

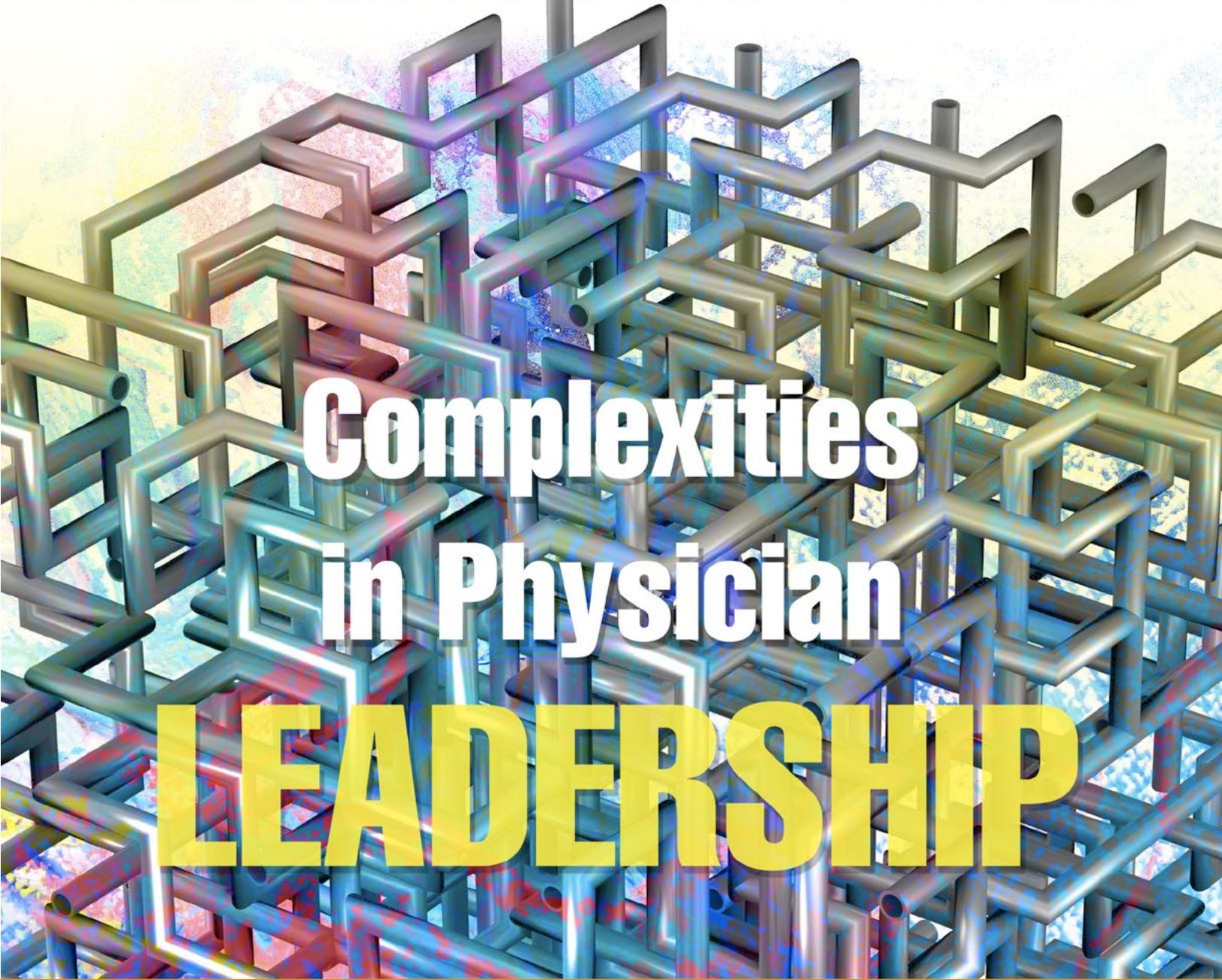
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# Physician Leadership

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## Complexities in Physician LEADERSHIP

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Waste of time or teachable moment?

A physician leader's role in managing patient safety incidents

Creating a powerful speaking style



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There are many reasons. Unlike cars, which do not have a mind or behaviour that affects their production, patients — with their intentional and unintentional behaviour within their own socioeconomic environment — do influence health system outcomes. Because of the resulting complexity, cause and effect are unpredictable and difficult to study.

This circumstance also defines the context into which one places leadership; the complexity of the context makes it difficult to attribute results in patient outcomes directly to improvements in leadership effectiveness, even though common sense may say so loud and clear. If the level of effectiveness makes no difference, then why have programs for leadership improvement in health care at all?

Evaluating the effectiveness of leadership development programs is also difficult because the focus of different programs may well differ. More so in Canada and Australia than in the United Kingdom and some of the successful health organizations in the United States, many development initiatives, particularly for physicians, are focused on *leader* development (individual) and less on *leadership* development (the capacity of groups and organizations for leadership as a shared, collective process).<sup>7-9</sup> This implies a need to incorporate leadership development into the structure and culture of organizations and the health system.

The implication is that our approach to leadership development must



overcome the preoccupation with individual leader development, important though it is.<sup>10</sup> This is important for physicians who, due to time and financial constraints, often take leadership development programs with peers at a time convenient for them, somewhat in isolation from the rest of the system. In fact, many stakeholders in the health system approach the development of leadership skills in isolation. If we are to accomplish transformational and sustainable changes, there is an urgent need for intra-organizational and system-wide collaboration and leadership training across disciplines.

A third complication in evaluating the effectiveness of leadership development is the number of factors in program design and delivery that determine that effectiveness. West and colleagues<sup>10</sup> reviewed the evidence showing what facilitating factors

affect whether and how individual interventions lead to improvements in performance in the health system. Among them were the design of programs, the knowledge and skills of the facilitators, motivation of trainees, supports in the workplace, and processes to maximize the transfer of training.<sup>10</sup>

Given the increased complexity of leadership development programs, those factors would be even greater in number and interaction. Compared with leader development, West et al.<sup>10</sup> found that leadership development as a shared, collective process was far less well explored and researched. The evidence that is available, particularly in the National Health System and some US organizations, highlights the importance of collective leadership<sup>10,11</sup> and advocates a balance between individual skill-enhancement and organizational capacity-building.<sup>8,9,12</sup>

Although academic traditions have focused on leadership in terms of entities — leaders, followers, their relationship, and shared goals — this new orientation to leadership is defined by three additional key outcomes<sup>13</sup>:

- Direction: widespread agreement within a collective (team, organization, or system on overall goals, aims, and mission)
- Alignment: the organization and coordination of knowledge and work in a collective
- Commitment: the willingness of members of a collective to subsume their own interests and benefits to those of the collective

Viewing leadership in such terms means that the practice of leadership would not only involve leaders, followers, and their shared goals, but would also include the production of direction, alignment, and commitment. Learning programs would not be confined to the development of leaders, followers, and shared goals alone, they would focus even more on the processes between those entities. A recent Partnerships in Health System Improvement research study<sup>14</sup> found that, in such an approach, contemporary notions of autonomy, accountability, and collaboration were deeply challenged. Therefore, leadership programs would have to address these mental models.

Currently, we are in the midst of a huge learning opportunity, a “teachable moment” in Canada’s health care system. If we don’t embrace that collective leadership opportunity, all leadership development programs, past and present, will have been a terrible waste of time because, so far, there are no outcomes in terms of direction, alignment, and commitment to show for those efforts. If we truly want to transform our health system, those leadership processes have to take place inter-organizationally, across national and provincial institutions. For all determinants of health, not just for health care, governments, practitioners, and policymakers have to exercise the shared leadership necessary for efforts across the system to be aligned and integrated to meet the needs of patients, service users, and communities — efficiently and effectively. If we really care about

our Canadian health system, we all have to learn, develop, and lead together.

Can governments, practitioners, policymakers, and *all* stakeholders sit down at national and provincial levels to decide on those leadership outcomes?<sup>13</sup> One of the first notions of effective leadership is a shared vision. The fact that we don’t have one speaks to the need for shared leadership development. How can we not, as a nation, decide what *direction*, goals, and mission we want for our health system? Because of this ongoing indecision on what we want, it is no surprise that we don’t know how to deliver it.<sup>15</sup> If we have no clear idea of what health care means in Canada and what it should deliver, how can we expect any policy reform to lead to real transformation?

The recent Naylor Report<sup>16</sup> on innovation highlights the opportunity for greater *alignment* — the “teachable moment” that is available to us. If a leadership imperative for alignment is the integration of knowledge and work in a collective,<sup>13</sup> then the Naylor committee’s report charts a path forward.<sup>16</sup> This group of knowledgeable people with vast experience in academia, health care, and business was given the mandate to identify the five most promising areas of innovation to reduce growth in health spending, create financial sustainability, and improve accessibility and quality of care. It was also charged with recommending five ways in which the federal government could support innovation in these areas. The vast amount of solid information in the report is based

on evidence from the literature, from conversations with thousands of Canadians, from initiatives by entrepreneurs in business and industry, and from new research commissioned specifically for this report.

