances.

There is sometimes a tendency to describe the health care system as something outside of us, a set of structures, processes, and rules that govern how we work. However, according to the systems-thinking literature, we are not separate from the systems of which we are part. As Senge<sup>8</sup> said, “Systems thinking shows us that there is no outside; that you and the cause of your problems are part of a single system” (p. 67). How then, can we look at the health care system from different perspectives including those of

physicians, nurses, health care staff, educators, patients, communities, and families to develop a more holistic understanding of what works, for whom, and under what circumstances to support systems change?

Finally, it is important to note that although systems thinking encourages us to view situations and contexts differently, changing the system also requires us to act. This could mean letting go of or “releasing” something to create space for something to grow<sup>10,11</sup> or “doing” or “being” something new or different to connect the system more effectively to itself. How can we do this, and how can we also recognize what to let go of to bring about positive change in health care? We argue that stories and storytelling could play an integral role to support meaningful systemic change. In this article, we explore the role of stories and storytelling in our health care system; however, first we share a story to ground this discussion in storytelling and possible action.

### **A window into the health care system: Cheryl’s story**

At the age of 33, I was working on my doctorate and traveling back and forth to Uganda. I was relatively healthy, albeit exhausted, and, given everything that was happening in my life, that seemed relatively normal. And so, when I went for my annual physical and inquired about a lump in my groin, the possibility that it was simply

an ingrown hair seemed probable; however, it did not seem to go away.

A year later, the lump remained. This time, I was sent for some tests. I specifically recall having an ultrasound and, after the technician examined my groin, she asked if there were any other areas that felt abnormal. When I asked if something was wrong, she responded that she could not divulge such information; however, I sensed from her interaction something was amiss.

Several weeks later, I saw a surgeon, and as he palpated the areas, he questioned why I was there; from his perspective I was young and healthy and it was likely nothing. I left his office in tears. Six weeks later I had a biopsy. Two days later the surgeon called, I was diagnosed with non-Hodgkin lymphoma. I had cancer.

A month later, I met my oncologist, still unaware of the type of cancer I had, the staging, or what my prognosis was. I was scared, alone, and confused. Fortunately, when my oncologist walked into the room, he greeted me and said, “Tell me about you, not about your symptoms, but about who you are.”

In that instant, I felt like my perspective mattered. That day, and over the next couple of years, we discussed and explored treatment options together. It felt safe to ask

questions and to express my concerns. Rather than feeling like a passive participant, I felt I was an active agent in my own health care.

Reflecting on my experience, I wondered how my story could contribute to better understanding of the health care system. I also wondered how my story differed from others (e.g., other people living with cancer, my oncologist, my nurses) and was curious about the role stories could play in facilitating change.

## The power of storytelling

Wheatley<sup>12</sup> argued that “If a system is in trouble, it can be restored to health by connecting it to more of itself. To make a system stronger we need to create stronger relationships.... The system is capable of solving its own problems” (p. 145). Stories can connect us to the human faces and voices of those in the health care system, including those we are here to serve. In the context of Cheryl’s story, this could mean engaging in conversations between patients and health care providers to better understand the “other” more fully.

Not only do stories and storytelling have the clear potential to connect our health care system to itself, but they might also help us uncover elements of our systems that we might well let go of. For example, Zimmerman and colleagues<sup>13</sup> talked about how bureaucratic processes and attitudes, and even artificial hierarchies, can stand in the way of effective collaboration.

In Cheryl’s story, artificial and ineffective hierarchy emerged at various points. This story inspired us to wonder whether the process of how a diagnosis is communicated could be revisited or adapted to help allay patients’ fears.

Stories and storytelling also have the potential to help us understand the health care system from multiple perspectives and enhance our understanding of the system, its interactions, and outcomes. According to King,<sup>14</sup> stories shape our reality. In essence, stories are active and influential agents of systemic change. Yet, in a system that is considered to be heavily influenced and informed by bureaucracy, hierarchy, and expertise, there is the potential for stories to be limiting if we choose to privilege one story over another. As Adichie<sup>15</sup> noted, “There is danger in a single story. The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.”

In Cheryl’s story, differing perspectives and unspoken stories limited meaningful understanding. To create systems change in health care requires us to privilege and understand multiple and diverse narratives from the perspectives of physicians, nurses, health care staff, educators, administrators, technicians, patients, and many others. Creating space to understand this interwoven complex web of narratives can support us to see and understand the system through different lenses or points of view, understand

its complexity beyond our own scope, and highlight new possibilities for change. In the context of Cheryl’s story, this could be gathering stories from her physician, the oncologist, the surgeon, and others to build a broader understanding of system complexities.

Finally, stories and storytelling have the power to bring us together and refine our shared vision and commitment to change. Through the process of storytelling, both narrator and audience become intimately involved in the same story,<sup>16</sup> and storytelling becomes a collaborative process of “retrospective meaning making.”<sup>17</sup>

According to Bolman and Deal,<sup>18</sup> storytelling can also be an important tool for enhancing and perpetuating culture, identity, and tradition. Stories give flesh to shared values and sacred beliefs. Everyday life in organizations brings many heartwarming moments and dramatic encounters. Turned into stories, these events fill an organization’s treasure chest with lore and legend. Told and retold, they draw people together and connect them with the significance of their work (p. 407).<sup>18</sup>

Perhaps most important in relation to systems change, Senge<sup>8</sup> suggested that storytelling can highlight a “teleological explanation” enrolling narrator and audience in a clear and higher purpose, “an understanding of what we are trying to become” (p. 354). Through stories we can redefine our shared values and our

commitment to system change. In the words of the late Richard Wagamese, storytelling can support us to co-create “the best possible story we can while we’re here; you, me, us together.”<sup>19</sup>

In essence, storytelling has the potential to reconnect us to our higher purpose and redefine our shared commitments. In the context of Cheryl’s story, this could mean involving patients like Cheryl in decisions regarding health care to ensure that patients, physicians, and other health care actors are committed to the same purpose and outcomes.

## Reflections and conclusion

Stories and storytelling are ubiquitous in human experience.<sup>20</sup> Stories have perpetuated knowledge and culture since the dawn of time and have potential to serve as effective interventions toward positive change in health care. Stories and storytelling can shed light on the complexity of the system and highlight possibilities to bring about systems change by connecting the system more effectively to itself and/or identifying what in the system we can let go of.

Holding space for multiple stories and narratives from a diversity of actors in the health care system also offers an opportunity to further understand the complexity of the system and take relevant and effective actions toward change. Finally, storytelling can bring us together to reimagine our collective purpose. Now we are faced with the challenge of how – how can we create space to

share stories with one another and change the health care system, story by story?

## References

1. Martin D. *Better now: six big ideas to improve health care for all Canadians*. Toronto: Allen Lane; 2017.
2. Simpson C, Walker D, Sinclair D, Wilson R. How healthy is the Canadian health-care system? *National Post* 2017;25 Sept. Available: <https://tinyurl.com/y7l8yqea>
3. Schneider EC, Sarnak DO, Squires D, Shah A, Doty MM. *Mirror, mirror 2017: international comparison reflects flaws and opportunities for better U.S. health care*. New York: Commonwealth Fund; 2017. Available: <https://tinyurl.com/y7olbe55>
4. Qudrat-Ullah H. *Better decision making in complex, dynamic tasks*. New York: Springer; 2014.
5. Thomas L. On meddling. In *The medusa and the snail: more notes of a biology watcher*. New York: Bantam; 1980.
6. Williams B, Hummelbrunner R. *Systems concepts in action: a practitioner’s toolkit*. Stanford, Calif.: Stanford University Press; 2009.
7. Meadows D. *Thinking in systems: a primer*. White River Junction, Vt.: Chelsea Green; 2008.
8. Senge P. *The fifth discipline: the art and science of the learning organization*. New York: Currency Doubleday; 1990.
9. Stroh DP. Why good intentions are not enough. In *Systems thinking for social change. A practical guide to solving complex problems, avoiding unintended consequences, and achieving lasting results*. White River Junction, Vt.: Chelsea Green; 2015:12-8. Available: <https://tinyurl.com/y9m8ddj3>
10. Gunderson L, Holling C. *Panarchy: understanding transformations in human and natural systems*. Washington, DC: Island Press; 2001.
11. Hurst DK, Zimmerman BJ. From life cycle to ecocycle: a new perspective on the growth, maturity, destruction, and renewal of complex systems. *J Manage Inquiry* 1994;3(4):339-54.
12. Wheatley M. *Leadership and the new science: discovering order in a chaotic world*. San Francisco: Berrett-Koehler; 1999.

13. Zimmerman B, Reason P, Rykert L, Gitterman L, Christian J, Gardam M. Front-line ownership: generating a cure mindset for patient safety. *Healthc Pap* 2013;13(1):6-22.
14. King T. *The truth about stories: a native narrative*. Toronto: House of Anansi; 2003.
15. Adichie CN. The danger of a single story (video). New York: TEDGlobal; 2009: at 13:05. Available: <https://tinyurl.com/mh9v5hl>
16. Riessman C. *Narrative methods for the human sciences*. Thousand Oaks, Calif.: Sage; 2008.
17. Chase S. Narrative inquiry: multiple lenses, approaches, voices. In Denzin N, Lincoln Y (editors). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, Calif.: Sage; 2005: 651-6.
18. Bolman L, Deal T. *Reframing organization: artistry, choice, and leadership*. San Francisco: Jossey-Bass; 2003.
19. Polling J. We are story. *The Times* 2017;16 March. Available: <http://www.mindentimes.ca/we-are-story>
20. Baldwin C. *Storycatcher: making sense of our lives through the power and practice of story*. Novato, Calif.: New World Library; 2005.

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# Five fundamentals of civility for physicians: Part 2



Michael Kaufmann, MD

This second of two articles on the fundamentals of civility for physicians focuses on communication, self-care, and responsibility. Adopting these behaviours empowers us to take responsibility for our own well-being which, in turn, enables us to do and be our best under all conditions.

**KEY WORDS:** civility, communication, self-care, responsibility, professionalism, conduct, respect, burnout, leadership, CanMEDS roles

Incivility in the health care system can have an enormous negative impact and consequences. In contrast, civil behaviour promotes

positive social interactions and effective workplace functioning. This second of two articles focuses on the final three fundamentals of civility: effective communication, self-care, and responsibility. An earlier article dealt with respect and self-awareness.<sup>1</sup>

## Communicate effectively

Words are powerful. They can flay like whips. Hastily chosen, they can unnecessarily hurt and discourage. On the other hand, words well chosen, considerate, and timely can lift spirits, motivate, and connect us.

When we communicate with someone, be it in person, online, virtually, or in real time, we must remember that we are interacting with another human being, living, breathing, working, and vulnerable – just like us. At its core, civil communication is courteous and respectful. Sadly, this can be forgotten during the course of medical training, practice, and public discourse.

## Everyday communication

Here are some common sense considerations for civil conversation.

- Greet others warmly. Gently push vital preoccupations to the side, just for a moment.
- Be inclusive. When others approach, invite them to join the conversation.
- Thinking the best of others is a decent thing to do. Draw on your respect for them.
- Engage in conversation genuinely when the

opportunity arises. The ball has been tossed to you. Turn it over in your hands, feel it for a moment, then toss it back.

- Be curious. What are they thinking? Feeling?
- Maintain your integrity. Share to the extent that you are comfortable without being dishonest or misleading.

## Two kinds of silence

Silence can help or hinder civility in communication. Active listening is the first kind of silence. If communication is sending and receiving information, then listening is as important as speaking. Not talking in key situations is the other, unhelpful, form of silence. Communication withheld when it is expected, needed, or would be appreciated is a pernicious choice.

## Listening

Imagine a time when you had a good conversation with a colleague or friend: you came away feeling buoyed up, heard. How did you know that?

They didn't talk that much and they didn't talk over you, waiting for an opening in your narrative so they could punch through with their own ideas. They faced you with a relaxed posture and didn't fidget. They smiled occasionally. They set their smart phone aside. Pauses in the conversation were comfortable spaces that invited you to share more detail. When they did speak, it was to ask a question that really confirmed they were trying to understand what you were saying and feeling. They didn't hurry away.





Plan your listening deliberately: behave as if you are listening and be a cooperative listener. Silence is your tool.<sup>2</sup> Focus on the other person and what they are saying. Self-awareness is key. Listen to your inner voice busily reviewing, comparing, identifying, maybe judging, planning your next words, tempting you to interrupt. Silence it – until the right moment.

### **Praise**

I think that many physicians find it difficult to offer praise. Why compliment someone for simply performing as we expect? The answer is that a well-deserved compliment is a considerate act of support. It is capital deposited into the inter-personal bank of good will. Genuine praise strengthens relationships now, facilitating more difficult conversations later, should they be needed.

### **Constructive feedback**

If it's a challenge to offer praise, then it's really tough to provide constructive feedback and guidance. When a colleague is underperforming, struggling,

distressed, distressing others, and/or behaving in an unprofessional manner, approaching them as a friend, colleague, or leader is a responsible thing to do. There are many guiding frameworks to consider when giving constructive feedback. Motivational Interviewing (MI) is one of them.

MI offers principles for effective communication with someone who is resistant to, or ambivalent about, change.<sup>3</sup> A motivational conversation is embedded in a collaborative and supportive relationship. The physician leader is a guide who helps to clarify his or her colleague's goals and explore effective behavioural strategies to move toward achieving them. Unhelpful strategies also need to be identified – often by the colleague on their own. This is known as developing discrepancy: "How's that working for you?" Learning how to roll with resistance is vital: a bloody-minded response to a bloody-minded stance calcifies obstinacy. Ultimately, an effective motivational approach supports

the other's self-efficacy in finding ways to make necessary change.

