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The Power of AND

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EDITORIAL

"The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time and still retain the ability to function."
– F. Scott Fitzgerald

And...

Johny Van Aerde, MD, PhD

"And" is a powerful word for leaders in health systems. As the health care industry has evolved at an ever-accelerating pace over the last few decades, health care providers have been faced with treating more patients AND having fewer resources, with using standardized evidence-based practices AND meeting the individual patient's needs. Physicians are expected to implement new technologies AND maintain the personal touch in patient-centred care, something that has become particularly acute with the accelerated use of virtual care. The tension between all these pairs, between these apparently opposite poles has been amplified by COVID which has also introduced even more dilemmas.

Interdependent pairs of alternative viewpoints are called polarities.[1,2] Opposite poles need each other over time to reach outcomes that neither one can reach alone. However, it is foreign to think of opposites as connected and concurrent. Thus, the challenge involves reconciling polarities – two seemingly opposing values that can complement each other when applied in a balanced way.

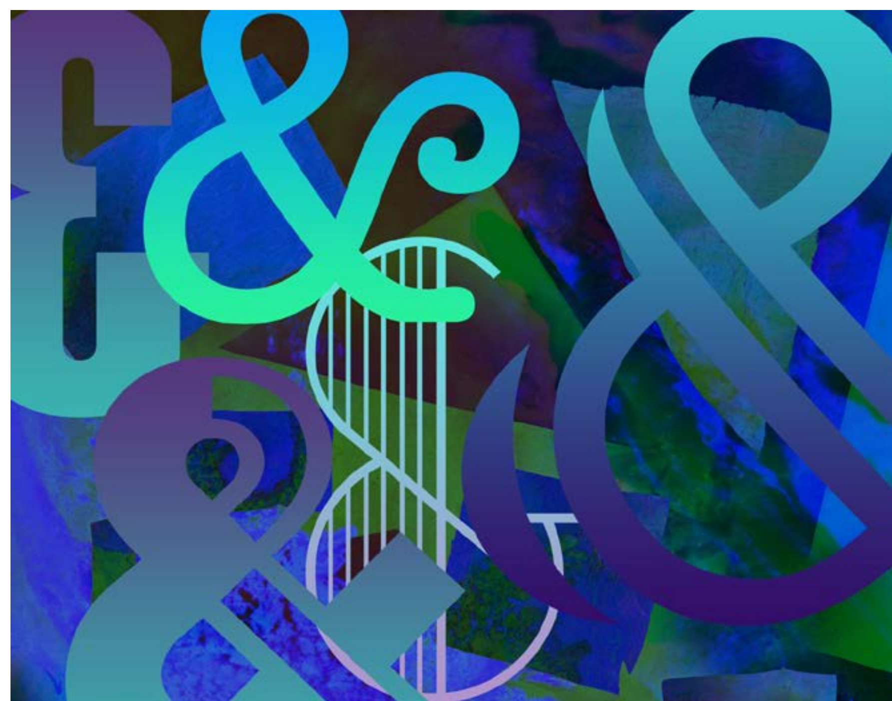
Polarity thinking is about "both-and," moving away from a "you are wrong and I am right" view to "we are both right." This kind of thinking doesn't replace problem solving; it supplements, and should supersede, our traditional either-or thinking and acting.

Polarity thinking helps us balance the tension between two competing values, rather than favouring one over the other. Often, there is emotion and bias between the poles, which makes us fall into the trap of choosing. Consequently, we become engaged in a battle between values, rather than leveraging the two poles and fighting for both in balance. The result is that nobody wins.

When an issue arises, step back and ask, "Is this a problem or a polarity?" For example, during this pandemic crisis, the problem to be solved is not just the population's health or the economy; there is a need to balance both health AND economy. Another polarity is the acute stress on our health care system caused by COVID-related disease AND the need to maintain access to regular health care services for non-COVID illnesses. The COVID pandemic also has us struggling with the old but very powerful polarity, individual freedom AND the common good; the controversy over mask-wearing falls under that category. This is not new, as societies throughout history have had to find ways to provide for the collective (liberal values) while also meeting the needs of individuals (conservative values). In short, polarities are unavoidable and are present in every individual, team, organization, and nation.

One of the major differences between problem solving and polarity thinking is the demand for continuous vigilance to leverage the polarity. Leveraging a polarity is not easy, particularly when you have held a strong preference or bias for one pole over the other. It requires you to do the hard work of committing to real actions that effectively reap the benefits of both poles.

Canadians have approached the COVID crisis as a problem rather than a polarity. Such an approach



might be acceptable for a very short period during the initial chaotic phase of a crisis, but once the situation has entered a more chronic phase, polarity thinking is crucial to minimize the losses for all. No matter which pole we favour, the losses will affect everyone. For example, if we overfocus on controlling the virus without paying attention to the economy, the latter will collapse, creating a different variety of health issues for Canadians. As a result, both health and the economy will be affected negatively. On the other hand, if we overemphasize the economy with insufficient attention to the health aspects of the virus, the virus will cause so much havoc that neither the health system nor the economic system will have enough healthy people to sustain it.

Unfortunately, our society seems to have difficulty managing polarities. The word "and" is absent from the vocabulary of many politicians and those who elected them, leaving little room for collaboration against a common enemy. As physicians, we were trained to solve either-or problems. As physician leaders, it behooves us to be aware of polarities and our own biases favouring one or another pole. To balance the many polarities the current crisis has accentuated, we have to use the word "and" much more frequently. If we don't, everyone will ultimately lose.

