Tell It Like It Is

Duncan G. Sinclair

At a recent social policy conference – Recovering Together? Fiscal Pressures, Federalism and Social Policy, hosted by Queen's International Institute on Social Policy – there was much discussion of "healthcare's crowding out" of others of the determinants of health, education and income security being the predominant examples. I was struck by the loose language, four words/phrases in particular, used to describe reality – *healthcare, system, single-payer* and *publicly funded*:

- *Healthcare* is not really that. The term is jargon describing what is primarily sickness or illness care, and mostly for those with acute illnesses at that.
- Our healthcare *system* is by no means singular, nor is it a system as the word is defined ("a group or set of related or associated material or immaterial things forming a unity or complex whole" [*The New Shorter Oxford English Dictionary* 1993]). What we are referring to are actually 10 provincial, three territorial and one federal taxpayer-funded programs to insure provincial, territorial and on-reserve First Nation residents, members of the armed forces and RCMP against the cost of in-hospital and physician (and some limited other) services.
- The two related adjectival phrases, *single-payer* and *publicly funded*, are equally misleading. A real system of healthcare services, whether an insurance or delivery system or both, would certainly include prescription drugs, mental health, nursing, rehabilitation, home and long-term care and a number of other services essential to the prevention of illness and the maintenance and restoration of health. Except for in-hospital and physician services, these other services are paid for largely or entirely out-of-pocket or through commercially available insurance plans. In Canada, as in other developed countries, both private and public payers support the full spectrum of services required to support the health of the population.

Why don't we tell it like it is? I suspect it is because *health* and *healthcare* are more positive, comforting words than sickness and illness. Maybe we want to convey a sense of being on the side of the angels, somewhat comparable to the intent of our governments' use of the term *gaming* as a substitute for *gambling*. Perhaps we use *system, single-payer* and *publicly funded* as expressions of wishful thinking!

In any case, failing to tell it like it is, is a bad habit. It misleads the media and public, reinforces complacency and thus throws up yet another unwelcome obstacle in the path of creating a real system to provide us with the full range of health and sickness services Canadians need to optimize their health. HQ

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Physician Leadership: Necessary and in Need of Nurturing – Now

Chris Carruthers and Julie Swettenham

Physicians are increasingly moving beyond their already-demanding clinical roles to become chief executive officers (CEOs), chiefs of staff, clinical leaders, board members, deans and directors. Is this a good thing, and should physician leadership be encouraged? Or as Ron Liepert (2009, August), minister of Alberta Health and Wellness, asserts, are physicians better at diagnosing and treating people than running $8 billion organizations?

Some organizations have had notable success with physician leaders at the executive level. Kaiser Permanente and the Veterans Health Administration in the United States were both turned around by their physician CEOs. In Canada, leading hospitals, such as Montreal's McGill University Health Centre, The Ottawa Hospital, Toronto's Sunnybrook Hospital, St. Michael's Hospital and University Health Network, all have CEOs who are physicians. In each case, these CEOs have earned the respect of staff, physicians and community members alike; and in each hospital, quality improvement is a strong focus. But whether or not an organization has a physician as CEO, it is important that it has a physician as part of the collective leadership team, for the complexity of health organizations demands multi-faceted leadership.

Physician leadership can come into play in many ways. Physicians clearly have a role in promoting and ensuring quality of care and a "patient first" attitude wherever they work. In health organizations where change management is an objective – whether it involves raising quality, reducing the number of adverse events, boosting staff retention or improving patient/client satisfaction – engaging physicians is vital. If physicians are not "on board" and part of the change process, the chances of achieving success

are slim. In terms of culture, the role of physicians can be fundamental in shaping an open medical group practice culture, where mistakes are dealt with in a constructive manner.

Physicians can build teamwork, valuing the varied skills and contributions of their co-workers. In helping to recruit or hire other physicians or health team members, they can ensure that hiring decisions are made with the desired culture of the organization in mind. They can be mentors to new or younger physicians, both in terms of clinical leadership and leadership in general. They can encourage and recommend skills-building, leadership or management and other continuing education courses.

Physicians can provide leadership, or at the very least input, into what human resources, practices, programs, technology and equipment are most needed for the optimum performance of physicians and other healthcare workers in the organization. If a workspace is being designed or redesigned, physicians should provide advice on what makes for the most effective and efficient use of space.

Performance oversight also falls under physicians' domain. They can show leadership by striving to minimize inappropriate practice style variations, at least within their organization. When weaknesses are exposed through such things as patient satisfaction scores, physicians can and should be part of the solution-finding process.

Physicians also have a large role to play in bringing about innovation, especially in – although not limited to – clinical care.

What Are Some of the Challenges?

Mountford and Webb cite three major reasons why physicians do not choose to become leaders. First, there is "an ingrained skepticism about the value of spending time on leadership, as opposed to the evident and immediate value of treating patients" (Mountford and Webb 2009). Physicians can see the results when they treat a patient, while the impact of leadership is hard to determine. Second, for physicians who feel motivated to move into management, there are often no career development or financial incentives. Quite simply, they are not rewarded for helping to build a better delivery system. Third, there is little provision for nurturing clinical leadership capabilities. Leadership and management training are lacking. It is often the physicians themselves who recognize the need for additional management training and who undertake it on their own time.

Physicians who choose to become managers generally do not want to lose their clinical skills, which they have worked hard to gain. Another major challenge is therefore keeping up those skills while striving to fulfill the demands of a management role. This is difficult and requires supportive colleagues and a reduced clinical load.

There are also more personal challenges for the physician leaders themselves and those who work with them, including the following:

- A risk of losing "street cred" with clinical colleagues
- The greater risk of unemployment as a manager than as a clinician
- A need to learn humility
- The need to learn how to be a team player; Jeffrey Lozon, who was president and CEO of St. Michael's Hospital from 1992 to 2009 found that physician leaders "forget they have joined a team [in which] their voice may not be heard, or at least not heard as loudly" (Sullivan 1998: 918)
- The need to learn how to communicate effectively
- A loss of popularity – Leaders have to make tough decisions and deliver bad news
- The need to relearn accountability; Lozon underscores that physician leaders are "accountable to [their] organization, not to [their] colleagues" (Sullivan 1998: 919)
- A need to overcome historic mistrust between physicians and health administrators

This is quite a daunting list, and the surprise is not that more physicians do not step into leadership roles, but that so many do, despite the challenges.

Physician Leadership Is Worth It!

Those physicians who remain and advance in their leadership role generally do so because they genuinely want to make a difference, and they see a role for themselves in helping to bring about the changes that they think are needed. Physician leaders are in an excellent position to do this, particularly as they are "hybrid" leaders, combining their professional clinical skills with the management skills that they have also developed. They have a foot in both worlds and can bring the insights gained in each world to the other, encouraging greater understanding of the challenges facing both managers and clinicians.

Physician leaders, whether at the board table, at the executive's desk or in the CEO's office, have much to contribute. In moving Canada's much-criticized and highly valued health systems forward, their voices must be heard. HQ

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