Although it is beyond the scope of this article to go into MI strategy in depth (or other effective communication paradigms), here are some tips that help structure difficult conversations:

- Plan and rehearse your conversation ahead of time.
- Choose a place and time that is private and unhurried.
- Use empathy and open reflection on what you are hearing: "I imagine you found yourself in a difficult position..."
- Seek to genuinely understand and support the other person's goals whenever possible.
- Use open-ended questions without judgement: "tell me more about that...", "help me understand..."
- Focus on accepted facts and behavioural observations, not the person: "I'd like to discuss an incident that arose in the OR last week..." rather than: "How can you have been so thoughtless...?"
- Monitor your own emotional reactions, biases, and "stories" you are telling yourself about the other person and their circumstances.
- Clarify expectations and preferred outcomes objectively.
- Clarify consequences/ contingencies that are relevant to the circumstances.
- Support positive behavioural choices and outcomes.

Watch out for these common conversation stoppers:

- “You...” (accusatory “finger wagging”)
- “You always...” (exaggerated over-statement)
- “You never...” (exaggerated under-statement)
- “Don’t take this personally, but...” (it is personal)
- “With all due respect...” (it is not respectful)
- “I shouldn’t have to tell you this, but...” (inappropriate assumptions)

### Receiving feedback

Just as giving feedback requires skill, so does receiving it with an open mind. Not one of us can judge ourselves perfectly. If it rings true, gracious acceptance is appropriate. If not sure, then perhaps a thoughtful response such as: “You’ve given me something to consider. Thank you for that.” And if you just can’t accept the feedback as valid, then a civil response might be something like: “I appreciate that’s how you see things, but that just doesn’t make sense to me.” Counterattack – adopting an aggressive stance, will quash any hope of useful dialogue, blocking positive outcomes and the promotion of respectful workplace relations.

### Communication in the digital age

Electronic communication and social media have changed so much about the way professional communication takes place. Like all innovation, electronic and online communication offer many benefits, but also pitfalls that open the door to new forms of incivility. Whether it’s an entry into an electronic medical record, email,

tweet, or blog, there appears to be something about sitting at one’s computer that permits unpleasant messaging of all forms.

Our thinking and communication practices must evolve with the digital revolution to preserve personal and professional integrity and high-quality relationships in the workplace. As the CMA Code of Ethics affirms: “Treat your colleagues with dignity and as persons worthy of respect.”<sup>4</sup> This ought to be the case whether our communications are face to face, in writing, online, in social media, or in any other form of communication in the digital age.

Here are some thoughts about maintaining civility in electronic and online communication:

- Keep professional and personal communications separate.
- Email communication should be brief and respectful. Use face-to-face communication to resolve conflict.
- Consider all comments posted online to be public. Would you say them to or about someone in person, in front of others?
- Be mindful and respectful of local corporate/institutional social media policy when functioning as an advocate within the health care system. The necessary role of advocate and the right to free speech do not protect physicians from the consequences of libel and defamation.<sup>5</sup>
- Remember that digital communication never goes away. The uncivil comment you make in a moment of pique

often can’t be taken back and the record is permanent!

- It is our ethical obligation not to impugn the reputation of colleagues.<sup>4</sup> Pause for a moment, especially if your emotions are high, before completing any digital entry or pressing “send.” Re-read the message later. Ask yourself: “Is there anything defamatory about this message? How would I feel if this were a message posted by someone else referring to me?”

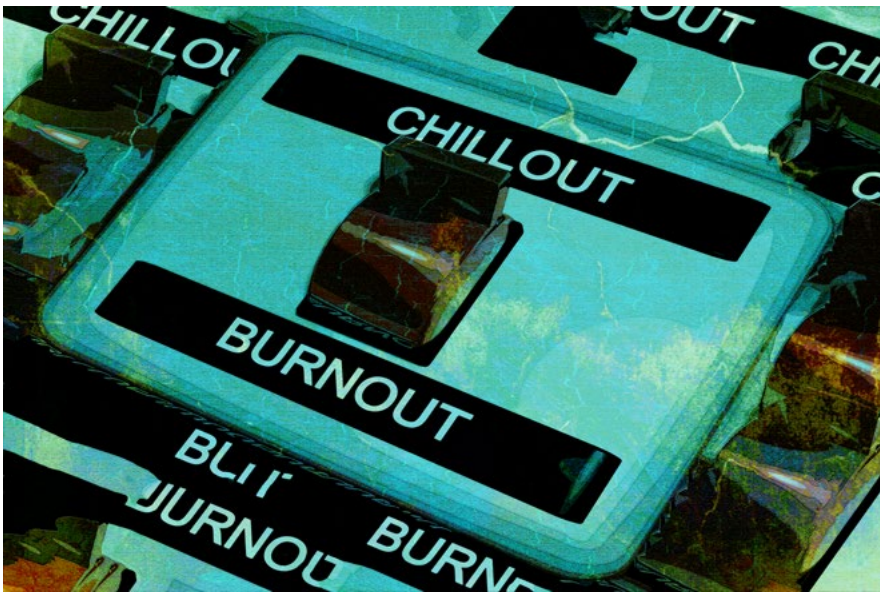
### Take good care of yourself

“If you’re not tough enough to stand it, you should get out.” This is a time-honoured meme of our profession: self-sacrifice, denial of our own basic physiological and emotional needs, is a professional virtue. But one day, taut and “toasted,” this is the doctor who lashes out at a colleague or co-worker in a most uncivil way. Tightly wound, he or she will “shoot the first thing that moves.”

### Civility and burnout

When a person has to perform day after day under demanding conditions beyond their personal comfort zone, unable to unburden themselves, there is fatigue, exhaustion, distress, burnout, illness, and, for some, incivility. This is a time when one is most likely to fall back on deeply ingrained modalities of flight or aggression.

Burnout looms as one of the greatest challenges to the medical profession. Nearly half of physicians surveyed report some degree of burnout, no matter what their specialty or where



they are.<sup>6,7</sup> This is inhumane and unacceptable.

Maslach described the dimensions of burnout as exhaustion (physical and emotional depletion), depersonalization (cynical detachment), and a sense of ineffectiveness.<sup>8</sup> Major antecedents of burnout include excessive workload, perceived lack of control, insufficient reward, poor professional community support, a sense that fairness is absent, and a mismatch between one's personal and occupational values and those perceived in the workplace.<sup>9</sup>

Highly motivated doctors with intense investment in their profession are particularly at risk.<sup>9</sup> So often have I heard doctors explain their workplace incivility this way: "I do what I do and say what I say only to get the best possible care for my patients." I believe they are being sincere even as they are unaware of the paradox: treating co-workers badly has negative impacts on patient care. Chronic stress-related irritability, impatience with others,

and failing empathy all predispose to workplace conflict and low morale.

#### **Personal resilience**

Optimizing one's own health and resilience practices is a choice within our control. Much has been written about the self-care practices that bolster resilience, including my own BASICS series.<sup>10,11</sup> Resilience can be thought of as the ability of an individual to respond to stress in a healthy, adaptive way, such that personal goals are achieved at minimal psychological and physical cost; resilient individuals not only "bounce back" rapidly after challenges but also grow stronger in the process.<sup>12</sup>

Self-care is foundational. In an environment that demands peak performance from us every day, attending to basic personal needs provides the vitality necessary to go out into the world and apply our skills in a way that enables a genuine connection to colleagues, co-workers, and patients. Beyond the intuitively obvious benefits

of taking care of ourselves, we now know that healthy lifestyle practices for doctors translate into better care for patients.<sup>13,14</sup> Truly, even for the most dynamic of doctors, paying attention to our own needs makes sense.

#### **Community**

Resilient physicians say that their professional friendships, alliances, and networks keep them healthy.<sup>11</sup> Doctors come together in many ways that foster genuine mutual support – journal clubs, Balint groups,<sup>15</sup> Finding Meaning in Medicine groups patterned on the work of Rachel Remen<sup>16</sup> are but a few examples. With a few simple guidelines, peer support groups are easy to form.<sup>17</sup>

Any professional grouping of doctors and co-workers, like family health teams, hospital or university departments, can be considered as communities worthy of self-care. In effective workplace communities, practical decisions about work distribution, remuneration, resource sharing, and so on are made in a spirit of fairness, friendship, and mutual support. Conflict, when it inevitably appears, is managed respectfully and effectively. In healthy workplaces, doctors can be genuine with one another and share their experiences as well as their feelings of stress and vulnerability. Compassionate professional communities acknowledge the self-care needs of their members and know how to respond when someone is over-burdened or suffering. These are all matters of compassion and imagination. Physician leaders set the tone.

### The culture of medicine

The health of doctors and, therefore, the health of our profession and the populations we serve are taking shape as a core professional value. This and other aspects of civility are clearly described in the widely used CanMEDS competency framework in the "Professional" section.<sup>18</sup>

Gone are the days when self-care practices for doctors were considered just a good idea – a luxury for which we had neither time nor sufficient motivation. Organized medicine at every level is weighing in on physician health through policy and program development. Physician health is a political issue.<sup>19</sup>

### Be responsible

Sharone Bar-David describes the broken windows theory: when a neighbourhood broken window is not fixed expeditiously, crime rates will rise. Likewise, when incivility is not addressed promptly, whenever and wherever it arises, it will escalate and spread through a community and culture like a contagious disease. It is our individual and collective responsibility to prevent that.<sup>20</sup>

### Being responsible for ourselves

The way we treat people matters, always and in any situation; for that we are responsible. Extraordinary accomplishment and exemplary behaviour in some circumstances do not permit or forgive belittling, shaming, or any other such treatment of colleagues, co-workers, learners, or patients at other times.

Our primary mission can also obscure personal responsibility. When others on the health care team feel the hurtful impact of a doctor's incivility, they are unable to work well with that individual. Patient care can be compromised as a result.

Recognizing our internal locus of control, we can take responsibility for our own choices by making civil choices that are the ones most likely to have a positive impact on everything and everyone around us. It is our personal responsibility to understand the five fundamentals of civility and apply them in our daily lives.

### Being responsible for others

Even considering a medical tradition of rugged individualism, there are times when we are "our brothers' keepers." Sometimes, there are witnesses when a doctor behaves in a manner that is disruptive or hurtful toward others. An observer to an episode of incivility who chooses not to react in any way is a bystander, a part of the problem. Clarkson<sup>21</sup> talks about the "bystanding slogans," thoughts that can block a helpful response. Here are a few of them:

- "It's none of my business."
- "Someone else will take care of this."
- "I don't want to be hurt myself."
- "I don't know what to do."

The responsible thing to do is to become aware of these and counter them with more rational and helpful thoughts. Here are some suggestions, considering the examples listed above:

- "It is incumbent upon me to help. We are all in this together."
- "If I don't say something, it's likely no one else will and the problem will persist, maybe worsen."
- "That person might be suffering in some way, and helping them is worth the risk that they might lash out at me."
- "I'll get some advice about what to do next."

Armed with a sense of responsibility, a little courage, good timing, and some practical advice, anyone can approach the individual whose behaviour must be challenged. A simple initial question, "Are you okay?" signals compassion and invites engaging conversation.

### Being responsible for workplace culture

Workplace cultures ("the way we do things around here") vary tremendously: collegial, respectful, fragmented, competitive, supportive, toxic, healthy, and so on. Doctors often work in health care teams even though they may not be directly employed by their hospital or other health care institution. That can set the doctor apart from other co-workers. There are also cultures within cultures, where the social tone can vary widely and civility values seem to be at odds with one another. The same doctor can be rude and intimidating in the operating room yet warm and supportive on the wards.

Leadership is key. All doctors are leaders by virtue of their



professional standing and the patient care dynamic. But it is the special responsibility of our designated physician leaders, be they department heads, chiefs of staff, university chairs, residency program directors, political representatives, or others, to understand their role in shaping and guiding workplace values and cultures.

It is also incumbent on physician leaders to understand the systemic contributors to physician stress and to implement the various organizational strategies that promote physician engagement and reduce burnout.<sup>22</sup>

### **Being responsible for the culture of medicine**

The idea of memes (like genes in a biological sense) as units of transmissible cultural information

is intriguing.<sup>23</sup> It can be argued that there are a number of medical memes contributing to the “incivility crisis” in the medical profession. Some examples include:

- Superior knowledge and technical excellence permits and forgives rudeness and other forms of incivility.
- The ultimate responsibility for patient outcomes lies solely with the doctor, thereby justifying any form of workplace and/or public behaviour no matter how it might affect others.
- Patients’ well-being comes first (ahead of our own).

These memes inform our attitudes and beliefs. They are modeled for us, overtly or implied, reinforced through training and practice, and

passed along to each subsequent generation of doctors. But are they true? Unalterable? Which of our memes ought to be preserved and which ought to be changed or discarded? Our senior colleagues, seasoned by experience, may have a particular wisdom to offer. The newest members of our profession possess modern personal and social values that might improve the humanity of our profession. We ought to listen to them.

**Our professional goal is to heal whenever possible and to comfort, always. We are honoured to work and connect closely with others on this mutual mission.**

In today’s complex professional environments, characterized by

stressful political and economic changes, power imbalances, multiple agendas, technological evolution and revolution, and so much more, civility as a shared responsibility might be the only way through.