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PERSPECTIVE

No person left behind: improving physician wellness in Canada

Jason Chaulk, MD

Canadian health care costs are unsustainable and are among the highest in the world. A greater focus on system-level initiatives is needed, and recognizing physician wellness as a quality indicator for health care delivery may be part of the solution. Physicians' psychosocial health is a significant cause for concern and has been directly tied to patient outcomes. However, suicide rates among physicians are approximately 2.5 times those of the general population and burnout rates are twice those of other workforces. Investing in physician health programs (PHPs), specifically the components dealing with psychosocial issues, is one way to make medicare sustainable. Further, greater provincial government support of national guidelines for the formation of PHPs is needed. This commentary focuses on these background issues and suggests a path toward a more sustainable health care strategy focusing on physician well-being.

KEY WORDS: mental health, burnout, medicare, health promotion, suicide, public health, physician impairment, physician self-referral, quality indicators, health care

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System in shock

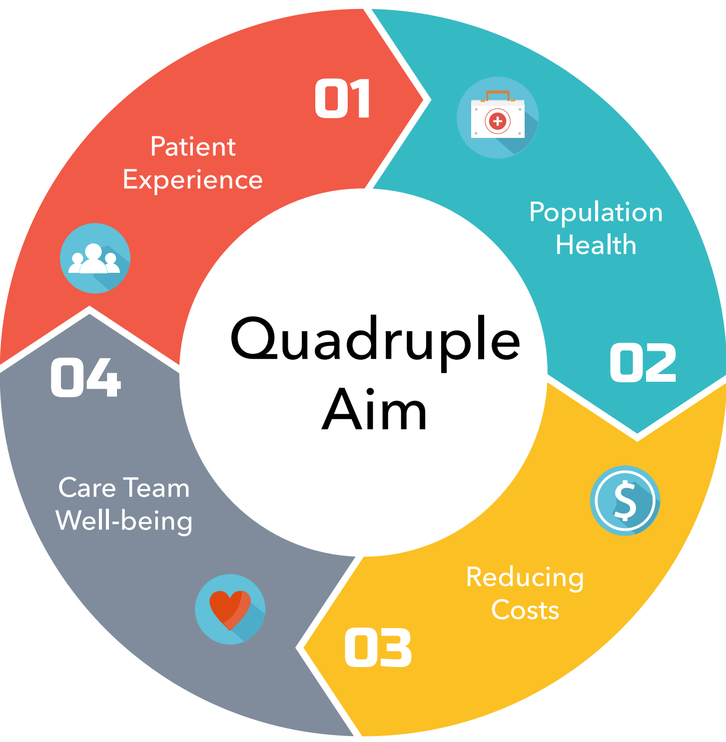
To say that Canada's health care system is "hopelessly sclerotic" may appear overly harsh. However, Neil MacDonald makes that statement in a 2019 article, in which he describes his experience with the system.[1] All too often, Canadians are starting their days reading about the crisis our medicare system is facing. The Canadian Medical Association (CMA) highlights this reality when it states that "Canada's prized Medicare system is facing serious challenges on two key fronts: in meeting the legitimate health care needs of Canadians and in being affordable for the public purse."[2] Sobering statistics back these opinions. In 2009, the EuroCanada health consumer index ranked Canada last among 30 countries in terms of health care efficiency.[3] Couple this with the fact that we spend 11.3% of our gross domestic product on health care alone, and the situation is clear.[3]

Adjusting the aim

To solve this crippling state of affairs, the Institute for Healthcare Improvement developed the Triple Aim framework.[4] It recommends that stakeholders examine three dimensions of health care performance: improving the health of populations, enhancing the patient's experience of care, and reducing the per capita cost of health care.[5] However, meeting these dimensions is reportedly pushing many health care providers, specifically physicians, toward burnout and reducing the chance of successful implementation.[6] The psychosocial strain that this framework places on physicians is concerning. As a physician with lived experience, I can understand the effect that

poor psychosocial health can have on both one's professional and personal lives.

Figure 1: Quadruple Aim



Evidence shows that poor physician mental health is linked to lower patient satisfaction, reduced health outcomes, and increased costs.[7] As Wallace et al.[8] discuss, poor health and inappropriate coping mechanisms may result in increased clinical errors and impede a physician's ability to counsel patients on healthy lifestyle behaviours.

Despite providing a roadmap to optimize the health care system and lower the fiscal burden, the Triple Aim framework has neglected the symbiotic relationship between those who provide care and those who seek care.[5] Based on this realization, the Triple Aim was expanded to include care team well-being and became the Quadruple Aim (Figure 1)[9].

A missed indicator

Evidence indicates that physician well-being is emerging as a significant quality indicator for health care system performance. Although obscured by the fact that physicians are often physically healthier than the general population, their mental health status is poor.[2] In Newfoundland and Labrador alone, a survey of approximately 500 physicians rated mental health as the number one priority area to be addressed by the Newfoundland and Labrador Medical Association (NLMA).[10] As a result of this survey, and specific physician wellness situations, the NLMA created the Physician Care Network (PCN). Like other physician health programs (PHPs), the PCN's mandate is to educate and promote the biological, psychological, social, and spiritual health of physicians in the province on their journey to a stronger self. I believe that following this model is a step toward reducing the stigma and stress that our local physicians face when seeking help.