It is a shame that this well-thought-out effort to highlight the need for shared leadership in the field of innovation has not been endorsed. The attempt at alignment, between federal and provincial agencies, between public health and private industry, between physicians and other stakeholders, between patients and the health system, all in the same report, was shelved the day before it was released. Ignoring the evidence and recommendations of that report did fit with previous findings by Marchildon and Di Matteo,<sup>17</sup> “Whereas physicians increasingly practice medicine based on evidence, policymakers and the implementing politicians seem to make their decisions often based on beliefs.”

In terms of the third desirable collective leadership outcome, *commitment*, we all have it, philosophically and intellectually. It is just that we fail, through expressions of self-interest, to subordinate that self-interest to decisions and actions that are in the best interests of the whole. Lazar et al.<sup>18</sup> identified an interplay of self-interests that has led to the present paradigm freeze. Political parties do not implement transformational health care policies unless they are part of the platform of a party that will replace the reigning party during the next election. In other words, when there are no transformational health care policies in the election

platform of the opposing party or when the opposition is not elected to power, the end result is no change, which is what has happened most of the time over the last 50 years. Professional associations, such as nurses' unions and provincial medical associations, have also been inhibiting forces against health care transformation by protecting their own professional turf and interests.

Lazar et al.<sup>18</sup> found that even health care consumers are reluctant to see transformation and that the chances of reform on a large scale — the type of transformational changes we need — are slim at best. Some of the conditions that might enable such transformational events are the same ones that most Canadians would not vote for if they had a choice.<sup>18</sup> Clearly our intellectual commitment does not translate into behavioural commitment. How different would the leadership outcome for commitment be if all stakeholders, i.e., government, public, and health care workers including physicians, limited their self-serving interests by practising the skills and style of “servant leadership”?<sup>19</sup>

The teachable moment is here; let's not waste it. We know that collective leadership development makes a difference; now we need to show it. We need to show how it contributes to better vision, alignment, and commitment to make our Canadian health care system realize its potential for future generations. The need for development of leaders and leadership is greater than ever. What this means for physicians is that being part of leadership is no longer an option; it has become

a requirement and an obligation. Together with all other parties, physicians have to ensure that the second decade of this century will be remembered as a teachable moment and not as a waste of time in the history of leadership development throughout the Canadian health system.

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*This article has been peer reviewed.*

# A physician leader's role in managing patient safety incidents

Tracy Murphy  
and Gordon Wallace, MD

## Abstract

Physician leaders can nurture a quality culture and achieve quality improvement (QI) goals by empowering health care providers to deliver high-quality, safe care; setting goals and expectations for QI; enabling staff to seek solutions and implement changes; and taking an active role in QI work.

Physician leaders play a central role in building and nurturing a just culture of safety in their organizations. In a just culture of patient safety, physician leaders and staff are committed to providing the safest possible care to patients and to protecting the interests of both patients and providers. Such a culture recognizes that, although mistakes happen and clinical outcomes are not always what was anticipated, all health care providers must work together to minimize risks.

Physician leaders should help to ensure that policies and procedures aimed at safe care are in place and adhered to in their organization. Leaders should also encourage care providers to assess everyday situations critically for potential risk and to speak out about their concerns.

## Leadership during patient safety incidents

A shared commitment to learning from patient safety incidents (see "A note about terminology") and to making improvements is a cornerstone of a just culture of safety. Participation of physician leaders as well as staff physicians is necessary in both quality improvement (QI) reviews (focusing on system issues to identify the causes of incidents) and

accountability reviews (focusing on the conduct or performance of individual health care providers). Physician leaders should champion their hospital's processes for properly structured reviews and help to ensure that the processes appropriately separate the accountability stream from the QI stream. In all jurisdictions, legislation protects QI materials and information from being disclosed in legal actions (and in some jurisdictions, the legislation further protects the information from disclosure in college proceedings). This means that information obtained about a physician during a QI review should not be used against the physician in the course of an accountability review (e.g., investigation, discipline, or privilege hearing).

On a related note, physician leaders should strive to avoid potential conflicts of interest when they are involved in annual performance reviews, in accountability and disciplinary matters, and in QI reviews of providers who report to them.

## How to promote quality improvement

Quality improvement for health care organizations means analyzing harm from health care delivery and making recommended improvements in patient care and clinical practices at a system level.

Physician leaders are crucial in nurturing a quality culture and achieving QI goals. This extends to helping empower other health care providers to deliver high-quality, safe care; setting goals and



**KEY WORDS:** quality improvement, QI reviews, risk, accountability reviews

improvement (QI) reviews (focusing on system issues to identify the causes of incidents) and

expectations for QI; enabling staff to seek solutions and implement changes; as well as taking an active role in QI work.



Physician leaders may wish to identify QI champions and the necessary infrastructure to support quality improvement in their organization. Where relevant, QI responsibilities should be included in physicians' job descriptions, and quality-related indicators may be used in physicians' performance evaluations. Physician leaders should advocate rewards for doctors involved in QI activities and

promote the benefits of QI and its uptake.

## Canadian Medical Protective Association support

The CMPA monitors changes in the law, the medical practice environment, and evolving leadership models.

Physician leaders should ensure that they have the appropriate liability protection for their specific role in their institution, including liability protection that may be provided by the hospital or regional health authority.

Members with questions are invited to contact the CMPA to speak with a medical officer.

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This is the last article in a three-part series written by the Canadian Medical Protective Association (CMPA) for physician leaders. Previous articles were on natural justice and fair process and managing physicians who exhibit disruptive behaviour. More information on all these topics can be found in the CMPA's *Medico-legal Handbook for Physicians in Canada* (2015). See <https://www.cmpa-acpm.ca/-/a-medico-legal-handbook-for-physicians-in-canada>

## A note about terminology

The World Health Organization (WHO) provides terminology to facilitate the sharing and learning of patient safety information globally. To support clarity and consistency in patient safety discussions, the Canadian Disclosure Guidelines<sup>1</sup> and CMPA now use these terms:

- **Patient safety incident:** An event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.
- **Harmful incident:** A patient safety incident that resulted in harm to the patient. Replaces the term “adverse event.”
- **No harm incident:** A patient safety incident that reached a patient, but no discernible harm resulted.
- **Near miss:** A patient safety incident that did not reach the patient. Replaces “close call.”

In Quebec, the applicable legislation defines the terms “accident” and “incident.” Neither of these terms corresponds exactly to the WHO terminology. An “accident” in Quebec means “an action or situation where a risk event occurs which has or could have consequences for the state of health or welfare of the user, a personnel member, a professional involved or a third person” (Quebec, *An Act Respecting Health Services and Social Services*, CQLR c S-4.2, art. 8). The term “incident,” on the other hand, is defined as “an action or situation that does not have consequences for the state of health or welfare of a user, a personnel member, a professional involved or a third person, but the outcome of which is unusual and could have had consequences under different circumstances” (Quebec, *An Act Respecting Health Services and Social Services*, CQLR c S-4.2, art. 183.2). The term “accident” in Quebec legislation would align with the WHO term “harmful incident” whereas the term “incident” would include the WHO terms “no harm incident” and “near miss.”

## THE FACILITATIVE LEADER: Managing the behaviour of challenging team members

Part 5 in a 5-part series on facilitation skills for physician leaders — an emerging necessity in a complex health system



Monica Olsen, MHRD and  
Mary Yates, MEd

### Abstract

Whether facing a new team or an established one, facilitative leaders can prevent difficult behaviour among its members by ensuring clear communication, an open environment, and effective meetings. In this article, we provide a number of tips for accomplishing these goals and intervening when poor behaviour demands it.

**KEY WORDS:** facilitative leadership, teams, challenging behaviour, meetings

Table 1. Sample questions that leaders might use to assess the needs of an existing team

<b>Context</b>	<ul style="list-style-type: none"> <li>• What issues compel us to meet now?</li> <li>• What is going on in the internal and external environment that requires our attention?</li> <li>• How will the compelling issues affect our conversations and decisions?</li> <li>• What are the known constraints affecting our decision-making?</li> <li>• What decisions have already been made?</li> </ul>
<b>Check-in</b>	<ul style="list-style-type: none"> <li>• How familiar are members of this group with each other?</li> </ul>
<b>Goals</b>	<ul style="list-style-type: none"> <li>• Why do we work together?</li> <li>• Are the end goals clear, realistic, agreed on, and relevant? (Note: these are actually four questions.)</li> </ul>
<b>Roles</b>	<ul style="list-style-type: none"> <li>• Who does what? (Meeting roles can include: time-keeper, recorder, someone to alert the group when the conversation is going off track, someone to keep track of decisions, someone to keep track of questions for which team members do not have answers, someone to draft the agenda for the next meeting)</li> <li>• Are these roles clear? Creating conflict? Suitable?</li> <li>• How is the leadership role managed?</li> </ul>
<b>Procedures</b>	<ul style="list-style-type: none"> <li>• Does the group have a clear set of rules to manage interactions?</li> <li>• Does everyone participate, or do a few dominate?</li> <li>• To what extent are members open and honest?</li> <li>• Are meetings thoroughly planned and structured or freewheeling?</li> <li>• How do members typically handle differences of opinion?</li> <li>• Are both organization and people impact factored into our problem-solving process?</li> <li>• How are important decisions usually made?</li> <li>• Does the group usually end meetings with a sense of achievement and clear action plans?</li> <li>• Do we have standards or principles to guide decision-making?</li> <li>• Are we clear on who we communicate to, when, and how?</li> <li>• Does the group ever stop and evaluate how it's doing and then take action to improve?</li> </ul>
<b>Relationships</b>	<ul style="list-style-type: none"> <li>• What is the atmosphere between members?</li> <li>• What is the best aspect of this group? The worst?</li> <li>• Are there any reasons why members might not be open and say what they really think?</li> <li>• How do we recognize and reward individual and team performance?</li> </ul>

In his national bestseller, Patrick Lencioni<sup>1</sup> clearly states: “No action, activity, or process is more central to a healthy organization than the meeting.... Bad meetings are the birthplace of unhealthy organizations and good meetings are the origin of cohesion, clarity and communication.” In this last article in our facilitative leader series, we stress the need for leaders to master challenging behaviour in meetings that otherwise squanders enormous talent and precious energy every day. We describe approaches for meetings of both new and existing teams.

