Anchoring Physician Engagement in Vision and Values: Principles and Framework

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Where Evidence Meets Action
Preface

Physician engagement is a top-of-mind issue in health organizations and systems.

Physician engagement arises out of the broader concept of employee engagement. Employee engagement has many definitions, and one that is commonly used is “... a positive, fulfilling, work-related state of mind characterised by vigour, dedication, and absorption.”¹

When organizations have engaged employees, their bottom line tends to be higher; their turnover is lower; they are more likely to develop, attract and retain high-calibre employees.² Health organizations and systems have taken note that there are potential returns from having more engaged employees and their physician colleagues. Research from countries around the world is underscoring that when physicians are engaged their organizations tend to perform better, have higher satisfaction levels, lower turnover rates, and improved patient satisfaction scores and patient outcomes.

In late 2011, the Regina Qu’Appelle Health Region (RQHR) completed a baseline physician engagement survey. The survey results demonstrated room for improvement in a number of areas including insufficient involvement of physicians in decision making, and a lack of trust and respect between physicians and administration. Significant work is now being focused on how to improve the situation regionally and provincially.

To this end, RQHR has now embarked on its Enhancing Physician Engagement (EPER) project. An established research framework for the project forms the fundamentals of ‘true engagement’ — acting together and deciding together. It builds on the regional RQHR values of compassion, respect, collaboration, knowledge and stewardship.

Three research papers have been authored over the summer of 2012. They are:

- Anchoring Physician Engagement in Vision and Values: Principles and Framework by Graham Dickson
- Compass for Transformation: Barriers and Facilitators to Physician Engagement by Metrics@Work Inc., Kelly Grimes, and Julie Swettenham
- A Roadmap for Trust: Enhancing Physician Engagement by Amer Kaissi

The RQHR believes that engagement is a leadership competency required for transformation and is not simply a top of mind, corner of the desk strategy. The RQHR hopes to further physician engagement, both within its own region and beyond by sharing its leading research and up-to-date insights from international leaders in physician engagement.

## Contents

**Executive Summary** ....................................................................................................................................... i

**Introduction** ................................................................................................................................................... 1

**The Approach** ................................................................................................................................................ 1

**Part 1: The Rationale and Purpose for Physician Engagement** ................................................................. 3
- Current Knowledge of Physician Engagement .......................................................................................... 3
- The Evidence: Thin as It May Be .............................................................................................................. 5
- A Systems Approach ................................................................................................................................. 6
- Measuring Engagement: Qualitative and Quantitative Approaches ....................................................... 7

**Part 2: Unpacking the Dynamics of Physician Engagement** ...................................................................... 9
- Independent Parts; Interdependent Functions .......................................................................................... 9
- A Duality of Perceptions: Respective Roles in the Health System ............................................................ 9
- Engagement and Leadership: The Missing Link ....................................................................................... 13

**Part 3: National and International Approaches to Physician Engagement** ............................................... 17

**Part 4: Factors Influencing Physician Engagement — A Typology** ........................................................... 18
- Table 1: A Typology of Factors Influencing the Quality of Physician Engagement ............................... 20

**Part 5: Definition of Engagement, Principles and Framework for Action** ................................................ 24
- Definition of Engagement ....................................................................................................................... 24
- Principles ........................................................................................................................................... 24
- Framework for Action: Physician Engagement ....................................................................................... 26
  - Steps for Action: Collaborative Leadership ............................................................................................ 27
  - Steps for Action: Challenging Mental Models ........................................................................................ 27
  - Steps for Action: Changing Environmental Conditions ....................................................................... 28

**Conclusion** ...................................................................................................................................................... 29

**Bibliography** .................................................................................................................................................. 30

**Appendices** ..................................................................................................................................................... 37
- Appendix A: Definitions of Engagement .................................................................................................... 37
- Appendix B: National and International Examples of Efforts to Improve Physician Engagement .......... 38
- Appendix C: DRAFT Terms of Reference for a Conjoint Committee to Initiate a Physician Engagement Strategy in Regina-Qu’Appelle Health Region .......................................................... 44
- Appendix D: Glossary of Terms .................................................................................................................. 46
This paper summarizes the results of a three stage process to conduct a semi-systematic review of the literature and a systematic analysis of the data to determine central factors and issues pertaining to improving physician engagement within the Regina-Qu’Appelle Health Region (RQHR) in Saskatchewan, Canada. It reviews those findings with a focus on the physician-administrator relationship and identification of seminal environmental factors that influence the quality of physician engagement. The paper summarizes the findings in a Typology of Factors Influencing Physician Engagement, and a DRAFT Principles and Framework, for consideration of RQHR.
Executive Summary

This paper, *Physician Engagement: Principles and Framework*, is one of three papers commissioned by the Regina Qu’Appelle Health Region (RQHR) in Saskatchewan to ensure physicians have an appropriate and rewarding role in determining the future of healthcare there.

The Approach

The first step in this study was to review two previous studies involving the author, to elicit fundamental concepts we would explore in a semi-structured review of literature published since 2010. A number of search engines were used to search peer-reviewed literature for the topics “physician engagement”, “medical engagement” and “mental models,” followed by a snowball process to identify articles. A realist synthesis approach was used to interpret the literature for implications for policy and action. This paper presents the literature and summarizes its implications in five sections and two appendices: (1) Rationale and Purpose for Physician Engagement; (2) Unpacking the Dynamics of Physician Engagement; (3) National and International Approaches to Physician Engagement; (4) Factors Influencing Physician Engagement: A Typology; and (5) Definition of Engagement, Principles and Framework for Action.

The Rationale and Purpose for Physician Engagement

During the past decade there has been a growing interest in, and demand for, physicians to be central actors in ensuring the health care system enhances access, sustainability, quality, and appropriateness of patient care. The literature describes efforts in Canada, the U.S., Australia and the U.K. to find optimal ways to engage physicians in shaping and implementing health reform in all jurisdictions.

Research showed limited empirical evidence about the positive impact of enhanced medical engagement on patient outcomes. However, many regard engagement to be vital to success of health reform. Our review of many definitions of engagement reveals it to be an interdependent, dynamic construct, in a constant state of flux depending on circumstances and actions taken that either improve or undermine it. Addressing engagement requires attention to the factors that have led to the current state of engagement (anywhere on a sliding scale from ideal to hostile), and to understanding the psychology of the physicians and administrators who work together.

Measuring engagement is required to establish a baseline for action. There appear to be only two acknowledged psychometric measurements that are valid and reliable for use in taking action to improve physician engagement. They are the Medical Engagement Scale (MES) developed in the United Kingdom and the Gallup Physician Engagement Scale in the U.S.

Unpacking the Dynamics of Physician Engagement

An organic systems approach is helpful to understand the dynamics of physician engagement and to lay the foundation for action. With it, we elicited the mental models of physicians and administrators, and the environmental conditions that shape the dynamic state of engagement in a specific context. We also described the substantive links among emphasizing leadership, leadership development and physician engagement.

Different mental models of physicians and administrators influence how they interact and work together. Mental models are created because physicians and administrators are prepared differently for their roles, have different motivations in choosing their profession, and the influence of professionalism on doctors (while administration is not recognized as a profession). They also each have distinct responsibilities and accountabilities and different experiences of organizational life.

The practical link between leadership and engagement is two-fold. First, leadership is an enabler for improving engagement. Second, attracting
Physicians to leadership roles in the health system is seen to be a central element of effective health reform. Because the LEADS framework has been adopted in Saskatchewan as the standard for effective leadership, and is supported by both administrator and physician communities, we have taken advantage of its leadership programming as part of the physician engagement action plan.

**National and International Approaches to Physician Engagement**

Physician engagement is a psychological state mediated through an interactive relationship between physicians and their working environmental conditions, seen through three frames: structural, political, and cultural. Environmental conditions are not automatically empowering for physicians, or disempowering. For example, accountability mechanisms can either empower or disempower; similarly, political approaches to supervision can either empower or disempower.

**Factors Influencing Physician Engagement — A Typology**

The paper presents a typology of the mental models of both physicians and administrators, as they relate to structural, political, and cultural environmental conditions. These are presented in four categories of roles: doctors in training; doctors in primary care; doctors in hospitals; and doctors in leadership roles in health regions or provinces. For engagement to improve, physicians and administrators must agree to work together on the issue, which requires being aware of each others’ mental models, being motivated to change environmental factors, and developing and implementing a plan to do so.

**Definition of Engagement, Principles and Framework for Action**

To initiate improvement in physician engagement, we must first define it and then articulate the rationale for improving it and the actions required to do so. We used this definition:

*Physician engagement is the initial, ongoing, energetic and committed involvement of physicians, in their diverse working roles within the health system, in order to:*

1. **Ensure that delivery of services to patients is done according to professional standards and personal ethics.**
2. **In collaboration with others in the community, hospital, region or province:**
   - Decide on efforts to determine the appropriateness of care;
   - Take action to improve the quality of citizen and patient care;
   - Plan and implement initiatives to enhance the efficiency of service delivery; and
   - Define the working conditions in which this work is conducted.

To ensure the “right” conduct for successful implementation of a physician engagement initiative, we propose a set of principles:

1. **Enhanced patients’ and citizens’ well-being is a shared goal of all partners in a physician engagement initiative.**
2. **Success of the health system (i.e., quality patient care and financial sustainability) is fundamental to the welfare of all physicians, regardless of role, responsibility, or formal position. As a consequence physicians have both rights (apertaining to their distinct clinical function) and professional obligations that influence engagement.**
3. **There are multiple solutions or ways of addressing physician engagement in a principled fashion. Identifying and acting on specific approaches to improve engagement is a joint responsibility of physicians, physicians’ representatives/leaders, professional bodies, administrators and other key players in the health system.**
4. **The quality of leadership as practised by individuals (in particular physicians and administrators), which is endorsed as appropriate by a system or organization, has a significant influence on the quality of engagement.**
5. *Healthy, productive organizations and systems provide members with opportunities to understand and shape the practices they are responsible for, and to grow throughout their career.*

6. *Effective organizational or system action requires alignment of authority with responsibility.*

These principles are the value foundation for action on physician engagement. There are three categories of action: collaborative leadership, addressing mental models, and changing environmental conditions. It is important the choice of actions is shared by physician and administrative leaders of this project.
Anchoring Physician Engagement in Vision and Values: Principles and Framework

Introduction

This paper is about the relationship between physicians — both individually and collectively — and the Canadian health system. Physicians are profiled here to tease out what is unique about the medical profession and ensure those factors are adequately considered when striving to integrate clinicians into the stewardship of a sustainable health system. It focuses on physicians not because engagement of other professionals is unimportant; indeed, their involvement is equally critical to the success of healthcare. Indeed, they, like physicians may well feel they deserve special treatment; and, in the spirit of respecting diversity, we acknowledge that need but will leave their concerns for other authors to pursue.

This paper, Physician Engagement: Principles and Framework, is one of three papers commissioned by the Regina Qu’Appelle Health Region (RQHR) in Saskatchewan to ensure physicians have an appropriate and rewarding role in determining the future of health care within that region. It may have implications far beyond the region, in Saskatchewan and nationally. However, we leave that for the reader to decide.

Note: Words defined in the glossary (Appendix D) are denoted by an asterisk (*) the first time they are used in the paper.

The Approach

The definition of engagement provided by RQHR to shape the initial investigation was “an energetic state of involvement with personally fulfilling activities that enhance one’s sense of professional efficacy.” (Maslach and Leiter, 2008). To take this definition, tease out its implications for the medical profession, and to create principles and framework, three stages of applied research were conducted, and are summarized in this report. A visual representation of those stages is shown in Figure 1.

Figure 1: Visual Representation of Applied Research Methodology.
The first stage of the process was to gather recent literature to augment that identified for two previous studies in which the author was a collaborator. One of those studies is conceptual, entitled PHYSICIAN ENGAGEMENT: Principles to Maximize Physician Participation in the Health Care System (Mohapel and Dickson, 2009), in which a conceptual analysis was undertaken in order to understand the dynamics of physician engagement and set some direction as to how to approach it from a strategic perspective. The second is an empirical, qualitative study entitled From the Inside Out: the Engagement of Physicians as Leaders in Health Care Settings (Snell, Briscoe and Dickson, 2011) in which more than 50 physicians were interviewed as part of a qualitative study to ascertain the factors that enhanced or undermined their experience of engagement.

These two studies elicited fundamental concepts that influenced the focus of the subsequent semi-structured literature review that underpins this paper. Because of the substantive literature search done for the earlier papers, this paper’s search was confined to the years 2010 — present. Initial search terms used were “employee engagement,” “physician engagement,” “medical engagement” and “mental models.” Databases were chosen for their comprehensive and international coverage encompassing health (Medline and EMbase on Ovid) and business and administration (Business Source Complete on EBSCOhost, ABI/Inform on Proquest). Medline and EMbase were searched simultaneously using the OVID platform to take advantage of the platform’s subject heading mapping function and to facilitate detecting and eliminating duplicates. A snowball approach was subsequently used to seek out further articles or documents pertaining to “professional identity,” “health reform,” and “medical leadership.” Peer-reviewed literature and grey literature from across Canada, as well as the United Kingdom, Australia, the United States, and New Zealand since 2010 was identified and reviewed. Findings and implications from the literature survey are organized in the next three sections of the paper.

The second stage of the process was to employ a realist synthesis approach to the results of the literature search (Mays, Pope and Popay, 2005). They describe realist synthesis this way:

In this approach, the primary focus is on the causal mechanisms or “theories” that underlie types of interventions or programmes. This sort of review aims to build explanations across interventions or programmes which share similar underlying “theories of change” as to why they work (or not) for particular groups in particular contexts (p. S1:12).

The intent was to outline the key factors that emerged in the literature review to define physician engagement then convert them, through praxis, into a set of principles and a framework for action that would provide an a blueprint for a successful physician engagement strategy. The “Definition of Engagement, Principles and Framework” is in Section 5 to this paper.

