



Canadian Society of Physician Leaders

WHITE PAPER

Accepting our responsibility

A blueprint for physician leadership
in transforming Canada's health care system

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Executive summary

Efficient and effective reform of Canada's health care system cannot occur without the active and willing participation and leadership of physicians. Physicians must work with others to change the structural, cultural, and political environment if we are to accomplish that goal. In addition, physicians' own views of leadership must change, along with the mindsets of system managers, members of other professions, and providers in pursuit of this aim. A number of challenges exist: capacity challenges, mindset challenges, collaborative leadership challenges, educational challenges, and alignment challenges. However, none of these is insurmountable.

The purpose of this white paper is to stimulate dialogue and action: to facilitate the development of an environment that will create the energy and commitment needed for physicians to take charge of their own future – on their own and in collaboration with their partners in the health care system. For transformation of the Canadian health care system to be successful, physicians must play a central role in planning and implementing change. This necessitates collaborative and distributive leadership in cooperation with other groups, such as citizens, administrators, politicians, and allied health care professionals, particularly because of the current fragmentation of the system at many levels.

As a profession, physicians have a unique and central role to play in service delivery, and, in most instances, they are paid directly by government rather than health care service delivery organizations. Currently, the processes and methods dedicated to creating and supporting physician leaders, i.e., education, mentorship, and professional leadership development, are disorganized, episodic, and limited in scope, if they exist at all. When changes in service delivery are expected, physicians must develop a critical mass of knowledgeable and effective leaders to ensure they are partners in the process.

Governments, administrators, and physicians themselves at all levels must formally recognize the role of physicians as leaders. Steps must be taken by all groups to ensure that the scope and breadth of physician leadership needed to effectively transform the health care system exist. To that end, a philosophy and infrastructure supporting the creation of meaningful physician engagement and leadership must be built.

This paper is the first step toward systematically and strategically improving physician engagement and leadership in the Canadian health care system. The process begins with an argument for and articulation of the goal. However, that in itself is not enough. Such a change requires broader systemic engagement of partners who agree on the challenges and the solutions. We recommend actions to stimulate structural, cultural, political, and personal change. Those actions must be informed by a broader dialogue about whether they are appropriate and, more important, how to make them work. The goal is to generate energy to improve physician leadership at all levels and make physicians true partners in efforts to achieve meaningful large-scale change.

What physicians should do

We recommend that physicians, individually and collectively:

1. Explore and challenge their personal mental models and the world views that restrict them from (a) engaging in the health care system and (b) realizing their potential as leaders.

2. Be willing personally to participate in and champion efforts by colleagues to understand the reform agenda within their provincial health care system and the implications for their own area of responsibility.
3. Take advantage of opportunities provided by colleagues, fellow professionals, health organizations, regions, and governments to participate in reform initiatives, especially patient-safety and quality-improvement initiatives.
4. Take steps to negotiate appropriate working conditions for physicians in a reformed health care system.
5. Become active champions for, and partners in, physician engagement and physician leadership development.

What health care service organizations should do

We recommend that health care organizations, including hospitals, primary care agencies, health regions, and long-term care organizations, either individually or collectively:

6. Measure the current level of engagement of their physician population, both those working in house and those working in partnership as independent contractors.
7. Gather data and information about the current state of physician leadership in their organization to understand roles, responsibilities, remuneration, time allocation, and contracts and determine a base line for improvement.
8. Make changes in organizational structure and design, jointly advocated by the organization and physician representatives, to alter policies and practices toward involving physicians in informal and formal leadership roles.
9. Engage in projects to ensure that the organizational culture is conducive to facilitating and supporting the engagement and leadership of physicians.
10. Use informal and formal communications approaches to ensure that physicians are aware of organizational issues and priorities and are able to respond and provide feedback on such issues.
11. Identify potential future physician leaders and ensure their mentorship and development.

What provinces and medical associations should do

We recommend that provincial ministries and medical associations take steps to:

12. Initiate negotiations to develop an enabling policy framework that formalizes and supports regional and organizational efforts to realize effective physician leadership and engagement.
13. In the absence of an appetite in both parties to enter into such negotiations, build trust as a first step toward an increased willingness to negotiate.
14. Work with universities and health research agencies, both provincially and nationally, to identify best practices; either conduct or gather research on the impact of various models of physician leadership and engagement; and share that knowledge widely with potential partners.
15. Publicize the benefits of meaningful physician engagement and leadership by explicitly recognizing those benefits.
16. Provide financial support for physician leadership development and remuneration for physicians in leadership roles.

What Canada should do

We recommend the following actions at the national level:

17. The Government of Canada and Health Canada are encouraged to endorse the recommendations of the Advisory Panel on Healthcare Innovation and, in the spirit of human resource development, instill in the national innovation hub strong support for physician leadership development and engagement.
18. The Canadian Society of Physician Leaders is encouraged to develop a national strategy, in partnership with other national physician organizations, such as the Canadian Medical Association and others, to coordinate their existing resources and new efforts to help provinces and regions increase physician engagement and leadership capabilities across Canada.
19. The Canadian Medical Association should develop a policy statement that recognizes the importance of physician leadership in health care reform and, through its subsidiary, Joule, reform and expand its existing efforts to increase physician leadership.
20. The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, provincial colleges, and medical schools across the country should expand their efforts to embed leadership development in formal medical education and professional development curricula and explore options, such as the Royal Australasian College of Medical Administrators, to recognize physicians who move permanently into formal leadership roles.

We hope this white paper will stimulate national, provincial, regional, and local conversations to identify and implement actions that will generate greater physician leadership in the area of health care reform.