### New teams

Physician leaders sometimes have the benefit of leading meetings in which team members are coming together for the first time to take on new work. In this case, they have the advantage of putting processes in place to prevent or reduce the incidence of challenging behaviour. It is always easier to prevent such behaviour than to manage it; although the following recommendations take time to implement, the investment is worthwhile.

## Create an environment of psychological safety

Challenging behaviour often occurs when decisions do not reflect the priorities of the team members. To mitigate this, physician leaders are urged to create an atmosphere that encourages team members to share, not only facts and data, but also their biases, perspectives, values, and assumptions.

## Clarify the context

Challenging behaviour may occur when team members are not clear on the context or the background for the team's work. Each member may have different information about why the team is coming together, some having "inside" information and others knowing very little. At best, this situation will create confusion and, at worst, it will result in an "us versus them" scenario, both of which can precipitate challenging behaviour.

Physician leaders who take time to clarify the context are less likely to have to deal with challenging behaviour, as all team members will be working with the same information to solve problems and, subsequently, make decisions.

Clarifying the context means addressing the following questions and issues:

- Why this change? Why this change now?
- What's going on "out there" that compels us to think about doing our work differently? What's going on out there that will impact the work we do over the next 2–3 years?

- Here's what we know (about this change and the impact of this change).
- Here are some of things we don't know (about this change and the impact of this change), and here are some things I will need your feedback on.

## Clarify goals, roles, interpersonal relations, and processes

Similarly, physician leaders are advised to clarify team goals (what the team is trying to accomplish, the results they expect to achieve), roles (what team leaders and team members will do to ensure that results are achieved), and meeting processes (how team goals will be accomplished, how the team will share information, solve problems, and make decisions). (See part 2 of this series for details.<sup>2</sup>) The more clarity the team members have with respect to team goals, roles, and processes, the less likely challenging behaviour will occur.

## Create and refer to team meeting guidelines

One of the first items on the agenda for the first meeting of the new team is the creation of meeting guidelines or rules of engagement. These agreements provide clarity regarding optimal interpersonal relations among team members during team meetings.

Meeting guidelines can be established by the team leader or by the team members. If the team is coming together for just a few meetings, it is quite appropriate for the leader to suggest guidelines.

Examples include "tell the truth," "listen hard and be decent," and "ROPES (respect, openness, participation, experimentation and safety)." In this case, the physician leader should explicitly propose the team meeting guidelines and spend a few minutes at the beginning of the first meeting explaining what he or she expects of team members.

If team members will be working together over a long period, the best approach is to engage them in creating their own meeting guidelines. When team members are consulted about their expectations, they are more likely to "own" their team meeting guidelines and follow them.

Early in the first team meeting, the physician leader is advised to ask the team members to reflect on and discuss responses to the following questions:

- What two or three things can the team leader do that will contribute to the success of our team's work?
- What two or three things might the team leader do that will interfere with the success of our team's work?
- What two or three things can team members do that will contribute to the success of our team's work?
- What two or three things might team members do that will interfere with the success of our team's work?

The responses are then compiled to create a list of five to seven meeting guidelines that are posted and reviewed during each team meeting.

## Use a check-in

A check-in<sup>2</sup> is a brief activity designed to enhance the climate by helping team members get to know one another and focusing attention on the work of the team. Team leaders who use check-ins help create a meeting environment that encourages team members to have positive relations with one another resulting in a lower incidence of disruptive, challenging behaviour.

## Provide a language for team members to describe dysfunctional meeting behaviour

Often, team members will leave a meeting feeling vaguely annoyed; they know the meeting did not go well but are unable to identify just what went wrong. Providing a language that helps them describe dysfunctional meeting behaviour makes team members more likely to voice their observations and experience during the meeting. This practice also empowers the team members to take responsibility for managing the meeting experience rather than expecting the team leader to be solely accountable. The physician leader is advised

to propose the following language to team members to describe dysfunctional meeting behaviours: hogging, flogging, bogging, fogging, frogging, dead buffalo (see part 3 of this series<sup>1</sup>). Since the language is humorous, team members are likely to use it.

## Optimize team size

The best size for a team is seven plus or minus two. Teams with fewer than five members may not have the cognitive diversity to make a good decision, whereas decision-making can be more difficult in teams with more than nine members, as balancing participation becomes more challenging. If the number of team members exceeds nine, ensure that the right people are included. Consider who needs to be at each team meeting (core team members) and who can attend team meetings on a consulting basis (subject matter experts) depending on the agenda.

## Ensure team meetings start and finish on time

Team members, who consistently show up on time only to have the meeting begin 10 minutes late,

are likely to become annoyed and disengaged. Similarly, team meetings that go on later than the agenda indicates will also cause irritation. A commitment to starting and finishing on time will help to reduce challenging behaviour, caused by team members feeling their time is not valued.

## Distribute minutes before meetings and include next steps

This practice allows team members to prepare for and focus on the business of the team meeting and can reduce unrelated and often challenging behaviour.

## Ensure fair distribution of work and recognize team member contributions

Challenging behaviour can occur when one or two team members feel that the bulk of the work is delegated to them. Physician leaders should ensure that work is evenly distributed and show appreciation for work done. Often, the work team members do on behalf of the team is “above and beyond,” and recognition from the team leader can help keep them committed and appreciated.

## Ensure members are clear on the team’s decision-making processes

Challenging behaviour may occur when team members are unclear about how decisions will be made. Teams often assume that this will be done by consensus, and when decisions do not reflect the

**Table 2. Examples of language to use when leader intervention is needed**

<p><b>Describe what you see:</b> Must be factual, non-judgemental, and not attribute motive.</p>	<p>“I’m noticing that we’re now on a topic that’s not on our agenda.”</p>
<p><b>Make an impact statement:</b> Tell the team member how the actions are affecting you, the process, or other people. Use this step only if the ineffective behaviour is persistent and previous interventions have been ignored.</p>	<p>“I’m concerned that we aren’t going to have time for our other topics.”</p>
<p><b>Redirect ineffective behaviour(s):</b> Can be done by either:  <b>a.</b> asking members for their suggestions or  <b>b.</b> telling members what to do</p>	<p><b>a.</b> “What do we need to do to get back to our agenda?”  <b>b.</b> “Would you please end this conversation so we can get back on track?”</p>

wants and needs of all members dissatisfaction may result (see part 4 in this series<sup>4</sup>).

## “Park” questions and ideas not related to the agenda

Record questions and ideas that arise during a team meeting but are unrelated to the agenda, but keep the discussion on track so that it ends on time.<sup>3</sup> The “parking lot” is helpful for recognizing team member contributions and ensuring that members are focused on what is relevant and important to them. Parked items often inform development of the agenda for the next meeting.

## Take time to make decisions

Physician leaders are reminded of the “inverted triangle” (Figure 1 in part 4 of this series<sup>4</sup>), which indicates that 80% of decision-making time should be spent gathering and sharing information; only 20% is used to make the decision. Challenging behaviour can occur when teams try to make decisions too quickly, with the result that they do not adequately reflect the needs of the team members. Physician leaders are advised to intentionally work through the information-sharing, problem-solving, and decision-making stages, purposely dedicating a good deal of time to sharing information and generating options.

## Existing teams

Often physician leaders “inherit” teams with long-standing, challenging behaviour that discourages optimal engagement

and productivity. In this case, preparation is as critical as facilitation of the meeting itself. We suggest that leaders take the following steps *before* facilitating their first meeting and then on an *ongoing* basis.<sup>5</sup>

## Before the first meeting

Assess the needs of the group using one or more of the following approaches:

- **One-on-one interviews** allow you to question members about the state of the team and their interactions. This is the best approach to help people be candid if there are sensitive issues in the group.
- **Group interviews or focus groups** work well when there are no overly sensitive issues or there are too many people to interview. This technique also allows observation of group dynamics before the actual meeting.
- **Surveys** offer an opportunity to gather anonymous information and generate quantifiable data.
- **Observation of the group in action** (ideally strictly as an observer, before formally leading the group) helps you grasp the interpersonal dynamics; assess the roles being played out and how members relate to each other.

