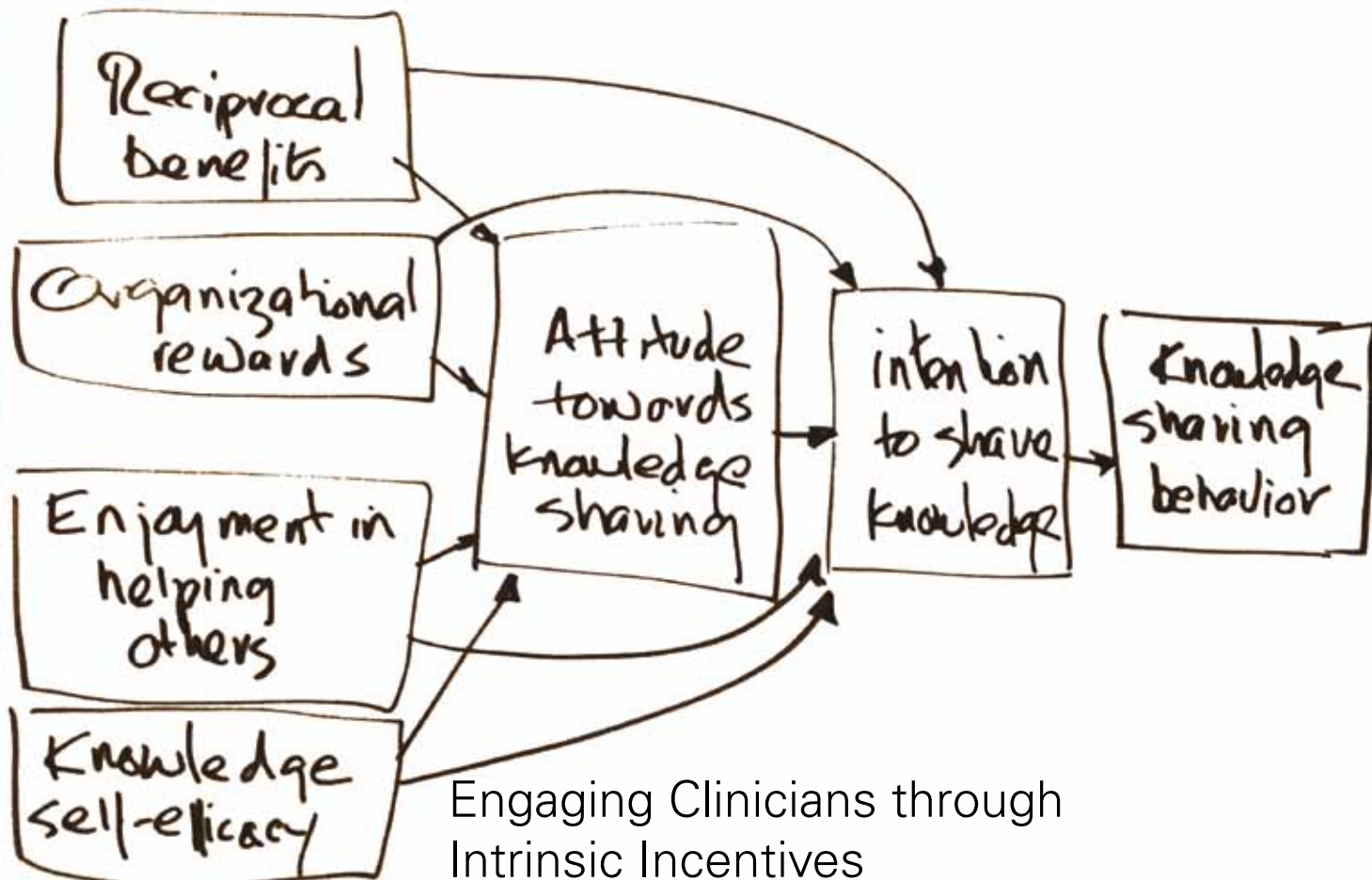


ENGAGING LEADERSHIP



Chris Carruthers, in conversation with Wendy Levinson

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In one of two interviews that touch on the importance of clinician leadership, Wendy Levinson (WL) – the chair of medicine at the University of Toronto and a quality and patient safety champion – shares with Chris Carruthers (CC) the importance of building a cadre of physician leaders who are passionate about quality and prepared to lead improvement efforts. She speaks to the importance of recognizing and rewarding quality through a much broader range of incentives that play to the intrinsic incentives motivating physicians than can be achieved with simple pay for performance schemes. In a wide-ranging interview, Dr. Levinson also touches on the importance of strong quality leadership to the professionalism and self-regulation of

medicine and how health systems must engage a broad range of clinicians to build and maintain momentum in quality improvement.

CC: Tell us about your role in quality improvement at the University of Toronto Department of Medicine and how you've been engaging physicians in quality improvement.

WL: I'm the chair of medicine at the University of Toronto. I moved back to Canada ten years ago, after practising and living in the US most of my career. The reason I think that's relevant is, I have continued to play a major leadership role in the US and especially in the issues around quality improvement and how to engage physicians.

When I moved back here, I thought we were quite far behind in some of the things that have already happened and are being learned in the US, so I did a strategic plan in our Department of Medicine. I found that everything had trickled up except for the plank on quality improvement, which was not really on people's radar screen at that time. So I've been very committed to engaging physicians in quality improvement.

In the US they've tried many models, including different formulas to pay for performance. But research in the area shows that the most effective and enduring way to engage physicians in quality improvement is to encourage them to make it part of their professional identity – their sense of professionalism – and part of what they do. Paying doctors for performance works while the incentives are in place, but after you take them away the behaviours often disappear. When I moved back here, I felt that the most important way to get the ball rolling was to develop a cadre of physicians who were really starting to be excited by and invested in quality improvement.

I don't run a hospital. My role is as an academic lead, so I'm not in the operational arm of a hospital but I'm very much in the position of helping to influence, support and encourage the faculty who in turn can lead. To do this, about ten years ago I developed something called the Quality Stars Program. It takes individuals, often young but mid-career people, trains them in the methods of quality improvement and helps empower them, giving them resources to go back to their clinical environment and work on issues that they are passionate about and do quality improvement.