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Canada's health care system

Introduction

Around the world, physicians are at the centre of the debate about health care system transformation, whether willingly¹⁻³ or unwillingly.⁴⁻⁷ The approaches and leadership styles of governments and the responses of medical associations vary remarkably. In the United Kingdom, Ontario, and Nova Scotia, governments are forcing changes on physicians that affect work conditions and funding formulae,⁴⁻⁷ while in Canada's western provinces, medical associations seem to be adopting a more collaborative relationship with their provincial governments.¹⁻³ As the sustainability of the Canadian health care system becomes more and more threatened, fundamental system changes are unavoidable. In the eyes of the public, physicians must be actively engaged in shaping those changes. Without physician engagement, system transformation will not occur.

The title of this white paper is a testament to the belief of the Canadian Society of Physician Leaders (CSPL) that physicians have a unique position and responsibility in the delivery of universal health care, and that efficient and effective reform cannot happen without their active participation.⁸⁻¹¹ The title also signifies that many physicians in the CSPL community are prepared to step up to accept the responsibilities associated with being a partner in reform efforts.^{12,13}

The content of this paper is fuelled by commitment, energy, and passion; guided by a clear goal; and accompanied by concrete suggestions for action drawn from the CSPL community. The paper is based on the results of a study¹⁴ conducted by the CSPL, with financial and personnel support from the Canadian Medical Association (CMA) and George & Faye Yee Centre for Healthcare Innovation (CHI) at the University of Manitoba; on data from Canadian and international studies on the physician leadership needed for effective reform of the health care system; and on conversations with CSPL members in a workshop setting. Yet, it is only a start: those writing this paper, and the physicians who contributed to it, are fully aware that a systemic, coordinated effort across the whole health care system is needed to ensure that the contribution physicians can make to reform is realized. This paper is intended to stimulate a next step: dialogue and action crafted together by all agents of the Canadian health care system in support of physician engagement and physician leadership.

The mandate of the CSPL is to support physicians and help them succeed in health care leadership and management roles, whether that role is a formal, paid position ranging from medical director

If system reform is to happen, highly proficient physician leadership is required.

to CEO or an informal leader in the community. As part of this support and development, the CSPL conducted a first-ever study of physician leaders in the Canadian health care system.^{13,14} The study provided insight into the responsibilities of physicians in formal and informal leadership roles; the various ways they are compensated and/or supported in their leadership work; practices pertaining to leadership education; and the distribution of leadership roles by age, type of organization, and medical specialties. The study also provided data on the real and perceived factors that encourage or discourage physicians from taking on and remaining in leadership roles as well as what organizations can do to grow the leadership capacity and capability of physicians.¹⁴

The purpose of this white paper is to stimulate national, provincial, regional, and local dialogues to identify and implement actions that will generate greater physician engagement and leadership to meet the challenges of sustainable health services delivery and subsequent health care reform. Physician engagement refers to the active and willing participation of physicians in local, regional, and provincial efforts to improve health in Canada. Physician leadership, formal and informal, is defined as the assumption of responsibility to influence others to work together to create the health care system of the future.

The paper is organized in three parts. First, the central elements of the reform challenge to health care in Canada are reviewed, highlighting the centrality of physician leadership to the success of that reform. Second, the challenges to growing responsible medical leadership in the reform context are presented. Finally, potential suggestions for action at the local, regional, provincial, and national levels are presented to stimulate dialogue and lead to collective action.

No future without us: physician leadership and the future of health care in Canada

It is inconceivable to think of a health care system without physicians. Their medical expertise and skill, combined with the one-on-one relationship between a clinical physician and each individual patient are fundamental to high-quality care. If each patient's care is the focus of clinical physicians, then caring for patients, collectively, is the passion that drives the physician leader. If system reform is to happen—with the relationship between physicians and patients at the core of change—highly proficient physician leadership is required.

The reform challenge

The pace of change in health care in Canada is increasing. Faced with reductions in federal transfer payments and ever-burgeoning health care budgets, provinces are looking for solutions that maximize efficiency by improving outcomes of patient-centred care and reducing costs.¹⁵⁻¹⁸ Yet, a lack of openness “to try innovative solutions is the most ‘striking difference’ between the health care systems of European countries and Canada.”¹⁹

The recent Report of the Advisory Panel on Healthcare Innovation⁹ remarked on Canada’s slow progress in reform. It identified “the need for fundamental changes in how healthcare is organized,

More physicians must be involved in leadership roles at the beginning and throughout the process of change.

financed, and delivered" and commented that "Canada's healthcare systems appeared to be ill-prepared to respond to various shifts in their context" (p. 120).⁹ The absence of physicians in meaningful roles was striking: "Time and again, the Panel heard that Canada's physicians are a superb national resource, but our healthcare systems have been organized around and under them in dysfunctional ways. The result is a waste of talent in all directions" (p. 18).⁹

Although limited, there is solid evidence that hospital performance benefits from physicians in leadership positions. Hospital quality ranks higher and patient outcomes are better when the CEO is a physician rather than a professional administrator.²⁰ Just a small increase (10%) in the number of physicians on a hospital board can have marked consequences; physicians can shape the hospital's quality vision and directly influence decisions about implementation and cost-quality trade-offs.²¹ In some provinces, primary care reform is being led by physicians who are seeking to build population-based health delivery systems based on new service delivery models that emphasize patient-centred care through interdisciplinary teams.²²

It is clear: where reform is proposed, whether at the policy level or at any other level of the health care system, more physicians must be involved in leadership roles at the beginning and throughout the process of change.^{8,23-26} Yet, few examples of systemic, ongoing efforts toward physician engagement and leadership have been identified in Canada.²⁷

At the policy level, provincial medical associations have been "entrenched" in tradition and "resistant" to health care reform.²⁸ To become more involved, they must see their role as extending beyond bargaining for physician remuneration into policy creation. At the same time, other parties must be willing to stop viewing the medical associations as "opponents" and embrace them as partners and collaborators in reform. For the medical associations' advice to be sought, politicians and senior health leaders must build processes and mechanisms to ensure that such advice is heard and then be willing to use it to shape decision-making. In British Columbia, for example, the government and Doctors of BC have taken a bold step in redefining those roles, with \$50 million allocated for a five-year plan to improve physician engagement in improving the health care system.¹⁻³

Evidence indicates that physician engagement in organizational and community-based reform is minimal.