Here are some sample questions<sup>5,6</sup> that can be tailored to fit your particular assessment approach (Table 1). Some of these were highlighted in part 2 of this series.<sup>2</sup> After the leader has gathered information about the group, a summary should be distributed to the members — either written

or key points on a flip chart — and it should be reviewed at the start of the first meeting. Ensure that time is set aside on the agenda to review and discuss this information, prioritize key issues to be addressed, and begin working on the most critical concern. We have found that, typically, it is best to begin addressing concerns that fall under context, followed by goals, roles, and procedures before resolving any issues under relationships.

## During meetings

During any meeting, periodically conduct the following four process checks<sup>5</sup>:

- Check the purpose to ensure that everyone is still clear on the focus of the conversation; e.g., “Are we still discussing our topic or have we shifted our focus?”
- Check the process to see if the approach used is working; e.g., “We agreed to work through this issue as a large group rather than subgroups. Is this approach working or should we try something else?”
- Check the time and ask members how the pace feels to them; e.g., “Is this discussion dragging or are you feeling rushed? What can we do to improve the pace?”
- Take the pulse of members by constantly reading faces and body language; e.g., “Where are you at? Is anyone feeling like they’ve dropped out? How can we get our energy levels up again?”

## Intervention

There will be times when meeting leaders need to make an intervention — a set of actions deliberately taken to improve the function of the group — particularly if:

- Members are having a side conversation
- People are interrupting and not hearing each other's points
- People become inappropriately emotional
- The discussion is stuck or off track

If the leader notices any of these problems, he or she should ask, what will happen if I do nothing? If the answer is that the group will be less effective, then the leader is obliged to take action. This can be done either in the group or “off-line,” e.g., after the meeting or during a break if that would be more beneficial.

The wording used for intervention must be carefully crafted; do not assume or judge. Here are three distinct components to guide the creation of your statement with an example for illustration (Table 2).

### Intervention wording for common challenging situations

Using the above guidelines, here are some appropriate interventions that facilitative leaders may want to incorporate into their toolkit.<sup>5</sup>

**When one person dominates the discussion:** “Pat, I notice that we’ve heard many ideas from you.

I’m concerned that we may not get to hear from others. Please hold the rest of your comments until the end so that other people can be heard.”

**When two people are arguing and not listening to each other:** “I’m noticing that you are each repeating your points. I’m concerned that you’re not hearing each other’s ideas. I’m going to ask you both to first paraphrase what the other has said before you make your own comment.”

**Members are disregarding their previously set guidelines:** “I’m noticing that you’re ignoring several of our guidelines. Let’s stop and look back at the guidelines we set last month. What do we need to do to ensure they’re being followed?”

**When someone is being sarcastic:** “Landry, I’m noticing that your good ideas aren’t being heard because of the tone of voice you’re using. How about stating that again, only in a more neutral way?”

**When one person is putting down the ideas of another:** “Joe, you’ve been ‘yeah butting’ every suggestion Gwen has put on the table. I’m going to ask you to tell us the pros and cons of each of the ideas. I want to make sure Gwen feels like she’s being heard.”

When people run in and out of a meeting: “In the last 10 minutes, I’ve noticed several people going in and out of the meeting. I’m concerned that this is disrupting the discussion. What do we need to do about this?”

### Summary

When dealing with challenging behaviour in meetings, leaders have four main options: ideally,

prevent the behaviour in the first place; intervene during the meeting; intervene following the meeting; or do not intervene. Even when confronted with challenging behaviour, facilitative leaders must be mindful that their intentions are to learn, to strengthen relationships, and to produce results.

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.” — Maya Angelou

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# Communicate clearly: a key way to protect against human rights complaints



Ena Chadha, LLB, LLM

## Abstract

Human rights complaints against physicians most often arise when patients believe they have received inadequate care as a result of discrimination. Such issues can often be avoided when physicians take time to explain their actions in treating the patient and the reasons for them.

**KEY WORDS:** human rights, physician–patient communication, conflict resolution

Over the past year, controversy surrounding physicians withholding health services for moral or religious reasons has generated significant media coverage. For example, both the *Globe & Mail*<sup>1</sup> and the

*National Post*<sup>2</sup> have published several articles about doctors in Ontario and Alberta declining to prescribe birth control because of conscientious objections. In spring 2015, the College of Physicians and Surgeons of Ontario (CPSO) revised its human rights policy regarding the legal duty of physicians to provide health services free of discrimination. The newly entitled policy, *Professional Obligations and Human Rights*,<sup>3</sup> attempts to elucidate the human rights responsibilities of doctors, with a particular focus on balancing competing physician and patient interests.

The policy states that physicians are expected to comply with human rights legislation and accommodate patients “in a manner that is respectful of the dignity, autonomy and privacy of the person.” This includes the requirement that doctors who are unwilling to undertake certain care because of moral grounds refer patients in good faith to a “non-objecting, available, and accessible” physician.

## Balancing physician autonomy with patient rights

Following publication of the new policy, the CPSO’s website was flooded with online comments suggesting that many members of the medical community believe that the policy and human rights law go too far and trample on doctors’ fundamental freedoms. Two Christian advocacy groups representing physicians have launched a legal challenge in the

Ontario Superior Court asserting that the policy violates doctors’ freedom of religion under the *Canadian Charter of Rights and Freedoms*.

A review of recent human rights



decisions highlights a dramatically different reality. Contrary to mainstream images of doctors being coerced to act against their personal beliefs, most human rights cases regarding medical services deal with patients’ complaints about inadequate care. Although the matter of competing human rights claims raises an important social topic, a survey of human rights jurisprudence from the past few years reveals that the majority of reported cases involve patients perceiving mistreatment by their doctor because of the patient’s protected personal characteristics, as opposed to denial of services because of the physician’s religious beliefs. As such, it may be helpful for physicians to understand the more common types of interactions that can result in patient complaints to human rights tribunals.

Throughout Canada, human rights legislation protects individuals from experiencing discrimination and harassment in certain social areas (e.g., housing, employment,

services, vocational association, etc.) on the basis of specific protected personal grounds (e.g., age, gender, race, disability, sexual orientation, family status, etc.). Discrimination is a direct or indirect action, communication, or decision that results in the unfair or disadvantageous treatment of an individual on human rights grounds.

Human rights legislation mandates that all service providers, including doctors and hospitals, ensure that their services are free of discrimination and that human-rights-related needs are accommodated. “Services” in the context of health care provided by physicians can comprise an expansive scope of interactions and items, ranging from medical office facilities (e.g., accessibility of premises) to consultations, testing, diagnosis, and treatment.

## Recent human rights cases

Set out below is a sample of decisions from two jurisdictions, Ontario and British Columbia, that process the highest number of human rights cases in the country. These cases illustrate the challenges of communicating properly during patient interviews and examinations. They expose a variety of ordinary misunderstandings that gave rise to conflictual patient–physician relations. Each of the cases spotlights the fact that patients are extremely concerned that their medical care not be influenced by the doctor’s preconceived or stereotypical notions regarding the patient’s race, sex, and disability, most especially when the health condition entails the use of pain

medication. The decisions also confirm that human rights tribunals will not second-guess doctors’ clinical decisions regarding proper medical treatment.

### ***Morrison-George v. Norman Krupa Medicine Professional Corporation***

After 30 years of receiving care from her family doctor, the applicant in *Morrison-George v. Norman Krupa Medicine Professional Corporation*<sup>4</sup> alleged that her doctor discriminated against her because of her race/ancestry and disability, as well as subjecting her to reprisal by removing her from his patient roster because she filed a human rights complaint. The applicant, an Aboriginal woman, lived with excruciating pain because of osteoarthritis and a degenerative disc condition. She claimed that her doctor told her that he required Aboriginal patients to undergo urine testing as a condition for continuing prescribing pain medication.

The doctor denied that he targeted Aboriginal people and explained that, because of guidance from the CPSO, he had instituted a urinalysis program for all patients prescribed narcotics. Based on evidence indicating that the doctor had conducted urine screening for 107 patients, of which only 15 were Aboriginal, the tribunal determined that the applicant’s ancestry and disability were not factors in the doctor’s request that the applicant undergo urine testing.

The Human Rights Tribunal of Ontario expressly noted that it has “no jurisdiction to evaluate a physician’s clinical decisions as to whether they are medically

appropriate.” It further found that the doctor’s decision to dismiss the applicant from his practice after she filed the human rights complaint against him did not amount to reprisal because the parties were, at that point, involved in an adversarial relationship, which would have placed the doctor in a conflict of interest had he continued to care for the applicant.

### ***EC v. Dr. GL***

The British Columbia case of *EC v. Dr. GL*<sup>5</sup> also involved a dispute resulting in the physician’s decision to terminate services. The applicant, who suffers from an adjustment disorder (a psychological condition involving extreme difficulty coping with stress), alleged that the doctor, over the course of three appointments, did not spend sufficient time with him, did not conduct a proper physical examination, and implied that he was addicted to painkillers. As evidence, the applicant relied on a tape recording that he made secretly during one of the appointments. The recording disclosed that the patient and doctor had a disagreement about whether the patient was told the appointment time was limited.