In the third stage of the project a panel of experts — both physician, administrator**, and human-resource experts — were asked to review both documents, provide feedback and refinement to both content and format, and suggest additional literature that might provide deeper insight into understanding the phenomenon of physician engagement. Revisions to the literature review, the analysis, and the definition of engagement, principles and framework were subsequently made.

This paper is an overview of the results of that three-stage process and presents the final typology and principles framework so developed. There are five parts to the paper: (1) Rationale and Purpose for Physician Engagement; (2) Unpacking the Dynamics of Physician Engagement; (3) National and International Approaches to Physician Engagement; (4) Factors Influencing Physician Engagement: A Typology; and (5) Definition of Engagement, Principles and Framework for Action.

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** Literature from countries such as Denmark, France and Sweden was not reviewed as the employment status of physicians differs significantly in those countries from Canada.
Part 1: The Rationale and Purpose for Physician Engagement

During the past decade we have seen a growing interest in, and demand for, physicians to be central actors in ensuring that the healthcare system enhances its access, sustainability, and quality of patient care (Clark, 2012; Weiss, 2011; Snell, Briscoe and Dickson, 2011; Atkinson, Spurgeon, Clark, and Armit, 2011; Canadian Medical Association, 2010; Mohapel and Dickson, 2009). The literature cites many reasons for this: for example, Lavis and Shearer (2010) highlighted the importance of physician engagement as a factor in strengthening primary health care in Canada. The British Columbia Medical Association (2010) published a document to guide both physicians and administrators to engage together in the quality improvement agenda; while Wilson, Powell, and Davies (2011) argued its central importance for successful quality improvement initiatives in the U.K. Gosfield and Reinertsen, (2003) emphasized the importance of physician engagement in the U.S. health system (in relation to other professional groups) stating that “patients primarily experience the health care system through their one-on-one relationship with a physician…. Most aspects of health care are ultimately derivative of physician behaviour” (p. 3).

Current Knowledge of Physician Engagement

But what is this phenomenon called physician engagement? In going back to basics, Webster’s dictionary defines engagement as “an arrangement to meet, or be present at a specified time and place; a job or period of employment; emotional involvement or commitment; the act of engaging; the state of being engaged as a betrothal, or hostile encounter between military forces” (www.merriam-webster.com/dictionary/engagement). In the management literature, engagement is a term that has been used to refer to “…a psychological state (e.g., involvement, commitment, attachment, mood), a performance construct (e.g., either effort or observable behaviour, including pro-social and organisational citizenship behaviour), a disposition (e.g., positive affect), or some combination of these.” (West and Dawson, 2012, p. 6). More definitions of engagement found in the literature are profiled in Appendix A2.

Common to most definitions of engagement are the concepts of a psychological commitment of the individual to a work enterprise, be it clinic, organization* or system; a desired set of behaviours that characterize evidence of engagement; a contribution in terms of results to the organization and/or system; and in some definitions (not all), a reciprocal commitment from the organization to provide what physicians need to maximize their contribution to those organizational results. It should also be noted that the Webster definition argues for a continuum of potential engagement — i.e., from hostile encounter to betrothal. Most of the other definitions found in Appendix A present an idealized definition of engagement. For example, Prins et al. (2010) argue that an earlier belief that engagement and burnout existed on a continuum is no longer valid. In their words engagement is “…a separate construct, a positive, fulfilling, work-related state of mind” (p. 237; italics in original). However, while it might be conceded that burnout may indeed be a separate construct from engagement¹, that does not mean that engagement of an individual or group does not exist on a relative scale from “disengagement” to “ideal engagement.” Indeed, the very point of measuring engagement (Prins et al., 2010; Clark and Spurgeon, 2011 — more later) is to determine where on that scale an individual, or a group of physicians might lie, as it relates to a specific organization or system context, and whether efforts should be made to improve it.

A second point about engagement from the Webster definition devolves from their use of the term “hostile engagement.” This term recognizes an attribute of engagement that is explicitly referenced in the Garg and Dickson (2006) definition but not the others:

² This list is not intended to be exhaustive, but representative of the prevailing notions in the literature.
³ The Prins study actually shows that highly engaged individuals can also suffer from burnout. Clearly the two constructs do not define a continuum. It might well be that someone can be so engaged with work (as defined in this study) that they expend unhealthy amounts of energy and become “burned out.”
interactivity. A strong case can be made that engagement, as a psychological state, is always in an interactive mode, influencing and being influenced by external environmental conditions both “hard” (i.e., structural) and “soft” (psychological state of physicians in relation to the psychological state of others). For example, Tims, Bakker, and Xanthopoulou (2011) found the same job resources that can be used to stimulate engagement can also stimulate personal resources, which in turn affects the level of engagement, and that engagement “…may vary even within the same person over time” (p. 121). Engagement might well be an interdependent phenomenon, where mutual cause and effect is at play.

Much of what contributes to a positive or negative state of engagement are either real or perceived relationship issues among groups of people, as well as from environmental conditions. If one looks at engagement from an organizational or systems point of view (i.e., maximizing the productivity of that entity) the group of actors that are most influential in enhancing physician engagement are administrators (Mohapel and Dickson, 2009; Dickinson and Ham, 2008). However, two questions arise from this observation: first, might there be a limit to a physician’s psychological capacity for engagement? And if so, where should it be invested, in the relationship with an administrator or organization, or in a relationship with the patient or groups of patients? Many physicians perceive the latter as their primary focus (Canadian Medical Association, 2012, Snell, Briscoe and Dickson, 2011; BCMA 2010; Bohmer, 2010). “Physicians have a different set of expectations and incentives from the health care community, patients and family in regard to their responsibility to improve patient experience across the continuum of care” (Beryl Institute, 2012, para. 2). Use of the term hostile engagement implies that a fractious relationship between one group and another group can snowball over time, while positive engagement implies a relationship that has grown and improved over time.

It should also be pointed out that the term “engagement” is not endorsed by all writers or health organizations as the appropriate goal for ensuring physicians actively contribute to health reform. Gosfield and Reinertsen (2010) have evolved their thinking to identify the ideal state as clinical integration: “Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.” (p. 16). The Fraser Health Authority in B.C. has stated that the challenge is “…collaboration with physicians. This goes beyond “engagement,” a term participants were not happy with. Engagement suggests an unequal power relationship. For physicians to buy into new approaches they will have to be equal partners in their development. Moreover, physicians should be encouraged to lead change.” (Fraser Health, 2011, p. 25; italics added).

The above-mentioned observations are important to the Regina-Qu’Appelle Physician Engagement Initiative for four reasons. First, while an idealized state of engagement is desirable to achieve, the true state may be anything but ideal. Therefore practical action to improve engagement must begin with a realistic assessment of where the context is with respect to the engagement continuum. To do an assessment, a valid and meaningful measurement tool (or tools) must be available. For those to be available there must be a consensus on what engagement means within Regina-Qu’Appelle, and instruments available to measure it. Second, if engagement is a function of interactive relationships between groups as well as with the environment, and if those relationships are fluctuating, fluid, and mutually influential, then we may have to look at models of social interaction and organization that recognize these dynamics in order to understand them and improve them.

Third, ideal states don’t just happen and rarely are they sustained. Constructs such as engagement are in a constant state of flux depending on emergent circumstances and actions. Without formal attention to the factors that have led to the current state of engagement (anywhere on a sliding scale from ideal to hostile), and a willingness to recognize what the reality is, and without subsequently monitoring and correcting conditions that influence the dynamic flux of the engagement continuum, circumstances are just as likely to regress as to improve. In essence,
engagement is in flow: either forward, or backward; it is never static.

A fourth and final point to take away from this discussion of engagement is the tight connection between the psychology of the individual and the context of the workplace, and therefore the importance of clear, constant and careful communication about the true purposes of an engagement strategy. Indeed, one might excuse physicians for seeing much of the engagement rhetoric as a deliberate stratagem by administrators to “get the most out of physicians” by having them experience work (as administrators define it) as a fulfilling, emotionally rewarding, and deeply satisfying experience. Wilkinson, Powell, and Davies identified this possibility, stating that doctors often have “suspicions of and cynicism about managerial motives and ‘hidden agendas’” (2011, p. 36). Physicians might also argue, and rightly so, that fulfillment, emotional reward, and personal satisfaction should be sought in one’s family and community engagements, as well through one’s work. Care must be taken to ensure that considerations of competing demands for engagement are respected in whatever efforts are made by the Saskatchewan health system to enhance physician involvement in their work, and that the motives for doing so are clear, respectful, and consistently and openly communicated.

It should also be posited, based on the above arguments that Maslach and Leiter’s (2008) definition of engagement may not be sufficient to truly capture the dynamics that are subsumed in “physician engagement.” Given the variety of viewpoints, and the conceptual confusion with respect to the term, there are two possible ideas that might be considered in the Regina-Qu’Appelle initiative. The first is that engagement can be defined — within broad parameters — in a manner that is consistent with the beliefs and views of participants in the context in which it is being used. And they should do that together. Second, consideration might be given to coming another term: one that is reflective of the true values and intents of the purpose of a “physician engagement” initiative, as in the case of Fraser Health. And third, it is clear that the concept of “physician as leader” needs more explanation in the context of such an initiative. More on this later.

The Evidence, Thin as It May Be

With the growing interest in physician engagement, and the many initiatives aimed at improving its quality, one would expect to find definitive empirical evidence that these efforts can be shown to improve health service outcomes. However, given the relatively recent interest in this phenomenon, it is not surprising that the evidence that does exist provides a strong process rationale for engagement, rather than being able to demonstrate that high levels of physician engagement are directly related to improved health outcomes. This is important to the Regina-Qu’Appelle project because physicians expect an evidentiary base to proposed change processes (BCMA, 2010; Gosfield and Reinertsen, 2010; Dickson and Lindstrom, 2010). So what evidence — beyond the process evidence — can be brought to bear on the value of physician engagement, as a formal initiative?

Goodall (2011) found that in the 100 top-ranked hospitals in the U.S. in 2009, there was a strong positive association between the ranked quality of a hospital and whether the CEO was a physician or not, suggesting that physicians in leadership positions may well enhance the quality of patient outcomes. Clark, Spurgeon, and Hamilton (2008) found that while there was “limited empirical evidence about the positive impact of enhanced medical engagement in organisational performance,” they did suggest that “the lack of engagement presented significant problems in the organisational pursuit for change and improvement” (2008, p. 7). West and Dawson, in their systematic review of studies of employee engagement explain the paucity of such evidence in that “little research on engagement has been conducted within health services specifically” (2012, p. 9). However, they go on to provide evidence that employee engagement can improve patient satisfaction and mortality, but do not provide any similar evidence on physician engagement.

One empirical study — Prins et al. (2010) — gathered data from a sample of 2,115 Dutch resident physicians. They found that resident doctors who were more engaged were “significantly less likely to
make mistakes,” which one can assume leads to improved clinical outcomes. Other articles provide anecdotal descriptions of successes in enhancing physician engagement through new governance models (Strumpf, Levesque, Coyle, Hutchison, Barnes, and Wedel, 2012; Holmes and Chu, 2012; John Hopkins Medicine, 2009), cost savings in the U.S. context (Sears, 2011), and new roles for physicians to create new care models (Welte, 2012; Bohmer, 2010; and Paulus, Davis, and Steele, 2008). However, they provide no evidence on the impact on patient outcomes.

Many of these references re-emphasize a point made earlier. Physician engagement already exists. It exists because a physician invests his or her psychological energy into improved patient care. In the current model of how physicians are engaged — with individual patients, in the community, in the health authority, or in the health system writ large — legal provisions, payment structures and psychological beliefs have helped to create the current state of physician engagement. However, recent changes in how governments conceptualize and administer health service delivery — i.e., a patient-centred philosophy that is based on a ‘single system’ perspective, and which has given rise to regionalization, an emphasis on inter-professional teamwork with the patient at the centre — has disrupted the flow of engagement. Funding sustainability issues have exacerbated the disruption (Canadian Medical Association, 2012). Indeed, it might have begun a downward spiral of physician engagement, in that physicians have a low trust level for politicians (Wilkinson et al., 2011), are suspicious of administrators who “are generally speaking in code for what they would like physicians to do but cannot get them to do” (Clark, 2012), and who are thrust together to have to work with fellow physicians and other health professionals in new and different ways. Gosfield and Reinertsen (2010) point out that a key question re physician engagement is “not about how to get physicians to engage with organizations and their projects” (p. 1). Rather, they say, the key question is “how to get physicians to engage with each other in improving quality, safety, and value” (p. 1). Clearly the challenge of physician engagement that Regina-Qu’ Appelle and Saskatchewan faces is multi-faceted, ever-changing, and inextricably connected with the challenge of health reform itself.

A Systems Approach

Unpacking any multi-faceted construct can be done in either of two ways. One way is to take a positivist, mechanical perspective in which the parts of a whole are discrete and independent; and when understood in terms of their cause and effect work together in a predictable fashion (simple or complicated systems). A second way is to adopt an organic, complex systems perspective. This perspective suggests that the parts of a whole are discrete and interdependent at the same time. They can be understood separately, while their interaction is not always understandable or predictable. In other words, overall the parts work together to create a whole that is dynamic, ever-changing, and in flow (Glouberman and Zimmerman, 2002; Plsek and Wilson, 2001; Stacey, 2000). From the description of engagement provided earlier, this paper has adopted the perspective of organic systems thinking to bring further understanding of what factors create physician engagement, how to describe them, and to demonstrate their interaction. A systems approach will allow for action to be taken to improve the state of physician engagement.