Similar steps must be taken simultaneously at all levels of the health care system to increase physician engagement. Although physicians occupy multiple roles, they are often disengaged, and provincial legislation may play a role.* For example, family physicians can be disenfranchised from regional decision-making; physicians in institutions often labour as independent experts, not engaged as champions to lead quality-improvement efforts; members of clinical teams may or may not be integrated into effective team practice; and those doing full-time university research are already one step removed from the clinical component of the health care system.

Evidence from the CSPL study¹⁴ also indicates that physician engagement in organizational and community-based reform is minimal. When the 689 physicians who responded to the questionnaire were asked to identify innovative organizational projects in which they were involved, only 39% responded. This suggests that 61% of the physicians surveyed were not invited to participate, did not know of innovative organizational projects, or did not consider them significant enough to mention. Of the 39% who did respond, a third reported that their organization did not support innovation. Reasons given for lack of support included: physicians

*In some provinces, legal restrictions limit the participation of physicians on governance boards, an issue that should be addressed.

Physicians remain mostly disengaged and, even when they are ready to be involved in change and innovation, some organizations do not welcome or are not ready for their engagement.

are not included in decision-making; there is no budget for innovation; and, within their institution, physicians are expected to conform, not innovate. In other words, of all respondents, three out of four either commented negatively on innovation or did not mention it at all!

Of those who responded to the innovation question, 27% provided examples, such as dyad relationships; professional development including Physician Leadership Institute [PLI] programs, LEAN training in-house, university programs, and coaching; committee structures such as quality assurance, collaboration, and networking; and physician engagement strategies. However, many of these constructs are simply variations on operational practices that have been in place for some time, certainly not reflecting “innovation” as the Panel on Healthcare Innovation described it.⁹ Our data also indicated that the size, structure, and reporting relationships of organizations seem to make a difference in physicians’ ability to engage in innovation: the larger the organization the less likely innovation was encouraged, primarily to avoid risk. Internal and external political pressures were also cited as deterrents to embracing innovation.

In short, physicians remain mostly disengaged and, even when they are ready to be involved in change and innovation, some organizations do not welcome or are not ready for their engagement.

The demand for collaborative leadership, especially physician leadership

Leadership is needed to build supportive organizational climates that stimulate innovation,^{29,30} engage staff in change processes,³¹ and support change in practice.³² Recent studies in Canada emphasize the importance of leadership to facilitate change and innovation in the health care system,^{24,32-34} including the need for more physician leadership.⁸ And the system needs collaborative and shared leadership, not “expert” or “heroic” leadership.³⁵⁻⁴⁰

Canada’s health care system is constitutionally fragmented. There are 15 delivery systems: ten provincial, three territorial (Yukon, Nunavut and the Northwest Territories), and two delivered by the federal government (Indigenous Health and the Department of National Defence). It is also split professionally, in terms of the scope and breadth of specialities that have a role in health service delivery; structurally, in terms of types of communities ranging from highly urban to remote and rural, aggravated by incomplete regionalization; and functionally, in terms of the dizzying array of diseases, health conditions, and varieties of programs that must be or could be funded and delivered by our universal health care system. Some components, such as universal drug or dental coverage, that should be part of the health care system, are not even included.

Exacerbating this fragmentation is the unique legislated and structural role occupied by physicians in the Canadian system. Although most other professionals and health administrators are employees of a publicly managed system, most physicians are independent practitioners funded directly for their service delivery by government on a fee-for-service basis. They often perceive their accountability as extending to the patient first, to their colleagues and profession second, and to the organized health care system third, if at all.

Fragmentation does not work to the advantage of the patient. A patient enters the territory of health service delivery without a map, without transit, without transportation. There is no clarity as to how or where to enter this territory or where the various services are located; this leads to disintegrated, peripatetic, and often untimely care.

New and different responsibilities and accountabilities toward sustainability and stewardship must be defined and negotiated.

Fixing the gross fragmentation of the Canadian health care system requires physician leaders with the skills and style needed for collaboration.

The complexity of this fragmentation is one of the reasons many provincial governments are hawkish on so-called patient-centred reform.⁴¹⁻⁴³ In addition to fiscal control, the stated purpose of governments' efforts is to provide a seamless continuum of care for the patient. That redesign would create an actual system, where all interdependent partners in the delivery and consumption of services would function as a whole, rather than as a series of independent, disconnected parts. Clearly, this implies changes in how physicians are contracted, employed, or compensated for their work. This is a large obstacle to fundamental system transformation. It also means that new and different responsibilities and accountabilities toward sustainability and stewardship must be defined and negotiated.¹⁻³ These changes have to be designed using a true patient- and family-centred lens, with physician leaders and physicians as partners to ensure that the results reflect medical evidence and are acceptable, fair, and workable. That active leadership role must be ongoing, systemic, and meaningful.

Collaborative leadership is the antidote to fragmentation.⁴⁰ Collaborative leadership emphasizes the centrality of relationships and highlights the importance of interpersonal, political, and strategic leadership skills to build substantive connections across and throughout a system. Through collaborative relationships, structural changes can be made to facilitate patient-centred care. The relationships in need of improvement include those between:

- physicians and other providers in the immediate care team⁴⁴
- clinical units traditionally operating in organizational silos⁴⁵
- physicians and administrators⁴⁶
- organizations and the community⁴⁷
- organizations in a region
- regions and a province¹⁶
- provinces and Canada

If physician knowledge and expertise are to be recognized, all physicians must take the initiative to create these relationships, either by reaching out to engage on an interpersonal level or by taking a leadership role within an institution or community. In short, fixing the gross fragmentation of the Canadian health care system requires physician leaders with the skills and style needed for collaboration.