## Conclusion

Civility begins with fundamental courtesy based on respect – for ourselves as well as others. Naturally, if we are to make civil behavioural choices, conscious effort based on self-awareness and effective communication skills is required. Even in the face of conflict and fierce disagreement, civility leaves us, and others, feeling intact and safe. Civility empowers us to take responsibility for our own well-being which, in turn, enables us to do and be our best under all conditions. Individually and collectively, we bear responsibility to inject civility into our professional relationships, communities, and culture, to fix the “broken windows” in the house of medicine.

Our professional goal is to heal whenever possible and to comfort, always. We are honoured to work and connect closely with others on this mutual mission. Civility is the vehicle we need to deliver our skill, knowledge, and compassion to others.

Let’s keep this conversation going.

## References

- 1.Kaufmann M. Five fundamentals of civility for physicians. *Can J Physician Leadersh* 2017;4(2):41-6
- 2.Forni PM. *Choosing civility: the 25 rules of considerate conduct*. New

- York: St. Martin’s Press; 2003: 51.
- 3.Miller WR, Rollnick S. *Motivational interviewing* (2nd ed.). New York: Guilford Press; 2002.
- 4.CMA code of ethics (update 2004 [last reviewed Mar. 2015]). Ottawa: Canadian Medical Association; 2004. Available: <https://tinyurl.com/h9bwkpi> (accessed 3 Jan. 2017).
- 5.Social media and Canadian physicians: issues and rules of engagement. Ottawa: Canadian Medical Association; 2011. Available: <https://tinyurl.com/ybx5yojr> (accessed: 3 Jan. 2017).
- 6.Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med* 2012;172(18):1377-85.
- 7.Lee FJ, Stewart M, Brown JB. Stress, burnout, and strategies for reducing them: what’s the situation among Canadian family physicians? *Can Fam Physician* 2008;54(2):234-5.
- 8.Maslach C. Job burnout: new directions in research and intervention. *Curr Dir Psychol Sci* 2003;12(5):189-92.
- 9.Kearney MK, Weininger RB, Vachon ML, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life: “Being connected...a key to my survival.” *JAMA* 2009;301(11):1155-64.
- 10.Kaufmann M. The basics: strategies for coping with stress and building personal resilience for physicians. Toronto: Ontario Medical Association; 2006-2008. Available: <http://php.oma.org/well-being/civility/> (accessed 3 Jan. 2017).
- 11.Zwack J, Schweitzer J. If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Acad Med* 2013;88(3):382-9.
- 12.Epstein RM, Krasner MS. Physician resilience: what it means, why it matters, and how to promote it. *Acad Med* 2013;88(3):301-3.
- 13.Frank E. STUDENTJAMA. Physician health and patient care. *JAMA* 2004;291(5):637.
- 14.Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med* 2000;15(2):122-8.
- 15.Salinsky J. A very short introduction to Balint groups. Manchester, UK:

- Balint Society; 2009. Available: <https://tinyurl.com/yda6nb9f> (accessed 3 Jan. 2017).
- 16.Remen R. Finding meaning discussion groups. Dayton, Ohio: Remen Institute for the Study of Health and Illness; 2018. Available: <https://tinyurl.com/y7r7tvoq> (accessed 3 Jan. 2017).
- 17.Kaufmann M. The five fundamentals of civility for physicians. 4: Take good care of yourself. *Ont Med Rev* 2015;82(6):12-5.
- 18.Frank JR, Snell L, Sherbino J (editors). *CanMEDS 2015 physician competency framework*. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015. Available: <https://tinyurl.com/j53ulbz> (accessed 4 Jan. 2017).
- 19.Albuquerque J, Deshauer D. Physician health: beyond work-life balance. *CMAJ* 2014;186(13):E502-3.
- 20.Bar-David S. *Trust your canary: every leader’s guide to taming workplace incivility*. Toronto: Fairleigh Press; 2015.
- 21.Clarkson P. *The bystander: an end to innocence in human relationships?* London, UK: Whurr Publishers; 2006.
- 22.Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc* 2017;92(1):129-46.
- 23.Harari YN. *Sapiens: a brief history of humankind*. Toronto: Signal; 2014.

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## The continuing challenge of patient-centred care



Michael Gardam, MD, and  
Judith John, BA

Why is patient-centred care (PCC) not embraced by physicians who clearly want the best for their patients? PCC is desired by patients, takes no more time to provide, and can result in better outcomes. We believe that physicians are hesitant to adopt PCC because it has been imposed from “outside.” Growing evidence suggests that engaging patients can improve outcomes – for the patient, the family, and the clinician.

**KEY WORDS:** patient-centred care, patient outcomes, clinical practice

If one takes a quick tour through websites of hospitals and health regions across the country, it quickly becomes evident that “enhancing the patient experience,” “person- or relationship-centred care,” and “patient- and family-centred care” have become common priorities. Many, if not most, organizations are working toward including the voice of patients in decision-making and stressing the importance of patients partnering in their own care. Some organizations, such as Toronto’s Holland Bloorview Kids Rehabilitation Hospital take this direction much further by building the patient voice into all decisions that govern how children are cared for.<sup>1</sup> From a patient perspective, the patient-centred care (PCC) movement is long overdue, clearly positive, and an important step forward for patients and their families.

Yet, we also know that PCC is not always greeted with the same positivity by medical staff. At first glance, this is surprising given that, in our experience, the vast majority of our doctors enter medicine wanting passionately to help people. So, focusing on the needs of the patient would logically be at the very core of their practice. We know of many colleagues who push themselves to the limit (and often beyond) trying to provide excellent care, putting in long hours, working on evenings and weekends. One would think that centring care around the needs of the patient could only help patients in dealing with their illnesses.

Why the hesitation for many doctors to “buy-in” to the PCC movement? In our experience, this is too often explained away by physician self-interest or paternalism. Although some of this likely exists, we believe there are many reasons why PCC has not always resonated with doctors. Some involve concerns regarding improvement in outcomes that are slowly being addressed in the medical literature, others involve human factors, such as issues around the increasing use of technology, while still others have to do with how doctors were engaged in the PCC movement in the first place. Confusion remains around what PCC means and how it can be incorporated into one’s practice.

PCC was defined by the Institute of Medicine almost two decades ago as “providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”<sup>2</sup> Don Berwick, of the Institute for Healthcare Improvement, has argued that “Patient-centeredness is a dimension of health care quality in its own right, not just because of its connection with other desired aims, like safety and effectiveness. Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it.”<sup>3</sup>

These visions do not include supplanting the expertise of the clinician; they do not mean that



Dr. Google will reign supreme. It is a misconception that PCC means that doctors must offer care that they disagree with because a patient requests it. What PCC does mean, however, is that the physician treats patients in a respectful manner, treats them like a partner in their care, and, if necessary, explains why they are unable to comply with the patient's wishes.

**Through storytelling, idea exchange, anecdotes, and situational experiences, we illuminate the challenges and the opportunities a true patient-centred, partnership approach can foster.**

In our experience, although such clinical disagreements occur, it is

misleading to focus on them, as the vast majority of unsatisfactory patient-physician interactions have to do with basic, everyday civility and respect. Patients look for a human connection, which is more than just knowledge and technical expertise. They want to be seen as real individuals, not just a disease or a puzzle to solve. They seek supportive partners who are not too impatient or brusque to welcome questions. And they know that the small things matter, that every interaction counts.

One of us (Judith) offers countless examples of just how a person inhabiting the blue hospital gown becomes invisible and how alienating that can be. She was called in for an MRI from a crowded waiting room with the words "brain tumour" rather than

her name. A doctor discussed her case with fellows in the doorway of her room – too busy to enter or make contact – without even acknowledging her presence. A clinical group reviewed her prognosis without explaining what the procedure would be, shutting her down when she had the temerity to ask questions.

Judith has also experienced the negative impact of technology on her patient experience, similar to that so poignantly illustrated in *JAMA* by a child's drawing of a physician hunched over a computer screen during her visit.<sup>4</sup> Technology, while a huge asset to sophisticated, advanced care, can be a barrier to humane connection: a wall of separation instead of a bridge to a care partnership. Once, when Judith



was visiting a clinician, it was clear that he was fully absorbed in the MRI images on his computer screen; he never glanced in her direction. She could have been an empty chair next to his desk. Finally, in frustration tinged with dry humour, she asked him if he had no interest in taking a look at the “packaging – me, the patient!”

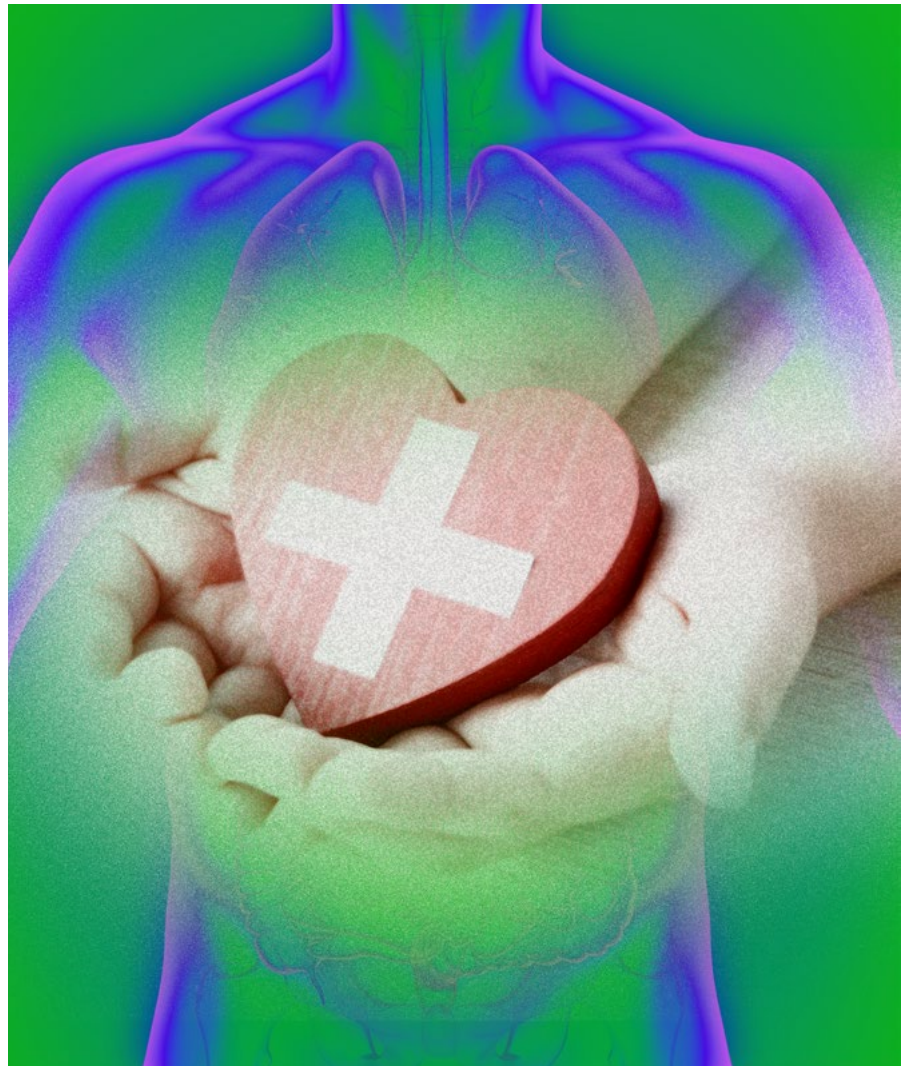
Does practising PCC take more time? We argue that, on the contrary, it can speed up working with patients as the level of understanding and dialogue takes a lot of misunderstanding out of the picture. Although it would be difficult to measure, we believe an engaged partnership, based on mutual trust and real communication, means better compliance, more effective visits, less follow up, and a positive impact on outcomes. Other physicians we have spoken with, who have embraced partnering with patients, have had similar experiences. While building a relationship on understanding and dialogue will likely take more time in the beginning, it is time well invested.

There is some evidence that practising PCC can improve patient outcomes. Perhaps not surprisingly, the complexity and variability of PCC interventions have made it difficult to show clear evidence of improvement. In a systematic review of PCC and patient outcomes, Rathert et al.<sup>5</sup> found evidence to suggest that practising PCC improves patient self-management and satisfaction. Some of the reviewed studies also showed improvements in

patient outcomes; however, many were challenged by lack of clarity regarding the intervention, dilution of the control group by the intervention, and other methodological issues. Similar biases and mixed findings have been reported by Dwamena et al.<sup>6</sup> in their Cochrane review, suggesting that although PCC may hold promise, more work is needed before it can be clearly associated with improved patient outcomes. Of interest, one study reviewed by Rathert et al.<sup>5</sup> showed an improvement in diabetes care with the implementation of a PCC program focusing on self-care and management; yet, the intervention

was not continued after the study ended because of lack of physician participation.<sup>7</sup>

Physician disinterest brings us to our final point: we think that one of the major reasons PCC has not resonated with physicians is because they have been asked to “buy-in” to a program that was largely, if not wholly, created by others. As defined by Mark Jaben,<sup>8</sup> buy-in means that others have identified a problem, envisioned what a solution looks like, worked on strategies and discussed options for implementation, and then brought a finished or near-finished product to the target





group and asked them to adopt it as their own. As business professor, David Logan, has said: "Asking for someone's 'buy-in' says, 'I have an idea. I didn't involve you because I didn't value you enough to discuss it with you. I want you to embrace it as if you were in on it from the beginning.'"<sup>9</sup>

Although some physicians have been at the forefront of PCC, most of the work has been championed by others and brought to physicians as a fait accompli instead of inviting them to co-create what PCC looks like in their practice. Because true PCC is founded on the principles of a real partnership, developing and then mandating the program unilaterally is doomed to scepticism and failure.