The doctor denied the allegations and submitted that conflict arose because the applicant had difficulty narrowing the focus of his medical concerns to one or two problems and because the applicant argued and questioned the doctor’s advice. The doctor asserted that he exercised good faith medical and professional judgement in terminating the doctor–patient relationship because of the lack of trust and because the applicant



discrimination, tribunals will not evaluate a physician's clinical decisions to see if they were medically correct. Rather, tribunals focus on whether the doctor's alleged misconduct was connected to the patient's human rights attributes, such as race, gender, disability, or other prohibited grounds.

Third, as evident from each of the summarized decisions, tribunals place a heavy onus on applicants to demonstrate that the alleged discrimination relates to the patient's protected human rights characteristics. Although none of the applicants in the four cases established such a link, a clear pattern emerging from the tribunal decisions is that serious legal consequences can occur when there is a problematic quality to patient–physician communications. The key lesson to be gleaned from these cases is that ordinary doctor–patient interactions, such as communicating about physical examinations or modifications to medication regimes, if poorly handled, can engender circumstances where patients perceive mistreatment on human rights grounds. In the discussed cases, because of a lack of clarity about what exactly was going to take place in the therapeutic exchange or about the reasons why the doctor was undertaking a specific course of action or consultation, each of the applicants misunderstood and personalized the doctors' comments and conduct as related to their individual human rights characteristics. The cases reveal an absence of adequate description and notice of the anticipated steps that were to be

taken during the patient–physician appointment, which in turn escalated to friction and irreparable misunderstanding.

It is inevitable that some patients will experience stress and trepidation when discussing their ailments. Doctors must strive to encourage patients to express needs openly, acknowledge patients' feelings, and readily provide details about the “how and why” of their recommendations. The cases show that physicians should attempt to explain their actions and advice clearly and exercise greater sensitivity, especially in dealing with pain management issues, to ensure that patients do not misconceive the doctor's motives.

**The key lesson to be gleaned from these cases is that ordinary doctor–patient interactions, such as communicating about physical examinations or modifications to medication regimes, if poorly handled, can engender circumstances where patients perceive mistreatment on human rights grounds.**

To build healthy relationships with their patients, physicians must communicate empathically, clearly, and informatively to manage patient expectations and avoid tensions that can lead to greater conflict. Thus, physician leaders must ensure that the doctors they mentor and support are trained proactively in positive communication, conflict management and resolution, and

human rights issues.

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# Creating a powerful speaking style



Mila Naimark

## Abstract

Whether you are presenting at a conference to educate the public, to share research findings with your peers, to influence government officials, or to inspire communities, these five simple tips will greatly enhance your impact.

## 1. Tailor content to your audience



### Problem

Although this may seem obvious, the reality is most speakers do not take the time to investigate the characteristics of their audience and run the risk of presenting content that is not relevant, important, or

meaningful to them. This lack of preparation shows. Audiences visibly disengage: people start looking at their smart phones, fidgeting in their chairs, reading their conference programs, closing their eyes and drifting off, or, even worse, exiting the room.

### Solution

- Request a list of the people who have registered for your presentation. If your point of contact is reluctant to provide this, then ask if it is possible to receive a list of attendees' positions and organizations. Assure your contact that you will not use the list to contact or solicit them.
- Review the list. What organizations are they from? What positions do they hold? What specializations do they bring? What geographic regions are they from?
- Look for clusters: are most people from a certain organization? Profession? Specialty area?
- What is important to those clusters? Why do you think they are attending? What matters to them about your topic?
- Tailor and structure your presentation to address what matters to those clusters. You may be used to following a set structure for your content. For example, presenting research may follow the formula: literature search, method, findings, and conclusions. This may be right for a clinician group, but not if you are speaking to the public, government officials, the media, donors, or business people. For those groups, step back

and think about what they want to know and structure your content accordingly.

## 2. Use familiar language



### Problem

The second pitfall for most presenters is using language that the audience does not understand or may be only vaguely familiar with. If you have gone to great lengths to tailor the content (see tip 1), don't undermine that by using unfamiliar language.

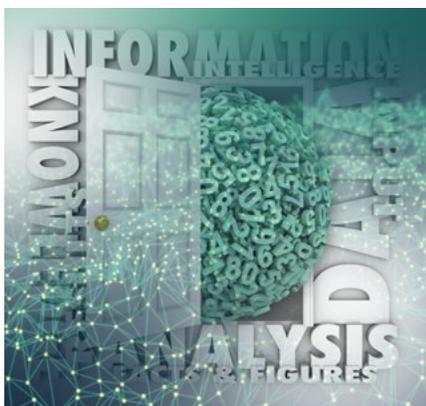
### Solution

- Jargon (acronyms, abbreviations, and technical terms) that may be common among your peers may be unfamiliar to your audience. If they know them, then use them. If they don't know them, either eliminate them or define them more than once as you go through your presentation. It is striking how often we are unaware of using jargon because it has become second nature to us as we go about our daily work. You can see whether this is an issue for you by tape recording your speech and then listening for the use of jargon. Awareness of it will usually break the habit.
- Although less common than jargon, some speakers like to "impress" an audience by using "fancy" language: great

for solving crossword puzzles, but not for expressing ideas and information clearly. Simple, everyday, common words are best because they express meaning immediately. Fancy words break attention and, once lost, it is hard to get it back.

- Long words should be avoided when shorter words will do. Shorter words are easier for an audience to grasp quickly. For example, show versus demonstrate, after versus subsequently, about versus approximately, try versus endeavour. Complex sentences that are full of long words become tedious to listen to and hard to grasp.
- Use specific and concrete words and avoid overly general, vague words. General words, by definition, allow for multiple interpretations whereas specific words are more precise in meaning.

### 3. Avoid too much detail



#### Problem

Generally, at conferences, people do not want to listen to a dissertation on your topic. They want the highlights — the big picture with a few well chosen details to back up important, sensitive, or controversial points.

Your talk is one of many that your audience has to listen to in a day, and there is only so much they can take in and absorb.

#### Solution

- Determine your central point. If I am your audience, what do you want me to do, believe or know? Do you want me to fund something? Do you want me to believe your research is ground breaking? Do you want me to change a certain behaviour? Do you want me to change my attitude about something? Do you want me to partner with you on an initiative? Once you are clear about the central point of your presentation, express it in one line — not a paragraph, just one line.
- Then determine the two or three arguments, reasons, or circumstances that form the basis of your central point and provide the relevant details that validate them.
- Time your presentation. It is important to stay within the period you are allotted. No one appreciates speakers who run over time. It may create negative feelings toward you, eliminate any goodwill you have built up, and end your presentation on a low note. Be sure to time your presentation and edit accordingly.
- Allow time for questions. Always leave at least 10 minutes for questions.

### 4. Make your slides easy to read

#### Problem

Slides are often so “busy” it is hard

for an audience to know what they are looking at, and that causes them to start reading and stop listening to you. Complicated slides often drain the energy out of the room and lead to audience fatigue from information overload. More information does not necessarily mean more communication.



#### Solution

- Design your slides to read like billboards. They should be as quick and easy to read as a billboard as you drive past. If you are concerned that that may be too little information to make your points, remember that conferences are events. They are not internal meetings where a great level of detail is required to make important decisions. They are about amplifying the highlights, not conveying all the detail. Also, you can expand verbally on the content that is visible on the slide.
- When appropriate, use pictures or diagrams rather than text. Figures help to convey information more quickly and easily in an event setting and are often the best way to illustrate a relationship, idea, or process.
- Limit text to no more than five bullet points. Bullets should be a single line, and sub-bullets should generally be avoided.
- Leave lots of white space. White space makes your

graphics (e.g., text, diagrams, pictures, charts, etc.) stand out.

- In a conference setting, dark slide backgrounds also make your graphics pop out, making it easier for your audience to grasp their meaning quickly.
- Limit the number of graphics on a slide to one or two (e.g., a text box and a chart) for easier reading.

## 5. Engage with your audience

### Problem

The final challenge for most presenters is engaging effectively with the audience. The audience needs to connect with you to connect with your message.



### Solution

- Smile. A smile does many things: it welcomes an audience, it makes you approachable, it makes you look confident, and it lifts the energy in the room. Imagine greeting your audience at the opening of your speech the way you would greet your friends at home.
- Look at your audience. Avoid spending too much time looking down, reading your speaking notes, or looking at the screen. Although you do not have to look at your audience all the time, you should try to do so most of the time. If the audience is small (fewer than 50 people), look at everyone at

least once. For a larger audience, split the room in your mind into four quadrants. During your presentation, look at different people in the eye in each of the four quadrants.

- Get out from behind the podium. The best and easiest way to engage with your audience is get as close to them as possible, even if this means standing fairly close to the edge of the stage. It builds rapport, displays confidence, and adds to a sense of dynamism. Watch a TED talk, and you will see that every speaker is out in front. Notice what a difference it makes in how the audience responds to them.

These are common sense tips, but the most important thing is to remember to use them. This requires taking the time to do things in a new way. Physician leaders are often so busy, it may just seem easier to take a presentation they have used in the past and try to make it work. However, that can be a waste of an opportunity. Investing some time and effort in using these tips will produce a significant return on that investment for you and your future audiences.