What physicians bring to health reform leadership

According to Maureen Bisognano, president and CEO of the Institute for Healthcare Improvement in the United States, physicians' clinical expertise plus leadership skills is a powerful combination. She states, "It's a wonderful sign that physicians are expanding from clinical care to include learning what it takes to be a good leader. When you can marry the leadership skills and the clinical background, you have an opportunity to lead in a very distinct and different way. When you get someone who knows what quality looks like, and pair that with a curiosity about new ways to think about leading, you end up with people who are able to produce dramatic innovations in the field."⁴⁸

In recognition of their special medical expertise, physicians have been granted a unique role in the Canadian health care system. Central to that role is what has been termed their fiduciary responsibility: "doctors putting their patients' interests above their own."⁴⁹ In other words, clinical physicians make decisions that are in the best interests of each individual patient. System

Physician leaders are well positioned to be “interface professionals”

physicians, i.e., physicians who are engaged at systemic level or in leadership roles, must also consider the collective welfare of patients. Balancing these competing demands is the moral and ethical dilemma of physician leadership, and we must ask who is best suited to take on this challenge. Because patient-centred care is so central to effective health care reform, physician leadership is needed to influence that reform at a systemic level.

Canada’s relative position vis-à-vis other developed countries in terms of fulfilling this fiduciary responsibility is poor; for example, wait times for an appointment with a physician or surgery in Canada are in next to last and last place, respectively, among other industrialized countries.⁵⁰ However, these measures vary widely among provinces,⁵¹ and it is clear that the number of physicians and the distribution of physicians must be addressed if we are to facilitate greater physician engagement. Ironically, that goal itself demands physician leadership.

Physician leaders are well positioned to be “interface professionals,” but need the skills to fulfill that function.⁵² Interface professionals bridge the disciplines of medicine, administration, management, and leadership to fulfill the systemic fiduciary responsibilities to Canadians. They understand the core business of patient care. Maintaining their connection to their clinical roots and going to those roots in the context of leadership decision-making will increase the legitimacy of their leadership with physician colleagues—something currently lacking¹³—and enhance the potential for physician engagement. To advocate their centrality to the health care system and its service delivery and to be effective interface professionals, physicians must learn and practise the knowledge, skills, and abilities of effective leadership and management.

The shift begins: realizing the leadership potential of physicians

A recent four-year study on leadership and health care system redesign concluded that “Quality physician leadership—at all levels—is required for reform to be successful.”⁸ The study highlighted not only “the fundamental importance of quality physician leadership for effective health reform to take place,” but also “the difficulty to access that capacity except in a few pockets of the system” (p. 18).⁸ The primary responsibility of physician leadership is to improve physician engagement through exemplary practices that are ongoing and meaningful.^{8,52} Such practices include understanding the leadership role in a reform environment; supporting other physicians in their efforts to be engaged; mentoring prospective physician leaders; and seeking resources to facilitate improved organizational conditions for physician engagement and leadership.

The first element in any change is generating evidence of the need for change that has precipitated the current state of the issue at hand. As outlined in its introduction, the CSPL study¹⁴ set out to define and document the extent of the problem, to identify the leveraging factors for influencing the issue, and to explore potential solutions for action. Some findings from that study are dispersed throughout this paper and highlight the overall need for systemic solutions.

A second element in the “shift” toward improving physician leadership and engagement was the recognition of these responsibilities by the Royal College of Physicians and Surgeons of Canada (RCPSC) in the CanMEDS 2015 Physician Competency Framework,⁵³ which is used as the foundation for medical education programs in Canada and numerous international jurisdictions. The role of “Manager” was replaced with the role of “Leader” to “reflect an emphasis on the

The practice of formal physician leadership in an organizational context shows wide variation across Canada.

leadership skills needed by physicians to contribute to the shaping of health care.⁵³ According to the competencies described under "Leader," physicians are to be advocates of

- patient safety and quality improvement, indeed to the point of ensuring both through the inclusion of standards, such as adverse event reporting
- improving the balance between professional practice and personal life
- appropriate resource allocation in support of patient's and patients' care
- the use of informatics to influence care and decisions regarding reform of care

By extension, all physicians currently operating in Canada's health care system have been asked to make those shifts of both mind and skills. When the "Leader" role is combined with some elements of the roles of "Collaborator," "Communicator," and "Health advocate," it is clear that physicians must use those competencies to influence health care at a systemic level and exercise the collaborative leadership needed to be active players in reform. That spirit inspired this paper, which explains the audacity of many of the recommendations.

The challenge of creating sustainable medical leadership

One of the definitions of insanity is doing the same thing over and over again, and expecting different results. Not only does this seem to lend credibility to the need for health care reform, but it could just as easily apply to the challenge of creating sustainable medical leadership. To realize our vision of sustained, viable, and meaningful physician leadership for patient-centred health care reform, the gaps between the current state and the future state must be identified and overcome through deliberate action. Each of the following sections deals with a different challenge created by those gaps and elaborates on actions to be taken, using some evidence from the CSPL study and other national and international evidence as background.

Growing capacity: numbers, roles, and responsibilities

Capacity is the number of physicians in leadership roles, the time available to do that work, and the degree to which a physician's job and role description enables him or her to exercise leadership responsibilities.

In terms of numbers of physicians identifying themselves as leaders, there is a significant gap between the current and desired state. With just over 80 000 physicians in Canada,^{54,55} fewer than 4000 could be identified by the CSPL as physician leaders, either because they had attended a PLI workshop or national leadership conference in the last five years or were CSPL members.¹⁴ The numbers are rather small, and efforts to increase them must be made. Certainly, if one posits the notion that all physicians can and should exercise leadership skills as part of the role that is now expected by the RCPSC and the College of Family Physicians of Canada through CanMEDS, achieving that goal is a significant challenge.