PCC is often thought of as a step-wise progression from informing patients, to consultation and involving them in their care, to collaboration, and finally to empowerment.<sup>10</sup> Although almost all patient encounters will result in patients being informed, we suspect that many encounters that occur in our health care institutions have not progressed much along the road toward true empowerment. Beyond clinical encounters, the patient voice also needs to be heard and incorporated into how we deliver health care. Organizations must move beyond vision statements and intentionally build structures and processes that incorporate the patient voice into everyday operations in addition to physician-patient encounters.

For examples, look to Kingston General Hospital<sup>11</sup> and Holland Bloorview.<sup>1</sup> This is the direction set by Accreditation Canada, which is now expecting health care organizations to engage patients in a meaningful way.<sup>12</sup>

Understanding the parameters, principles, and practice of PCC from the vantage point of both the patient and the practitioner – and how it is necessary and mutually beneficial – is the basis of a course we have co-created for Joule. Through storytelling, idea exchange, anecdotes, and situational experiences, we illuminate the challenges and the opportunities a true patient-centred, partnership approach can foster.

We believe, and growing evidence suggests, that engaging patients can improve outcomes – for the patient, the family, and the clinician. It can help alleviate physician ennui, something one of us (Michael) experienced as he began working toward a more patient-centred approach. It can help with job satisfaction in a highly stressful, pressured environment. It can take doctors back to their initial idealism and sense of purpose. And it can be done easily, daily, patient by patient, without extra time, expense, or angst – and with results. It all goes back to the words of William Osler: “The good physician treats the disease; the great physician treats the patient who has the disease.”<sup>13</sup>

## References

- 1.No boundaries: Holland Bloorview Kids Rehabilitation Hospital strategic plan 2017-2022. Toronto: Holland Bloorview Kids Rehabilitation Hospital; 2017. Available: <https://tinyurl.com/y9pjm9pa> (accessed 1 Nov. 2017).
- 2.Institute of Medicine, Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the twenty-first century. Washington: National Academies Press; 2001. Available: <https://tinyurl.com/yc6mgs6t>
- 3.Berwick D. What ‘patient-centered’ should mean: confessions of an extremist. *Health Aff* 2009;28(4):w555-65. Available: <https://tinyurl.com/y7m8rphd> (accessed 13 Nov. 2017).
- 4.Toll E. A piece of my mind: the cost of technology. *JAMA* 2012;307(23):2497-8.
- 5.Rathert C, Wyrwich MD, Boren SA. Patient-centered care and outcomes: a systematic review of the literature. *Med Care Res Rev* 2012;70(4):351-79.
- 6.Dwamena F, Holmes-Rovner M, Gauden CM, Jorgenson S, Sadigh G, Sikorskii A, et al. Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev* 2012;12:CD003267. Dec 12. Available: <https://tinyurl.com/y788djej> (accessed 16 Oct. 2017). doi: 10.1002/14651858.CD003267.pub2.
- 7.Glasgow RE, Nutting PA, King DK, Nelson CC, Cutter G, Gaglio B, et al. A practical randomized trial to improve diabetes care. *J Gen Intern Med* 2004;19(12):1167-74.
- 8.Jaben M. Quality café. The science behind resistance (slide presentation). Vancouver: BC Patient Safety and Quality Council; 2016. Available: <https://tinyurl.com/y83khwat> (accessed 13 Nov. 2017).
- 9.Mallet M, Nelson B, Steiner C. The most annoying, pretentious and useless business jargon. *Forbes* 2012;Jan 26. Available: <https://tinyurl.com/y9jehk53> (accessed 13 Nov. 2017).
- 10.Baker GR, Judd M, Fancott C, Maika, C. Creating “engagement-capable environments” in healthcare. In: *Patient engagement: catalyzing improvement and innovation in healthcare*. Toronto: Longwoods Publishing; 2016.
- 11.Judd M, Rivoire E, Maika C. Kingston General Hospital. In: *Patient engagement: catalyzing improvement and innovation in healthcare*. Toronto: Longwoods Publishing; 2016.
- 12.Thompson LJ, Clement L. People powered health: taking front-line ownership to the next level. *Healthc Pap* 2017;17(1):29-33.
- 13.William Osler quotes. BrainyQuote.com; n.d. Available: <https://tinyurl.com/y7ojhwb9> (accessed 14 Nov. 2017).

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# Could Saskatchewan become the best place in the world to practise medicine?

**Physician leaders co-design an integrated health care system**



Susan Shaw, MD, and Ivan Muzychka

Over the last 18 months, the Saskatchewan Medical Association has been leading discussions and actions around health system redesign. This work, which continues to evolve as the environment changes, aims to maximize opportunities to strengthen not only relationships within the system, but also the role physicians can and should play to make

Saskatchewan the best place in the world to practise medicine and receive care.

**KEY WORDS:** health care system transformation, physician-led change, integrated system, collaborative approach

More than 50 years after introducing medicare to Canada, Saskatchewan is again re-examining and exploring how best to redesign the health care system to better meet current and future needs of patients and families. The province's health system has seen profound change over the last two years. Starting in January 2017, it has been transitioning from 12 health regions to a single health authority. Parallel to this development, the Saskatchewan Medical Association (SMA), in partnership with colleagues in the Ministry of Health, has been engaged in a vigorous discussion about the merits of physician-led health system redesign. To date, the feedback has been positive even if the route toward consensus and action has been circuitous.

The leadership of the SMA has helped the province's physicians more actively imagine the development of a fully integrated health system. Through leadership education, discussions, and negotiations, physicians are attempting to shift the basic structures that typically drive the dynamics of health care systems in Canada. If they succeed, benefits will flow for physicians and patients alike. The mainspring

of this new vision of health care is physician leadership.

## Modernization or transformation?

Health system redesign discussions began in 2015 with work to update the fee schedule to better reflect the more modern practice of medicine, a project that was born in negotiations over the previous two years. The process to update the fee schedule engendered wider discussions about urgently needed fundamental changes in the broader health care system. It brought to the fore issues related to work-life integration, continuity of care, and stewardship of resources, to name but a few. Those working on fee schedule modernization quickly agreed that an update would only provide a mere tweaking of the system where a significant overhaul was actually required and desired.

Many problems that were initially identified as compensation challenges seemed to be attached to deeper underlying issues. Compensation debates and conflicts were often anchored in management structures and relationships and in the dynamics of the health care culture and tradition. In other instances, changes in demographics and advances in technology were at the root of a particular compensation problem. The predominant thinking was that many of the issues could be more constructively addressed through a larger re-imagining of the whole system.

During 2015 and early 2016, the modernization discussion matured into a wider and deeper conversation among SMA board members, many committee leaders, and even members. As these discussions evolved, they were more accurately labelled explorations into “health system redesign.” Their focus was on how to optimize Saskatchewan’s quadruple aim: better health, better care, better value, and better teams. At this stage, physicians agreed with the idea of health system redesign, but wanted more information and specifics on what it would entail and how it would look if implemented.

### Provincial and Canadian contexts

The doctors started these exploratory discussions within a dynamic political context. In 2015, the provincial government faced significant revenue reductions as oil and potash prices dropped. An overall downturn in the Canadian and United States economies added more fiscal challenges. Not surprisingly, such relentless fiscal pressures made governments careful about budget allocations across all portfolios, not just health.

At the same time, physicians, as well as other members of the health care system, were becoming increasingly frustrated. In 2014, the Commonwealth Fund ranked Canada 10th out of 11 peer countries.<sup>1</sup> Physicians, and others, were discouraged that despite considerable effort and funding, Canada did not consistently



achieve good results when it came to quality, safety, and access.

By 2016, more and more stakeholders had added their voices to the notion that transformational change was the only viable path to significantly improve the health care system. Fiscal sustainability continued to be an issue. Most provincial governments started looking for ways to hold health care costs steady. In many jurisdictions, health care consumed almost 40% of the budget.<sup>2</sup> Such expenditures were seen by many as unsustainable and, if not checked, might pose a threat to quality of care.

Some governments decided to act unilaterally. In Ontario, a bitter dispute between the Ontario Medical Association (OMA) and the provincial government erupted when, among other issues, the Ministry of Health and Long-Term Care made unilateral adjustments to the fee schedule to hold costs down. The dispute ultimately led to acrimony, not just between the OMA and government, but

between the OMA leadership and its members. This example served as a cautionary tale and provided an impetus for Saskatchewan physicians to keep discussing the merits of collaborative health care transformation.

### Engaging physicians in the discussion

The SMA board felt strongly that it needed to hear from its members on the topic and brought health system redesign discussions to the floor of its spring 2016 Representative Assembly.

In advance of that assembly, the SMA prepared a discussion paper titled “The future physician role in a redesigned and integrated health system.”<sup>3</sup> The paper was emailed to members and circulated on social media; the general feedback was positive. The paper was not prescriptive, but its purpose was clear:

The purpose of this discussion paper is to launch a dialogue among our members about

the compelling reasons for change and how we want to participate in the change process. Like good medicine, it begins with observation and diagnosis; without agreement on what the issues and problems are, no course of action or prescription is likely to lead to the desired outcome. The perspective is global rather than local, and grounded in one overarching ambition: to make Saskatchewan the best place in the world to practice medicine. If we achieve this goal, Saskatchewan will be the best place in the world to stay healthy, and the best place to receive health care. Our professional ambitions are indistinguishable from our ambitions for our province and our people.<sup>3</sup>

At the representative assembly, members shared their reactions to the discussion paper and gave SMA leadership the go-ahead to begin dialogue on how to co-create a fundamentally redesigned health care system. That physicians should be involved in fostering positive change in the system was widely accepted with little debate.

Following the assembly, the SMA and the Ministry of Health hosted an intensive two-day “visioning session” that brought together 25 leaders from the SMA, ministry, regional health authorities, college of medicine, and Saskatchewan’s Health Quality Council. More than half the participants were physicians. Participants explored the factors contributing to high-performing health systems around

the world, along with what would be required to put these ideas into action in Saskatchewan. The group focused on the ideal role of, and relationship with, physicians in a more fully integrated and redesigned health care system in Saskatchewan.

**A key point is that health system redesign dovetailed with the SMA’s strategic direction that sought to enhance physician participation and leadership in health care design.**

From this work came agreement on four core elements necessary to support health system redesign, create better partnerships with doctors, and provide better care for patients: strong physician leadership, better relationships and effective governance, use of data to optimize care, and alignment of compensation models.

**Centrality of physician leadership acknowledged**

On another front, the government of Saskatchewan was exploring ways to restructure its health care regions. In mid-2016, the minister of health appointed an advisory panel tasked with reviewing the regional health authority structure with a clear mandate to reduce the number of regions.

After consultation with the public and stakeholders and after examining other structures, the panel recommended the creation of a single provincial health

authority. One of the panel’s recommendations, however, pointed to deeper, more positive changes afoot in the province. The advisory panel recommended that physicians “play an active role in the planning, management and governance of the health system to achieve shared responsibility and accountability for health system performance.”<sup>4</sup>

These words were an explicit and public recognition that physician participation in health care management was necessary to achieve better outcomes. Such a statement in a policy document – one that was subsequently accepted by the government’s leaders – was a first in Saskatchewan and possibly in Canada. The SMA had spent close to a year emphasizing the importance of physician leadership and advocating greater involvement of physicians in health care management. This development – coming in early 2017 – was rightly seen as an achievement. For its efforts, the SMA could point to having realized a significant change in the way physicians were perceived by government. A key point is that health system redesign dovetailed with the SMA’s strategic direction that sought to enhance physician participation and leadership in health care design.

In July 2017, the Ministry of Health created a transition team tasked with managing the move to a single provincial authority. Two physicians – Drs. Kevin Wasko and Bruce Murray – joined the team as full members. More physicians contributed to the transition

process, many recruited by the SMA. Collectively, their work ensured the intentional integration of physician perspectives into new structures and processes emerging from the transition to one health authority.

## Listening to our physicians

As noted above, throughout 2016, physicians across Saskatchewan were exploring how to redesign the health system to improve the quality of care for patients and the quality of work-life integration for physicians. At the fall 2016 Representative Assembly, delegates continued to support redesign in principle with a commitment to listen and learn from their colleagues. Concerned that SMA leadership not get too far ahead of the general membership, the delegates encouraged SMA leaders to seek out more input from the broader community of Saskatchewan physicians.

Subsequently, the SMA surveyed all members in January 2017. Physicians were asked for their views on team-based care, data and accountability, compensation, and physician participation in health system redesign. Close to 650 physicians participated.

The survey showed that most physicians in Saskatchewan believe in their ability to help lead and redesign a health system. They believe that a more thoughtfully designed system would provide better care for patients and better value for the public. The survey clearly indicated that most doctors are outward-looking, wanting to influence the system beyond



their own practices. Physicians are also supportive of a team-based approach to care, with decision-making shared among other health care professionals.

Other highlights from the survey included:

- 87% of respondents agreed that physicians should be responsible for using health care resources wisely
- 68% believed that physicians have the skills to help lead and redesign the health system
- 89% of respondents thought physicians have an obligation to influence care beyond their own practices
- 98% agreed care is improved when delivered by teams working to maximum scope of practice
- 74% thought current compensation methods enable Saskatchewan physicians to practise high-quality medicine

The vast majority (88%) of respondents thought that the profession needs to promote

public reporting on health system performance. Other findings of note: 86% want to know how their practice compares to that of their peers; and 76% are using data from their practices to improve their own performance.