A related process consistent with systems thinking is described by Luoma, Hamalainen and Saarinen (2008). It is called the theory of complex responsive processes (Stacey, 2000; Suchman, 2002). The theory:

…provides a process-oriented account of organizational life that emphasizes the unity of thought and action and the social understanding of individuals…. According to the complex responsive processes view, organizational transformation as well as organizational phenomena that withstand time both emerge and re-emerge in people’s local interactions. Organizational transformation amounts to changing people’s behavior in local situations whereas routines, established power relations, legitimate conversational themes, irrespective of their apparent stability, are sustained only if they are expressed locally. In other words, transformation and reproduction, or change and stability, are
both intrinsically characteristic of all human interaction. (Luoma et al., 2008, p. 4).

Suchman (2002) suggests that the theory of complex responsive processes is an appropriate lens to apply to the improvement of physician engagement. Given the dynamic, interactive nature of engagement, the centrality of relationships (particularly the patient and the administrator relationship) to physician engagement, and the desire to change engagement practices in the Saskatchewan health system, it is important to pay attention to these constructs when planning actions for change.

**Measuring Engagement: Qualitative and Quantitative Approaches**

Earlier it was stated that in order to determine the state of engagement between physicians and various health-system contexts (micro-unit, primary care division, hospital, or region) an assessment of the level of engagement needs to be made. Given the many definitions of engagement it is not surprising that there is “no consensus on how to measure engagement” (Macey and Schneider, 2008, p. 78), but “…engagement is measurable, with some variability in the evidence gained by different measurement tools” (Clark, 2012, p. 4).

There are two basic approaches to measuring engagement. One is to use a validated, reliable psycho-metric test or instrument. The other is to utilize surveys to provide qualitative data on collective attitudes towards questions that represent concepts of engagement of meaning to the surveyor. In the first instance, the challenge is to find a test or instrument that accurately reflects the construct of engagement that is being measured. In the second instance, the challenge is to ensure that the survey questions are valid, from a construct and face validity perspective, to the concept being assessed. In either case, “It is critical that survey data be actionable. There is no practical value in a measurement program that has as a single measure of general employee attitudes toward work. What matters is in the details. Employee surveys are valuable tools only when they lead to action with the intent to improve organizational effectiveness” (Macey and Schneider, 2008, p. 80).

More specific to physician engagement itself, the literature search found only two acknowledged psychometric measurement approaches that provide documentation re validity and reliability and that also produce evidence for use in taking action to improve physician engagement. They are the Medical Engagement Scale (MES) developed by the National Health Service (NHS) in the United Kingdom, which has eighteen questions; and the Gallup Physician Engagement Scale with eleven questions⁴. The MES is designed to assess medical engagement in management and leadership in NHS organizations (Spurgeon, Barwell, and Mazelan, 2008). Atkinson et al. (2011) claim that it is useful when there “…is an awareness of, and sensitivity to current levels of engagement and their direction of travel” (p. 4). Their article documents the use of the MES to ascertain what can be learned from primary care trusts with high levels of engagement (according to the MES scale) compared to those with low levels of engagement. The MES has a hierarchical structure and provides an overall index of medical engagement. It also provides an engagement score based on three component meta-scales: working in a collaborative culture; having purpose and direction; and feeling valued and empowered. Each of these three meta-scales is itself comprised of two subscales (e.g., for feeling valued and empowered, the subscales are development orientation and work satisfaction) (Clark et al., 2008). The authors argue that:

> The scales were found to be reliable (ranging from 0.7 to 0.92) with an original database of over 23,000 NHS staff, and valid in terms of predicting external, independent measures.

⁴ Earlier on we profiled the Prins et al. (2010) article on resident physician engagement in Holland as an example of a study that provided evidence of demonstrating that a focus on engagement can produces improved results. In that instance the Utrecht Work Engagement Scale (UWES) was adapted for resident physicians. The UWES consists of specific components comprised of specific psychometric measures of discrete constructs such as energy or optimism. Similar models could be employed based on a particular jurisdiction’s definition of engagement and the qualities appertaining to that definition; however, going into the level of detail required to profile a list of such instruments is beyond the scope of this paper.
of level of engagement in the pilot organizations. A normative database for the MES has been developed representing a full range of size and type of trust and comprising just over 3,500 doctors in all (Spurgeon et al., 2008, p. 115).

Spurgeon, Mazelan, and Barwell (2011) claim in a subsequent article that using the Medical Engagement Scale “demonstrates a persuasive linkage between assessed levels of Medical Engagement…and independently gathered performance measures” (abstract). At present, the MES is used mainly in primary care trusts and secondary care organizations in the U.K., so its application in Canadian contexts is unproven.

The Gallup Physician Engagement Scale recognizes the interdependence of engagement on both psychological constructs within physicians as well as the organizational dynamics in which they work. It is distinct from the Gallup Q-12 survey which measures employee engagement (Harter, Schmidt, Killham, and Asplund, 2006). According to Gallup, (2012) they measure “Physician Engagement using a method unique to the role of the doctor” (para. 2). Specifically, the scale measures four emotional states of physicians that reflect (according to Gallup) an emotional response to their work environment. They are: (1) confidence or a basic belief that the hospital can be trusted; (2) integrity, or a feeling that the hospital treats them fairly; (3) pride or feeling good about being a member of the hospital; and (4) passion or viewing the hospital as an integral part of their lives (Sidebar: Levels of Physician Engagement). All of the examples provided reflect its use in a hospital environment.

There are no data in our literature review on the use of either the MES or the Gallup Physician Engagement scale in a Canadian context. Indeed, the literature we reviewed suggests that Canadian health authorities tend to utilize the Gallup Q-12 surveys (Harter et al., 2006) to measure physician engagement as a part of a broader employee engagement survey (Alberta Health Services, 2010, Fraser Health, 2011). Other approaches to surveying physician engagement have been developed on an ad hoc basis in response to individual health organization (or researcher) priority issues. For example, the Local Integrated Health Network Collaborative in Ontario has a 14-question survey aimed at assessing primary care physicians (Ontario Local Health Integration Network, 2011); the Ontario Medical Association is providing regional engagement services (OMA, 2011), the Ontario Hospital Association (2012) has a physician survey assessing the physician experience, including factors such as control over practice environment, resources, compensation and scheduling. Alexander, Lin, Sayla and Wynia (2008) developed a measure of physician engagement in addressing racial and ethnic healthcare disparities. While each of these measures may have internal validity and can be tracked over time to measure progress, they are all limited in terms of providing a metric of relative performance.

A final note: it is, on balance, counter-productive to measure a construct like physician engagement without an expressed plan for improving it, based on the results of the measurement. Recognizing the complexity of the physician engagement construct, and of the health system of which it is a part, Boustani, Munger, Gulati, Vogel, Beck and Callahan (2010) suggest that follow-through on initial measurement be conducted by process implementation teams to localize the content and localize or invent the delivery process (e.g., breaking down implementation to smaller and smaller micro-systems within an overall guiding plan). They highlight the importance of monitoring the delivery process and in particular, system members' interactions (because of the fundamental interactive nature of engagement). As part of the monitoring, they suggest it is important to detect emergent behaviours and where necessary to make course corrections. Finally, they espouse using the original measurement data to evaluate the impact of the selected change.
Part 2: Unpacking the Dynamics of Physician Engagement

In the previous section the point was made that physician engagement is a multi-faceted, dynamic, interactive, and somewhat controversial construct, and that there are many ways to approach its measurement. Unpacking it into its component parts — such that action can be taken to improve it — is the next step.

Independent Parts, Interdependent Functions

In systems thinking, organic systems are comprised of independent parts and interdependent functions: that is, there is an individual integrity to a part in a system that can be changed and manipulated, but there are also phenomena that in themselves only exist through interactivity between the parts. Plsek and Wilson (2001) describe the interactive phenomena as “…a productive or generative relationship (that) occurs when interactions among parts of a complex system produce valuable, new, and unpredictable capabilities that are not inherent in any of the parts acting alone” (p. 746, italics added). Changing one part might alter, eliminate altogether, or create novel existing interactive phenomena. What Plsek et al. (2002) don’t mention is that unintended change — and even intentional change — can produce phenomenas that are both constructive and destructive, as the term “hostile engagement” suggests. For example, a limited-contact relationship between an individual physician and an individual administrator might be perceived by the administrator as dysfunctional but by the physician as absolutely normal (as his or her day-to-day work with patients consumes all his or her attention). Likewise, action by one (the administrator, for example) to address the issue through a frank conversation can move that relationship from a neutral state to either a productive state or a completely dysfunctional state. To have such a conversation might be viewed by the administrator as the right thing to do, but depending on the quality of the conversation — its tone, message, and clarity of purpose; and the receptivity and psychology of the physician — it might have mixed results. This interaction could then spiral into an issue of principle between physician groups and the administration of the organization, and where previously there was no awareness of a relationship issue — either positive or negative — the idea takes on a life of its own.

A Duality of Perceptions: Respective Roles in the Health System

If we are looking at physician engagement from the role of overall performance or desired reform, then it is important to focus on the physician-administrator relationship as a critical success factor (Canadian Medical Association, 2012; Clark, 2012; Freund, 2011; Alberta Health Services, 2010). As Wilkinson et al., (2011) observed of health reform in the U.K., “…more initiatives have appeared than ever before, and the majority of these have come from the top-down mechanism of policy which is recognised as a barrier to clinician engagement” (p. 1). It is a little different in Canada, because of our more decentralized system of health financing and delivery; and because most health institutions are managed by long-serving administrators who have the responsibility for sustaining reform as part of their mandate: however, “…at the heart…is the relationship between physicians and health care administrators” (Kaissi, 2005).

As a consequence administrators are continually interacting with physicians, who in Canada largely run their own practices and are predominantly paid fees for service by government (Lavis et al., 2010; Payne and Briscoe, 2010). In Saskatchewan and throughout Canada, physicians and dental surgeons who have established independent clinics “…may have privileges at a hospital. These individuals may be highly engaged in their profession, but have a different level of engagement with their hospital organization” (Payne and Briscoe, 2010, p. 10). The nature of physician-hospital relationships is changing as the need for health reform increases. Some believe that over time, the granting of privileges has given way to a sense of physician entitlement. Historically, physicians have seen their role as patient advocate in the system. As tough decisions have had to be taken in order to reform the system, such as closing hospitals, closing beds, or restricting services, physician privileges have come under increasing pressure. The Canadian Medical Association (2010) points out that there are now employment, contractual arrangements, or appointment models
which are a combination of employment and privileges) emerging in the system. Similarly, new models of primary care delivery are emerging quickly in Canada. The dynamics of these reforms bring physicians and administrators into regular contact, sometimes causing friction, and posing challenges for those who lead and manage affiliated clinicians in our healthcare organizations (Payne and Briscoe, 2010).

Given the interactive nature of engagement, understanding the views of physicians and administrators of their respective roles in the health system is fundamental to understanding and improving physician engagement. There are a number of points to make here in order to begin that process.

It is important to understand that the roles physicians have in the system are increasingly diverse. For example, the physicians who were interviewed in a study on physician engagement by Snell, Briscoe and Dickson (2011) resided in a range of urban and rural settings across Canada, and worked in a broad range of general and specialty practices. They worked in the community, in healthcare organizations, and in formal (e.g., chief of staff, medical director, department head) and informal leadership roles (e.g., serving on committees, volunteering to head projects, acting as a board chair). A multiplicity of increasingly complex roles suggests that efforts to improve physician engagement, if directed at physicians across a health system, will have to be multi-faceted and multi-dimensional. Factors influencing engagement will manifest themselves differently as they relate to the unique contexts physicians work in. For example, physicians are of different genders, age and ethnic background; all of these conditions will impact the psychological dimension of engagement for physicians. And equally important, more and more physicians are moving into administrative positions.

A second point relates to another systems thinking construct: the importance of mental models in helping understand and explain physician-administrator dynamics (Senge, 2002; Argyris and Schon, 1996). Peter Senge (2002) defines mental models as, “deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action. Very often, we are not consciously aware of our mental models, or the effects they have on our behaviour” (p. 8). Different world views between administrators and physicians create an engagement challenge as they grapple with the challenge of maintaining high-quality patient care while being constrained through diminishing resources, and a societal demand for financial sustainability in healthcare (Tholl and Bujold, 2011). The literature identifies many such differences; we will mention three of the most fundamental here; but in the typology outlined in Part 4 of the paper, the fullness of these differences will be chronicled.

Most often, physicians perceive themselves to be the patient advocate and champion of high quality patient care in the system. Some go so far as to state that “…administrators do not know enough about the details of medicine to work with physicians in developing protocols” (Bohmer, 2010, p. 7). On the other hand, administrators might argue that they are the guardians of value for money in the system and that physicians are either unaware or insensitive to the realities of having limited financial resources: “We’re underwriting this whole adventure — paying consultants, guaranteeing salaries” (Gosfield and Reinertsen, 2010, p. 12). This can lead to a significant rift between physicians and administrators because many physicians believe that administrators do not provide the supports necessary for them to participate effectively in health reform initiatives: “Management doesn’t support doctors in involvement [in quality improvement initiatives] when we need additional time resources — we are not paid to ponder” (Brand, et al. in Wilkinson et al., p. 34). Indeed, in Saskatchewan and most cases across the country, physicians have been excluded from sitting on governing boards because of conflict of interest.

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5 For example, primary care reform takes the form of Integrated Primary and Community Care initiatives in B.C., Primary Care Inter-professional Teams in Manitoba, Primary Health Care Teams in Saskatchewan, Family Health Teams in Ontario, and a similar approach called les groupes de médecine de famille in Quebec.)
This difference of perspective “…brings up very deep-seated issues about ownership, control and identity” (Gosfield and Reinertsen, 2010, p. 12). Understanding these issues as they are perceived by each group and seeking methods and approaches to reconcile them is core to collective action to address both quality and sustainability (Dickinson and Ham, 2008).