Other components of capacity, such as clarity of roles, time allocation, funding, enabling policies and procedures, and appropriate assignment of roles and responsibilities, are also lacking. By way of example, the CSPL study¹⁴ shows that, in an organizational context, the responsibilities attached to formal leadership roles depend on what is negotiated between the organization and its physician members. There is no consistency or model to follow. Contractual models vary widely, remuneration and time allocations fluctuate dramatically even for similar responsibilities, and

support for leadership development is highly variable. The practice of formal physician leadership in an organizational context shows wide variation across Canada.

Table 1 illustrates this phenomenon. It shows the number of roles physicians in formal leadership positions may have (columns 1 and 2) and the amount of volunteer or uncompensated time they devote to fulfilling those roles (columns 3–7). Some physicians with only one formal role dedicate no extra time, while others expend over 30 hours per month of volunteer effort. Others have five roles and donate varying amounts of time. Although this might be interpreted as different physicians choosing to dedicate their time this way, it is also clear from other data in the CSPL study^{14,56} that there is exceptional variation in the amount of time formally allowed for leadership depending on the organization or region.†

Table 1. Number of leadership roles of Canadian physicians and distribution by uncompensated time spent in these roles.

No. formal leadership roles	n	Distribution of physician leaders by time spent in uncompensated leadership activities, no. (%)				
		0 h/month	1-9 h/month	10-19 h/month	20-30 h/month	> 30 h/month
1	222	49 (22)	64 (29)	45 (20)	26 (12)	38 (17)
2	207	21 (10)	75 (36)	65 (31)	26 (12)	20 (10)
3	74	7 (9)	13 (18)	23 (31)	17 (23)	14 (19)
4	23	2 (9)	5 (22)	7 (30)	5 (22)	4 (17)
5	26	2 (8)	6 (23)	9 (35)	4 (15)	5 (19)

Some degree of rational dedication of time and resources is needed if physicians are to fulfill their leadership role as true partners in health care reform.

The relationship between “independent” physicians, general practitioners or specialists, and the health care system is even more inconsistent and disorganized. The different types of relations are invented province by province or region by region, sometimes with involvement of government and/or the medical association. In many instances, these relationships are negotiated “one-off” by the individual physicians themselves.

In short, some degree of rational dedication of time and resources is needed if physicians are to fulfill their leadership role as true partners in health care reform.

The mindset challenge: leadership as part of a physician’s role

There is an ongoing shift in focus of the Canadian health care system, from disease and all its aspects to a broader perspective that includes promoting and enabling wellness. The view of “physician as expert,” constructed to address illness, is less suited to the needs of a wellness-focused system, which requires not only the medical expertise of a physician, but also the collaboration of a self-reliant citizen, with contributions from many other disciplines and stakeholders.⁹ In this context, shared or distributed leadership is required, where each contributor to wellness—citizen, community, government, and health care providers—must take the initiative to

† Other metrics that provide a better gauge of physician leadership capacity may well emerge as discussions on this white paper proceed. No better metric exists at this time.

create a productive experience in wellness. To accomplish this, physicians will need to practise a relationship-centred approach rather than assuming the lead.⁵⁶

Embracing the responsibility of being a leadership partner in health care reform challenges the independence mindset. For many years, physicians, because of their unique contractual relationship with the system, have revelled in their special status, which in many cases allows them to be independent business people and grants them significant freedom compared with other health professionals. While, over the past 40 years, the system around them has embraced public administration through the Canada Health Act as a way to organize care delivery, physicians have continued to see themselves as separate from those efforts to change the system. However, when reform happens, it inevitably alters the context in which physicians practise.

Embracing the responsibility of being a leadership partner in health care reform challenges the independence mindset.

Physicians appear to have two choices: either become part of the process of reform in a manner that allows them to negotiate with public administration and the public about what the future system will look like, or remain independent of it and accept whatever public administration and society negotiate for them. Taking the latter path denies the whole premise of this paper and is dangerous: in negotiation, if one side is not at the table, the other side will dictate the rules. To become more active, physicians must, therefore, challenge their own sense of independence and accept that how their time is allocated, how their work is defined, and how care is delivered will not be independently determined, but agreed on collectively.

Another prevalent view in the physician world is the tendency for clinical physicians to deem physicians who embrace formal leadership roles as having "gone over to the dark side."⁵⁷⁻⁶⁰ This notion not only demonizes physicians who wish to embrace the challenge of leadership, but it also sends a message to administrators and other leaders that there is something unseemly about those roles. Research shows that this mindset is nurtured to some degree in medical school and residency, then perpetuated, likely as part of the tribal tendency of professions, to maintain a sense of identity and self-regulation.^{56,57} Yet, if it creates real divisions between physician leaders and their clinical colleagues or between clinical physicians and administrators, then it is a mindset that must be challenged and altered to allow the physician voice to be heard at the tables of health care reform.⁶¹ Physicians who lead cannot represent the interests of their colleagues if they are estranged from them.

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It is difficult for many physicians, who are struggling to deal with the demands of their clinical work, to readily embrace change. For some truly dedicated physicians, simply fulfilling their clinical role in the modern health care system is a challenge. A significant number have experienced burnout: as many as 40-50% of those in the most stressful specialties and up to 25% of those in lower stress areas.⁶² Before asking physicians to embrace engagement and, ultimately, the functions of leadership, efforts must be redoubled to assist those who are currently struggling. Finding ways to reduce work-related stress and burnout, as a separate element of an action plan, is necessary if the challenges of engagement and leadership are to be realized.

For physician engagement, and subsequently physician leadership, to influence reform at all levels of the health care system, each physician must see him or herself as having a responsibility to participate as a partner. Where a clear separation between clinical practice and leadership activities currently exists in the minds of many physicians, these functions must come together. Indeed, even in CanMEDS, where leadership has now become one of the roles, one notices a progressive integration with other roles required by physicians, moving toward shared leadership: physician as collaborator, physician as advocate, and physician as communicator. One might also

argue that physician as scholar requires appreciation within the profession of the burgeoning literature dedicated to leadership and the research base that underpins collaborative leadership.