Of greatest interest and concern, half of specialists and two thirds of general practitioners also reported that they were at “risk of burnout.”

## Learning from others

The survey encouraged the SMA and Ministry of Health to continue to work in partnership on health system redesign. A working group continued to explore how to test the principles of health system redesign with a focus on the skills, roles, and relationships required for physicians to successfully take on greater leadership responsibilities, locally or at a provincial level.

By winter 2017, there was a general consensus that health system redesign would not be a newly created program of policy initiatives. Rather, it was more likely to be a systematic implementation of best practices emulated and scaled up from health regions in Saskatchewan and across Canada. Many of the challenges in health care, some reasoned, have already been solved. However, the solutions often exist in small units, in hospitals, or in one region. Many of these success stories have never been applied system-wide. Thus began the work of exploring models and best practices that could be scaled up and adapted to the Saskatchewan context.

The SMA and Ministry of Health continued to explore the underpinnings of the role of physicians in high-performing health care systems. Building on work done during the July 2016 visioning session, the SMA and Ministry of Health invited Drs. Bernadette Loftus and Murray Ross to discuss the Kaiser Permanente approach to physician and system leadership with more than 50 leaders and stakeholders. Interestingly, the Kaiser Permanente lessons were easily mapped to the principles that had been previously identified by Saskatchewan health stakeholders. Clearly, some of Kaiser Permanente's practices presented potential pathways to achieving better care, better health, better value, and better teams.

### Connecting the dots

The theme of the spring 2017 Representative Assembly was "Health care redesign: ideas to action." By now, a year had passed since this important discussion had begun. It was time to "connect the dots" and make abstract concepts more concrete. Examples of the four pillars of redesign were shared by Saskatchewan physicians leading change within the province. SMA members presented to their peers the results of cutting-edge work related to emergency department waits and flows, appropriateness of care, and data and accountability initiatives related to electronic medical records. A panel of physicians openly talked about the strengths and weaknesses of a variety of compensation models. Presenters

noted that these topics were not a set of disparate activities, but were in fact examples of ongoing health system redesign work.

Delegates were keen to explore different compensation models, and the idea clearly emerged that compensation issues are not only economic questions, but also relate to workload, burnout, and overall physician satisfaction, all key elements of health system redesign discussions. Much work in this area remains to be done, but holds promise.

### Future directions

As of November 2017, discussions continue about creating a pilot site in Saskatchewan where physicians and Ministry of Health officials can test redesign ideas. Physicians are identifying barriers and opportunities related to possible redesign/co-design efforts. The Saskatchewan Health Authority has developed a new leadership structure with four physician executives working as dyad partners with provincial vice-presidents. The SMA continues to foster debate and discussion on how enhanced physician leadership can help to transform the health care system.

The discussions happening in Saskatchewan may well have national significance. Physicians elsewhere face the same problems that motivated Saskatchewan doctors to take action. However, a fortunate confluence of environmental changes in Saskatchewan – including political commitments and a general

optimism about health care, together with larger changes such as amalgamation of health regions – are creating fertile ground for possibilities that could yield results not seen elsewhere.

If redesign principles are shown to be the mechanism to successfully usher in a more integrated health care system, Saskatchewan might again be the birthplace of a new chapter in Canadian health care history. A significant transformation cannot happen without an authentic dialogue with physician leaders. It looks like that dialogue might finally be happening.

### References

1. National health expenditure trends, 1975 to 2016. Ottawa: Canadian Institute for Health Information; 2016:20.
2. Davis K, Stremikis K, Squires D, Schoen C. *Mirror, mirror on the wall: how the performance of the U.S. health care system compares internationally*. New York: Commonwealth Fund; 2014. Available: <https://tinyurl.com/pacv7o5>
3. The future physician role in a redesigned and integrated health system. Regina: Saskatchewan Medical Association; 2016:4.
4. Optimizing and integrating patient-centred care. Regina: Government of Saskatchewan; 2017:5.

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# Accountability and trust: sitting on a three-legged stool



Darren Larsen, MD

Professional accountability is balanced and well supported on a three-legged stool made up of patients, clinicians, and the health care system. All three legs must be strong, and pressure must be exerted equally and oppositely through each of them at all times. Strength and stability of the stool is enhanced by building trust in our partnerships through consistent displays of trustworthiness. The challenge for physicians, patients, and the government during periods of critical change is to create processes that allow

safe displays of honesty, integrity, and reliability and acknowledge them when they occur.

**KEY WORDS:** accountability of physicians, trust, trustworthiness, patient-physician relationship, professionalism

## Accountability is shaping the culture of medicine

Much has been written in the United States about the intricacies of accountable care, the spillover of which surely influences our thinking in Canada. Some believe that accountability drives meaningful changes in behaviour that can improve quality and performance in our health care system.<sup>1</sup> Others think that agreements based on measurement and reporting drive change in one area but then have unforeseen consequences in another.<sup>2</sup> Without question, though, accountability is shaping the culture of medicine.

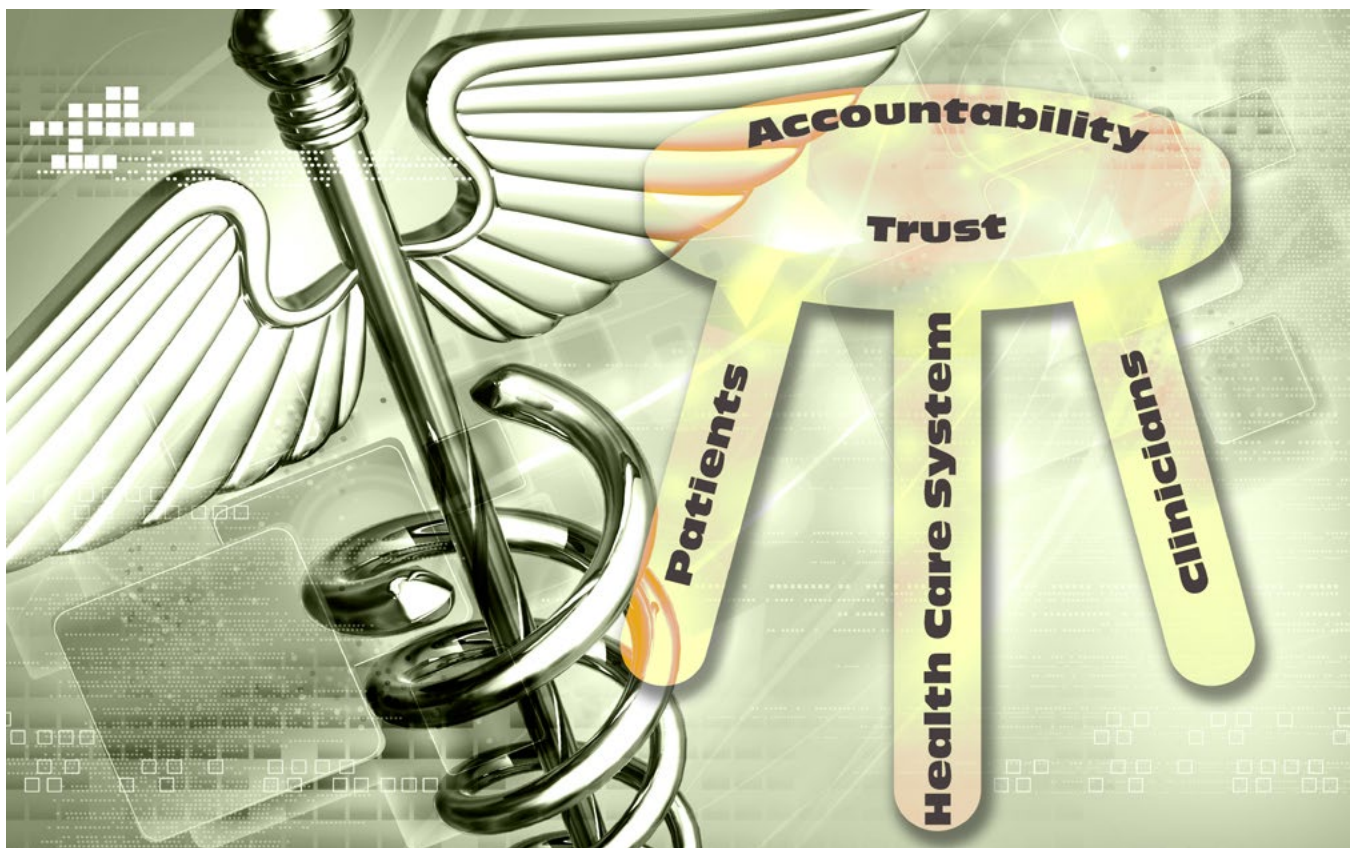
But what is it exactly? And how do we make it palatable? In my opinion, accountability is about *matching the desire to do the right thing with showing that the right thing is actually happening*. It connects intent with outcomes. When viewed in that light, the concept is actually rather familiar to health care providers. It has formed the basis of our evidence-based scientific thinking for decades.

Still, an analysis of the relationships on which accountability is based may be helpful in making the concept more agreeable.

Physicians maintain three professional accountable relationships: to patients, to peers, to the health care system. These interdependent relationships function like supports on a three-legged stool. Stability is certain if all three legs are strong; the forces exerted in each leg must be equal and opposite and exerted through its core. A leg can still support the stool while flexing and bowing to a degree, but ultimately each must be relatively strong for the stool to remain upright.

Recently physicians have felt unstable when perched on this stool. This is evident in statistics, such as “70% of residents are suffering from burnout.”<sup>3</sup> It shows up in displays of intraprofessional incivility and bullying.<sup>4</sup> Physicians may feel like they are not on a stool at all, but rather that they are trying to balance on something more like a fitness ball, where no stabilizing forces or supports exist. External pressures currently pushing health care range from political battles, to overcrowding of hospitals, to an increasingly aging and complex patient population. Without a stable stool, there is a strong likelihood that a provider will fall over. This is an uncomfortable feeling.

So how is balance restored for physicians? How can the stool be built so that there are three legs equally pushing up against the forces of professional gravity, thereby creating a safe place to sit and work? One way may be to create an environment in which a different type of conversation can be had between physicians, as well as among them, the health care



system, and their patients. Open communication in troubled times, really listening to and hearing what each side is experiencing, and having authentic non-judgemental dialogue enhances stability. It does so through the creation of trust.

In health care, trust seems to have slowly eroded away over the past two decades. It has been lost as patients realize that physicians are not the sole keepers of medical knowledge.<sup>4</sup> It has dissipated as care becomes more and more managed by administrators or others distant from the patient. It has been reduced as specialists become siloed away in sub-sub-specialties, less accessible to primary care providers, with fewer personal points of contact in the hospital corridor or cafeteria. It has been blocked by technology where voicemail and

fax have become the principal methods of communications between physicians. Perhaps this is just the “new normal” and cannot be changed. Physicians should ask themselves, though, if it is acceptable for a low-trust environment to be viewed as the norm.

Business literature is full of commentary on the creation of trust and the benefits it confers to intraprofessional relationships. Dr. Paul Zak, at Claremont Graduate University, has spent his career researching the neuropsychology of trust. He has shown that in organizations where there is a high level of trust, compared with similar companies with low trust, employees report 74% less overall stress, 106% more energy at work, 50% higher productivity, 76% more engagement, 13% fewer sick days,

and 40% less burnout.<sup>5</sup> Surely, then, there is good reason to rebuild a culture of trust in health care.

Baroness Onora O’Neill, a highly esteemed Cambridge academic and chair of England’s Equity and Human Rights Commission recently spoke in a TedX talk on the generation of trust and how this influences our professional relationships.<sup>6</sup> In her lecture, Baroness O’Neill posited that trust cannot simply be built; it must be earned. How, then, do physicians and their partners earn trust in accountability conversations? They do so, she says, by being trustworthy.

There is an important difference between trust and trustworthiness. Baroness O’Neill asserts that humans scan for trustworthiness

constantly and that it is perceived via three qualities or traits: honesty, integrity, and reliability. Trustworthiness is naturally evaluated as well as displayed by each of us in every interaction we have and can be improved with attention. Trust is earned over time and by fairly consistent displays of the above three traits as physicians interact with each other and the system.

Offering up opportunities to trust one another exposes vulnerabilities. It requires safety. Trustworthiness is not the sole responsibility of physicians, but also of the two other partners with whom they work closely in health care. Over time, constant exposure to the principles of trustworthiness buttresses weaknesses in the integrity of the legs on our three-legged stool.

**Trusted relationships can be nurtured through dialogue, direct and honest communication, and by working side by side on challenging health care issues.**

### Patient accountability

Trust between physicians and patients has changed over the past few years. There has been an implicit social contract in the doctor-patient relationship, and it is still seen as sacred. The medical social contract is explained well by Creuss and Cruess.<sup>7</sup> In their thinking, society's and patients' expectations of providers in such a contract are:

- Services of the healer
- Guaranteed competence
- Altruistic service
- Morality and integrity
- Promotion of the public good
- Transparency
- Accountability

In turn physicians can expect from society and their patients the privileges of:

- Autonomy
- Trust
- Monopoly
- Status and rewards
- Self-regulation
- A highly functioning health care system, sufficiently resourced

It is easy to see where this social contract may be failing us, and likely these principles could be modernized. In the past, patients trusted doctors simply because they possessed a body of knowledge and insight that the untrained person did not. In turn, physicians would see a return of trust when advice was sought, followed, and found to be valuable. Now, patients have exposure to countless opinions and unlimited access to information on the Internet. They are much more able to make informed choices as to how they treat and care for themselves without medical expertise. There is no longer a monopoly on knowledge.