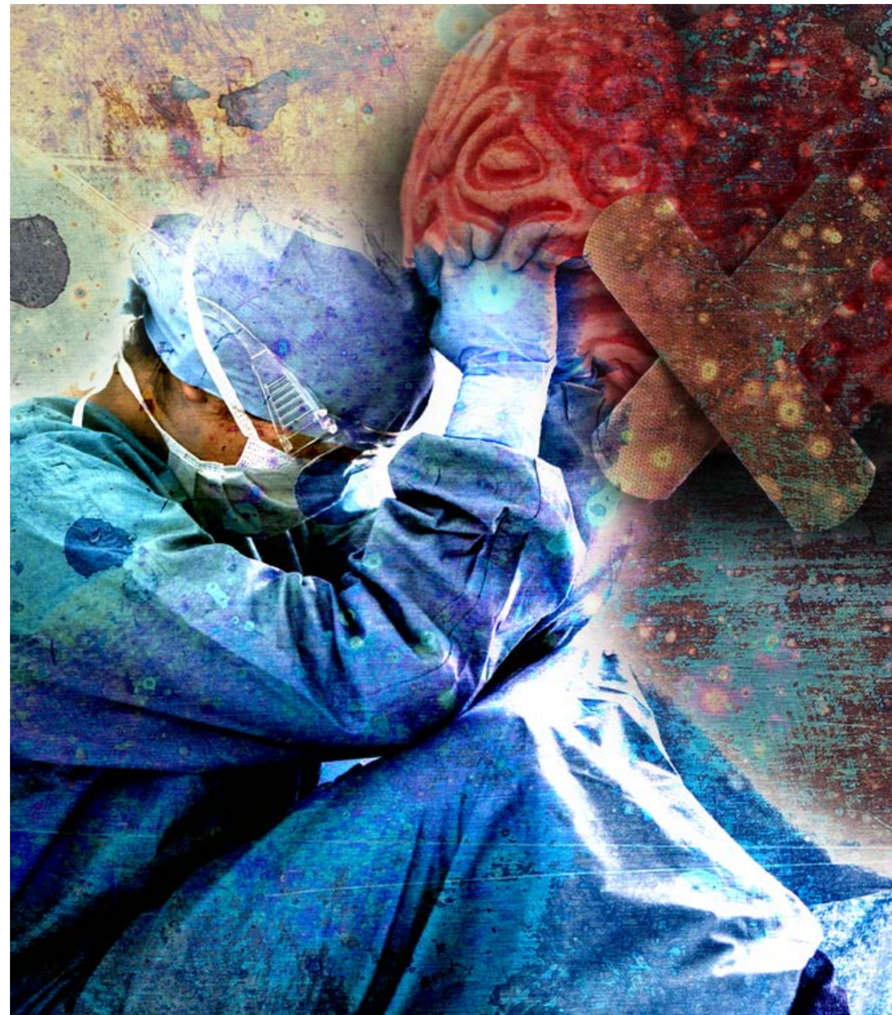
Nationally, physician mental health is at a critical stage, with burnout rates double those of all other workforces.[11] Rural areas are particularly stressed: up to 50% of rural physicians are experiencing serious burnout.[12] Compounding this reality is the frightening statistic that physicians have completed suicide rates that are approximately 2.5 times those of the general population, and they are at an increased risk of debilitating depression.[2] With 30% of physicians in Canada suffering from depression and only 33% having a family physician, is it a wonder that "the collective state of physician health remains a significant threat to the viability of Canada's health system"?[13]

Plan for action

To address this threat to patient care and health care sustainability, the CMA recognizes that a neoliberalist approach to health care is unreliable and that a more system-level approach is needed.[2] Adopting a more holistic definition of health that recognizes physician wellness as an amalgam of social, biophysical,

and community-based factors may be part of the solution.[6] One way to begin is by having system-level influencers invest more capital in PHPs, specifically, the components dealing with psychosocial issues.

It is critical to establish structured organizational and system-level solutions, such as PHPs, to help physicians improve their well-being.[13] Furthermore, universal access must be created to reduce the stigma around physician mental health, as 76% of Canadian physicians feel ashamed to seek help and fear reprisals from regulatory bodies.[14] Such a goal could be met by creating national guidelines for PHPs and by placing them under the various provincial departments of health and community services. This approach would strengthen the acceptance of PHPs and point out the critical importance of tackling the physician health crisis.



The average cost of training a medical student for four years in Canada is $260,000; for a resident, the cost is about $100,000 a year.[15]

Economics

Discussion of the economic burden of physician training strengthens the case for nationally guided PHPs. The average cost of training a medical student for four years in Canada is $260,000; for a resident, the cost is about $100,000 a year.[15] In addition, approximately 30% of Canada's physicians who suffer burnout contemplate leaving medicine; in the United States, approximately 42% of physicians contemplate withdrawing from full-time clinical practice or restricting their scope of practice.[16]

Statistical analysis has shown that a variety of stressors are adding to physician burnout and a desire to reduce work hours, with loss of control over clinical practice structure (odds ratio [OR] 1.81), implementation of the electronic medical record (OR 1.56), and poor work–life integration (OR 1.65) at the top of the list.[17]

If the current system goes unchallenged, it will not take long to see an economic effect.[6] More alarming are data from a Canadian analysis that show that the cost of reduced work hours and early withdrawal from clinical practice secondary to burnout is $213 million.[18]

Acknowledging that government-level support may be challenging, given the fiscal reality many provinces are currently facing, the federal government could set aside a component of provincial transfer payments to help support PHPs. Simultaneous implementation of a memorandum of understanding would ensure proper use of the funds and allow monitoring of outcomes.

Oversight

PHPs court controversy and have their detractors. Some physicians are concerned that PHPs are "diagnosing for dollars" and pushing self-referred physicians into expensive treatment programs.[19] In a system where medical professionals pay for all treatment out-of-pocket and in which there are no standardized treatment costs, cracks exist, through which inappropriate actions can fester. This reality strengthens the need for nationally mandated operation standards and oversight of PHPs throughout Canada with an amalgam of public and physician-based funding. Such governance would help reduce stigma and inappropriate treatment of self-referring physicians and lead to increased community capital for physician well-being, quality of patient care, and fiscal outcomes.