In short, part of any effort to increase leadership capacity within the physician community must aim at altering the mental models that challenge that effort.

Physician leaders need to be active players in the renegotiation of their roles and functions in the health system.

The collaboration challenge: becoming part of the health care reform team

The need to overcome self-interest and “turf wars” (a people problem) and the need to coordinate processes and procedures to serve patients more effectively and efficiently (a technical problem) are consistent themes for those looking at leadership capabilities and for the health care reform challenge.³⁷ To solve the technical problem, we must first solve the people problem. In that context, all physicians must be skilled in the ability to build collaborative relationships at all levels of the system.

One of the challenges of building collaborative relationships is redefining the nature and degree of physicians’ independence relative to their institutional responsibilities (i.e., government, region, hospital, etc.). For a stronger relationship to emerge, between a physician and an administrator, between a physician and multidisciplinary team members, or among physicians, the current understanding of physicians’ autonomy and independence versus the meaning of their accountability must likely be challenged.^{9,63} Viewing others in the health care system as partners, accompanied by changes in behaviour, requires a mind-shift to overcome fragmentation in the system. For example, Evans and colleagues argue for a mental model shared by physicians and other partners to reform patient care, resulting in a common world view that recognizes “shared responsibility [and] a willingness to share the burden of work and act as a team to contribute... to the delivery of integrated care.”⁶⁴

Deliberate efforts are required to overcome cultural and structural factors that create fragmentation. For example, informal communication in hospitals often occurs within professions (physicians to physicians, nurses to nurses, administrators to administrators) rather than across disciplines.⁴⁵ A natural division, caused by professionalism, leads to tribalism and a tendency to create an us versus them mindset.⁶⁰ This fragmentation is compounded by structural factors, such as independent contractual arrangements resulting from physicians’ unique legal and business role in the health care system. This circumstance can be exacerbated if the physician does not understand his or her responsibilities to other components of the system. Understandings, correct or not, become imbued in the culture, often reinforced by how physician leadership is characterized in terms of roles and responsibilities: administrators handle the budget, for example, because physicians can’t; physicians are allowed only small amounts of time for their leadership responsibilities, whereas administrators are full time in those roles; and physicians are not provided with the same training as administrators even though the same results might be expected of both. Nowhere is this discrepancy better illustrated than in many of the dyad models of leadership used in the country.

These differences can become anathema to successful health care reform. In most reform challenges physicians’ input is vital. This is true whether the issue is a new focus on care, regionalization, or sustainability of the health care system; a shifting of resources from hospital to home and community care; or processes to improve quality and safety. For physicians to be

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effectively engaged in creating new models of care and ensuring their work is consistent with the work of others, they need to be active partners in the reform work. This partnership may well result in a renegotiation of the roles and functions of physicians, including the selection of physician leaders, defining expectations for constructive leadership, and credentialing. This will challenge current beliefs around autonomy, independence, and purpose.

In short, physician leaders need to be active players in the renegotiation of their roles and functions in the health care system.

Growing leadership capability

For physicians to be effective as leaders in health care system reform, they must have the capabilities associated with modern collaborative leadership, especially the ability to act as a partner in the reform process.^{8,65,66} Because of the diverse dimensions of the health care system, physician leaders with collaborative capabilities are required at all levels: communities, clinical practices, regions, and institutions that provide health services, as well as medical associations and enterprises that are active in health reform.

Because they were not included in the formal education syllabus,⁶⁷ many of these capabilities—including emotional intelligence, relationship building, inter-professional teamwork, large-scale systemic change, organic systems thinking, and coalition building—were either self-taught through experience or were not learned at all.** In addition, mastering these capabilities often requires a mindset and combination of knowledge and skills that are rarely cultivated during the process of becoming a physician.

Table 2 (page 16) shows some of the inconsistencies between medical education and leadership education and indicates that the largest gaps in knowledge and skills among physicians who take on leadership roles are in the domains of self-leadership, coalition building, and systems transformation.

In short, if the abilities required to lead effectively in the modern health care environment are desired in physician leaders, then an organized and focused effort must be made to provide physicians with the opportunity to develop appropriate skills and identify potential physician leaders early.

The education challenge: can leadership be learned?

Some physicians believe that they are leaders, by virtue of their training and position; others believe that leaders are born, not made. The first notion is often reinforced within the profession and by others with whom physicians come into contact when they are granted a leadership role in patient care. However, when physicians act omnipotent and fail to engage others in that care, they lose the “followership” of patients and partners in the health care system. The second notion, that leaders are born, not made, feeds into the belief that in becoming a physician, one is playing out one’s inherent leadership purpose. These two ideas can create a blind spot for physicians,

**Currently, at the University of Toronto Medical School, the University of Manitoba Max Rady College of Medicine, and at McGill University, these topics have been integrated into the curriculum.

Table 2. Capability gaps among physicians leading health reform.

LEADS capabilities*	Skills needed for individual patient care	Skills needed for physician leadership	Skills taught in medical school†
Lead self			
Be self-aware		++	
Manage yourself	+++	+++	
Develop yourself	+	+++	
Demonstrate character	+	++	
Engage others			
Foster others' development		++	
Contribute to creating healthy organizations		++++	
Communicate effectively	+++	+++	✓
Build teams	+	+++	
Achieve results			
Set direction	+++	+++	✓
Strategically align decisions with vision, values, evidence	+	++	✓
Take action to implement decisions	+++	+++	✓
Assess and evaluate	+++	+++	✓
Develop coalitions			
Purposefully build partnerships and networks to create results		++++	
Demonstrate commitment to customers and service	+++	+++	✓
Mobilize knowledge	+	+++	✓ (patient-related)
Navigate sociopolitical environments		+++	
Systems transformation			
Demonstrate systems/critical thinking	++ (critical thinking only)	++++	✓ (patient-related)
Encourage and support innovation	+	++++	
Orient yourself strategically to the future		+++	
Champion and orchestrate change		++++	

*This table is based on the five domains of the LEADS framework to describe collaborative leadership capabilities, as it is research validated and it is used to underpin leadership development in the CMA's Physician Leadership Institute programs, CSPL programs, and in many jurisdictions across Canada.^{29,64,65}

†Because of the introduction of CanMEDS 2015, this column may be different for some medical schools from 2017 onward.

preventing them from learning to be more effective as leaders through good educational opportunities.