Trust from the social contract is now based on a shared relationship. The insights physicians can offer are in the interpretation of information

through the lens of experience and previous exposure to similar patients and problems, as well as a deep longitudinal knowledge of the patient. As doctors show trustworthiness and adapt to this new reality, *if* they adapt to it, accountability changes. It becomes more equal. This leg of the stool is the easiest to keep strong as it is tested and reinforced dozens of times each day in patient care.

### Peer accountability

The second leg of accountability is that of peer to peer. Doctors have had trust and assessments of trustworthiness built into their learning from their very first days in medical school. They take advice from colleagues on how best to care for some of their most challenging medical dilemmas. For the most part, this trust is based on strong relationships between them. There can be variability in trust based on experience and individual interactions with specific colleagues, which allows choice, as trustworthiness builds over time. One may choose to wait longer to have a patient see Dr. Jones because one trusts her judgement more, even when a more accessible doctor may have the same level of competence but is not seen as having the same degree of reliability or integrity.

Trust in the community of physicians as a whole may have diminished as well. Reasons may include system barriers to maintaining a strong medical community of practice (increasing degrees of sub-specialization, siloed locations of practice where hospital and community physicians rarely mix, fewer personal



connections with peers), some could be related to demands on time, and some may be related to a changing professional mix in the work environment.

With effort, though, trustworthiness between peers can be enhanced in this difficult time. Trusted relationships can be nurtured through dialogue, direct and honest communication, and by working side by side on challenging health care issues. Again, to build better connections and trust, clinicians need to increase their trustworthiness. Colleagues should be seen as partners rather than adversaries,

supporting a diversity of ideas and multiple opinions on how to solve any collective problem. This will strengthen the second leg of the stool. In using and nurturing trust, physicians are being accountable.

### **Accountability to the system**

A very important third leg of accountability comes from physicians' intersection with the larger health care system. This includes the structures that surround their work (hospitals, regions, community agencies) and the government that funds most of it. There has been a huge erosion of the strength of this stool

leg recently. Some would even go so far as to say that, in some provinces, it has rotted completely. If we agree that the integrity of the wood itself is poor, then it behooves us to find ways to build in strength and resilience from the outside, like a cast on a broken limb.

Trustworthiness is hard to assess when you fear that at any time the three tenets of honesty, integrity, and reliability are missing. Bracing and bridge-building will allow trustworthiness to accumulate on both sides of the relationship. Both providers and system planners must strive for ways to show that each is being honest, acting with integrity, and exhibiting reliable competency. This will be hard work, especially when agendas are not the same. And it will not happen all at once.

Trustworthiness can be built with constant acknowledgement of work done in good faith. It will require transparency, patience, careful observation, examination of failures, and celebration of success. The relationship does not need to be perfect for trustworthiness to be shown, but the approach *does* need to be consistent. To succeed at earning trust, physicians and the health care system must view each other with open minds and watch for examples of cooperation that enable change so that these are not missed.

In positions of vulnerability, both doctors and health system leaders should be careful not to make assumptions about the motivations and intentions of



Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. *Intern Med J* 2012;42(5):569-74. doi:10.1111/j.1445-5994.2012.02766.x

3.Holmes EG, Connolly A, Putnam KT, Penaskovic KM, Denniston CR, Clark LH, et al. Taking care of our own: a multispecialty study of resident and program director perspectives on contributors to burnout and potential interventions. *Acad Psychiatry*

2017;41(2):159-66.

<https://doi.org/10.1007/s40596-016-0590-3>

4.Boyle T. Ontario doctors 'distressed' over wave of bullying, infighting. *Toronto Star* 2017;Feb 27.

<https://tinyurl.com/gn484ze>

5.Zak PJ. The neuroscience of trust. *Harv Bus Rev* 2017;Jan/Feb:85-90.

6.O'Neil O. What we don't understand about trust. TEDxHousesOfParliament; 2013. Available: <https://tinyurl.com/ybrgv7s> (accessed 15 Oct. 2017).

7.Cruess SR, Cruess RL. Professionalism and medicine's social contract with society. *Virtual Mentor* 2004;6(4). Available:

<https://tinyurl.com/qzvjq8p>

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the other. With care and repair, a broken, unstable stool leg can be replaced with a stronger one made of new hardwood. This wood will not be without its knots, but knots don't necessarily weaken the core of the leg. It can be strong despite its imperfections and is much more interesting to look at. With this earned trust, bilateral accountability is easier to understand and maintain.

**Professional accountability is balanced and well supported on a three-legged stool, made up of patients, clinicians, and the health care system.**

### Achieving balance, finding strength

Professional accountability is balanced and well supported on a three-legged stool, made up of patients, clinicians, and the health care system. All three legs

of the stool must be kept intact and strong, and pressure must be exerted equally and oppositely through each of them at all times. Strength and stability of the stool is enhanced by bracing weakened legs and by building trust in our partnerships through consistent displays of trustworthiness. The challenge for physicians, patients, and the government during periods of critical change is to create processes that allow safe displays of honesty, integrity, and reliability and acknowledge them when they occur. Over time, less and less effort will be required to find balance, and eventually there will be comfort felt in just sitting, knowing that we won't fall over.

### References

- 1.Phipps-Taylor M, Shortell SM. More than money: motivating physician behavior change in accountable care organizations. *Milbank Q* 2016;94(4):832-61. doi:10.1111/1468-0009.12230
- 2.Mannion R, Braithwaite J.

# Physician leadership development through the lens of LEADS and competency-based education

## Manitoba pediatric residents' experience

Ming-Ka Chan, MD, Celia Rodd, MD, Elisabete Doyle, MD, Eleanor MacDougall, MD, Jenette Hayward, MD, and Karen Gripp, MD

Leadership development for health care professionals has received increasing emphasis globally, with a focus on starting training early and continuing throughout the career life cycle. In this case study, we review the current milieu of physician leadership education opportunities in pediatrics at the University of Manitoba, showcase some exemplars, and discuss enablers and challenges. Our leadership development programs are incremental; use

formal and informal teaching, role modeling, and mentor support; and provide abundant opportunities for application. Local initiatives are further enriched by regional, national, and international opportunities to engage in interdisciplinary and interprofessional learning. Our program is robust and supported by a culture that values such development. Increasing momentum is needed to enhance the formal curriculum, further integrate it into a competency-based education model, train the trainers, and increase opportunities for experiential application. Processes and outcomes must be measured and evaluated to understand the return on investment and make the case for ongoing support and sustainability.

**KEY WORDS:** leadership training, leadership development, resident education, mentorship, CanMEDS, LEADS, pediatrics

The need for leadership development for health care professionals has been steadily growing, and it is recognized as integral to the global educational mandate.<sup>1</sup> The Future of Medical Education in Canada (FMEC) reports for both undergraduate<sup>2</sup> and postgraduate<sup>3</sup> learners recommend that leadership development start early and continue throughout the professional life cycle. The University of Manitoba, and particularly the Department of Pediatrics and Child Health, wholeheartedly embrace this philosophy. Our curriculum centres around the need for “leadership education for all physicians” with additional “leadership education for some,” such as chief residents. Although the FMEC reports<sup>2,3</sup> specify the need for collaborative leadership, our current offerings are largely concentrated within our discipline, with some joint resident and faculty opportunities.

The objective of this article is to describe the curricular opportunities provided to our pediatric residents with respect to leadership training. These include both targeted episodic and longitudinal offerings, which are predominantly direct and in person. In addition, we discuss facets of experiential learning and application, along with the feedback and mentorship so critical to lifelong leadership development.

The evolution of residents as leaders begins with the acquisition of skills, followed by opportunities

to practise leadership and receive coaching feedback, which is provided and enhanced by senior resident and faculty role models. Graded supervision allows advancement to increased levels of autonomy. The LEADS framework<sup>4</sup> (*lead self, engage others, achieve results, develop coalitions, systems transformation*), integrated with CanMEDS competencies,<sup>5</sup> provides a useful organizational scaffold on which to base our curriculum.

### Transition to discipline

In the first few months of residency, leadership development begins with a focus on *leading self* and *engaging others*,<sup>4</sup> with some targeted sessions on *achieving results*.<sup>4</sup> Residents reflect on personal strengths, goals, and barriers; practise communication skills; and learn and practise feedback skills, supported by online modules. This stage is further buoyed by the assignment of experienced core-of-discipline (second- and third-year) resident mentors, who provide fundamental support at this early stage, as new residents require not only orientation to residency, but often also adaptation to a new environment.

Early in the first year, all residents participate in and reflect on a nurse-shadowing experience to engage and better appreciate the perspective of others. Fundamental skills in team leadership are developed through formal courses in neonatal resuscitation and pediatric advanced life support, as residents accept explicit responsibility as a

team leader to assign roles and facilitate team communication. During ward rotations, participation in monthly mock code scenarios reinforces the key learning points of respectful and effective communication and collaboration.

### The overarching goal of ASK is development of lifelong learning skills by engaging the residents around questions relevant to best care practices (achieve results), as well as enhancing their ability to appraise literature critically

Since 2016, all first-year residents participate in a four-week rotation titled “academic skills and knowledge” (ASK), building on the experience of other successful pediatric programs.<sup>6-8</sup> Using adult-learning strategies, sessions are mostly interactive in a small-group setting.<sup>9</sup> Residents prepare ahead of time and lead sessions; didactic information is applied immediately in a practical manner; and opportunities abound for residents to share existing knowledge as well as reflections. For a small (< 5%) portion of the curriculum, residents use online tools, such as the Tri-Council Policy Statement ethics tutorial<sup>10</sup> and the Institute for Health Improvement Open School on Quality Improvement.<sup>11</sup>

The overarching goal of ASK is development of lifelong learning skills by engaging the residents around questions relevant to best care practices (*achieve results*),

as well as enhancing their ability to appraise literature critically. By doing this, we aim to improve their ability to understand and apply pediatric literature and support their mandatory scholarly projects as they develop into clinicians and leaders.

As part of the leadership focus, all preceptors introduce themselves and highlight individual career trajectories and their roles in and outside the department apart from clinical duties. Many faculty have additional credentials, such as specialized graduate degrees, in addition to Royal College training. Moreover, the residents learn to see preceptors as role models and leaders, locally, nationally, and internationally. Such extended introductions enable residents to forge links with the hospital; past residents have commented on increased comfort with approaching faculty and seeking leadership, advocacy, and scholarship opportunities.

Using deliberate initiatives, residents are asked to see the hospital, patient care, and leadership as shared activities. Inclusiveness is explicitly fostered by residents alternating groups and roles, such as leader and follower. Through informal mingling, teamwork, and the creation of a trusting environment, residents develop a remarkable cohesiveness that enables increasingly mature feedback on small-group presentations. Residents also have opportunities to contribute to improvements in health care, engage in stewardship, demonstrate leadership, and discuss career



planning – all key competencies of a leader. These opportunities often involve simulated or self-designed plan-do-study-act cycles.

The ASK curriculum serves as a finale to the “transition to discipline” period. With the benefit of role modeling and direct application, residents evolve from passive observer and “complainer” (as one resident described it) to feeling empowered and self-motivated. Residents achieve their goals of learning how to *engage others*<sup>4</sup> to create a healthy organization, in part by using their skills in critiquing medical literature to implement these goals and *achieve results*.<sup>4</sup> Through cooperation with others and a better understanding of the many roles that preceptors play, residents see themselves evolving into truly multi-dimensional pediatricians. In formal course

feedback, one learner expressed the view that the rotation had helped integrate leadership skills for residents, teaching them that they were part of the effort to improve pediatric care practices locally and globally.

### Foundation of discipline

During the latter two-thirds of the first year of residency, the “foundation” stage, the leadership curriculum continues to build on previously integrated materials with more emphasis on *engaging others* and achieving results.<sup>4</sup>

Central to all apprentice-style training, role modeling by more senior residents and faculty, combined with exposure to training experiences, is a rich and productive method by which learners develop as leaders.

Such role modeling occurs during clinical training, formal sessions such as journal club, and committee participation. All residents are required to participate in committees where representatives for each year of training liaise with other residents and faculty, learning to facilitate successful bidirectional exchange by transmitting concerns and suggestions between their own cohort and the committee.

Later in the first year, residents begin looking for supports for other training requirements, for which faculty mentorship is coordinated. Faculty mentors assist with guidance on topics including scholarly pursuits, work-life integration, and career decisions, with potential additional areas of interest, such as ethics, global health, education, or leadership.



With the addition of a third mentor for the resident's scholarly project as well as individual guidance from program directors, the mentorship support provided to residents throughout their training is both intentional and complementary.

In the clinical setting, the evolution of foundation residents as leaders is well illustrated by their three one-month blocks on the inpatient wards. For the first two blocks, they are managers of care for up to 6-8 patients on weekdays. During overnight and weekend call, residents admit patients and also provide cross-coverage for up to 20-25 patients, which requires quick assimilation of skills in time management, communication, and knowledge-gathering. Foundation residents use teaching and feedback skills in their new position as role models, taking on partial responsibility for supporting more junior learners in patient care, such as acting as a buddy for medical students on their first call night. Assisting medical students and early management of their own patients, with support from senior physicians, are the main leadership goals of these first two ward experiences.