Another difference in mental models between physicians and administrators revolves around beliefs about the role and importance of professionalism. “The medical profession holds a rare position characterised by high respect and trust of the community which in turn is inextricably tied to significant professional and personal responsibility” (Royal Australasian College of Medical Administrators, 2012, p. 4). Many doctors have taken 10 or more years of elite university study in order to be recognized as a doctor with a professional designation (Clark, 2010). Also medical training has “traditionally emphasized clinical autonomy in decision making and allegiance to professional rather than organisational values” (Gillam, 2011, p. 1). Moreover, physicians are required to compete to get into medical school, compete to receive their undergraduate degree, compete to get into their specialty training program of choice, and increasingly compete to gain privileges. After this intensely competitive process, one should not be surprised if physicians have difficulty cooperating when invited to collaborate as part of a physician engagement process.

Medicine is a powerful profession with a long and distinguished history, even “more powerful than nursing” (Clark, 2010, p. 265), and “…heroism is a characteristic of the medical profession as a whole,” (Korica and Molloy, 2010, p. 1885). This circumstance creates strong fault-lines between physician groups and administrative groups (Gover and Duxbury, 2012). That power can manifest itself in a strong sense of identity, sometimes called “tribalism” (Braithwaite, 2010, p. 5), or by “old boys clubs” (Braithwaite, 2004). From an administrator perspective there are “…insecurities associated with being a chief executive. Doctors who become chief executives experience a change in their professional identity and the role of leaders occupying hybrid positions is not well recognized” (Ham, Clark, Spurgeon, Dickinson and Armit, 2011, p. 113). Professional designation brings status, the right to practise, legal obligations, and a livelihood that is fundamentally important to physicians6, and “In times of change, clinicians identified more with their work group, services or department than their organisation, and this identification can act as a psychological protective mechanism” (Braithwaite, 2010, p. 5). As a consequence, many physicians feel more accountable for their performance to their colleagues and peers than to the administrators and are guided by the dictates of their professional college or association, “…hence the contemporary clinician-manager is required to discuss, negotiate and persuade rather than require, insist or demand, in order to achieve objectives and get things done. Delicacy and diplomacy on the part of clinician-managers are needed to deal with powerful, autonomous and sometimes egotistical clinicians” (Braithwaite, 2004, p. 254).

It should be pointed out that the studies that generated the above comments were conducted with physicians working in hospitals. In the case of primary care, family physicians may have an even stronger sense of professional autonomy. It is only recently — in the past five years or so — that primary-care physicians (as independent consultants) have been required by government policy and circumstances to work in inter-professional team practices or, as large coalitions, to take a collaborative, population-based approach to primary-care delivery.

Lavis et al.’s (2010) study on strengthening primary healthcare in Canada emphasized the strength of the mental model of professionalism and its influence on physicians. For example they found professional associations were very influential in generating reform. They cite “…the involvement of the General Practice Service Committee (and thus physician engagement and buy-in)” in British Columbia and “…the Quebec Federation of Family Physicians (who) had been involved in policy planning regarding

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6 Some view the opportunity to work as a right to make money to offset the investment in their education, and the late entry to the workplace.
new delivery models and the roles of other providers” (p. 37) in the success of programs in those two provinces to foster physician engagement.

On the other hand, administrators are rarely part of a professional body*, and where those do exist they are usually voluntary in nature, like the Canadian College of Health Leaders; and therefore are less powerful in influencing the behaviour of their members. Rather than possessing a strong sense of group identity defined by their professional expertise, administrators are shaped more by their organizational role and experience. In Canada, their group identity is more a function of their commitment to public service or an individual healthcare organization, as opposed to a profession. Administrators are far more constrained by the fact that they work within a set of legal, regulatory and policy rules and demands, and are required to be accountable for their own and their organization’s actions (Currie and Lockett, 2011, p. 294).

Administrators, like physicians, also exhibit tribal tendencies — when they seek guidance, connect on a social level, or interact formally with others in an organization, they tend to do so with other administrators (Braithwaite, 2010).

Unlike the vocation of medicine, administrators rarely choose their career in university (more often than not it is a ‘serendipitous’ career choice made for promotion purposes) (G. Rowlands, personal communication, May 12, 2011). Administrators come from a variety of backgrounds — nursing, physiotherapy, pharmacy, finance — as well as increasingly from medicine. These different backgrounds sometimes condition them to see the world differently from doctors. For example, Clark (2010) points out that:

In the medical profession, from its very beginnings, physicians did not supervise fellow physicians. Instead, they were groomed and positioned to be autonomous professionals. In contrast, the vast majority of nurses were prepared as practitioners over whom nursing administrators would exercise strict authority. This case example of divergent educational structures illustrates that strategic decisions made at the inception of a profession influence the ways in which it is positioned for power (p. 265).

Administrators are not required to invest up to ten years in university education to qualify for their role. For example many administrators are “…rank-and-file nurses…educated in hospital-based certificate programs” (Clark, 2010, p. 265). Much of their learning is on the job and many of those jobs are part of a bureaucratic hierarchy that defines roles, responsibilities and accountabilities. Braithwaite (2004) cites the example of a chief executive “…who had been promoted through the ranks and did not value highly or really see the need for managerial training for himself or others. Instead, he viewed management as largely common sense, and acted as if it was about command and control” (p. 249). He was not well-regarded. In the administrator’s world:

…roles are interdependent; time perceptions are more relaxed (for example, to finish a project “right away” may mean completion within a month or quarter); and thought processes are systemic and focused on doing the greatest good for the greatest number of people. In the physician’s world, described as an expert culture, making a decision and moving on is more important than emotional respect; roles are hierarchical with the expert at the lead; time is more condensed (“right away,” to a physician, often means today); thought processes are linear and physicians are taught to work through problems using a reductionistic approach and real time clinical decision-making (O’Hare and Kudrle, 2010, p. 40-41).

Administrators typically function in a committee structure or in a constant flow of meetings. Decisions are often democratic or consensus driven (Buller, 2003; Braithwaite, 2004). Administrators often schedule such meetings during their nine-to-five working day and are frustrated when physicians cannot attend due to patient commitments, or choose not to. Others are sometimes reluctant to “…put additional work onto clinicians: ‘managers were particularly aware they were asking a great deal from staff who were inadequately rewarded’” (Finlayson, 2002 in Wilkinson et al., 2011, p. 36). Multi-disciplinary teams are often created to implement
change (for example, in Saskatchewan the ‘lean’ change movement requires engagement of all front-line staff in process improvement) and doctors often find it difficult to attend meetings unless scheduled around their clinical responsibilities (usually early morning or late evening).

In the administrative world, accountability for results is a collective organizational effort on behalf of many, physicians included. Managers feel political pressure “…to deliver rapidly on a range of competing and often conflicting targets” (Wilkinson et al., 2011, p. 36). However, physicians, by the nature of their work, like to function autonomously, making quick, definitive decisions, and see patient care as their primary accountability. Consequently, efforts to generate collective accountability in the organization run contrary to physician beliefs in the over-riding accountability to the patient or to the profession. Increasingly, the public, and administrators (their agents in health organizations) are using scorecards, dashboards, performance measurement, and publicly reported evaluations. However, physicians “…decry many of these efforts because they focus on measures the physicians do not feel they can personally control” (Gosfield and Reinertsen, 2003, p. 16). It is therefore not a surprise that some administrators might believe that “…doctors deliberately withhold or confound information to frustrate management efforts, such as incident reporting” (Wilkinson et al., 2011, p. 34).

It is clear the different mental models of physicians and administrators can cause conflict and disengagement in the workplace, particularly if they operate under the radar of official policy or are the product of unconscious behaviour. It is not plausible to dismiss these views as simply a matter of attitude that can easily be changed (Hodgkinson, 1991, Pfeffer, 2005, Berwick, 1998). As Pfeffer states:

…it in order to do different things, at least on a consistent, systematic basis over a sustained time period, companies and their people actually must begin to think differently. That’s why mental models affect organizational performance and why they are a high leverage place for human resources to focus its organizational interventions (p. 124).

As an example, Gosfield and Reinertsen point out that “physician mindsets… (can) lead them to believe they are, in fact, providing evidence based medicine when the data shows otherwise” (2010, p. 5). Berwick (1998) describes another mental model as the boundaries among professions, and between physicians and administrators. There are very many real reasons for the emergence of mental models; and to believe that one can change them quickly or simply by policy fiat, or by dictum to achieve physician engagement is folly. Yet constructive change can be made in a long term, inclusive process, in which the two act as partners in leading that change. This takes us to the next topic, the link between leadership and engagement.

**Engagement and Leadership: The Missing Link**

What is the link between leadership and engagement? Can the words be used interchangeably? Or are they separate, but conjoint concepts? For example, Mohapel and Dickson (2009) make the argument that:

Engagement is a leadership behaviour. Leadership, like engagement, requires open communication that ultimately impacts the direction, vision, and policy of the organization. The goal of physician engagement is to get physicians taking a strategic leadership role in the health care system. To do so, physicians need to utilize their character, emotions, intellect, knowledge, skills, experience and resources into the broad health system for the ultimate betterment of patients (p. 7).

The Enhancing Physician Engagement at RQHR Project Plan, which outlines the overall initiative in Saskatchewan, mentions leadership development in many instances as the enabler of engagement. Statements are made that RQHR will: “identify highly interested physicians that can then be supported through leadership development,” and “A short list of physicians will be created who have attended a large number of engagement sessions. These physicians will be provided leadership support through access to a leadership coach”.

Anchoring Physician Engagement in Vision and Values: Principles and Framework | 13
So what is the “engagement-leadership link”? And is the distinction important? To answer the last question first, the distinction is important — without conceptual clarity, without clear boundaries that define a construct that generates action, important intellectual constructs can become slogans — used loosely to justify a multiplicity of purposes, muddying the conceptual landscape and leading to confusion. Secondly, without conceptual clarity, one might mount separate initiatives to address physician engagement and physician leadership — without realizing the commonality of focus or purpose, leading to redundant expenditures and dilution of energy.

In Appendix A we profile a number of definitions of engagement in order to understand it better. Many authors have done the same for leadership. A root definition for leadership that underpins the many Canadian healthcare organizations is “…the capacity to influence others to work together to achieve a constructive purpose” (Dickson, 2003, p. 10). The ‘working together’ component of this definition is the conceptual connection to engagement; and is represented in LEADS in the domain of Engage Others (i.e., working collaboratively and effectively with others: Payne and Briscoe, 2010); and the domain of Develop Coalitions (working collaboratively with other organizations: Cikaliuk, 2010). It should be noted that a deliberate decision to have a common framework defining leadership for all professions (including the Canadian Medical Association and administrators i.e., LEADS), was agreed to by organizational affiliates in order to have a common language and a common understanding about what good health leadership looks like in Canada (Canadian College of Health Leaders and Canadian Health Leadership Network, 2012).

The practical link between leadership and engagement is two-fold. First leadership is an enabler to improve engagement (Mohapel and Dickson, 2009) so physicians and administrators who wish to improve engagement can use leadership skills to do so. Gosfield and Reinertsen (2010) state it this way: “…one element is foundational to all leadership work (re engagement): effective leaders of clinical integration and physician engagement take a leadership stance (p. 28, bold and italics in original).

Second, attracting physicians to leadership roles in the health system is a goal of physician engagement. Leadership by physicians — regardless of formal role or responsibility within the health system — is seen to be key to effective health reform, and in particular to achieve the quality agenda so central to that reform (Canadian Medical Association, 2012; West and Dawson, 2012; King’s Fund, 2012; Wilkinson et al., 2011; Snell, Briscoe and Dickson, 2011; Chadi, 2009; Mohapel and Dickson, 2009; and Dickinson and Ham, 2008). Goodall (2011) provides evidence that physicians in leadership roles can improve outcomes in a hospital setting.

Aidan Halligan, from the National Health Service, speaking at a Canadian Medical Association forum stated it this way: “The biggest single obstacle [to health system transformation] is the lack of clinical leadership in transforming culture and overcoming custom, tradition and convention” (Canadian Medical Association, 2010). In a survey by the Deloitte Centre for Health Solutions (2012) health CEOs identified “facilitating physician alignment and integration into leadership roles” (p. 4) as a major challenge facing them. The Canadian Society for Physician Executives (CSPE), in partnership with the CMA has also created a Canadian Certified Physician Executive (CCPE) designation for physicians who have completed a rigorous education program in leadership. This suggests a major move in professional ranks to encourage physicians to take on more leadership roles in health reform.

7 This definition is the foundation for the LEADS in a Caring Environment Framework (LEADS) adopted by and used by the Canadian Health Leadership Network (www.chlnet.ca/leads-caring-environment-framework), the Canadian College of Health Leaders (www.cchlccls.ca/default_conferences.asp?active_page_id=649), and the Saskatchewan Leadership Program (www.saskatoonhealthregion.ca/SLP/documents/SLPBrchure.pdf) that is referred to in this project’s overview paper.

8 The Saskatchewan Medical Association has more graduates from the CCPE program than any other province in Canada.
Let us turn our attention now to leadership as it is currently being described and promoted in Saskatchewan Health and the Canadian health system — in the form of the LEADS in a Caring Environment capabilities framework (LEADS) (Dickson and Tholl, 2011). The choice of LEADS as a leadership framework in Saskatchewan is important for three reasons in a discussion of physician engagement. First, it acknowledges and treats everyone in health reform — physician, administrator, nurse — as potential leaders of reform, and partners in that endeavour. In this regard, Canada’s approach to leadership is markedly different than other jurisdictions (Clark 2012, Royal Australian College of Medical Administrators, 2012) because Canada’s physician community does not espouse a form of leadership distinct from other professions as other jurisdictions do. So although strategies to improve physician engagement may be profession-specific, the leadership skills required to accomplish it are not. Therefore the “boundary” mental model described by Berwick (1998) is challenged from the beginning by LEADS.