As an example, the model developed by the Joint Reference Committee of the American Psychiatric Association could be applied to the Canadian system and help meet these goals.[20] Such models cite a 75% success rate for American PHPs and are built on the premise that medical regulators must recognize the need for access to rehabilitation services, confidential support teams, and community resources specific to physicians' mental health.[2] They imply that physicians should not be penalized for seeking treatment. Why would we expect any less for our Canadian physicians?

Is there another option?

As health care costs continue to soar in North America, we would be remiss not to explore alternatives to PHPs that require moderately large capital infusions to get off the ground until physician membership and government budgets make them financially sustainable. Many large health care institutions across North America report that physician peer-support programs (PEERSPs) are useful "initial vehicles" to help meet a large majority of physician wellness needs. In fact, they reduce the number of referrals to more formal PHPs.[21]

Specifically, PEERSPs are based on a supportive relationship between people who have a common lived experience. They have a mandate to provide psychologically safe, supportive, and empowering coping skills in a fully confidential manner.[22] Lending support to the benefit of a PEERSP as an initial intervention for physicians is the fact that 98% of surveyed anesthesia providers felt that discussing adverse events with a peer was most effective, and 88% felt that it should be standard procedure.[23] A larger survey[21] showed that the well-established Mayo Clinic Office of Staff Services was accessed by 75% of their physicians, scientists, and senior administrators for financial counseling and 7% for peer support yearly.

A complete analysis of PEERSPs and their implementation is beyond the scope of this commentary; however, it is clear that when implemented with good organizational structure and when coupled with PHPs they are a strong weapon in the fight against physician unwellness. Any formal PHP in Canada should use a well-functioning PEERSP to help reduce financial costs and simultaneously reduce physician stigma attached to engaging in any wellness infrastructure.

With lived experience in the area of physician mental health, I can confirm the need for a robust PHP system to reduce the shame, fear, and financial burden that some current systems place on physicians who need assistance.

Conclusion

With a Canada-wide call for increased social investment and funding of mental health promotion coming from such recognized bodies as the Canadian Mental Health Association and the Canadian Medical Foundation (CMF), the social milieu is at the right point for reducing physician health stigma and increasing system-level acknowledgment of the crisis of inefficiency and eroding quality of care facing our medicare system.[24] As the CMF eludes to, our national associations, health authorities, medical regulators, and physicians must amalgamate their acceptance and interactions with PHPs by using a consistent framework to fulfill the health needs of all physicians while addressing a broad gap in the equity of and access to services.[24]

Furthermore, such a framework must focus on the high rates of burnout in rural areas and ensure that our rural physicians are not excluded from such initiatives.

With lived experience in the area of physician mental health, I can confirm the need for a robust PHP system to reduce the shame, fear, and financial burden that some current systems place on physicians who need assistance. Based on the limited discussion above, physician distress cannot be ignored, and we, as a nation, cannot avoid the challenges of securing one of our most precious cultural identities, public health care.

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PERSPECTIVE

Leadership in medical education: call to action

Victor Do, MD

Leadership development in medical trainees is a frequent topic of discussion as we continue to grapple with better equipping physicians for the realities of "modern medicine." Leadership is a critical competency for physicians to foster. Ironically, medical education rarely integrates leadership development into formal curricula. The conversations and formal policies around leadership development are relegated to the "hidden curriculum" of medical education. This paper describes the experience of Canadian medical trainees who pursue leadership opportunities and further training to develop leadership competencies in the context of relevant literature on leadership development. As leadership is a crucial competency to prepare physicians for medicine in 2020 and beyond, promotion of early leadership development in medical training is urgently required.

KEY WORDS: leadership development, medical education, policy, national learner organizations

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Current perspective of learners in undergraduate medical education

At their spring general meeting in 2016, Canadian Federation of Medical Student (CFMS) members wrote and endorsed a comprehensive policy paper: Advocacy and Leadership in Canadian Medical Student Curricula.[1] The document was meant to serve as a resource for local schools to develop leadership and advocacy curricula. This effort highlighted the passion that medical students have for formal training in these skills. Unfortunately, little progress has been made on its recommendations.

As junior trainees, medical students in 2020 recognize and understand the importance of thoughtful, effective, collaborative leadership. Although physicians are often expected to take on formal or informal leadership roles, medical schools and residency continue to lack formal leadership training to prepare future physicians for these roles. At the time of writing, I was unable to find a review that provides direct comparison between leadership curricula at Canadian medical schools.

Where there are leadership threads in undergraduate medical programs in Canada, they exist primarily as free-standing lectures or workshops that are not thoroughly integrated into the curriculum map.[2] A survey of such curricula conducted by CFMS also found that many programs omitted important concepts, such as integration of health promotion, equity, diversity, and inclusivity, as core leadership principles.[2]

As a result, there is a significant student-led effort to increase

leadership education exposure, including student-organized after-hours activities and students pursuing opportunities independently through certificate programs and other course-based education.

Leadership development in medical education: a broader view

The broader medical education community has recognized the importance of leadership development in medical education for many years now. Recommendation 8 of the 2012 Future of Medical Education in Canada (FMEC) postgraduate education report[3] notes the need to "Foster the development of collaborative leadership skills in future physicians, so they can work effectively with other stakeholders to help shape our healthcare system to better serve society." Although several steps to promote progress were outlined, there has been a paucity of action on this recommendation.