The Quality Stars Program started small. Then I recruited a leader in quality improvement who is an academic – Kaveh Shojania, who was General Internist at the University of California at San Francisco, then went to Ottawa and then came here to Toronto. With Kaveh's help, the University developed the Centre for Patient Safety. He took on the course and has turned it into a certificate program that engages these physicians in learning about quality improvement. That's one stream we've used to engage physicians by giving them information about quality improvement and then helping support them in developing projects they are passionate about in the clinical environment.

CC: How do you identify these individuals? Do they come to you, or do you go to them?

WL: Well, in the beginning, it was a bit of both. When we started this it was novel, so people didn't know what it was. We had to look around to see who might be interested and who was already doing a little bit of it, but without much background in how to do quality improvement. Now, after ten years, it's got a life of its own. There are people beating down the door for that course. Initially, we had about 15 people in it. Now there are regularly 40 people or more wanting to take it every year.

The second thing is recognizing and, especially, rewarding people. I don't live in the hospital and pay people to do clinical quality improvement, but I can reward them in several ways. We have a major award every year for research, one for education and now one for quality. The award gives quality improvement stature and showcases the heavy hitters in the field. We nominated people for awards who are doing clinical quality improvement whenever we could. I recently learned that there's an award for innovative curriculum. We nominated the certificate course I just told you about, and it just won the University Award for innovative curriculum.

Another way we can reward people is to promote them for doing those activities. We've been doing that informally, but now we have job descriptions that will be well known to you, Chris – clinician scientist, clinician investigator, clinician educator and clinician teacher. Kaveh and I wrote an article in the *Annals of Internal Medicine* in *JAMA* a while ago about promoting people who do quality improvement. As a play on words, we called them CQIs – Clinical Quality Improvers. We're developing a new job description for people who do this as their meat and potatoes, and criteria on how we would judge them at three-year review – we do a three-year review of all new faculty members – and on how we can promote them.