Second, LEADS endorses a construct of distributed leadership*, in which change is perceived to be created by the leadership of a variety of people throughout the health system* rather than the actions of a few (Currie and Lockett, 2011; Baker and Denis 2011; Avolio, Walumbwa and Weber, 2009; Gronn, 2008). This opens the door to physician leadership regardless of the physician’s role and position; it acknowledges that leadership is a function of what a person does, not the position they hold. Clark, Spurgeon and Hamilton underscore the importance of a distributed approach, stating that “engagement means attaining a strengthened contribution from all, rather than a potentially isolated few” (p. 7).

Third, LEADS recognizes a fundamental principle of distributed leadership: the difference between power over and the power to. “In the first case power is understood in negative terms, as implying that an actor is able to compel another actor to do what s/he would not do him/herself. The second type of power is considered to be facilitative, and thus positive, in the sense that it involves an action that accomplishes something, enabling certain goals to become defined and then reached” (Collin, Sintonen, Paloniemi and Auvinen, 2011). LEADS is transformational rather than transactional in philosophy9 (Avolio, Walumba, and Weber, 2009): it focuses on the interactivity of leader and follower, just as engagement focuses on the interactivity of a physician and those with whom they have relationships. Given the challenge of change initiatives such as Lean in Saskatchewan, and the philosophy of involvement of all staff, a leadership approach that models a facilitative style of leadership is important for success.

A further value of LEADS is that leadership development programs can enrol all professions and administrative groups. The programs themselves can facilitate dialogue and interchange among physicians, administrators and other professionals who aspire to lead, helping to bring their mental models to the surface and put them under scrutiny. Leadership development activities that encourage listening to physicians and promote two-way communication creates openness and enhances the potential for physician engagement (Sears, 2011, John Hopkins, 2009, Clark, Spurgeon and Hamilton, 2008). The Canadian Medical Association’s Physician Management Institute (based on LEADS) uses those techniques. Its in-house programs are available for other health professionals as well as physicians (CMA Physician Management Institute, 2012). However, that approach may be a two-edged sword: physicians may prefer to learn leadership together, to feel they are in a safe environment; and administrators may eschew programs that have the aura of being physician specific.

The Saskatchewan Medical Association (SMA) has been very assertive in using these programs to develop physician leaders in Saskatchewan (Saskatchewan Medical Association, 2012) which bodes well for its support of leadership development strategies. It might be of interest for the SMA, the CMA, and the Regina-Qu’Appelle Health Region to consider the potential of redesigning the Physician Management Institute program for a broader audience.

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9 Avolio, Waluma, and Weber (2009) define transformational leadership as “Leader behaviors that transform and inspire followers to perform beyond expectations while transcending self-interest for the good of the organization” (p. 423).
The collaborative, relationship building skills implicit in LEADS are important for physicians to learn. Physician leaders are being encouraged by their professional organizations, including the CMA, CSPE, and SMA, to move from a model of ‘expert leadership’ to one of collaborative or shared leadership. In this form of leadership patients and other care providers become partners; sharing the risk, the responsibility, and benefits accruing from working together to co-create the future of health service delivery (Dickson and Briscoe, 2010). And administrators, some of whom who also cling to old models of leadership, will also have to adapt. The expert model of leadership of some physicians, and the heroic model of leadership of some administrators places them in a competition for control, rather than collaborating, which is one of the fundamental causes of poor engagement. Scott (2010) outlines this potential paradox: if physician engagement is not healthy prior to launching such programs, it will “negate these initiatives and demand a new perspective on how to mobilize leadership throughout an organization” (p.13). In short, for leadership development to enable physician engagement, there has to already be a basic foundation of engagement.

At a more macro level, physicians and their representative organizations have not generally been actively engaged in health-policy development or healthcare system leadership. However very recently the Health Care Innovation Working Group (HCIWG) was established by Premier Brad Wall of Saskatchewan and Premier Robert Ghiz of Prince Edward Island. This group tabled its report in July, 2012 (The Council of the Federation, 2012). The process by which the report was prepared marks a new chapter in physician and nurse engagement in the policy development process. Both the CMA and the Canadian Nurses Association were involved, from the striking of this working group in January through to the release of the report in July. They helped draft, vet and finalize the recommendations, which included overall enhancement of leadership in health care.\(^\text{10}\)

At a more micro level dyads — shared leadership and management models in which physicians and administrators are paired together to lead and manage a department or program — have been used in a number of health organizations across the country to operationalize the construct of distributed leadership, at least within the management structure (Saxena, 2011, Megran, 2012). Dyads are important to note here because they have been tried in Saskatchewan and “have a potential to be highly effective” (Saxena, 2011, p. 2), or to “become a battleground for power struggle instead of power sharing” (Saxena, 2011, p. 2). Dyad approaches are also employed in Alberta (Calgary Region), Vancouver Island Health, and Capital Health in Nova Scotia. However, it should be noted that Baker and Denis (2011) argue that dyads have had limited impact, and are only one element of a physician engagement strategy.

Dyads have the potential to be effective if they are a true partnership in apportioning leadership responsibility; if the physician has adequate time to fulfill his or her responsibilities; if those responsibilities reflect the unique perspective and skill set of each partner; and if there is a constructive relationship between the partners (Saxena, 2011). It is the latter — “challenges of communication, quality of relationship, and commitment to the partner” (Saxena, 2011, p. 43) that most often detracts from the effectiveness of the partnership, and building the relationship needs to come ahead of focusing on tasks. Saxena (2011) provides evidence that putting two individuals with very different mental models together in a partnership and not giving time and developmental opportunities for them to challenge and adapt those mental models to shared leadership is a major impediment to success. She provides six recommendations for maximizing the benefits of dyads to Saskatchewan Health (Saxena, 2011), ranging from strategic support, to operational.

\(^{10}\) The Health Action Lobby, a strategic alliance representing over 30 national health organizations, was also built into the final drafting process. One of the biggest challenges was for the CMA to fully engage the provincial and territorial medical associations in the drafting process (since healthcare is a provincial responsibility). By all accounts this innovative process of physician engagement worked well and the process will continue as governments work toward generating the second report. (B. Tholl, personal communication, August 29, 2012.)
considerations and the use of leadership development programs for dyad partners. Implicit in the overall success of the dyad model is that both partners understand and are skilled at the practices of leadership: self leadership, interpersonal leadership, and strategic leadership.

**Part 3: National and International Approaches to Physician Engagement**

In this section of the paper we provide selected examples of practices and processes to improve engagement — that is, explicit efforts by health organizations or physician groups to contribute practical approaches to improve engagement. The choices aim to improve engagement by attending to some of the factors influencing engagement. It must be noted that many of these are snapshot reflections; in many instances (e.g., Ontario Local Health Integration Network 2011, Canadian Medical Association 2012) the documents reflect an intention to begin efforts at physician engagement, often suggesting the development of action plans, and sustaining their implementation over time. Without further evidence, long-term success of these strategies is therefore difficult to assess.

Appendix B provides an overview of some selected examples that surfaced during the literature review. These examples were chosen to show the variety of approaches tried and the broad scope of advances, as opposed to the frequency with which they have been employed by other jurisdictions (for example, the reference in Fraser Health to the dyad approach does not suggest that is unique to Fraser Health; indeed many earlier references were provided of other sites using this approach). Some are a structural approach (e.g., the creation of a specialist division of the Royal Australasian College of Physicians); others more a political approach (i.e., a physician engagement summit in Fraser Health in B.C.). All the examples in Appendix B show a long-term commitment to improving physician engagement, part of a process that is ongoing.

The information is presented in four columns. Column 1 provides the name of the specific jurisdiction. Column 2 indicates contextual factors (i.e., what level of the system — e.g., micro to macro — the action is aimed at influencing). Column 3 provides a short overview of the essential components of the specific engagement approach. Column 4 indicates the engagement factor the action appears to operationalize. It should be noted that in identifying these actions as examples, one can only judge on the language of intent; not the actual quality of implementation. Even great ideas to improve engagement can backfire and lead to great disengagement depending on the quality of implementation (for example, a use of an engagement survey to assess the level of engagement combined with a promise of an action plan to improve it will improve engagement if implemented as planned; however, if the survey is done and no action is taken, it will likely diminish the quality of engagement).

An analysis of the table in Appendix B confirms that physician engagement is more than a psychological construct; it is a psychological state mediated through an interactive relationship with the conditions in the environment physicians work in. Those conditions can be described from three frames of reference: structural*, political*, or cultural* (Bolman and Deal, 2008). For example, factors such as the contractual relationship of the physician with the health system and how they are paid are structural; and factors such as where power lies both in and outside of the formal power structure and how it is understood to be exercised are political in nature; and attitudes such as physicians traditionally viewing those physicians who move into administration as having “gone to the dark side” are cultural.

Let’s use an example from the above Appendix B to illustrate these factors as they might play out in engagement. The dyad approach — found in Alberta, Saskatchewan, and in the Geisinger model in the U.S. (Paulus et al., 2008) — is a structural change aimed at improving the relationship (and therefore the engagement factor) between a physician and an administrator. Formal approaches to defining the

11 Bolman and Deal (2008) actually describe four frames by which to observe organizational dynamics. The fourth is Relationships. Engagement is about a relationship — between physicians and the health organization and/or system — and as such that frame is the overarching focus of this paper.
roles, allocating time and resources to roles, outlining how the two will work together — are also structural in nature. Cultural factors that will influence whether or not the structure will work include how administrators and physicians can overcome traditional customs or beliefs about how they work (e.g., tradition might have it that administrators work eight-hour days in an office doing paperwork and rarely if ever engaging in conversations with physicians; and physicians devote those same hours to patient care and don’t have the time to meet with administrators). Political factors include how powerful the doctors are as an organized professional body both provincially and locally; whether they choose to wield that power; how they use that power; and whether they intend to do so in a manner to support the dyad structure’s successful implementation.

It is also important to note that these conditions are not automatically empowering for physicians, or disempowering. For example, the structuring of accountability mechanisms can be either disempowering — if imposed and if one is accountable for responsibilities one has not been given authority to pursue; or empowering — if mutually negotiated and agreed upon. Similarly, political approaches to supervision can either empower or disempower; micro-management, for example, removes the autonomy from a physician to act commensurate with their responsibility.\(^{12}\)

Essentially, for an engagement strategy to work it must align purpose and practice between the intent (improved relationship between physicians and health system) and the structural, political, and cultural conditions that exist in the environment.

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\(^{12}\) It is also important to recognize the difference between a rhetorical commitment to empowerment as opposed to a behavioural commitment to it. This might be called, ‘bogus empowerment’; i.e., a state whereby structural provisions to engender empowerment exist on paper but political practices do not operationalize them (Bolman and Deal 2008, p. 152).

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Part 4: Factors Influencing Physician Engagement — A Typology

Because administrators usually have the responsibility of setting terms and conditions of engagement, or designing the conditions that define an organization (or, system-wide, politicians and public servants) it is important they be aware of how those conditions can be empowering or disempowering for physicians. We have also made the point earlier that what works to empower physicians is also a function of how their mental models (the psychology of engagement) interact with the environmental conditions in which they work. Mental models determine to a great extent whether or not those conditions are viewed as empowering or not. Given the nature of those conditions, either positive or negative (from an empowerment perspective) and the innate psychological state of the individual physician, engagement can move along the continuum from disenfranchisement to meaningful engagement, for both individual physicians and groups of physicians. Consequently, efforts to improve engagement can be stimulated by changing conditions to make them more empowering as well as exposing divisive mental models that drive doctors and administrators apart in organizations and systems.

Table 1 represents an attempt to show, for various roles that physicians play in a health system, the factors that are most influential in determining the quality of engagement for that role. The evidence for the content of these tables comes from two sources: first, the literature reviewed in the first part of this study; and second, the dialogue with physician experts in the second stage of the study. Roles are divided into four categories: Doctors in Training; Doctors in the Primary Care Sector; Doctors in Hospital Settings; and Doctors in Leadership Roles in Health Regions and or Provinces. This is because engaging physicians is not simply a function of putting more physicians into formal leadership in the system; it is also because doctors act as informal leaders throughout their careers to ensure patients individually and collectively receive the best care available. Similarly, physicians are often expected, whether they like it or not, to take on leadership roles in communities, particularly remote and rural
communities. In other words, regardless of role, age, or position, doctors have an informal leadership role to play in system reform; and therefore any engagement strategy must be holistic in that regard.

Each section of the typology contains five columns. Column 1 and Column 5 identify the physician role being profiled, and the corresponding administrator role. Column 2 lists the possible mental models physicians in that role bring to the enterprise. Column 3 gives the environmental conditions that can are at play or can be manipulated to affect physician engagement. These are described in three sub-categories: structural, political and cultural. Column 4 depicts a number of prevailing administrator world-views that influence their perspective on the engagement landscape.