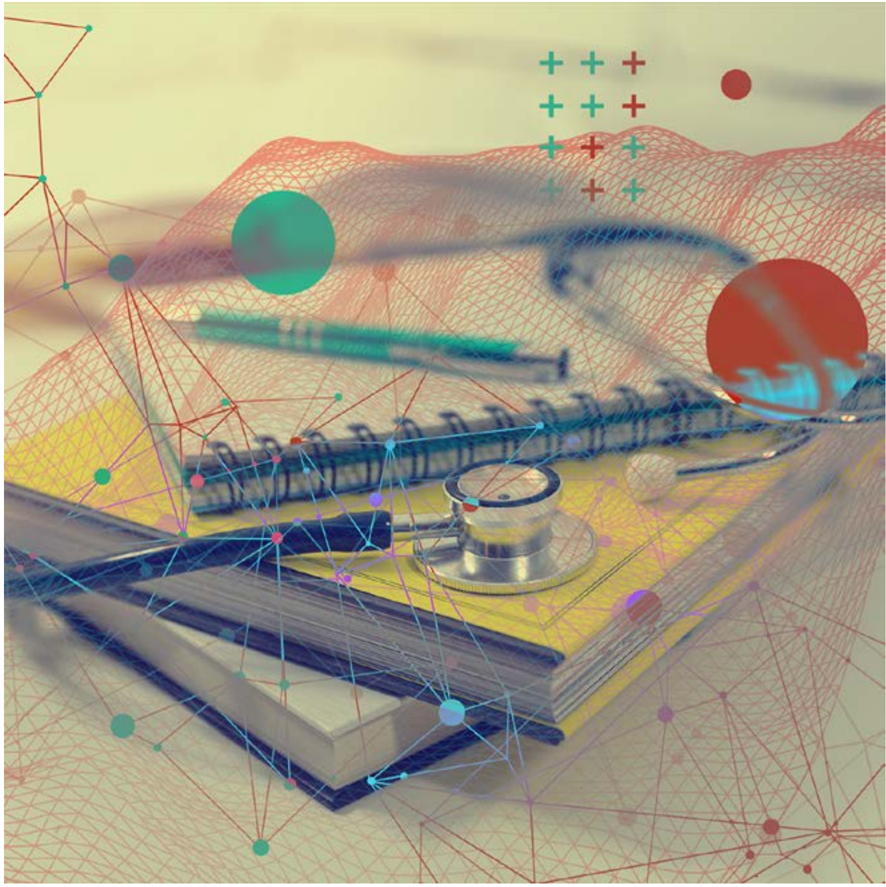
In 2015, the CANMEDS physician competency framework[4] changed the previous Manager role to Leader, which is defined: "As Leaders, physicians engage with others to contribute to a vision of a high-quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers." An accompanying list of key and enabling competencies touches on other aspects of health care management, including quality improvement. Efforts have been made to develop resources to integrate this CANMEDS role into residency curricula, and a number of scholarly articles have been published detailing school- or program-specific approaches to developing formal and informal residency leadership curricula/ activities.[5-7]

However, data on learner perceptions and confidence in leadership training are currently lacking. Future specific evaluations of this aspect are necessary to allow us to better understand curricular gaps and assess the effectiveness of current teaching.

Beyond the curriculum: other barriers to leadership development

Students who have formal peer-elected leadership positions commonly experience significant difficulty getting time off from rotations and/or rescheduling other educational activities to fulfill their commitments. Many meetings are held during regular weekday working hours and, although participating faculty may have protected time for the meetings if this work is part of their academic appointment, learners face additional barriers, even when they are "excused" from duties. To fulfill training requirements, learners report being required to work additional weekends and/ or additional call, making their schedules difficult to navigate. This is a disincentive to participate in leadership.

Mentorship and professional development to prepare learners for these roles are often lacking. Participating in formal leadership



roles is a significant time commitment and, without support from faculties, may contribute to distress among these learners. Anecdotally, many learners who participate in formal leadership roles have experienced this barrier and often remark at the end of their term that, although they appreciated the opportunity, they feel completely exhausted and would not do it again.

At certain institutions, learner participation in meetings is more supported; at others, the culture of the program or clinical care site makes it very difficult for a learner to feel comfortable asking for time to participate. It is important to acknowledge that these constraints affect not only learners; the same challenges are also reported by faculty.

In contrast, students are actively encouraged and supported to engage in academic research. School policies often allocate "*x*" days for students to attend conferences where they are presenting research, and some schools have a formal research curriculum or certificate programs that further "legitimize" these pursuits, unlike leadership endeavours. For example, as part of its curriculum, Dalhousie has a research in medicine program, which supports students to do a research project during their pre-clerkship training. Students are eligible to receive scholarship support for these efforts. Other schools have research certificate programs; for example, the University of Alberta's Special Training in Research program recognizes research endeavours outside the formal curriculum.

These research programs are supported and sanctioned by their faculties, meaning formal mentorship, recognition on the student's performance record or transcript, support to present research and attend associated conferences, and more. In contrast, no leadership training certificate programs or integrated leadership development and project support within undergraduate medical education currently exist in Canada.

Supporting those on national learner organizations

National organizations have traditionally expressed concern with the lack of learner representation at important decision-making tables. Although this has improved significantly, the lack of institutional support for learners to actively participate in such activities continues to have many consequences. Consequences include missing the learner perspective entirely, frequent turnover in the learner representative on committees, and overrepresentation of specialties and institutions whose culture is more supportive of this involvement, limiting the diversity of viewpoints. Although such national organizations as the Association of Faculties of Medicine of Canada have expressed the desire to have the learner perspective as part of decision-making, this will not be achieved unless concurrent policies are implemented to support this ideal.