The truth is that leaders are both born and made.^{29,67,70} Just like athletes or musicians, leaders may be born with a certain talent and can develop it further by acquiring knowledge and learning the skills defining the craft. Many of the leadership capabilities required of physicians are not taught in medical school.⁷¹⁻⁷³ Although these attributes can be learned in the “school of hard knocks,” the purpose of formal learning is to speed up the natural developmental process.

The need to introduce these opportunities throughout the Canadian health care system is urgent and is a pre-condition for the required transformation of that system.

A well designed leadership program will help develop innate leadership talents by replicating real-life experiences in a relatively safe environment for practice purposes, and by providing the knowledge and skills needed for dealing with those experiences. Good programs will also use the real workplace environment as a laboratory for learning. Much research has been done on best practices in leadership programming, and, to develop physician leadership, best practices should influence opportunities provided for physicians to develop their leadership skills.^{68,70,74} A life-long learning pathway is desirable to provide a phased developmental process for physicians throughout their career.

To maximize learning, the solutions designed to enhance opportunities for physician leadership development have to be matched with high-profile leadership challenges implicit in the health care reform agenda (institution, province, country).⁶⁹ If the challenge is specific to a hospital’s need to improve quality and safety, then the leadership program for physicians in that hospital should use that challenge as a vehicle for learning. If it is developing multi-professional models of primary care for patients with multiple morbidities, then leadership programs should embrace that issue.

The scope, breadth, and reach of leadership programs for physicians in Canada is extensive. Some are not rationally designed around best practices, and some are not necessarily aimed at explicitly addressing high-profile health reform issues. Nor is there any systematic process to ensure that physicians gain access to the most appropriate program. However, steps are being taken across Canada to address these issues. The physician leadership programs offered by the CSPL and the CMA’s Joule meet some of the best practices criteria. The recent change in CanMEDS 2015, in which the role of “Manager” was changed to “Leader,” has spawned significant activity within the medical education community to design and deliver competency-based programs for medical students and residents.^{53,70-73,75} Such efforts must be ramped up, become more integrated, and ensure responsiveness to local needs for the desired results to be achieved.

In short, because there are no systemic learning programs to develop physician leaders, the need to introduce these opportunities throughout the Canadian health care system is urgent and is a pre-condition for the required transformation of that system.

The alignment challenge: overcoming fragmentation of effort

A theme running through all of the challenges associated with both health care reform and building physician leadership is the degree of fragmentation that exists within the Canadian health care system. Therefore, reformers are not only faced with the need to align efforts for maximum effect across multiple organizational and professional boundaries, and across self-defined turfs and identities, but must also raise awareness of the benefits of doing so.

The fragmentation is exacerbated when one recognizes that much leadership development is done by partners outside the health care system: universities, private enterprises, and special interest initiatives such as health quality councils. Fragmentation is even reflected in the wide variation in how physicians are compensated and supported for taking on leadership roles. According to the CSPL survey,¹³ only 54% of physicians in formal roles are paid or reimbursed for undertaking educational programs (Table 3, columns 5 and 6 added together); 46% of physicians in formal roles, who wish to take a PLI course or a university program, must pay for that privilege themselves. Physicians in informal roles have a much lower rate of support.

Table 3. Number of physicians receiving various types of support for leadership roles*

Level of leadership role	Stipend only	No Support	Salary only	Salary & education	Stipend & education	Total
Executive/management/registrar/public health	16	5	9	48	25	103
Board position	12	6	1	3	5	27
Academic lead	2	0	0	12	11	25
Clinical lead	34	17	10	15	31	107
Academic/clinical lead	20	6	7	19	14	66
Other	14	8	2	15	4	43
Total (%)	98 (26)	42 (11)	29 (8)	112 (30)	90 (24)	371 (100)

To join together around a common set of leadership skills, the CSPL should partner with other organizations to initiate steps toward that coherence, by convening a national dialogue on how to proceed.

CanMEDS demands the learning of a common set of profession-specific and universal competencies during medical school and residency; however, what is taught about leadership is determined solely by the program or teacher without guidance from a common set of standards or expectations. This is beginning to change. A number of studies have validated the use of the LEADS framework as a viable and reliable articulation of the leadership capabilities required for large-scale change.⁷⁶⁻⁷⁸ Over the last five years, LEADS has begun to define a set of leadership expectations for organizations in the Canadian health care sector. The CSPL and the CMA are using it as a common language for teaching leadership. The Toronto International Summits on Leadership Education for Physicians (TISLEP) led to an ongoing international collaboration – Sanokondu (<https://sites.google.com/site/sanokondu/>) – in the form of a grassroots network of physicians and leadership educators in eight countries that combined LEADS with CanMEDS 2015 to guide development of an internationally relevant competency-based curriculum for medical residents.⁷¹ There is potential to combine efforts around leadership development in the physician community by using a common language of expectations and to align the work of the physician community with other health leaders who also use LEADS, in the pursuit of health care reform.