For engagement to be improved, regardless of its starting point, physicians and administrators must agree to work together to achieve the goal; they must all be aware of their own mental models and those of the other, in order to ensure they do not unknowingly disrupt their mutual efforts; and third, they must consider all of the factors they can manipulate to improve engagement, and develop a plan to do so. The foundations of that plan — its principles and framework — are the substance of the final section of this paper.
Table 1: A Typology of Factors Influencing the Quality of Physician Engagement

<table>
<thead>
<tr>
<th>Physician Role</th>
<th>Physician Mental Models</th>
<th>Environmental Factors Influencing Engagement</th>
<th>Administrator Mental Models</th>
<th>Administrator Role</th>
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<tbody>
<tr>
<td>Doctors in training</td>
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<tr>
<td>Physician Mental Models</td>
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<tr>
<td>• Early commitment to becoming a career doctor; entrance through university program.</td>
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<td>• Unique and special profession distinct from organizational context.</td>
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<tr>
<td>• Steeped in the ethos of the primacy of patient care; altruistic nature of medicine.</td>
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<td>• Expect high levels of intellect (IQ) and academic challenge to be required (little emphasis on EQ).</td>
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<td>• Strong sense of confidence, autonomy and independent decision making.</td>
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<td>• Status appeal.</td>
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<td>• Reliance on own skills of problem solving and decision making; enjoy challenging others and defending decisions.</td>
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<td>• Competitive…compete to get preferred residency training slots (CRMS match).</td>
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<td>• Required continuing professional development.</td>
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<tr>
<td>Environmental Factors Influencing Engagement</td>
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<tr>
<td>Structural</td>
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<tr>
<td>• 7-10 year (or more) university commitment for doctors; 4-5 years for administrators.</td>
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<td>• Medical school run by profession and restricted to doctors; administration programs run by academics and not restricted to any profession.</td>
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<td>• Common curriculum for docs (CanMeds) with little focus on organization or systems role; no common curriculum for administrators, but major focus on organization/systems role.</td>
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<tr>
<td>Political</td>
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<tr>
<td>• Compared to administration programs, entrance to medical school is highly competitive.</td>
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<td>• Licence to enter medical profession dictated by outside college; no such licence for administrators.</td>
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<tr>
<td>Cultural</td>
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<tr>
<td>• Medical schools emphasize special status and professional autonomy of doctors; no such emphasis for administrators.</td>
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<td>• High performance (grades, ranking), hard work and 24/7 define expectations of physicians; no such definition for administrators.</td>
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<tr>
<td>Administrator Mental Models</td>
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<tr>
<td>• Don’t necessarily have an up-front commitment to being an administrator; often trained as nurse, or other (e.g., business).</td>
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<td>• Enter administration through workplace promotion more often than through university program.</td>
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<td>• View role as a function to perform in organization rather than a profession to belong to.</td>
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<td>• Motivated by pursuit of social good and/or career advancement.</td>
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<td>• Expect some academic challenge but skills on the job more important for success.</td>
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<tr>
<td>• Some autonomy but acceptance of organizational role.</td>
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<tr>
<td>• Collaborative decision making.</td>
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<tr>
<td>• Ongoing growth and development usually discretionary.</td>
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Administrators in training: career preparation
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<th>Physician Role</th>
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<th>Environmental Factors Influencing Engagement</th>
<th>Administrator Mental Models</th>
<th>Administrator Role</th>
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</table>
| **Doctors in primary care** | • Physicians view commitments to practice and patients come before organizational or systems requests.  
• Feel in charge as leader of practice — both clinical and administrative roles; creates issues for autonomous practice of other professions; often see them as advisory to their decision making.  
• May focus less on enabling others and capacity building.  
• Perceive their accountability is to patients, peers and professional body.  
• Assume legal liability for patient care.  
• Leadership and management are learned through experience; often with business orientation.  
• Expect quick decisions and fast results.  
• Peer approval most influential.  
• More insular view of health enterprise. | **Structural**  
• Primary care physicians often operate independently and are disconnected from most parts of the health system.  
• Practice and patient care demands fill typical working day — little other time available.  
• Fee-for-service means livelihood depends on number of patients seen, rather than quality of care — delimits availability.  
• No formal role in management; health authorities minimizes informal contact.  
• No data-base of primary care physicians — where they are and how to reach them.  
• No other profession takes a financial hit to promote collaboration. | **Political**  
• Professional association support for participation in policies/programs aimed at physician engagement can leverage involvement.  
• Informal leadership ability, if employed, can influence health authority or community. | **Working with primary care where it intersects with hospital or regional roles** |
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<th>Physician Mental Models</th>
<th>Environmental Factors Influencing Engagement</th>
<th>Administrator Mental Models</th>
<th>Administrator Role</th>
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</table>
| Doctors in hospitals | - Focus on patients before finances.  
- Data driven; evidence-based (although don’t always act accordingly)  
- Sometimes suspicious of managerial motives.  
- May have a superiority complex: “She’s just a GP”.  
- Interested in quality care and making their practice/role efficient.  
- May perceive administrators as lacking knowledge/ skills for clinical improvement.  
- Often don’t bring an interpersonal focus to organizational meetings or inter-professional teams: not tuned into emotional undertone.  
- Doctors can be highly competitive amongst themselves.  
- Post-modern management theory may be opaque, if not incomprehensible, to many physicians. | **Structural**  
- Often physicians have a separate business operation that demands time.  
- Physicians tend to stay for lifetime careers; administrators have high turnover.  
- Formal decision making structures and consultation processes with administrators and boards may or may not be in place for doctors.  
- Clarity about the roles of managers, their authority in relation to doctors and related accountability can influence engagement. | - Tend to emphasize budgetary challenges in decision-making.  
- Typically function by committee; oriented to slow decisions and group decision making.  
- Often underestimate importance, contribution of, and workload affecting physician involvement.  
- Often emphasize hierarchy and position rather than expertise to justify decisions.  
- May misinterpret time for patients as apathy toward organization and system priorities.  
- Sometimes believe doctors deliberately withhold information (i.e., incident reporting).  
- Administrators sometimes compete with each other for promotions and status in the organization. | Administrators in hospitals or regions |
| **Political**  
- Conflicting demands for change — from administrators, bureaucracy, outside organizations such as professional associations.  
- Bureaucratic power and micro-management disempower managers and clinicians.  
- Medical advisory or other committees may not be cohesive or influential.  
- Same individuals tend to take on roles of physician champions and leaders. | | |
| **Cultural**  
- Challenge to move physicians from a clinical focus on individual patients to a broader institutional/system focus.  
- Both physicians and administrators may distrust physicians who take management positions.  
- Inappropriate self-interested actions by physicians reduce trust and confidence. | | |
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<th>Physician Role</th>
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<th>Environmental Factors Influencing Engagement</th>
<th>Administrator Mental Models</th>
<th>Administrator Role</th>
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</table>
| Doctors in leadership roles in health regions or provinces | • Comfortable with commanding, pace-setting leadership; less so with collaborative styles.  
• Multiplicity of roles — e.g., academic position as well as hospital — can create conflicts of loyalties, priorities.  
• Natural tendency to put clinical issues ahead of organization issues.  
• Value credibility with physician colleagues; most physician leaders retain clinical responsibility as a reality check.  
• Make effort to engage, and develop comfort in working with administrators through informal methods (in dyads, or other models). This improves relationships.  
• Sometimes blame administrators for inability to decide and take action.  
• Demand evidence to validate change.  
• Often suspicious/ sceptical of politicians. | Structural  
• Is there a well-defined process to identify and select potential leaders?  
• Is there infrastructure support for quality improvement (board and organization)?  
• Is there clarity on shared management roles — responsibilities, accountabilities, time and allocation of resources?  
• Are there strategies to support physician engagement, such as policy, communication and education initiatives?  
• Are there agreed metrics for engagement?  
• Is there a leadership development program?  
• How well are inter-professional teams implemented and supported? | • Emphasize style that suits personality, rather than variety of styles required.  
• Decisions focus on population approach not individual patients.  
• Can be overly budget conscious and disproportionately dedicated to efficiency as opposed to quality.  
• Value credibility with administrative peers; do not retain front-line responsibilities — may lack reality checks.  
• Make effort to engage, and develop comfort in working with administrators through informal methods (in dyads, or other models). This improves relationships.  
• Sometimes blame physician groups for resisting change and not understanding politics.  
• Sceptical of, but feel accountable to, politicians. | Senior Administrators in hospital or region (board or senior leaders) |
|               |                         | Political  
• Appropriate representation of physicians in senior leadership roles.  
• Credibility of physician leaders with colleagues, and ability to speak on their behalf.  
• Ability of physicians and administrators to master leadership that resonates with clinicians, each other, and front-line staff.  
• The strong public influence doctors’ professional bodies have. | | |
|               |                         | Cultural  
• Physician leaders are usually perceived as either still clinicians, or having moved to administration; rarely both.  
• Quality improvement initiatives work to involve physicians. | | |
Part 5: Definition of Engagement, Principles and Framework for Action

The purpose of this section of the paper is to translate the knowledge gleaned from the semi-systematic review of the literature and described in Parts 2, 3 and 4 into a set of principles to guide action on physician engagement, and a practical framework to initiate its implementation. As with many organizational or system-wide interventions that required significant change, the Principles and Framework need to outline clearly the value foundations that create the rationale for change, and as part of the praxis implicit in this exercise, outline the implications for action that those values imply. A starting point is to articulate a definition of engagement consistent with the findings in this paper.

Definition of Engagement

The foundation of any enterprise dedicated to physician engagement must begin with a definition of engagement that is accepted and agreed upon throughout the system that is dedicating resources to its accomplishment. In the case of Regina-Qu’Appelle, and for this paper, the following definition is presented for discussion purposes:

Physician engagement is the initial, ongoing, energetic and committed involvement of physicians, in their diverse working roles within the health system, in order to:

1. Ensure that delivery of services to patients is done according to professional standards and personal ethics.
2. In collaboration with others in the community, hospital, region or province, physicians can:
   - Decide on efforts to determine the appropriateness of care;
   - Take action to improve the quality of citizen and patient care;
   - Plan and implement initiatives to enhance the appropriateness, quality and efficiency of service delivery; and
   - Define the working conditions in which this work is conducted.

This definition acknowledges both the psychological state of engagement and the external environmental conditions of engagement. To lay a foundation so the Regina-Qu’Appelle Health Region can pursue action to improve and sustain a positive state of engagement for physicians in the region, a set of principles to guide that work based on the findings in this paper are presented next.

Principles

Principles are the “guiding sense of the requirements and obligations of right conduct” (Merriam Webster, 2012) as it relates to a change in focus or strategy in an organization. In this instance, to ensure the “right” conduct as it is relevant to successful implementation of a physician engagement initiative, a set of principles logically flow from our treatment of the topic in the first three sections of the paper as well as the comments and input from physicians and administrators in the second part of this study. These principles are:

1. Enhanced patients’ and citizens’ health and well-being is a shared goal of all partners in a physician engagement initiative.
2. Success of the health system (i.e., quality patient care and financial sustainability) is fundamental to the welfare of all physicians, regardless of role, responsibility, or formal position. As a

13 The author would like to point out that these principles are created not to guide Regina-Qu’Appelle in its physician engagement journey, but to lay the foundation for the proposed action plan that is outlined in the next section of the paper. A final decision as to what principles are appropriate within the context of Regina-Qu’Appelle Health Region to guide its project must be made by all partners in that enterprise.
Anchoring Physician Engagement in Vision and Values: Principles and Framework

In the complexity of health care, patient well-being is the function of coordinated action between many different individuals and professions. The tax dollar that is dedicated to patient well-being is the source of remuneration for the economic welfare of health care providers, physicians included. With remuneration, come both rights and obligations, distinct to the role and function of individuals and groups. These rights and obligations, as they pertain to physicians, must be respected.

3. There are multiple solutions or ways of addressing physician engagement in a principled fashion. Identifying and acting on specific approaches to improve engagement is a joint responsibility of physicians, physicians’ representatives/leaders, professional bodies, administrators and other key players in the health system.

Our analysis of the research has identified many different models and approaches to physician engagement. The choice of which approaches are consistent with the value system of Regina-Qu’Appelle health region, and the physicians working in or with that region, should be mutually determined.

4. The quality of leadership as practised by individuals (in particular physicians and administrators) and that is endorsed as appropriate to a system or organization, has a significant influence on the quality of engagement.

The literature is unequivocal in its position on the importance of quality leadership as a major facilitating factor in achieving and sustaining physician engagement at all levels of the health system (micro-macro). A principled approach to achieving physician engagement would be to ensure that efforts to improve leadership are aligned with other related initiatives. Almost all conceptualizations of leadership emphasize the importance of skills to improve the level of understanding of the role of others in the system, and the requirement of building collaborative relationships across organizations, professions, and individuals.

5. Healthy, productive organizations and systems provide members with opportunities to understand and shape the practices that they are responsible for, and to grow throughout their career.

Modern leadership literature is clear that “people support what they help create.” The definition of engagement advocates for “the initial, ongoing, energetic and committed involvement of physicians” in the health system. As a matter of principle, therefore, physicians should be involved from the initiation point of that activity, and throughout any formal process.

6. Effective organizational or system action requires alignment of authority with responsibility.

When individuals or groups work together to solve problems and initiate action, it is vital for success of those collective endeavours that there is clarity around distribution of authority, and accountability commensurate with that allocation of responsibility. Indeed, it might be argued that ‘the rule changes’ that are being initiated by government, and thence by health authorities in Saskatchewan, have required adjustment and alteration of existing accountability and responsibility models between physicians and other partners in the system. Any successful change project will therefore attempt to surface this issue and negotiate roles, responsibilities and accountabilities together.

14 It might also be argued that the redistribution of accountability and responsibility inherent in these change initiatives could be a cause of physician disengagement, and therefore, that the methodologies employed to implement a physician engagement initiative must address the issue frontally, and that participants need to model a willingness to make adjustments in current practice in order for it to be successful.
The above-described principles are the value foundation for the generation of action on physician engagement. When extrapolated into action, guided by the literature findings earlier documented in this paper, they create the base upon which a Framework for Action can be constructed.

**Framework for Action: Physician Engagement**

The framework for action connects the findings of the literature as it relates to “best practices” of physician engagement (referred to in Table 1) to the above set of principles to define three focal points for action: **Collaborative Leadership, Addressing Mental Models, and Changing Environmental Conditions**. Figure 2 provides a visual representation of how the principles and focal points for action combine into an overall Framework for Action. The larger circle represents the overall context in which the initiative is being implemented, and into which the actions are inserted.

Figure 2: Framework for Action
The Physician Engagement Framework, including the definition of engagement, and the principles, when combined with the research articulated earlier in the paper imply that certain actions are likely to be more efficacious than others in creating improved physician engagement in Regina-Qu’Appelle and across Saskatchewan. There are three categories of action recommended: Collaborative Leadership, Addressing Mental Models, and Changing Environmental Conditions. It is important, commensurate with everything that has been stated to this point in the paper, that the choice of actions to be taken is jointly shared between physician and administrative leaders of this project.