It is important to acknowledge that staff physicians are also often asked to join committees and take on certain leadership-type roles "off the side of their desk" without formally allocated full-time equivalents (FTEs) and, thus, often requiring work to be done on weekends and evenings. Further, even those with formal roles and allocated FTEs are often required to spend much more than the allocated time on leadership roles. This issue is not isolated in medical education, but is systemic in medicine in general. In recognizing this, though, medical education should not continue to perpetuate this phenomenon, but rather build a medical culture where these roles are valued, where faculty and learners are supported with mentorship and professional development to prepare and foster satisfaction and success.

Defining leadership in medical education

One of the difficulties of making progress in advancing leadership development in medical education is the lack of a shared definition of medical leadership on which a national curriculum could be based. Although CANMEDS describes the Leader role,[4] a multitude of different leadership theories, models, and definitions continue to evolve as our insight into the competencies required to navigate our health care system continues to advance.

Studies have outlined learner and faculty perspectives on leadership development in medical education, important topics to cover, and approaches to teach these competencies.[8-10] It may be time for a renewed collaborative effort by learners and educators across the medical education spectrum to commit to reviewing the definitions, competencies, delivery methods, and other aspects of medical training focused on a leadership curriculum. The aim of this should not be defining and teaching leadership for the sake of "teaching leadership," but rather we should closely link our work with how we can influence health outcomes.

Leadership skills for all trainees

With all the discussion regarding leadership, one may ask, "what if I never want to be in a formal leadership role?" This highlights another misconception that is often associated with the conversation around leadership development and competencies. Physicians need not be in formal leadership roles to display outstanding leadership skills. Medical students, residents, and staff physicians must use leadership competencies every day. As we further explore the definitions of leadership and how we develop it in learners throughout the career spectrum, we must also take time to consider how the renewed focus and influences of physician well-being, equity, diversity, inclusivity, and other emerging areas of focus affect theories of leadership.

Ward senior resident, for example, whether regarded as a leadership role or not, requires significant leadership skills. Senior residents have an untold amount of influence on patients, other medical trainees, and allied health members of care teams. Their knowledge of how to support others in reaching their greatest potential, foster a health-promoting environment, model patient care with dignity and respect, and much more make it a very difficult job to do well, even if one is very competent in the Medical expert role.

The urgency of this work is important to recognize. The medical education community has the potential to significantly improve physician training by optimizing how we development leadership skills.

Taking collective action

Making meaningful progress in integrating leadership development into medical education will require the following steps.

1. Organize a virtual summit attended by medical education stakeholders across the trainee spectrum, including undergraduate and postgraduate deans and learners, to initiate development of a strategic framework to implement the FMEC's recommendation 8, Foster leadership development.[3] Implementation should include an oversight group

comprising undergraduate and postgraduate medical education leadership and learners to monitor progress and ensure accountabilities.

2. Develop a formal undergraduate and postgraduate Canadian medical leadership curriculum framework aligned with the FMEC objectives. The oversight group may be able to play a role in helping the many different initiatives at different institutions connect and collaborate.
3. Residency programs and undergraduate medical programs should re-evaluate how their curricula, policies, and culture support leadership development among learners in the program.
4. Ensure that the learner perspective is represented in discussions on policy changes in leadership development.
5. Medical schools must commit to improved continuing professional education in leadership competencies for faculty.
6. Undertake ongoing leadership development program evaluation and reform. This should be supported by multi-institutional academic research to study the effects of this progress and work on medical student and resident leadership competencies.

Medical students, residents, and their representative learner organizations are ready and eager to make meaningful progress toward these goals. Through collaboration and commitment, transforming leadership development for physician trainees can make a substantial difference in health care delivery. Improved physician leadership competencies will allow physicians to more effectively integrate patient perspectives, foster collegiality and a renewed positive culture, and navigate the challenges that technology poses regarding how we practise among a host of other opportunities in 2020 and beyond.

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OPINION

The "gift" of COVID-19: a golden opportunity to slow down and refocus

Peter Brindley, MD

With far fewer distractions, we finally have what we claim we always needed: time to think, reflect, and make sense of the nonsense. The problem is we have equal amounts of time to fall into despair. I tend to experience both optimism and despair, in equal amounts, often on the same day.

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It is so common for people to become emotional on long journeys, especially plane rides, that travel agents have a name for it: "the mile cry club."[1] Theories include relative hypoxemia (i.e., lower brain oxygen), a feeling of vulnerability (you are perilously high up and straddling flammable fuel), and the otherworldliness of travel (we didn't evolve to race across the planet). This six-foot-tall, 220-pound doctor has long tried to play the "ICU tough guy," but it's time to come clean. Before COVID-19 grounded me (quite literally), my academic job turned me into a frequent flier, and travel made me a not-infrequent crier. I suspect some of you can relate despite your exalted leadership titles and high-brow portfolios. Regardless of when and how your emotions leak out, it is worth acknowledging how COVID-19 has taken us all on quite a ride.

Months of living "la vida lockdown" has resulted in many disruptions to our previously manicured lives. One of the biggest is how, where, and whether we get to travel. Plane journeys used to offer the gift of down time. Now, in the age of COVID-19, this is as likely to come from a long car ride: something that Canada "specializes" in. With far fewer distractions, we finally have what we claim we always needed: time to think, reflect, and make sense of the nonsense. The problem is we have equal amounts of time to fall into despair. I tend to experience both optimism and despair, in equal amounts, often on the same day.

Regardless, I frequently use long trips to unwind. This starts with reflecting on all of the patients with overdoses, gunshot wounds, car crashes, and medical futility that I have stickhandled through the ICU. However, these early thoughts can be brushed aside by reassuring myself that at least I tried my best and by assuming that, because I am exhausted, it must have been important work. It gets tougher two hours into the journey and deeper into my headspace. This is when I think about broader concerns with my profession's (and my society's) obsession with biomedicine and technology, rather than community and connection. It is usually at the three-to-four-hour mark that I admit to nobody but myself that we do a great job of "processing" patients, but are less reliable at truly "caring" for them. The five-hour mark is when I question why I can't, literally and figuratively, slow down.