### Author

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Time to renew



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# Leading the medical division: a small business in academia



Nahid Azad, MD

## Abstract

The organization of academic medical staff is complex. A division, the smallest unit in the structure, is essentially a small business that needs full-time entrepreneurial leadership to succeed. The leader must develop a strategic plan, establish goals, build teams, and develop a budget. A division should strive to become a centre of excellence.

**KEY WORDS:** medical division, leadership, organizational structure, skill set

The organization of medical staff in an academic environment in Canada is complex and

frequently confusing. The roles, responsibilities, and objectives of the various organizational units are often vague and difficult to understand, and the reporting and accountability structure unclear. Moreover, the organizational structure is often based on medical specialty (the service provider perspective) rather than quality, timeliness, and health outcomes (a patient-centred perspective).<sup>1</sup> Within this environment, the division based on medical specialty is usually the lowest organizational unit.

**Although there is talk about medicine becoming more “patient-centred,” such a transformation would require major organizational restructuring, which is unlikely to occur any time soon.**

In this article, we investigate the challenge of leading such a medical division, starting with an overview of its organizational environment, summarizing the key roles of the division leader, moving to the leadership skill set required for success, recommending a business plan, and ending with a leadership career planning roadmap.

## Environmental context

What is a division? A simple question with a complicated answer. It is an organizational unit, usually based on a medical specialty. Division members and the division itself work in a complex interdependent network of organizations. The division provides

various types of services (clinical, research, teaching, governance) and interacts with a variety of other medical organizations associated with operational dependencies, but typically it is not directly accountable to any of these other organizations. For example, as a minimum, the division will concurrently be providing clinical service to a hospital, research to a university or other sponsor, medical instruction to residents, and governance to various medical organizations. I will use the term “clients” to refer to the collection of organizations that receive services and products from the division.

Although there is talk about medicine becoming more “patient-centred,” such a transformation would require major organizational restructuring, which is unlikely to occur any time soon. Within the current organization, a division often comprises individual contributors, with teamwork and collaboration occurring both within the division and with other divisions. In this context, how does a division determine its shared core values and client value propositions?

What is the division trying to achieve? Another simple question with a complicated answer. There are many types of divisions: some large, some small, some with a visible agenda, some whose role is less clear. The division often operates in an environment where, at senior levels, there exists a strategic plan with a breakdown into specific initiatives. Sometimes these plans have a clear focus and specific goals; sometimes the high-level plans are vague and provide little direction. In either

case, they often provide very little guidance at the division level. More important, the division operates in a partnership environment that contains multiple senior-level strategic plans, which do not necessarily align. The division does not benefit from the clarity provided by a hierarchical structure usually employed in the private sector. How does a division prioritize programs within a diverse set of opportunities and expectations?

We live in challenging times. Demands on the health care system are increasing, yet funding is often capped or even reduced. The care focus is shifting toward a patient-centred approach, giving patients and their families more control over their care plan at a time when the typical patient is becoming older and more complex, often suffering from many age-related diseases, such as heart failure and dementia. Universities are demanding both more pure and more translational research. Physicians are expected to expand the scope of their work as clerical and administrative functions are transferred to them to compensate for hospital cutbacks. Funding is gradually moving from a “best effort” to a goal-oriented, results-based model. In this new context, divisions will be competing for both funding and support staff. Times are tough and getting tougher. How does a division thrive in this disruptive environment?

For a variety of political and bureaucratic reasons, none of the above will change in the foreseeable future. Consequently, when examining division leadership, we must recognize and accept that

help will not come from above, and we must focus on the division itself.

## Roles of a division leader

The division leader must find a way to navigate this complex environment while balancing new program development with existing program commitments. “Vision and leadership matter. They embody the spirit and values of the organization.”<sup>2</sup>

I argue that the best way to think of a division is to recognize that it is essentially a small business. This business has a variety of clients for its products/services and a variety of suppliers providing products/services to it. The division must be responsive to the needs of its clients, or they will find alternative suppliers to meet their clinical, research, education, and governance requirements.

Moreover, the division needs a diverse set of clients; for long-term success, it cannot be critically dependent on any one client as its funding source.

Consequently, the division leader must be an entrepreneur, constantly looking for business opportunities to strengthen and develop the division. The leader has to be continuously promoting and building new programs in conjunction with division clients and always seeking new clients and opportunities. This networking and marketing role is crucial for division success. Accepting the status quo is a recipe for the gradual decline of division productivity and reduced value to its clients. “Without reach, there is no challenge. Without risk, there is no reward. Without vision, there is no future.”<sup>2</sup>

Therefore, successful division leadership is a challenging full-time



job. Key responsibilities of the division leader include the following.

## Developing the strategic/business plan

Naturally, the division must have its own strategic plan, and there are many ways to develop and reinforce such a plan.<sup>3,4</sup> The plan provides the framework to focus and scope the division's programs. It specifies what types of clients to seek, what type of patient population to focus on, what type of research to pursue, what services to offer, and what types of members to recruit.

**A division cannot be everything to everybody. It does need a value proposition that should be carefully chosen and clearly articulated on a client basis.**

This strategic plan should fit within, but not necessarily be directly coupled to, the variety of senior strategic plans. The plan must include a standard breakdown defining strategic directions and goals that allow the leader to clearly articulate what the division is doing, what it is trying to achieve, the performance and quality metrics, the business rationale, the timeline, and the help it needs for success.

Without a shared vision, how will members know where they are headed? To paraphrase Lewis Carroll<sup>5</sup>: "If you don't know where you are going, any road will get you there."

Within this context, flexibility is

required to meet existing client requirements and to take advantage of new clients and opportunities. The division must also team with partners to provide new services. Agility and entrepreneurial spirit are required to take advantage of opportunities to advance toward the division's goals, of course, with the ability to reliably deliver on commitments.

A division cannot be everything to everybody. It does need a value proposition that should be carefully chosen and clearly articulated on a client basis. Once this is done, the division should strive for excellence in its chosen field. The alternative is a slow decline in the relevance of the division, and its effectively "going out of business."

## Leading division programs and establishing goals

Within the context of the strategic/business plan, the leader must work with clients and members, both to develop programs and to define the division's business goals and deliverables. Program decisions must be based on comprehensive business case analysis, which must be reviewed regularly to ensure that the funded programs are delivering optimal value. The division must follow best-practice project management processes to ensure on-time, on-budget program completion, of both its internal goals and its commitments to clients.

These program goals and commitments provide the framework to develop team and individual members' roles, responsibilities, and accountabilities.

## Medical staffing

Medicine is labour intensive. The division cannot succeed without proper membership, and the medical staff is the cornerstone of success. A high-quality strategic plan and the successful implementation of programs within this plan will help attract the best candidates.

The objective is to build teams, not a collection of independent contributors. The dynamics of high-functioning teams result in the most productive and valuable divisions. It is well said: the whole is greater than the sum of its parts.

The leader must work with individual staff members to develop job descriptions, negotiate objectives, build career development plans, and assign roles and responsibilities. To ensure program continuity, the leader should have succession plans for all division members.

Assigning members to new leadership responsibilities brings innovation and revitalized energy to these roles. After about four years in a given position, members tend to move out of an innovation mode into a maintenance mode. That is the time to assign another member to that role to bring new ideas and energy.

Finally, the leader must mentor and support both individual members and teams, providing regular constructive feedback to help achieve agreed objectives. The leader must foster career development, both inside and outside the division.



## Budgeting

The division leader is accountable for the budget. The budget process forces the leadership and members to make difficult program choices. The challenge is to be sufficiently transparent to lead the division through this process, yet keep all members fully engaged and actively supporting the funded programs.

In summary, all the above entrepreneurial roles are essential for the success of the division as a small business.

## Leadership skill set

Countless books have been written about the essential entrepreneurial skills required to lead a small business. I will mention only a few that are particularly relevant to medical division leadership.

First, we must recognize that trust is mission critical. “Successful working relationships are built on reciprocal loyalty and trust. Reciprocal loyalty and trust are the foundation of any great working culture, large or

small. They are the reasons people love what they do and where they do it. Trust is so easy to lose and so hard to get back.”<sup>2</sup>

Second, the leader must think strategically and creatively to work with division members, partners, and clients to build an aspirational strategic business plan. The leader must be able to inspire division members through active, progressive, constructive, and visible leadership to achieve the plan goals.

As Larry Page<sup>6</sup> states: “My job as a leader is to make sure everybody in the company has great opportunities, and that they feel they’re having a meaningful impact and are contributing to the good of society.”

Third, the leader needs people skills and emotional intelligence. The best leaders have a sense about people, empathy, timing, and communication. At all levels of management, leaders with more emotional intelligence tend to have greater success. Everyone likes to recognize and celebrate

success, often starting with a simple “thank you” and potentially leading to a division celebration. Margaret Heffernan<sup>7</sup> states: “It’s the mortar, not just the bricks” and “the dynamic between people is what brings organizations to life.” More and more attention is being paid to the power of organizational culture.<sup>8</sup>

Fourth, a leader must have excellent communication skills. Most of the leader’s time will be spent communicating with members, stakeholders, and both existing and potential clients. Consequently, the leader must be a good listener, build strong relationships, have good negotiating skills, be an effective speaker, have good networking and influencing skills, and, finally, good coaching and mentoring skills.