**Steps for Action: Collaborative Leadership**

- The initial, ongoing, active formal involvement of doctors at all levels of activity aimed at improving physician engagement; including shared decision making and shared contribution, is implicit.
- The establishment of a process and the signing of a formal agreement, to clarify that there is a shared understanding of effective leadership and management — as represented by LEADS — and a commitment to behaviours consistent with LEADS, agreed upon by both administrator representatives and physician representatives, is encouraged.
- How well administrators and physicians are encouraged, enabled and empowered to lead, at all levels, will be a key stimulus for improved engagement. This emphasizes the importance of distributed leadership models (e.g., dyads); the importance of partnering with the Saskatchewan Medical Association in its efforts to improve physician leadership; and clarification of leadership roles and responsibilities throughout the organization or system (i.e., physicians who are given leadership roles must have time and authority commensurate with accountabilities). Therefore, ongoing learning opportunities for both physicians and administrators to learn leadership and management in an inter-professional setting need to be encouraged.
- Given the rapidly changing, ever-evolving policy environment emanating from government, the influence of research as it relates to clinical protocols and practices, and the influence of professional colleges and associations, there is a need for physician and administrator leaders to become more comfortable, knowledgeable and proficient in change management processes. Expectations for learning and the responsibility for funding it are shared between physicians and their profession (CME funding), and between the individual healthcare organization (Professional development days) and the overall health system. Clarity as to those expectations in a policy format would enhance the potential for engagement.

- Fair compensation is suggested for physicians who lose revenue as a consequence of contributing to taking on formal or informal leadership positions to improve engagement.

**Steps for Action: Challenging Mental Models**

- When mental models assert themselves, they need to be respectfully challenged and discussed. Mental models traditionally are unconscious: so not surfacing them gives them free rein to shape opinions and actions.
- Practices to improve engagement are best pursued from a shared “no blame” attitude: the system is what it is, to reform it we need to understand it and move forward together.
- Addressing the differences in view and perspective as it relates to how administrators and physicians see the world, and their expectations of physician engagement is encouraged. For example, sometimes, the term physician engagement is used to describe what somebody else should do; e.g., when administrators talk about physician engagement, they are generally speaking in code for what they would like physicians to do but cannot get them to do; but when physicians speak about engagement, they are speaking in code for what they already give that is not appreciated, valued or supported by the administration (Clark, 2012). Surfacing mental models though structured dialogues, and enhancing informal contact is important; and the tough questions of power, control and
responsibility need to be aired in a safe place for dialogue.

- Leadership-development programming — in which both administrators and physicians participate — if appropriately facilitated and taught, can provide opportunities for safe dialogue and sharing of mental models.

- The creation of tools, or activities that can both surface and illuminate mental models, would contribute in a valuable fashion to the ability to share world views more effectively.

**Steps for Action: Changing Environmental Conditions**

- A first step in improving environmental conditions is to create a change team for engagement that involves physicians from the beginning in shaping the initiative. An initial step for this team will be to determine the readiness of, and the receptivity of, both physicians and administrators to take on this challenge. *NOTE: a suggested template for the terms of reference for this group can be found in Appendix C.*

- Many of the structural, political and organizational cultural attributes of the health system either enhance the potential for engagement or undermine it. An audit of those conditions would be valuable from an appreciative inquiry perspective; i.e., to determine what is already working and that could be enhanced; and to identify gaps between ideal practice and existing practice that need to be filled.

- Engagement conditions are different depending on size and breadth of context (i.e., micro, meso, or mega systems). Alignment of action to address structural, political, and cultural factors from micro to macros levels is required for success, and is best done simultaneously, employing processes and procedures to allow interaction and communication between, as well as across, levels.

- This paper has identified a number of practices employed in other jurisdictions that can be used to enhance efforts at physician engagement. A review of those practices, an assessment of their alignment with the values in Regina-Qu’Appelle health region, and the practicality of implementing them is suggested.

- A measure for engagement agreed upon by both administrator and physician representatives needs to be employed and implemented; and action plans to improve it (including ongoing monitoring and course-correction methods) aimed at reaching established engagement targets should be developed.

- Initiatives to improve physician engagement also need to be aligned from the micro clinical environments all the way to the macro, or provincial environment; as efforts in one place might well confound efforts at other levels, if not aligned.
**Conclusion**

This paper has attempted to review the new but growing literature on physician engagement, and through a rigorous process of the realist synthesis approach to analysis, tease out the implications for the potential implementation of a successful region or province-wide initiative to improve physician engagement. The concept of engagement itself was explored and analyzed and a new operational definition — commensurate with the situational context in Regina-Qu’Appelle Health Region — was proposed.

A detailed analysis of the literature also pointed out that the challenge of engagement requires that stewards of organizations delivering most health services (administrators) and physicians need to work together for maximum value to patients and citizens. This action needs to happen at all levels of endeavour where physicians are central to health service delivery and reform. However, the literature also points out that mental models of both groups divide their efforts; and environmental conditions that have grown up over years of history either impede or enhance the potential for engagement. These have been articulated in a typology that proffers a summary of the most important considerations, organized by physician role. Finally, a Framework for Physician Engagement has been crafted, that extrapolates the knowledge learned into a set of principles and three focal points of action, and that could serve as a starting place for dialogues between administrators and physicians to enhance physician engagement.

In the process of writing the paper, four key issues did surface that may require further dialogue and discussion. The first is that the term physician engagement might not be politically viable as a descriptor for this work; it will depend on how it is received by those involved at Regina-Qu’Appelle Health Region. This is not to denigrate the intent of the existing initiative, or much of the substance outlined here to achieve it: however in the spirit of recognizing the power of culture (and therefore of language) it would be prudent to be aware of the potential for backlash against the term. Second, the paper does not know the current state of physician engagement in Regina-Qu’Appelle; nor was that within the scope of the paper. If there are implications that suggest otherwise, those are completely inadvertent and unintended. Third, although the findings were directed specifically at the Regina-Qu’Appelle Health Region, there are implications for the province, and potentially, Canada. For example, if in-house physician management institute programs could be re-packaged to make them attractive to both administrators and physicians in Saskatchewan (i.e., based on an agreement between the SMA, CMA, and Regina-Qu’Appelle), they might also be repositioned nationally. Similarly, if the “medical administrator” specialization (identified in the RACMA example from Australia) has appeal provincially, it might also have appeal nationally.

Finally, it is clear that a rigorous and disciplined approach to improving physician engagement is a major undertaking, demanding the very leadership skills that may be a precursor to the current state of engagement. Before beginning, it would be wise to ascertain whether there is the leadership capacity in the system to ensure the initiative can receive the baseline support it needs to be successful. Physician engagement is a very laudable goal and a very elusive one that challenges many of our leadership practices to their very core.
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Luoma, J., Hamalainen, R. and Saarinen, E. (2008). Acting with systems thinking: complex responsive processes and systems intelligence. Systems Analysis Laboratory, Helsinki University of Technology. Accessed online on August 16, 2012 at www.google.ca/#hl=en&gs_nf=1&cp=17&gs_id=2l&xhr=t&eq=Luoma%2C+Hamalainen&pf=p&sclient=psy-ab&q=Luoma,+Hamalainen&gs_l=&pbx=1&bav=2,2,ou.2,2,0l2.3243.4846.0.5083.12.11.0.1.0.0.196.196.0j8.6.0....0...1c.1.64&bav=on.2,or.r_gc.r_pw.r_qf.&fp=255436577c469f4d&biw=1920&bih=998.


### Appendix A

#### Definitions of Engagement

<table>
<thead>
<tr>
<th>Definition of Engagement</th>
<th>Reference</th>
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<tbody>
<tr>
<td>An energetic state of involvement with personally fulfilling activities that enhance one's sense of professional efficacy.</td>
<td>Maslach and Leiter (2008)</td>
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<tr>
<td>A measure of a physician’s emotional and intellectual commitment to an organization. A physician is considered to be engaged when they display all three of the following engagement behaviours:</td>
<td>Clark (2012) (used in The Ottawa Hospital in Ontario, Canada)</td>
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<tr>
<td>• consistently SAY positive things about the organisation as a place to practice</td>
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<td>• intend to STAY and continue practice at the organisation</td>
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<tr>
<td>• strive to achieve above and beyond what is expected in their daily role.</td>
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<td>Involvement in managerial decisions, and in implementing changes.</td>
<td>Dickinson and Ham (2008, p. 7)</td>
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<td>A positive, fulfilling, work-related state of mind characterized by vigor, dedication, and absorption.</td>
<td>Schaufeli et al (2002, p 74)</td>
</tr>
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<td>The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care.</td>
<td>Spurgeon, Barwell and Mazelan, (2008, p. 214)</td>
</tr>
<tr>
<td>The individual’s investment of energy, skill, ability, and eagerness in the work performed. Engagement includes “involvement” and “commitment” yet goes beyond to include observable behaviors such as:</td>
<td>The HR Capitalist, (2012) accessed at <a href="http://www.hrcapitalist.com/2008/01/i-just-tried-to.html">www.hrcapitalist.com/2008/01/i-just-tried-to.html</a></td>
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<tr>
<td>• Attention to task detail</td>
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<td>• Commitment to assignment completion</td>
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<tr>
<td>• Involvement in special projects</td>
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<td>• Communication willingly, effectively with others</td>
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<tr>
<td>• Demonstration of personal/ professional improvement</td>
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<tr>
<td>• Initiation of problem-solving and/or conflict resolution</td>
<td></td>
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<tr>
<td>• Innovation regarding processes and procedures</td>
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<tr>
<td>The interactivity of individual physician personality, character, knowledge, skills and resources—with those of the clinic, community, hospital, health authority, or society—for the betterment of patients.</td>
<td>Garg and Dickson (2006)</td>
</tr>
<tr>
<td>A positive, fulfilling, work-related state characterised by vigour, dedication and absorption. High levels of energy and willingness to invest in work define vigour. Dedication is defined as feelings of enthusiasm, pride and inspiration about one’s job. Absorption means being so engrossed in work that time passes quickly and other things do not matter.</td>
<td>Prins, Hoekstra-Weebers, Gazendam-Donofrio, Dillingh, Bakker, Huisman, Jacobs, van der Heijden (2010).</td>
</tr>
<tr>
<td>The active contribution of doctors within their normal work to enhance the performance of the organization which itself supports and encourages quality care.</td>
<td>Quality, Safety and Patient Experience Branch, Hospital and Health Service Performance (2010), Australia.</td>
</tr>
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</table>
### Appendix B

**National and International Examples of Efforts to Improve Physician Engagement**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Contextual Factors</th>
<th>Description</th>
<th>Engagement Factors</th>
</tr>
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<tbody>
<tr>
<td>Canada</td>
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<tr>
<td><em>Canadian Medical Association</em> and <em>Canadian Society of Physician Executives (2012)</em></td>
<td>CMA Policy document. Volunteer Medical Assn. at the national level; approx. 90,000 members. Does not bargain: bargaining done at provincial level.</td>
<td><em>The Evolving Professional Relationship Between Canadian Physicians and Our Health System: Where Do We Stand?</em> This document articulates the rationale for, principles for, ideas for, and supportive actions to be taken by the CMA in support of physician engagement. <em>Canadian Certified Physician Executive</em> designation: and <em>Physician Management Institute</em> programs aligned with LEADS framework.</td>
<td>• Formal championship of the importance of physician engagement to health reform, based on consultation with members. • Enhancement of leadership development opportunities for physicians.</td>
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<tr>
<td>BCMA (2010)</td>
<td>Provinces have constitutional control over health care; Provincial Associations represent doctors in that province for bargaining, etc. Primary care physicians are independent business people in the most part; specialists as well.</td>
<td><em>An Incomplete Guide to Engaging Physicians Into Quality Improvement.</em> A guide describing how and why physicians might get engaged, a description of the behaviours of administrators that will or will not catalyze that engagement, and how you would know physicians are engaged. <em>General Practices Services Committee:</em> A provincial committee of physicians established by BCMA to support primary care integration and community involvement.</td>
<td>• Surfaces mental models and what they look like in action • Identifies barriers to effective engagement • Outlines actions to be taken by both administrators and physicians that overcome barriers • Structural approach for ongoing consultation/stewardship of change.</td>
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</tbody>
</table>

*Appendix B refers to examples of efforts to improve physician engagement in Canada and BCMA (2010) with specific details on the context, description, and engagement factors.*
<table>
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<tr>
<th><strong>Fraser Health (BC) (2011)</strong></th>
<th><strong>Alberta Health Services (2010)</strong></th>
</tr>
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One of six health authorities in BC delivering care provides care to more than 1.6 million people living in Metro Vancouver and the Fraser Valley; both urban and rural (full spectrum of care). Doctors can be employed, contracted, or appointed to roles within hospitals.

- Summit to develop strategy for physician engagement/leadership
- Two physician leads were identified and funded to provide overall physician leadership, focus on engagement and oversee planning.
- **Six Physician Engagement Strategies**
  1. Designating Physician Co-Leads.
  3. Partnering Physicians with Operational Engineers.
  4. Optimizing Communication to Physicians.
  5. Creating a bilateral Statement of Expectations for both the physicians and the JPOCSC administration.
  6. Designing and Implementing a comprehensive Physician Education, Training and Orientation Program.
- Online communique entitled PHYSICIANS, Midwives and Dentists—updated regularly.
- Dyad structural approach formalizes direct contact between administrator and physician.
- Formally requested physician input into engagement strategy.
- Regular, ongoing communication easily accessible.

Largest health authority in Canada; province-wide in scope and full spectrum of services.