If you will allow me to persist with this fairly unoriginal analogy, namely that medicine is like a cross-Canada journey, our hectic distracted life styles seem akin to driving on, despite a warning light on the dashboard. During a long career – just as with a lengthy road trip – you may have to pull over to the side and look under a smoking hood. You might not like what you find. In short, the COVID-19 journey means time to think awkward but important thoughts. The extra time spent inside my own head has left me convinced that emotional connection matters

more than electronic connection, pills, or devices ever could. These are especially inconvenient truths for anyone working in biotechnical medicine.

Last year — 1 BC or the year before COVID — I boarded a plane after backpacking in Alaska and northern British Columbia with my elder son. The scenery and the challenge were "just what the doctors ordered": humbling, inspiring, and distracting (the Canadian holy trinity, you might say). My son and I had reconnected during challenging days and nights. We had been entirely sans Internet and fully avec each other, and if it wasn't on our backs then we didn't need it. We got to the airport gloriously tired and beaming with "we showed them" pride.

The problem was that before even taking off we both slipped into old ways and reached impatiently for the latest news. I often feel a sense of duty that I should keep up with current events, even though they reliably leave me cold. Regardless, as I read page after page of despair and anger, I questioned whether I was returning to "civilization" or leaving it. If nature had been my antidote, then, hyperbole aside, urban life might be some sort of poison.

Nature deficiency disorder (NDD) was described in Richard Louv's 2005 book, *Last Child in the Woods*.[2] The point is that, just like friendship and family, nature is a form of "life support." We shouldn't starve ourselves or our patients, even if NDD has yet to be medically sanctioned by the World Health Organization (WHO) with an ICD-code. NDD is also not in the psychiatrist's bible, the *Diagnostic and Statistical Manual of Mental Disorder* (DSM).[3] But

let's talk about the hallowed DSM. It has ballooned to 900 pages, 350 disorders, and includes things that seem more personality than pathology. For example, the new DSM includes apathy syndrome (i.e., you can't be bothered) and oppositional defiance disorder (namely, you may be a teenager).

Tongue in cheek criticisms aside, my bigger point is that after a quarter century of doctoring, I don't need the DSM or WHO to tell me something matters. I worry that people forget the importance of nature for the same reason that they fail to go after a better version of themselves. It is usually some combination of fear, finance, access, or perceived lack of time. Inadequate time spent in nature doesn't need to medicalized, but sometimes we do need to be reminded that tweets actually originate from birds and facetime once occurred without a screen. Not everything that matters warrants a pill, requires a life coach, or benefits from the modern medical industrial complex.

Alongside NDD is the "biophilia hypothesis,"[4] popularized by Edward Wilson in 1984, of all years. His argument is that humans have an innate need to connect with nature. The same is true of the widespread desire to connect with animals. This is why emotional-support animals mean so much to so many. It is also why so many of us have grown up with pets, and why more will do so, courtesy of "pandemic puppies." This inbuilt love of nature is why we adore babies, children, and any animal with floppy ears. Notably, these three things were among the first to be banned from hospitals during the COVID lockdown. In an increasingly urbanized, impersonal, and now locked-down world, it will take efforts to rebuild empathy and connection. Fortunately, there is hope.

Pet therapy is increasingly popular in hospitals.[5] Sadly, where I work, the ICU, these furry love bombs were verboten well before COVID-19. I suspect that, within my career, we will discover that human and canine microbiomes can coexist and that doggy-power is as strong as some of our lacklustre pills. In addition, more hospitals are building patios,[6] so that staff, and especially long-stay patients, can get some restorative fresh air. Spaces in hospitals where patients (even those, perhaps especially those, on ventilators) can get some sunshine are not an unnecessary luxury, nor are they an impossibility in the Canadian climate. With over three-quarters of Canadians now dying in hospitals and approximately one-quarter dying in an ICU,[7] death has become institutionalized, so let's get it right. Given that death rates are still 100%, and holding steady,[8] let's put effort into saving deaths not just saving lives.[9]

In some countries, family doctors now write outdoor exercise prescriptions for their patients. The concerning part is that this took so long, and it has still not taken off in a country as naturally blessed as ours. We all know that going for a run, a walk, or a cycle clears our head, so why not prescribe "two bike rides and call me in the morning."[10] Another "treatment" that could save both lives and cash is not a drug, nor surgery, nor even that Monty Python medical machine that goes "bing."[11] Instead, it is "community," and "social connection." Data from a Somerset village (the Compassionate Frome Project[12]) suggest that when isolated people are supported by community groups, then emergency admissions fall and erstwhile patients – why can't we just call them people – feel better. The investigators came to understand what our grannies always knew: much of what truly matters is not inside a modern hospital, even if that hospital is a technological marvel. This must-read-about Frome project also encourages us to throw away our doctor-only words (i.e., dyspnea) and use words that patients use (i.e., "give me enough breath so I can see my friends"). "Patient-focused" means delivering what patients crave (the ability to get out of the house), not what is most convenient for us (i.e., puffers and steroids).

We are increasingly electronically connected but socially disconnected. It's too easy to wholly blame the Internet, and so I won't. In fact, the Internet is likely the symptom as much as the disease. After all, I needed that remarkable technology to write and reference this article and for you to read it. However, the Internet should be a tool, and the point with tools is that we can put them down. Instead, our phones and tablets are increasingly hijacking our attention, and, hyperbole aside, manipulating our thoughts.[13] They become the first thing we look at in the morning and the last thing at night. The Internet does this by offering the illusion of community while creating people who are alone in their bedrooms and unfulfilled at their desks.