In the final months of the foundation stage, the third ward block shifts the focus from leading an individual student and one's own patients to leading a team. Just before this block, an annual preparatory one-day case- and simulation-based "transition to senior" workshop facilitates development of skills for those moving to a senior role as ward team lead and overnight senior on-call resident. For the first half

of this third block, the resident continues as a foundation resident, but closely observes the "core" resident's management skills and interactions with others. In the latter half, the roles are reversed. The foundation resident takes on the role of team leader, while the core resident takes on the duties of the foundation resident, but provides support through coaching feedback and as a resource. The transitioning resident is further supported by faculty.

On-call leadership consists of a two-week "night float" block during which the foundation resident screens patients in the Emergency Department, reviews cases with junior learners, and manages the three teams caring for up to 75 patients. During the first three overnight shifts, the foundation resident is buddied with a core senior resident who provides graded supervision. As reflected by a recent graduate: "This style of leadership training is very effective as we [residents] are able to develop our skills very early on, and have the benefit of one-on-one mentorship from senior residents who have already gone through the process."

At the end of these two transition rotations, a comprehensive assessment of each resident's readiness to move to the core stage determines further progress.

### Core of discipline

As residents transition from their junior role into the senior (core) period in years two and three of the four-year program,

responsibilities evolve to more independent practice with continued faculty support. Residents refine existing skills to *achieve results*<sup>4</sup> and begin to evaluate *system transformation*.<sup>4</sup> Pediatric residents rotate as ward team leaders for four months and develop skills across many domains, including guidance of junior learners (including those in difficulty), prioritization and triage of responsibilities, and professional communication, while solidifying skills needed to provide comprehensive care to pediatric inpatients.

Scheduling of these rotations is intentionally spread over two years with the first ward senior rotation often coordinated with a fourth-year transition-to-practice junior attending, who provides additional guidance and role modeling, along with the faculty. The fourth and final ward rotation, at the end of third year, is deliberately arranged with a first-year resident, so that the core resident can provide high-level mentorship with faculty guidance.

During these core years, residents receive dedicated and structured learning opportunities to advance clinical leadership through courses such as "Advanced trauma life support," "Pediatric advanced life support renewal," and "Trauma resuscitation in kids," the latter facilitating exposure to intense, high-fidelity simulation along with debriefing experience and further training in team dynamics.

Monthly mock codes occur, with leadership by one of the three ward senior residents and

collaboration with other health care professionals. Each mock code scenario is written by the current Pediatric Intensive Care Unit (PICU) residents and reviewed by PICU and pediatric emergency preceptors. Real-time review, assessment, and debriefing are carried out by both nursing and physician evaluators, including the resident authors. A second monthly simulation opportunity is organized by a resident-led simulation committee and facilitated by faculty.

As in the first year of training, residents continue to participate in at least two committees. Junior-senior resident pairing on these committees allows for continuity in skill development as well as peer mentorship and coaching. On a monthly basis, residents lead colleagues in reviewing articles during journal club sessions. Deliberate engagement of faculty and residents around mentorship occurs informally and formally, including annual retreats as well as twice-yearly mentoring sessions hosted in a faculty home to discuss

career planning and provide guidance.

An annual group advocacy project engages all third-year residents to directly impact an important pediatric health issue. This project allows for a higher level of collaboration, both within the resident cohort and the community, with a timeline designed for residents to advance from idea to completion within one year. By stepping into the wider public, each resident begins a journey in community leadership. One recent participant remarked how this initiative provides “real growing experience to move outside of the hospital and meet with community groups, government and the media.”

### Transition to practice

The final year of residency brings together accumulated skills with an emphasis on critical thinking and knowledge synthesis vital to successful independent practice. Thinking outside the hospital

environment, residents explore developing coalitions<sup>4</sup> and how to transform<sup>4</sup> the health care system. The university’s office of postgraduate medical education supports an annual seminar in practice management, sponsored by the Canadian Medical Association/Joule. Numerous opportunities for leadership include collaborative organization of an independent study curriculum for the Royal College certifying examination.

All final-year residents rotate through the ward as a junior attending (JA) for two weeks, during which they oversee the ward team and are responsible for attending-level tasks. The JA takes 24-hour home call for 10 of the 14 days on rotation and receives the first call for all existing and new patients, with faculty providing continual support as well as retaining ultimate responsibility for patient care. JAs are coached and assessed on their ability to fulfill the expected role at the level of a consultant pediatrician.



To further foster leadership development, Continuity Clinic occurs as a 12-month longitudinal experience from the end of third year to the end of fourth year. For one half-day a week, residents attend a general pediatrics outpatient clinic, with a designated preceptor. Goals of Continuity Clinic include gaining proficiency in all responsibilities associated with carrying out a community pediatric practice. Real-world experiences require balancing clinic flow and patient satisfaction with increased efficiency and judicious management of resources and consultants. Exposure to administrative tasks incorporates the complexity and leadership challenges of office practice management.

### Leadership development of selected residents

In addition to this exposure for all residents, two residents are selected each year to function as chief residents for one year starting toward the end of their core training. Chief residents play a vital role in hospital functioning and the administration of the pediatric postgraduate program, in part by active participation on many hospital committees and regular meetings with residents, program directors, and the department head. Administrative tasks include organizing various teaching, managerial, and leadership responsibilities. With the support of the program directors, chief residents problem-solve on a daily basis. During this year, each chief resident is also expected to take on a project to advance pediatric resident education.

These longitudinal experiences are further enhanced through the annual 2.5-day Canadian Pediatric Resident Leadership Conference, which focuses on collaboration and leadership skills. Past attendees have primarily included chief residents in core programs across Canada, but recent and current conferences also involve subspecialty residents. The upcoming 2018 conference will co-locate with the annual International Conference on Residency Education, which has a resident-specific stream for leadership development.

### Enablers and challenges

The Department of Pediatrics strongly promotes leadership in many ways, including provision of protected time for residents, dedicated time for faculty endeavours, funding for administrative costs for the ASK rotation and the health advocacy project, and financial support for additional leadership programs, such as the annual Canadian Pediatric Resident Leadership Conference. The program directors and faculty have a culture of valuing leadership education and mentorship; a monthly Pediatric Medical Education Interest Group was established to develop faculty (and residents) as teachers and leaders.

As a key theme of the department, mentorship integrates resident and faculty programming. An annual departmental fund of \$10,000 supports broader activities through a competitive application process, and the university dean's

office provides prioritized funds for faculty toward educational and leadership development.

As described above, all residents benefit from active coaching in their process of becoming leaders. Residents are given feedback midway and at the end of each rotation on their leadership ability, including suggestions for advancement. Leadership is also reviewed and promoted at semi-annual meetings with one of the program directors.

Although our culture is supportive of leadership development, there are still areas requiring further work, such as interdisciplinary and interprofessional learning and teaching opportunities. The upcoming implementation of competency-based medical education (CBME) will require integration with national standards. However, our longitudinal competency-based and integrated leadership curricula should be easily adapted to this new model. We expect further enhancement of expected outcomes and processes will occur during adoption of CBME, where *leading teams* is a defined activity and expectation. Measurement of our processes and outcomes is still in early development.

### Conclusions and next steps

The topography of pediatric postgraduate leadership education at the University of Manitoba is both robust and effective, with widespread support by engaged learners and teachers a key factor in its success. The

integrated use of CanMEDS competencies<sup>5</sup> with the LEADS framework<sup>4</sup> provides a scaffold for curriculum development and design. Implementation of ongoing collaborative approaches with other disciplines and health care professions continues.

Ensuring leadership training and opportunities for application to all residents, while adapting programming to meet individual learning trajectories in a CBME environment, requires further refinement. As the landscape of leadership education continues to shift with development of more undergraduate leadership education programs around Canada and the world, these changes will influence the postgraduate (and faculty) milieu. Training the teachers as well as conducting program evaluation of our processes and outcomes must be a priority to ensure ongoing support and sustainability.

## References

1. Frenk J, Chen L, Bhutta Z, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010;376(9756):1923-58.
2. Future of medical education in Canada (FMEC): a collective vision for MD education 2010–2015. Ottawa: Association of Faculties of Medicine of Canada; n.d. Available: <https://tinyurl.com/y8dmoxb9> (accessed 24 Nov. 2017)
3. Future of medical education in Canada postgraduate project (2012). Ottawa: Association of Faculties of Medicine of Canada. Available: <https://tinyurl.com/ybwtsp3jw> (accessed 14 Dec. 2017)
4. Dickson G, Tholl B. *Bringing leadership to life in health: LEADS in a caring environment: a new perspective*. London: Springer-Verlag; 2014

5. Frank JR, Snell L, Sherbino J (editors). *CanMEDS 2015 physician competency framework* Ottawa: Royal College of Physicians and Surgeons of Canada; 2015. Available: <http://canmeds.royalcollege.ca/en/framework> (accessed 31 Dec. 2017).
6. Wood E, Kronick JB, Association of Medical School Pediatric Department Chairs, Inc. A pediatric residency research curriculum. *J Pediatr* 2008;153(2):153-4,154.e1-4.
7. Abu-Laban RB, Jarvis-Selinger S, Newton L, Chung B. Implementation and evaluation of a novel research education rotation for Royal College of Physicians and Surgeons emergency medicine residents. *CJEM* 2013;15(4):233-6.
8. Roth DE, Chan MK, Vohra S. Initial successes and challenges in the development of a pediatric resident research curriculum. *J Pediatr* 2006;149(2):149-50.
9. Palis AG, Quiros PA. Adult learning principles and presentation pearls. *Middle East Afr J Ophthalmol* 2014;21(2):114-22.
10. Interagency Advisory Panel on Research Ethics [Internet]. Ottawa: Government of Canada; 2016. Available: <https://tinyurl.com/brubhaf> (accessed 10 Dec. 2017)
11. Open school home page. Boston: Institute for Healthcare Improvement; 2018. Available: <https://tinyurl.com/y9dbz6n7> (accessed 10 Dec. 2017).

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perspective on leadership teaching in the residency program and provided an overall review. Karen Gripp wrote the sections on core (PGY2-3) and transition to practice (PGY4) residents and provided overall edits.

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## STORIES FROM OUR CCPES

We asked CSPL members who are Canadian Certified Physician Executives (CCPE) to tell us something about their “path” to leadership: what inspired them, how they succeeded, what they’ve learned. We hope that their experiences will provide you with food for thought on your leadership journey.

## Journey into the unknown



Gary Ing, MD

I had a dream the other night. Around 2 a.m., I received a call from an Emergency Department physician. He said all 30 ED beds were filled with patients. Several were admitted, but there were no beds available in any of the nursing units. Another 20 patients

were in the waiting room. One or two of these patients had chest discomfort as their presenting complaint. The after-hours manager was actively deploying nursing staff from other areas to provide support to the ED. Patient flow had stopped and the situation was untenable. The ED physician said that if hospital officials did not provide an immediate solution, he would not accept liability. Furthermore, he contemplated leaving the department because of the unsafe environment.

I woke up in a state of panic. It was not a dream. The situation was actually taking place. Does this scenario seem familiar?

In the 1990s, I attended a leadership conference in Toronto. A session entitled “Why do you want to be the chief of staff” captured my attention. The speaker pointed out that, as we venture into the “dark side of medicine” (i.e., leadership), there are many unknown and unpredictable consequences that may have a profound impact on our careers. On reflection, these words remain true.

Back in 1979, six months after I began to practise medicine, I became chief of the Department of Emergency Medicine at Windsor Western Hospital Centre. I was appointed, not because of my qualifications, but rather by default, as no one else was available. Hence, my journey into the “unknown” began.

Until 1995, Windsor had four acute care hospitals, but financial

challenges led the Ontario government to launch a “hospital restructuring” program across the province. Its objective was to merge hospitals and create “centres of excellence.” This process created a great deal of uncertainty and stress for both professional and hospital staff.

In late 1994, I received a call from our CEO at the Metropolitan General Hospital. He asked me to serve as the interim chief of staff for the merger with Windsor Western Hospital Centre. I thought that it would be an interesting experience and it was for a short term; therefore, I accepted the hospital’s offer.

As a result of the merger, I became chief of staff for the new Windsor Regional Hospital (WRH). The other two hospitals came together as Hôtel-Dieu Grace Hospital. I found myself managing professional staff from different cultures, who had also been very competitive before the merger. As many of the medical leaders were senior to me, it was difficult to gain their trust and respect. I had many sleepless nights while praying for miracles to assist me in my job.

I realized that I was not adequately trained to manage a staff of 350 during that merger process. I began to attend courses offered by the then Physician Management Institute (PMI). I also registered for sessions on presentation and facilitation skills at the University of Western Ontario.

Over the next 5-6 years, I witnessed a significant change in attitude and behaviour among our

professional staff. It was amazing to hear some of them use the term “we” instead of “I” and “you.” I have learned a great deal from everyone whom I worked alongside during that challenging period and I consider them mentors: board members, CEOs, VPs, directors, managers, and professional staff leaders. They taught me how to view a complex situation through different lenses and that together we can develop effective solutions. I also applied what I learned in the PMI courses – i.e., leadership awareness, negotiation, conflict resolution, etc. – in everyday situations.

If you are interested in my advice, I would like to offer the following points.