CC: This would be another class in the buffet of potential promotions that you could move forward.

WL: Yes. In reality we already have a set of criteria, something we call Creative Professional Activity. We're modifying it for the CQI criteria as they're quite similar.

CC: Just to clarify, somebody who takes a strong lead in quality improvement could be equally matched against somebody who's a strong researcher in the promotion line.

WL: Yes. I did some survey research with my colleagues, the chairs of medicine across North America, and found that many of them are struggling with what to do to get these people promoted. Quality improvement is a local endeavour, for instance – getting your hospital to do hand hygiene. If you just got your hospital to do hand hygiene, it would be hard to get promoted because promotion at U of T requires innovation and evidence of impact outside your institution. To get promoted here, people will have to be more creative than just taking what's already known about hand hygiene, for example, and getting it to work on the Burn Unit.

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CC: They have to move it up to another level.

WL: They do.

CC: How do clinicians link their quality improvement efforts to a quality improvement plan or other metrics? Have you seen that link?

WL: Now that the CEOs have an incentive in their salary for some performance metrics, they report to the board on these quality metrics. There's a big appetite at the hospitals for physician leadership. Bob Howard, the CEO of St. Mike's, is very invested in quality improvement. He's gone to IHI, and he's making this a part of his mission at St. Mike's. A while ago he was talking to me about a particular unit and a particular physician who was resistant to change and to quality improvement activities. The physician said to him, "We have the best unit in Canada. Why would you want to go screw it up?" That's a very frustrating attitude, but often physicians and other clinicians get very comfortable in how they're doing things. The CEOs are eager for physician leadership that can embrace quality improvement, see it as the norm in the institution and champion those kinds of changes with their colleagues. The hospital leadership, Bob Bell and Barry McLellan and Bob Howard, are eager for us to train those clinicians and have them come to their work environment with more knowledge and skills to work on the local needs. The certificate program has both lectures and projects that they're working on at their institution as part of the learning experience.

CC: When you've trained those 40 leaders, they go back to the unit. They have to work with their colleagues. What are the keys there? How do they get the naysayers at the table? You've recruited the champions; you've recruited those who've had the interest, but how do these docs go back and bring the apathetic naysayers on board?

WL: It's really change management. You don't start with the naysayers. You have an enthusiastic champion and you start with those people who are ready to lead. Their colleagues are academic physicians. You give them data, you show them the gaps and you show them where they stand. It's change management. You help people see a reason to be interested in "Could we do this better?" You give people feedback that they're not getting an A – they're getting a B or a C compared to their colleagues. Doctors are competitive. You harness their natural competitiveness in a good way.

CC: What else is needed to change behaviour?

WL: The maintenance of certification for physicians in the US requires practice improvement. All the boards are moving to open-ended certification based on meeting ongoing requirements for maintenance of certification. In order to keep your certification in the US, you will have to participate in practice improvement.

Let me describe a diabetes practice improvement project. You have to collect data from multiple sources: patients who give feedback to an independent source, an audit of your charts and your practice, and also a systems review of how your office practice is organized and how this facilitates or is a barrier to the care of patients with diabetes. You take that data, you send it to the board and you get feedback about how you're performing compared to your peers, for example, whether your patients are getting foot exams and hemoglobin A1Cs; counselling about exercise and weight control; and your patient ratings of certain kinds of communication – not just a global patient satisfaction rating. Then you have to do a Quality Improvement plan based on what you learned, implement the Plan and re-measure, and send the re-measurement to the board.

CC: That's excellent, because it would obviously engage our community physicians too.

WL: Absolutely. When you make changes like this, older practitioners like me can be very resistant, but over time young people just start to realize this is how we do it. Orthopedics is particularly advanced. Orthopedic surgeons have a 360-degree evaluation that is required as part of maintenance of certification now. It includes feedback from nursing, patients and peers.