Fifth, the leader must be passionate and demonstrate total commitment to achieving the business plan. All change is introduced by projects; all deliverables are delivered by projects. The leader must demonstrate best-practice project management skills. The leader must lead by example. Division members will emulate the leader’s behaviour, good or bad.<sup>9</sup>

Note that the division leader need not be and cannot be a subject matter technical expert in all the areas of division activity. His or her leadership skills are more important than technical skills. The leader needs only general technical knowledge of the division’s technical work.

In summary, at Google,<sup>10</sup> human resources assess managers’

performance partly based on the following nine behaviours:

- They communicate clear goals for their team.
- They regularly share with their team relevant information from their own manager and senior leadership.
- They give actionable feedback that helps their employees improve their performance.
- They show consideration for their employees as individuals.
- They keep their team focused on its priority results/deliverables.
- They have meaningful discussions about career development with each member of their team at least once every six months.
- They possess the technical expertise required to manage their team effectively.
- They do not micromanage by getting involved in details that should be handled at other levels.
- Their employees would recommend them to their colleagues.

Selection of a division leader is challenging. Management accreditation, such as Canadian Certified Physician Executive or others, is recommended. The required leadership skills are different from division member skills. Senior management must avoid the Peter Principle<sup>11</sup> at all cost — promoting people to leadership roles simply because they were successful in their previous roles is a flawed strategy with serious consequences. Moreover, leadership approaches are shifting to become less hierarchical and more empowering.<sup>12</sup> Many senior leaders believe that one of their

most important responsibilities is succession planning and the selection of the right junior leaders.

## The division as a centre of excellence

In the private sector, market competition dictates that companies have to manage resources and prioritize programs very carefully. To this end, many companies support only products or services that they believe will have the potential to be in the top three positions in the marketplace. The market will tell them if they made the correct decisions.

## The first step is to determine whether you have the aptitude for leadership. Do you have the passion, energy, vision, and entrepreneurial spirit for this demanding role?

Given that retaining the status quo will lead to a slow decline in the relevance of an academic division, what can divisions use to provide guidance and help determine whether they are successful? I propose that a division should try to become a centre of excellence. A centre of excellence is a premier organization, known for providing exceptional service in a sphere of expertise that provides leadership, advocacy, best practices, research, support, and training. Not all divisions will succeed, but all divisions should try to achieve this aspirational strategic goal.

The centre of excellence model provides sufficient scope to encompass all division goals and

commitments. The division strategic plan must provide the framework to achieve success as a centre of excellence.

Leading the division on the journey to becoming a centre of excellence is a difficult, demanding job that requires the full attention of the division leader to navigate the complex academic medical environment. The role requires small business and entrepreneurial leadership skills, and senior management must ensure that the leader has the requisite aptitude and skills for such a demanding role.

## Navigating the journey to leadership

As discussed above, a diverse set of leadership skills is essential to the success of the division. But how does one prepare for such responsibility? I suggest the following roadmap as part of your career development plan to help navigate this journey.

The first step is to determine whether you have the aptitude for leadership. Do you have the passion, energy, vision, and entrepreneurial spirit for this demanding role? Leadership is not for everyone, despite his or her best efforts. I recommend an “Is management for me?” type of course to provide an honest assessment of your personality traits and behaviours and determine your fit for a leadership role.

Observing leaders is the second step. We can all recognize superior leadership and role models. Start

to learn the skills and emulate the behaviours that contribute to their success.

The third step is to find a mentor — a person with coaching skills and wisdom that can only come from experience. This person will often be in the same field, but outside your immediate organization.

Training is next. Medical education focuses on hard-core medical competencies. Additional hard-skill training is needed in areas such as project management. However, leadership is mostly about working with people, and inspiring a division requires a host of soft skills. These skills include communication, networking, collaboration, influencing, building relationships and trust, emotional intelligence, and conflict resolution, among many others. These skills are more important than the traditional medical competencies.

Practice is the next step. As part of your career development, take advantage of project management opportunities with increasing complexity, particularly those that require extended teamwork and networking that allow you to practise your leadership skills.

Finally, work with senior management to become part of their succession management plan. Once part of this plan, you will have many opportunities to practise your leadership skills and build a positive track record.

With this background, training, and practice, you will be well positioned to take on division leadership with confidence. You will be able to

bring new energy and ideas to the division and have an immediate positive impact.

## Conclusion

At this point, some may feel that successful leadership is an impossible task. But this is not true. I am sure that, within your faculty, there are many excellent leaders and their divisions are thriving. In my case, as an example, I can recommend the Division of Cardiology at the University of Ottawa Heart Institute. My recommendation is based on the complex Ottawa Hospital, Heart Institute, and Department of Medicine operating environment and the nine Google behaviours mentioned above.

The division is a recognized Centre of Excellence, and the team wins many awards at the annual department recognition ceremony. With this track record, the division is able to recruit new energetic and innovative members. The division leader clearly demonstrates his pride in the accomplishments of all team members. The results of excellent leadership speak for themselves.

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# Physician identity: benefit or curse?



Graham Dickson, PhD

## Abstract

Physicians who move into leadership roles have the benefit of knowing the physician world and, therefore, are the bridge between the profession and public management. However, such moves are often viewed as a betrayal of the physician identity, a move to the “dark side” by their colleagues. Doubts about their identity may also influence their ability to be confident in their new role.

**KEY WORDS:** physician identity, negative attitude, physician leadership, cultural identity, ritualized professional identity

One of the most interesting findings from a recent study by the Canadian Society of Physician Leaders (CSPL)<sup>1</sup> was that, for physicians surveyed, “maintaining

a clinical practice was important for credibility and for staying in touch with reality” when moving into formal leadership roles. In other words, doctors who choose to eschew their clinical practice to move into administration are perceived by their physician colleagues as abandoning reality and shunning their professional roots.

The question then arises: is there something “special” about the role of physician, something unique in the doctor’s sense of identity that creates this dynamic, a dynamic that cannot be anything but obstructive when physicians are needed in leadership roles in the health care system? As Thomas Andersson<sup>2</sup> states, “the medical leadership challenge is not only a structural and/or competence challenge, it is just as much an identity challenge” (p. 84).

The CSPL study described this phenomenon as the presence of negative attitudes within the physician community: when colleagues move into formal leadership roles, their failure to retain a clinical practice is seen as “going to the dark side.”<sup>1</sup> A physician I knew once described the dark side phenomenon this way: physicians who move into formal leadership roles go from “comforting the afflicted” to “afflicting the comfortable.” Another way of putting it is that physicians abandon their identity and move to a place where they actually betray that identity.

The physician interviews in the CSPL study indicate that negative attitudes about the value of administrative work are

active early in the lives of some participants. These same attitudes are echoed by medical school professors, residency supervisors, and in the workplace. Participants acknowledged their own negative attitudes toward taking on physician leadership roles and indicated that they had to find a way to counter those internal attitudes. It is as if doctors are enculturated to agree with William Shakespeare who once said, “The prince of darkness is a gentleman.”<sup>3</sup>

Recently, I reviewed a few articles that help shed light on this interesting cultural phenomenon. It is cultural because it is a shared belief among many physicians, a customary or traditional way of thinking that permeates the mindset of many doctors. It is a belief that has almost become a fact, in that for many doctors it appears to describe reality. How has this “reality” arisen? How deep rooted is it, and how open is it to change?

The first article suggests that this attitude begins early within a physician’s career and may well be a result of how physicians are educated in medical school. Doja and colleagues<sup>4</sup> make the point that, in medical schools, there is a formal curriculum, an informal curriculum, and a hidden curriculum. Explaining the latter two, they state, “The informal curriculum consists of the unscripted, ad hoc, and interpersonal forms of teaching and learning that take place among faculty and students, as well as between students at different levels of training,” and “the hidden curriculum, in contrast, is a set of influences that function at the level of organizational structure and

culture.” Together, the informal and hidden curricula constitute a set of expectations, learning moments, and unwritten rules that are transmitted to students through the attitudes, beliefs, and perspectives modeled by those teaching the programs and then reinforced, culturally, by discourse among medical students themselves.

Doja and colleagues<sup>4</sup> go on to state that various learning processes have been identified in the hidden curriculum, including “the loss of idealism and adoption of a ‘ritualized’ professional identity.” One manifestation of that professional identity is the deeply ingrained attitude that assigns different levels of status to separate physician groups: in this case, the belief that physicians who move into administration are betraying their clinical roots.

The second and third articles focus on the concept of identity. By definition, identity is a person’s psychological core: the mental and emotional heart of one’s sense of self. It addresses questions such as, “who am I? or who do I want to be? Andersson<sup>2</sup> states that identity is “an ongoing, social construction of the self” (p. 85). John Farrell Quinn<sup>5</sup> states that a physician “adopts an identity focused on the primary function (as a clinician), which is given a superior priority and distinction” (p. 8). He suggests that identity is constructed through an ongoing discourse among the members of one’s profession and the subsequent discourse regarding that profession’s identity within society. Both authors suggest that if Doja and colleagues<sup>4</sup> description of the hidden curriculum

in medical school is correct, perceptions related to the dark side phenomenon are transmitted at the beginning of the physician’s career, from the moment he or she enters medical school.