Currently there is no convening force at the national level to champion or influence greater coherence of efforts to develop physician leadership. Each university, college, and organization that chooses to offer a leadership program can do so, without any guarantee of excellence other than the reputation of the school or the initiative itself. There are no standards regarding time allocation, best practices, or foundational competencies, except as determined by each individual effort. There is competition for a physician audience in the open market, and it is “buyer beware” in terms of choosing a program that will have the desired results in terms of developing the skills needed for health care reform. If the latter is the goal of improving physician leadership, we must make sure our efforts accomplish it.

Efforts to promote physician leadership can be enhanced by linking them with other national initiatives with the same goal. Active participation of the CSPL, the CMA, and other organizations in initiatives such as the Canadian Health Leadership Action Plan⁷⁹ is imperative. If the system needs to join together around a common set of leadership skills, then the CSPL should partner with other organizations to initiate steps toward that coherence, by convening a national dialogue on how to proceed.

Rising to the challenge: recommendations for growing physician leadership

This white paper addresses the following issues:

- For transformation of the Canadian health care system to be successful, physicians must play a central role in planning and implementing change. This necessitates collaborative and distributive leadership in cooperation with other groups, including citizens, administrators, politicians, and allied health care professionals, particularly because of the current fragmentation of the system at so many levels.
- As a profession, physicians have a unique and central role to play in service delivery, and, in many instances, they are paid directly by government, rather than by health care service delivery organizations. Consequently, when service delivery changes are anticipated, physicians must develop a critical mass of knowledgeable and effective leaders so as to be partners in the reform process. Currently, the processes and methods dedicated to creating and supporting physician leaders are disorganized, episodic, and extremely limited in scope.
- Governments, administrators, and physicians themselves at all levels must formally recognize the role of physicians as leaders. Steps must be taken by all groups to ensure that the scope and breadth of physician leadership needed to effectively transform the health care system exist.

To address these issues we present suggestions for action that embrace structural, cultural, political, and personal change. The goal is to stimulate energy for improving physician leadership at all levels in the firm belief that, over time, those efforts will coalesce into meaningful large-scale change. We present suggestions in four categories: what physicians should do; what health service delivery organizations should do; what provinces should do; and what Canada should do.

What physicians should do

We recommend that physicians, individually and collectively:

1. Explore and challenge their personal mental models and the world views that restrict them from (a) engaging in the health care system and (b) realizing their potential as leaders.
2. Be willing personally to participate in and champion efforts by colleagues to understand the reform agenda within their provincial health care system and the implications for their own area of responsibility.
3. Take advantage of opportunities provided by colleagues, fellow professionals, health organizations, regions, and governments to participate in reform initiatives, especially patient-safety and quality-improvement initiatives.
4. Take steps to negotiate appropriate working conditions for physicians in a reformed health care system.

5. Become active champions for, and partners in, physician engagement and physician leadership development.

What health care service organizations should do

We recommend that health care organizations, including hospitals, primary care agencies, health regions, and long-term care organizations, either individually or collectively:

6. Measure the current level of engagement of their physician population, both those working in house and those working in partnership as independent contractors.
7. Gather data and information about the current state of physician leadership in their organization to understand roles, responsibilities, remuneration, time allocation, and contracts and determine a base line for improvement.
8. Make changes in organizational structure and design, jointly advocated by the organization and physician representatives, to alter policies and practices toward involving physicians in informal and formal leadership roles.
9. Engage in projects to ensure that the organizational culture is conducive to facilitating and supporting the engagement and leadership of physicians.
10. Use informal and formal communications approaches to ensure that physicians are aware of organizational issues and priorities and are able to respond and provide feedback on such issues.
11. Identify potential future physician leaders and ensure their mentorship and development.

What provinces and medical associations should do

We recommend that provincial ministries and medical associations take steps to:

12. Initiate negotiations to develop an enabling policy framework that formalizes and supports regional and organizational efforts to realize effective physician leadership and engagement.
13. In the absence of an appetite in both parties to enter into such negotiations, build trust as a first step toward an increased willingness to negotiate.
14. Work with universities and health research agencies, both provincially and nationally, to identify best practices; either conduct or gather research on the impact of various models of physician leadership and engagement; and share that knowledge widely with potential partners.
15. Publicize the benefits of meaningful physician engagement and leadership by explicitly recognizing those benefits.
16. Provide financial support for physician leadership development and remuneration for physicians in leadership roles.

What Canada should do

We recommend the following actions at the national level:

17. The Government of Canada and Health Canada are encouraged to endorse the

- recommendations of the Advisory Panel on Healthcare Innovation and, in the spirit of human resource development, instill in the national innovation hub strong support for physician leadership development and engagement.
18. The Canadian Society of Physician Leaders is encouraged to develop a national strategy, in partnership with other national physician organizations, such as the Canadian Medical Association and others, to coordinate their existing resources and new efforts to help provinces and regions increase physician engagement and leadership capabilities across Canada.
 19. The Canadian Medical Association should develop a policy statement that recognizes the importance of physician leadership in health care reform and, through its subsidiary, Joule, reform and expand its existing efforts to increase physician leadership.
 20. The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, provincial colleges, and medical schools across the country should expand their efforts to embed leadership development in formal medical education and professional development curricula and explore options, such as the Royal Australasian College of Medical Administrators, to recognize physicians who move permanently into formal leadership roles.

Summary

Significant growth in physician engagement and physician leadership is required for health care reform to fulfill its promise in Canada. To achieve that growth, physicians must work with others in the health care system to change the structural, cultural, and political environment and mindsets to be consistent with accomplishing that goal.

A number of challenges exist: capacity challenges, mindset challenges, collaborative leadership challenges, educational challenges, and alignment challenges. None of these is insurmountable, and they will change if action is taken. The purpose of this white paper is to stimulate that action: to create the energy, commitment and influence needed for physicians to take charge of their own future, both on their own and in collaboration with their partners in the health care system. There truly can be no meaningful, lasting change without physicians, or by physicians alone. Whether the issue is health reform or improved physician engagement and leadership, it must be tackled together.

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