If we don't hold ourselves accountable, and really be serious about our professional accountabilities to the public, the government will and should regulate us.

CC: Why don't we do this in Canada?

WL: I have an ongoing dialogue with the Royal College about it, and I've written about it. I wrote an article in *JAMA* comparing regulation in the UK, the US and Canada. I think we're behind. The Royal College is trying; they've been talking to the boards about using some of the methods developed in the US so that they don't have to reinvent the wheel – we're too small a country for that.

CC: One of the steps the Ontario government took a while ago was to stop paying for certain procedures such as electrocardiograms and other investigations before cataract surgery. Do you think there's a role for governments to get involved in the things we're talking about, such as maintenance and competence and certification. If the Royal College or the CPSO are slow to make changes, should the governments step in?

WL: I'd say yes. I know the US Medicare program has for a long time refused to pay for operations on the wrong limb. But I feel very strongly that physicians need to guard professional self-regulation as a really important privilege of the profession. If we don't hold ourselves accountable and really be serious about our professional accountabilities to the public, the government will and should regulate us. I have tried to argue that Canada is ripe for government intervention, because physicians are not self-regulating in a serious way.

The evidence for that is what happened in the UK, in a series of events that culminated in the Bristol inquiry. Following the Bristol inquiry, physicians are no longer self-regulating, although they do have input into the regulation process. I look at Canada and the episodes like the estrogen/progesterone-receptor testing in Newfoundland and other events like that. You just know that Canadians will wake up one day and say, "What are you talking about? You mean that this can happen in our hospitals? You mean to tell me that doctors, as opposed to every other profession, never have to take another test to prove that they are competent after they finish their training?"

CC: I would agree totally with you.

WL: You might, but believe me I got hate mail after I wrote some of those articles. I wrote one in *JAMA* and one in *CMAJ* called "Are We Passing the Test?" I had some really nasty letters.

CC: The US has always been criticized, but Medicare is a national program and can set national standards. In Canada we have no national professional standards. Each province sets its own.

WL: Right, except that we have the Federation of Medical Regulatory Authorities of Canada, and the College of Physicians and Surgeons of Ontario, which is enabled by the government, could work with their counterparts as they have to set some guidelines that influence practice. We don't have a national regulatory body, but we do have a confederation of provincial bodies that work together and try and have similar standards. The provincial bodies could implement something like this, and the Royal College could implement it.

CC: Your certificate program is focused on academic physicians, but how do we engage physicians in community hospitals? They don't have much opportunity or access to learning about quality improvement and the processes. Is that a fair comment?

WL: Well, yes and no. The American Board of Internal Medicine, which I know the best, certifies 250,000 physicians and they all have to participate in practice improvement to keep their certification, no matter where they're practising. We've developed all these products and resources that help teach them and that are highly relevant to their practice.

CC: But if I'm a physician in Hawkesbury, Ontario, or a similar community and I want to learn the basics of quality improvement, where do I go in Canada?

WL: You don't have to anywhere. You can get on the Web.

Canadians will wake up one day and say, "... You mean to tell me that doctors, as opposed to every other profession, never have to take another test to prove that they are competent after they finish their training?"

CC: But I can't find a Canadian program. It's usually American, or from IHI or something like that. Is that a fair comment?

WL: It doesn't matter. You can't tell me that an internist in Canada who's caring for diabetic patients should practise differently than in the US.

CC: Many times I hear in Canada, "Well it has to be Canadian content." I reply, "Well, in some cases, yes, but in many cases, no, it's universal." What about the costs of attending US programs?

WL: You know how much it costs me to maintain my certification in the US Board? About \$1,800 for ten years; that's \$180 a year, and that includes access to all of these practice improvement modules. By contrast, I pay \$750 a year to the Royal College.

CC: Let me go back a bit though. To have access to the resources of the American boards, do you have to be certified by the American boards?

WL: The Royal College is trying to work on that to see if they can arrange access to those resources for a nominal fee. **HQ**

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