- Respect the team members you work with, especially the ones with whom you might come into conflict.
- Keep calm even in chaotic situations. Everyone around you watches you closely. How they react may be dependent on the signals you send them.
- Never disregard an idea from a member of your team. Sometimes, an innocent thought may turn out to be a game changer.
- Negotiate only when you are prepared and compromise whenever appropriate. Keep in mind the other party has to save face.
- Lead with flexibility in style. Consensus-building, a team approach, and lead by example are common strategies to gain trust and respect. However, in critical or urgent situations, do not be afraid to take charge. Being

a “dictator” for a short period may yield a prompt resolution to your problem.

- Be humble in your successes, accept failures, and learn from them. Don’t be afraid to pat yourself on the back once in a while!

In October 2013, our hospitals in Windsor underwent a realignment process, with the result that WRH assumed responsibility for administering all acute services in Windsor and the surrounding area with a population of close to 400 000. For me, this is déjà vu à la 1995.

My journey into the unknown has been full of surprises and challenges. I have no regrets, because my life has been filled with gratifying unique experiences. Yet, I still have a few more miles to go in this journey.

### Author

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## My leadership journey



William Sischek, MD

My journey as a physician leader really began with the arrival of the Health Services Restructuring Commission (HSRC) in 1996. That commission, struck by the Ontario government to address ever more challenging problems of health care delivery in the province, eventually recommended and caused a large number of fundamental changes.

The HSRC was my real initiator into the world of leadership. Recommendations of amalgamation, closure, and rationalization of hospitals and other facilities, visions of interconnected regions with improved communications, overhaul of primary care, and better defined academic health sciences networks were the foundation of my early years in physician leadership.

I had joined an academic department of anesthesia in January 1988 during a period of seemingly unlimited resources and possibilities in provincial health care. Soon, though, fiscal realities were being identified, which caused many to stop and ponder the way forward. By 1995, it was evident that the system was due for a major redesign. The conversations had turned to increasing demands on services and personnel with a diminishing ability to fund the enterprise, not only in Ontario but across our country, where similar exercises were underway.

One of the earliest impacts on health care in my world was the formation of the London Health Sciences Centre (LHSC). The previously independent University and Victoria hospitals

were brought together as a single corporate entity in 1995 just before the formal establishment of the HSRC. New challenges of previously separate hospital departments under the common umbrella of the then University of Western Ontario medical school brought realities of wholesale change. New governance structures, lines of accountability and authority all presented in a flurry of activity as the two hospitals worked toward a common future.

I found myself engaged in discussions of the changes and emerged at an early career stage as a site chief in the combined Department of Anesthesia, responsible for operational and personnel activities of an approximately 20-person subgroup department of the LHSC. Like so many other physician leaders of the time, I had no formal training, experience, or mentoring to help me perform the tasks at hand. I had barely begun the job when the HSRC arrived and shortly after mandated further wholesale changes to our region: closure of hospital sites, new construction of others, redesign of mental health care services, resiting of clinical services, and closure of units along with other changes. The stage was being set.

I engaged in my new role and sought the skills I needed by turning to the Canadian Medical Association's Physician Management Institute (PMI). At the time, it offered four programs of learning, covering change and conflict management, negotiation, governance structure and influence, as well as finance basics. I found I was not alone.

The many colleagues from across the province and country who participated with me formed a base for both learning and support. I was able to draw on that base from time to time, sometimes for advice and, at other times, simple support.

The network I joined was a growing one. It provided me with guidance and access to resources; it was also a place to exchange information and insight. I was able to share information and I learned to anticipate some major disruptions, including shortages of physicians then nurses across our system. Increased demand for clinical services during a time when there was an increasing desire to raise the bar of credentialing for many health professions posed its own challenges. There were so many skills to be acquired, all while still trying to maintain a busy practice of medicine, not to mention helping my wife raise our growing family!

In 2011, the ongoing hospital systems restructuring in London necessitated that St. Joseph's Health Care London divest itself of obstetrics and its neonatal intensive care unit. It was to assume its long-term role as a primarily ambulatory medical and surgical care centre with limited inpatient capacity. By this time I had left the site chief position at LHSC behind, had engaged in its Medical Advisory Committee as the chair, and participated on the LHSC Board, where I had worked with operational and governance changes related to restructuring.

In 2011, I helped create and then filled the position of city-wide

clinical coordinator of our now Department of Anesthesia and Perioperative Medicine. The tasks at hand involved full integration of three previously separate departmental groups and development of common policies and approaches to work load, including integrated call and fair treatment financially, all while trying to nurture and grow the academic life of the department. There was a need to ensure that the system flourished while no one was allowed to quietly "de-skill" in the new ambulatory care unit.

The focus of my administrative work was the operational aspects of fostering city-wide integration of the department while tending to its human resource and personnel challenges. I worked with our chair/chief and the other two site chiefs, with the site chiefs overseeing the operational details of the LHSC sites and helping support the city-wide efforts. Skills in organizational change management, fiscal responsibility, influencing and guiding systems and the people running them, maintaining standards of professionalism, and managing disruptive behaviour – all learned years earlier – were brought to bear for nearly six years.

The constant need to remain vigilant and attentive while anticipating new challenges meant revisiting earlier lessons learned and eventually creating some new ones of my own. I was presented with opportunities for ongoing learning and administrative skill acquisition in many ways, including availing myself of the CMA's Physician Leadership Institute (PLI) programs, which had replaced the old PMI. I reconnected with and

rejoined the Canadian Society of Physician Leaders (CSPL), a society I had been exposed to in my earlier administrative days. There, I again came to see the value of networking and support, which peers and colleagues can offer as no one else can. I occasionally undertook a new role, the mentoring and guidance of fellow leaders who might benefit from lessons learned along my own path.

It has been 14 months now since the planned “wind down” of the city-wide clinical coordinator change position I occupied. I am pleased and proud to observe the effects I have had on the systems that I engaged with. I have been able to champion a city-wide approach to the care of surgical services where the same anesthesiologists who practise superb subspecialty academic patient care also provide excellent clinical care to our ambulatory patient population. I have been part of a system that encourages surgical services to use both of the major tertiary hospital sites and the state-of-the-art ambulatory facility at St. Joseph’s. Our department has fostered and helped grow a strong chronic pain program that is flourishing on the SJHCL site and providing opportunities for multidisciplinary care of that patient population. I have helped develop innovative approaches to sedation services for the ambulatory care population’s invasive services.

After 25 years in leadership roles at the local, provincial, and national levels, I realize I’ve learned many things that guide me as I work. For example, **nothing can surpass planning**. It is so important to

clearly identify goals before beginning any task or filling any function. Keeping those goals in mind, it is important to identify both the system components and the people who will be keys to the effort, plan the needed conversations, and establish healthy relationships and open channels. If the conversations are “difficult” or have a negative aspect, as they sometimes will, it is even more important to plan them thoroughly. It not only helps me navigate the problem, but, more important, it also provides clarity and support to the people whom I address as they go forward. Most important, I have learned that **engaging the system and those around me is paramount**. Paraphrasing a sentiment I frequently hear in my home and family, you don’t get to comment unless you’ve gotten involved and try to help out.

These things, along with many other achievements, have given me great satisfaction and continue to encourage me to apply myself as a university-based clinician-administrator, as a clinical academic physician, but, most important, as a physician leader. I continue on my leadership journey at this time, in new roles again, looking forward to the next opportunities, challenges, and achievements that our health care system presents to me.

### Author

William Sischek, MD, is a senior physician leader with a focus on operational management and system change.

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### BOOK REVIEW

## The Future of the Professions

### How Technology Will Transform the Work of Human Experts

Oxford University Press, 2017  
Richard Susskind and Daniel Susskind

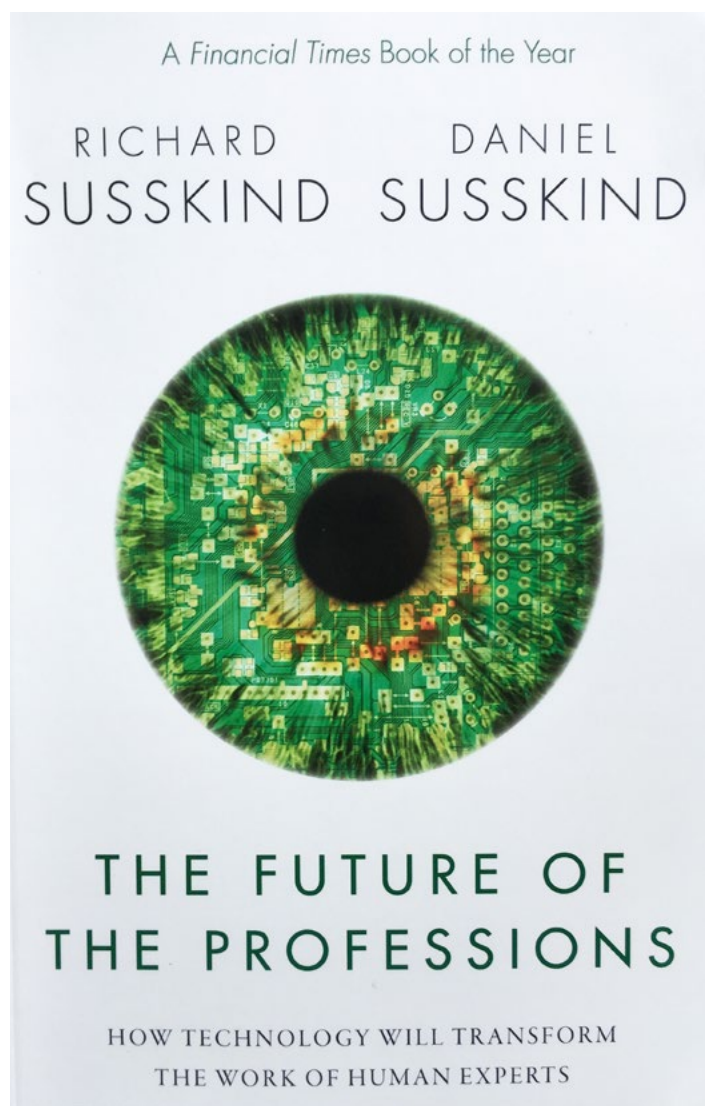
Reviewed by Johny Van Aerde

This book provides a descriptive, predictive, and normative account of why our professional institutions, including health care and medicine, will not and should not endure in their current state. Although it addresses all professions (health, education, clergy, law, architecture, and a few others), they share similarities, and one section addresses health and physicians specifically.

The Susskinds, father and son lawyer/academics, argue that professions have earned a privileged position in society, a mandate for control in their fields of specialization. In essence, the professions operate under a type of social contract: they are the gatekeepers of specialized knowledge and expertise, they are allowed to self-regulate their activities, and we place our trust in them to advise and help us.

This social contract has many drawbacks: the professions are notoriously conservative and reluctant to change, and they have become antiquated, opaque, and unaffordable. Until recently, there was no better system, but soon





technology will allow alternatives. It is these alternatives, some of which exist already, that the book explores.

The authors challenge the social contract and they propose seven possible new models for producing and distributing expertise in society:

- The **traditional model** is familiar to most doctors, as it is the way we currently deliver our services. That is, human professional providers undertake their work, usually by way of real time, face-to-face

virtual teams rather than physical organizations. They offer multidisciplinary services.

- The **para-professional model** is similar to the traditional model in that services are provided by way of consultation, one human being with another. However, the provider here is not a specialist, but rather a person with more rudimentary training in a discipline. These para-professionals are supported by procedures and systems that allow them to do some parts of the work historically done by an expert.
- In the **knowledge engineering**

interaction, and are rewarded according to the amount of time spent. They use technology for greater efficiencies to streamline and optimize traditional tasks and work.

- The **networked experts model** also involves professional human providers, but they cluster, more or less informally, via online

**model**, knowledge in a given area of expertise is incorporated into systems made available to less expert or lay people as an online self-help service.

- In the **communities of experience model**, evolving bodies of practical expertise are crowd-sourced, that is, built-up through the contributions of past recipients of professional services or of non-experts who have managed to sort out problems for themselves. Wikipedia operates in this manner.
- The **embedded knowledge model** involves the distillation of practical expertise into some form that can be built into machines, systems, processes, work practices, or physical objects. For example, digital personal monitoring systems, worn as watches or woven into one's clothing, feed physiological data into a central processing system that provides feedback about normal limits, abnormalities, and pending risk.
- In the **machine-generated model**, practical expertise originates in machines, not humans. Although the machine-generated model will involve big data, artificial intelligence, and technologies yet to be invented, it remains to be seen how this content will be used or distributed

No doubt some physicians will find doom and gloom in these predictions. Although the authors see a steady decline in the demand for human professionals in the long term, they think a great deal of work has to be done by humans in the near term. And

although machines will take over some tasks, there will be new tasks and physicians will have to think about the future of the professions from the point of view of the recipients of professional work, i.e., the patients.

Skeptics will say that some tasks can only be done by humans. The authors argue that routine tasks, even extremely complex ones, can be done by rules-based machines, and, although physicians like to think otherwise, much of what they do is fairly routine. Do the benefits of mechanization (e.g., increased access) outweigh the loss of craft, the preference for human interaction, and the need for empathy. The authors argue that the benefits probably do outweigh any single one of these costs.

This book is recommended reading because society, professionals, and physicians, in particular, are operating with limited vision and flawed assumptions about the future of professional work. You might disagree, but the Susskinds are correct when they caution us not to let our mental models from the last few centuries limit our thoughts as to what might come to be. We might as well be prepared and participate in the coming revolution.

### Author

Johny Van Aerde, MD, MA, PhD, FRCPC, is editor-in-chief of the Canadian Journal of Physician Leadership and a former president of the Canadian Society of Physician Leaders.

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