- Performance indicator developed to assess and monitor physician engagement as a priority in AHS’s strategic plan.
- **Measure: Staff and Physician Engagement:** Overall engagement score: percent favorable physicians/practitioners. NOTE: measure does not appear to distinguish between employee and physician engagement.
- The portfolio of the Chief Medical Officer has developed a variety of strategies to contribute to the meaningful engagement of physicians, practitioners and other clinicians in the operational and planning activities of AHS.
- AHS Realignment—establishment of AHS Zones and Dyad Structure.
- Formal articulation of strategic intent to improve physician engagement; built in all Senior Leader Performance Agreements.
- Ongoing awareness of, and measurement of state of engagement
- Strategies articulated to improve engagement, including structural realignment (dyad).
### Ontario Local Health Integrated Network (LHIN) (N.D.)

[LHIN website](https://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Get_Involved/LHIN%20Community%20Engagement%20Guidelines%20and%20Toolkit-%20February%202011%20FINAL(1).pdf)

LHINs are not-for-profit organizations responsible for planning, integrating and funding local health services in 14 different geographic areas of the province to make it easier for patients to access the care they need. LHINs are required by legislation to ‘engage the primary sector’ but do not have formal funding or planning authority for most primary care models, with the exception of primary care services provided through Community Health Centres.

#### Primary Care Physician Engagement Resource Guide and Toolkit.

The Primary Care Physician Engagement Resource Guide and Toolkit provides a foundation for physician engagement efforts and a framework to guide future engagement activities.

The document provides LHINs with a range of preferred engagement techniques that can be used to strengthen physician relations, communication and partnerships.

Tools and instruments such as surveys, communications techniques (i.e., online, focus groups), education sessions (workshop outlines) and consultative structures are described. Use of these tools is at the discretion of each LHIN, although they are all strongly encouraged to have a strategy in place.

### Saskatchewan Medical Association (SMA)

[SMA website](https://www.sma.sk.ca/Default.aspx?cid=600&lang=1)

Provincial association representing all physicians in the province.

SMA Board has made leadership development for its members a strategic priority, and has had significant success in preparing physicians for leadership roles. It provides funding so Saskatchewan physicians can enrol in the Canadian Medical Assn’s PMI program; and encourages members to achieve a Canadian Certified Physician Executive Program (based on LEADS). It has ensured its Board members are actively aware of Saskatchewan Health Reform activities; and seek out opportunities to help shape reform.

### Saskatoon Health Region

[Health Region website](https://www.saskatoonhealthregion.ca/SLP/index.htm)

Organizational Learning and Effectiveness People and Partnerships Department

Offers leadership program to dyad partners within Saskatoon Health based on LEADS; five one-day workshops over six months to a year. Developed provincial program based on LEADS.

### Capital Health in Nova Scotia/Isaac Walton Killam (IWK) Children’s Hospital

[Health website](https://www.cdha.nshealth.ca/my-leadership)

Two organizations in partnership with Dalhousie University

Fully At the Table (FATT) FATT is a leadership development opportunity created in partnership with Capital Health and the IWK that is specifically designed so doctors can become more effective leaders. The 16 hours of workshop and experiential learning is based on the LEADS Framework and emphasizes the development of leadership skills required for engagement.

### Tools and techniques to:

- Enhance contact and the quality of communication.
- Assess state of engagement (survey).
- Educate—i.e., increase awareness and understanding of physician needs; LHIN responsibilities.
- Organize consultation and ongoing roles for physicians in stewarding primary care priorities.
- Assess ongoing evaluation of engagement strategy success.

- Utilizes leadership development as a tool to improve engagement.
- A physician group is being pro-active in preparing themselves to be better at the skills of engagement.
- Physician engagement is front and centre in its strategic plan.

- Structural solution: dyad.
- Utilizes leadership development as a tool to improve engagement.

- Leadership development focus.
- Emphasis on self-awareness (e.g., mental models) and skills of management and relationship building (e.g., Communication and Dialogue; conflict resolution).
<table>
<thead>
<tr>
<th><strong>Australia</strong></th>
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<tbody>
<tr>
<td>Royal Australian College of Medical Administrators (RACMA) <a href="http://www.racma.edu.au">www.racma.edu.au</a></td>
<td>Specialist designation for Medical Administrators in Australia and New Zealand.</td>
<td>RACMA is a medical specialty college of more than 800 members in public and private health services organisations across Australia, New Zealand and overseas. In creating such a College, it legitimizes, within the profession, the physician that chooses to move from clinical work into administrative work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Addresses mental model that often exists that to move to administration from a clinical role is moving to ‘the dark side’—that is, betraying one’s clinical professionalism.</td>
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<td></td>
<td></td>
<td>• Has curriculum for medical leadership; young doctor’s program.</td>
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<td></td>
<td></td>
<td>• Addresses accountability differences between clinicians and administrators that can lead to mistrust and confusion and delimit engagement.</td>
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<tr>
<td>United Kingdom</td>
<td></td>
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<tr>
<td>NHS Institute for Innovation and Improvement <a href="http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/clinical_engagement.html">www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/clinical_engagement.html</a></td>
<td>Unitary system in Britain (separate from Wales, Scotland, and Ireland) but all unitary. 10 years of significant reform of service delivery models.</td>
<td>Medical Leadership Competency Framework (established to define standards for medical leadership to be imbued in programs, practices). Medical Engagement Scale (MES) used to measure engagement of physicians in many primary care trusts; hospitals.</td>
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<tr>
<td></td>
<td></td>
<td>• Effective measurement.</td>
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<td></td>
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<td>• Raises profile of importance of leadership development for physicians.</td>
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<tr>
<td></td>
<td></td>
<td>• Represents system-wide commitment to improving physician engagement.</td>
</tr>
<tr>
<td>United States</td>
<td>SVHC is an HMO-- an organization that provides or arranges managed health care for health insurance, self-funded health care benefit plans, individuals and other entities in the US as a liaison with health care providers (hospitals, doctors, etc.) on a prepaid basis. Primary care and acute care physicians are contractually linked to HMO.</td>
<td>Governance solution: Established an integration task force of physicians, administrators and board members to transition to a model in which both primary care physicians and specialists could become hospital employees. However, doctors did not want to be employees. Recommendation calls for a governance structure that includes a CMO for each of the acute and primary care service lines; and a CEO that is a physician.</td>
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<tr>
<td><strong>Southwestern Vermont Health Care (SVHC) (Birk, 2012)</strong></td>
<td>Geisinger physicians provide approximately 40 percent of GHP’s patient care services, with the remainder provided by a network of more than 10,000 physicians and forty hospitals.</td>
<td>Geisinger manages through twenty-two system-wide clinical service lines, each co-led by a physician-administrator pair. Geisinger operating units (that is, all service lines as well as each hospital, GHP, and central support functions) are responsible for achieving their own annual quality and financial budget targets. Funding Approach: Fixed budgets and incentive payments are provided, the latter conditional upon performance in meeting quality indicators, with actual payment amounts prorated based on the percentage of targets met for ten quality metrics. To encourage team-based care and support, incentive payments are split between individual providers and the practice.</td>
</tr>
<tr>
<td><strong>Geisinger HMO (Paulus et al, 2011)</strong></td>
<td>A network of 25 hospitals with its own health plan. Doctors are a mix of salaried employees and independent practitioners.</td>
<td>Redesign of clinical protocol practice and implementation. Allows doctors to override standardized clinical processes/protocols in ambiguous situations when in patient’s best interests. However, analyses such overrides to learn if indeed divergence from protocol should change protocol. Internal support unit supports and evaluates doctors’ innovative ideas.</td>
</tr>
<tr>
<td>John Hopkins Medicine</td>
<td>Johns Hopkins Medicine, headquartered in Baltimore, Maryland, is a $6.5 billion integrated global health enterprise and one of the leading healthcare systems in the United States.</td>
<td>Physicians are assigned as team leads for quality care improvement projects. Manager creates a compact to clearly define what is expected of each. Hospital provides support of percent of physicians time in return for a number of responsibilities commensurate with compact; works with hospital as partner. Utilizes dialogue at staff level to communicate with physicians. Grand rounds; quality meetings.</td>
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Appendix C

DRAFT Terms of Reference for a Conjoint Committee to Initiate a Physician Engagement Strategy in Regina-Qu’Appelle Health Region

Purpose

The purpose of the Regina-Qu’Appelle initiative on physician engagement is to:

- Effect sustainable improvements in healthcare system performance through the active involvement and participation of physicians in all facets of service delivery reform.
- Maximize the quality of the patient experience and citizen confidence in the Reina-Qu’Appelle and Saskatchewan health system.
- Ensure that physicians, in a multiplicity of roles, provide active support and involvement in provincial and regional efforts to make the health system more accessible, efficient and effective.

Membership

- Appropriate physician representatives of the four levels identified in the Typology presented in Part 4 of the paper (4).
- Appropriate administrator representatives commensurate with interactivity with each of the four roles (4)
- Ministry of Health Representative
- Representative of the Saskatchewan leadership development plan/strategy
- Representative of the SMA responsible for leadership development
- Other members as deemed appropriate, but not to disrupt equal balance of physicians and administrators.

Definition of Physician Engagement

Physician engagement is the initial, ongoing, energetic and committed involvement of physicians, in their diverse working roles within the health system, in order to:

1. Ensure that delivery of services to patients is done according to professional standards and personal ethics; and
2. In collaboration with others in the community, hospital, region or province:
   - Decide on efforts to determine the appropriateness of care;
   - Take action to improve the quality of citizen and patient care;
   - Plan and implement initiatives to enhance the efficiency of service delivery; and
   - Define the working conditions in which this work is conducted.

Assumptions

- Each individual physician’s engagement will vary, as a function of their own character, capacity, and personal need (i.e., family, community, and professional obligations).
- The overall physician engagement capacity of an organization or system can be measured and needs to be measured to be improved.
• Organisation and system factors (structural, political and cultural) play a crucial role in providing the conditions under which the individual’s propensity to engage is either encouraged or inhibited.

• Improving engagement requires collaborative efforts on behalf of administrators and physicians to aligned across structure, politics and culture.

• The mental models embraced, the behaviour of, and methods used by people in positions of formal leadership within the health sector (physician or administrator) are major factors influencing the quality of physician engagement.

• Policies and actions within health organization or system structures and processes related to physician engagement must allow for adaptation to situational context.

**Principles**

The principles are:

1. Enhanced patients’ and citizens’ well-being is a shared goal of all partners in a physician engagement initiative.

2. Success of the health system (i.e., quality patient care and financial sustainability) is fundamental to the welfare of all physicians, regardless of role, responsibility, or formal position. As a consequence physicians have both rights (appertaining to their distinct clinical function) and professional obligations that influence engagement.

3. There are multiple solutions or ways of addressing physician engagement in a principled fashion. Identifying and acting on specific approaches to improve engagement is a joint responsibility of physicians, physicians’ representatives/leaders, professional bodies, administrators and other key players in the health system.

4. The quality of leadership as practiced by individuals (in particular physician and administrator) and that is endorsed as appropriate to a system or organization, has a significant influence on the quality of engagement.

5. Healthy, productive organizations and systems provide members with opportunities to understand the shape the practices that they are responsible for, and to grow throughout their career.

6. Effective organizational or system action requires alignment of authority with responsibility.

**Parameters**

• Expectations for engagement of individuals (physicians and others) within organizations and systems must be balanced with competing demands of work-life balance; personal wellness; individual dignity; and community contribution.

• While recognizing the need for organization or system involvement, meeting the needs of individual patients requires physicians to provide health care that is based on the wise and cost-effective management of limited clinical resources, including wise use of their specialized skills and time.

• Engagement practices must be conducted in a manner that are compliant with all legal requirements and conditions pertaining to the role of physician and health system partners.

• Engagement practices must comply with physicians’ ethical and professional obligations in the care of their patients; and with the ethical obligations of other health system partners.

• Engagement practices need to respect the business imperatives that guide a physician’s livelihood, as well as the health system’s need to create sustainable clinical service delivery.

• The availability of time and other resources available to facilitate the interactions and activities required to improve physician engagement.
Appendix D

Glossary of Terms

Administrator: An individual employed under contract by the regional health authority, community long term care facility, provincial public service, to fulfill a management and leadership role in health organizations/systems.

Distributed Leadership: An approach to understanding leadership as a shared construct at all levels of an organization and system; and distributed amongst many different individuals and organizations, who all are needed to exercise leadership when it is required.

Health system: The totality of the publicly-funded efforts to provide services to patients of Saskatchewan, and that is multi-faceted in the number of organizations, professions, and individuals engaged in one form or another to provide services to patients or citizens (e.g., primary care, public health, hospitals, home and community care, extended care, etc.).

Leadership: the capacity (either individually or in concert) to influence others to work together to achieve a constructive purpose (in this case, a highly functioning health care system).

Organization: Individual entity established to deliver a package of services to a particular group of clients (citizens or patients): e.g., hospital, regional authority, long term care home.

Professional body: Organizational entity established to protect the interests of a specific health care profession such as medicine (e.g., provincial medical association) or to protect the interests of the public in relation to a specific health care profession or subspeciality (e.g., College).

Measurement: The act of determining, on a sliding scale from 0-100, the current state of a relative phenomena, and being expressed in numerical terms.

Mental Model: A world view (assumptions, values, beliefs) representative of an individual or group of individuals, that acts to shape how they interpret the world around them.

Structural Conditions: Conditions influencing engagement that are a function of organizational designs, formal policies, procedures, roles, responsibilities that are used to distribute authority, power and resources to individuals in a collective enterprise (e.g., organization or system).

Political Conditions: Conditions influencing engagement that are a function of informal use of influence, power, expertise, knowledge, or charisma within formal boundaries and rules to shape activities and events.

Cultural Conditions: Conditions influencing engagement that are a function of shared values, beliefs, customs and traditions that take the form of rituals, stories, language, and mindsets that are common within an organization or components of an organization.