**Indeed, one interpretation of the concept of identify is that it is the foundation of one’s self-image, which we challenge at our own psychological peril.**

Quinn<sup>5</sup> and Andersson<sup>2</sup> both agree that the long history — over 2000 years — related to understanding the role and function of the physician within society has given that identify great clarity and emotive depth. Abandoning or trying to change one’s identity is to defy deep-seated beliefs and, therefore, create psychological dissonance. When professionals, such as physicians, share a perception of identity, and that sense of identity is reinforced through an ongoing history of discourse with other professions and groups that reinforce it, it becomes more impervious to change.

Indeed, one interpretation of the concept of identify is that it is the foundation of one’s self-image, which we challenge at our own psychological peril. If elements of identity are then perceived to be tested — by a career shift from doctor to administrator — a natural resistance and even potential demonization can emerge that becomes embedded in the professional culture. In addition, the physician who makes such a shift may well “become stressed and dissatisfied when the behaviors expected in their role

are inconsistent” i.e., behaviour of clinician and that of leader,<sup>2</sup> when leaders are often construed as “the enemy.”

Andersson<sup>2</sup> outlines a number of elements that define physician identity. The first is a unique expertise in medical science. The second is an assumption — deeply rooted in the concept of professionalism — of a high level of autonomy and individual responsibility. A third — also grounded in professionalism — is that physicians’ activities are self-governed to a higher extent than in other professions. A fourth is a strong focus on a life-long career, the dynamics of which are negotiated and defined within the profession itself. Emphasizing this point, Quinn<sup>5</sup> states, “physicians... [are] confined to a professional group that excludes others... there is reluctance to become subordinate to those outside of their group,” e.g., non-physician administrators and physician leaders themselves, who have the added stigma of abandoning their professional identity. It is deeply self-referential and, therefore, highly internalized.

It is instructive to compare these factors that define physician identity with factors associated with the role of leader/manager in the health care system. Doing so illustrates the gulf of difference between the two roles. The very role of manager is relatively recent in a historical sense. What is now called public management (e.g., expressed in Canada through the Canada Health Act and its agents, such as public health systems, hospital boards, primary care networks,



and regionalization of health service delivery) is a 40-year-old phenomenon, whereas the role of physician is thousands of years old. Indeed, I once had the privilege of seeing a newly graduating physician proudly standing beside a sculpture of the caduceus in Ephesus, Turkey, which had been found recently during an excavation at the ancient home of Hippocrates, as her parents clicked away with their camera to capture this proud moment.

It is important to note, too, that leader/managers who are employed in the system do not belong to a profession, whereas doctors do — with the attendant rigour demanded of them to qualify to enter and the distinction that belonging to such a profession generates. Doctors who move into leadership roles may be perceived by their colleagues as forsaking that effort.

Another major difference is that modern leader/managers are generalists rather than medical specialists. They see their role as building relationships and acting through and with others to get things done, rather than taking pride in the exercise of individual

responsibility, as doctors are prone to do. These major differences highlight the identity challenge physicians face, when they choose to become credible and influential leaders in the health system.

The dark side phenomenon is hard to resolve. It is well known in the leadership world that “culture eats strategy for breakfast.” To change that culture is a daunting task. Deeply ingrained notions of physician identity, rooted in thousands of years of construction, are the source of the dark side phenomenon. However, culture can change when the unconscious mindsets and beliefs of people are surfaced. Demonization by some physicians of their colleagues who move into administration is counterproductive.

For all these reasons, it is understandable that physicians who move from clinical roles to administrative roles may see that move as both a benefit and a curse. A benefit in that they can use their knowledge, expertise, and influence to serve many patients at once, not just one patient at a time. A curse in that they alienate some of their colleagues in doing so, and may well have lingering doubts about their own identity, which may in some ways influence their ability to be confident in their new role.

This state of affairs is counterproductive. The current

health system can only benefit when the physician perspective is brought to bear on the future of that health system. Physicians who move into leadership roles have the benefit of knowing the physician world and, therefore, are the bridge between the profession and public management. It is best to build and grow that partnership, rather than continue to attenuate it. Let’s put the dark side controversy to rest.

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*This article has been peer reviewed.*

## BOOK REVIEW

# Inspired Physician Leadership: Creating Influence and Impact

Charles R. Stoner and  
Jason S. Stoner

American Association for Physician  
Leadership, 2015

Reviewed by Johny Van Aerde, MD,  
PhD

The need for physician engagement and leadership is greater than ever. When physicians are engaged in monitoring organizational performance, better outcomes from clinical and financial measures occur, and quality of service improves.<sup>1</sup> In 2015, this fact was reconfirmed: the CEOs of the top five health organizations in the United States are physicians.<sup>2</sup>

However, while the need for physician leaders is apparent and growing, not enough doctors are poised to engage and succeed in leadership roles. Besides deficiencies in training and skills, financial and status disincentives further contribute to physicians' reluctance and ambivalence about assuming formal leadership roles.

*Inspired Physician Leadership: Creating Influence and Impact* is intended to help physicians

# Inspired Physician Leadership

Creating influence and impact

By Charles R. Stoner and Jason S. Stoner



An American Association for Physician Leadership® publication

transition into leadership roles. The authors extrapolate knowledge from the world of leadership into the world of physicians, based on their long experience as academicians and executive coaches. It is a book for established physician and non-physician leaders, for academicians and teachers interested in leadership in general and in physician leadership specifically. It is not meant for emerging physician leaders who are looking for their first textbook.

The book is unique because it is solidly based on evidence and because some chapters focus

on specific difficulties doctors encounter when transitioning from clinician to leader. Each chapter gives at least one real-life example of a physician facing a problem related to the chapter topic. The book is strong in providing evidence for why physicians, with their training, mental models, and assumptions, are at risk of failing when tackling those topics. The book is less strong in the practicalities, in how to apply the evidence and theories in day-to-day life.

Physicians demand a blend of evidence and pragmatism, and

Inspired Physician Leadership is guided by those core tenets. Physicians deal with evidence. To gain credibility with doctors, Stoner and Stoner ground the book in sound research, accepted theories, and best practices. Because physicians have little time, the delivery of that knowledge is meant to be practical, realistic, and approachable. The book provides plenty of good, solid evidence, but falls somewhat short on pragmatism in some chapters.

The authors first introduce the challenges of transitioning from clinician to physician leader and the mind switches that go with that transition: from doer and respected independent performer to interdependent leader; from expert with technical skills to leader with interpersonal skills; from reactor or resistor to change leader; from social embeddedness that includes personal pride, interpersonal prestige, and status to losing part of that identity. Because doctors are intelligent and action-oriented, they are often impatient, inflexible, and perfectionist. As a result, their underdeveloped listening skills, quick comprehension of issues, and decisiveness do not set the average clinician up for success as a leader.

The chapter on tone deals with self-awareness and self-management, one's related emotional intelligence, and how these elements connect with the construct of trust. Models of trust-building could have been explored more widely, and the link with credibility and respect could have been made more clearly. The chapter includes a good sample of references to literature

on emotional intelligence and authentic leadership.

Dialogue and communication dives somewhat deeper into the concepts of engaged listening and inquiry. However, the dynamics of dialogue could have been explored much more and applications with examples are missing. The barriers to good dialogue, and how to watch out for them, are well elaborated. Overall, this chapter has useful elements, while other important features of communication and its practice are missing.

The chapter on teamwork and collaboration includes helpful sections on the dynamics of team development, what is needed to build a successful team, how to hold effective meetings, team communication, trust, and conflict. This chapter includes lots of evidence and references on many aspects of teams.

The conflict chapter provides insight into the origin, management, and resolution of conflict. It, too, offers plenty of evidence and research, but provides little practical advice. Like all the chapters in this book, this one explains how physicians, in general, perform in this particular domain.

The chapters on negotiation and motivation seem to be more suitable for the organizational non-physician leader than for physicians. Of interest is the research evidence on what motivates physicians: the impact of their work, the feeling of accomplishment on completing a difficult and challenging task, recognition, autonomy, respectful collegial interactions,

compensation, and, most important, identity as part of societal status. The chapter does not do well in addressing the factors, other than motivation, that would help the leader change behaviour in either self or others.

The book finishes with a chapter on change management, which touches on the very basics. It is insufficient for those who want to influence and accomplish change in an organization.

In short, this book is worth owning because it contains a lot of evidence-based knowledge on leadership in general. More specifically, it helps us understand *why* physicians are at high risk of failing when transitioning from the mindset of clinician to that of leader.

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ROYAL YORK HOTEL, TORONTO

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### 2-DAY PRE-CONFERENCE COURSES (MAY 11–12, 2016)

CSPL Crucial Conversations

PMI Influencing Boards

PMI Leadership Strategies for Sustainable Physician Engagement

PMI Disruptive Behaviour: A Rational Approach for Physician Leaders

PMI Self-awareness and Effective Leadership



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