Social reconnection is difficult, but, then again, so is any health intervention that truly matters. Too often, I have reached for my phone, read something dispiriting, cursed the state of the world, did nothing about it, and then repeated the whole ridiculous process. It mirrors what I tend to do after each micro-dose of tragedy at the hospital. In contrast, with nothing to do but drive and hike and think, we all have a golden opportunity to slow down and refocus. I would call it a "reboot," but it's time to give up anything that smacks of computer-worship. COVID-19 offers us time and space to become a slightly better version of ourselves, and for that reason it is both blessing and curse. It is tough to know where to start, but, why not take a hike.

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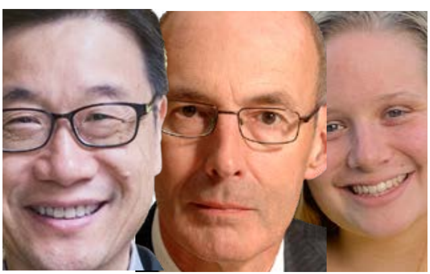
Principle-driven virtual care practice to ensure quality and accessibility



Kendall Ho, MD, Ken Harris, MD, and Toni Leamon

COVID-19 has accelerated the use of telehealth or virtual care (VC) as an alternative form of health care delivery. Clearly, VC provides unprecedented convenience and timeliness for patients seeking care from their health professionals. As a result, a substantial increase in telehealth providers is occurring, and the Canadian government is investing millions to support digital health care treatments and telehealth services. However, it is vital that the health professional community carefully examine the quality of care being delivered digitally and determine when it is appropriate to use VC as an alternative to face-to-face care. This article highlights some principles for health policymakers, health professionals, and health consumers to consider to ensure that VC is used appropriately and ethically for the right health conditions and in the right contexts.

KEY WORDS: virtual care, COVID-19, telehealth, quality of care, medicolegal issues, training, policymakers

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COVID-19 has precipitated a rapid change in the delivery-of-care landscape, including the accelerated use of technologies, commonly known as telehealth or virtual care (VC). A study from the United States suggests that, although 11% of consumers used telehealth in 2019, this rose to 76% in May 2020.[1] The number of telehealth sessions increased 50 to 175 times in the same period. In June 2020, the Canadian Medical Association published a national poll showing that "almost half of all Canadians have now accessed a physician using virtual care options," with a 91% satisfaction rate among those who experienced this service.[2] The need for ongoing VC is clear as the second wave of COVID is upon us.

Clearly, VC provides unprecedented convenience and timeliness for patients seeking care from their health professionals, one of five key trends that will influence growth of telehealth.[3] As a result, a substantial increase in Canadian telehealth providers is occurring, and the federal government is investing $13.4 million to support digital health treatments and telehealth services.[4]

In this time of VC boom, it is vital that the health professional community carefully examine the quality of care being delivered digitally and determine when it is appropriate to use VC as an alternative to face-to-face care.[5] This article highlights some principles for health policymakers, health professionals, and health consumers to consider to ensure that VC is used appropriately and ethically for the right health conditions and in the right contexts.

Principles of virtual care

Although it is acceptable to challenge traditional thought, the use of VC should always be

anchored on the principles that underpin the practice of medicine itself. Modern information and communication technologies should only be considered as tools to facilitate and optimize care. Their use should benefit our patients and do no harm — a fundamental tenet of medical practice.

The following key principles differentiate VC from in-person practice. They should be considered in the education of health professionals and trainees to support sensible adoption of VC in health care delivery. The principles fall into four domains: clinical, medicolegal, andragogic, and social.

Clinical

Clinical quality optimization

Judging whether to choose VC for health service delivery should be based on whether it is a reasonable or better option than in-person encounters in providing safe, accessible, timely, and high-quality health care to patients.

Considerations include:

- likelihood of accessing in-person care (e.g., patient is in a rural location where timely in-person care is impossible)
- quality, quantity, and reliability of information acquisition
- sufficiency of peripheral observations of the patient
- absence of direct physical examination for clinical decision-making and, in some instances, for meeting the standard of care
- potential of VC to impair judgement or introduce bias in decision-making
- incorporation of current best practices and accepted standard of care in VC

Communication facilitation

Like other communication tools used in medicine, VC should support or enhance communication with patients to augment information gathering and relationship building.

Considerations include:

- optimizing accuracy in history taking
- sharing of diagnosis and management details with patients
- building a relationship of trust with patients and families

Continuity of care

VC encounters should be considered as time points in a continuous string of interventions in longitudinal patient journeys.

Considerations include:

- establishing a clear process for patient follow up after the VC encounter
- arranging clinical handover of patient information to other health professionals after the VC session, e.g., rural-urban health professional handovers or interprofessional handovers in team-based care

Medicolegal

Informed consent

When engaging patients in the use of VC, adequate disclosure of benefits and risks is necessary, so that they are fully informed and not acting based only on perceived advantages (e.g., convenience, travel avoidance).

Considerations include:

- proper risk disclosure, frank discussion with patients, and opportunities for them to ask questions
- documentation of informed consent

Confidentiality and privacy

Patient privacy and maintenance of confidentiality of information exchange must be preserved

through VC, just as it is for in-person care.

Considerations include:

- ensuring the use of secure software and communication infrastructure during patient–physician exchanges
- storing information and preventing unauthorized access by third parties
- maintaining a proper VC record and its availability to patients and caregivers and for medical auditing

Consistency with the legal/ regulatory frameworks
Choosing VC should take into account the current legal and regulatory frameworks, including:

- jurisdiction of practice and licensing
- existing telemedicine/ VC professional practice guidelines
- privacy and confidentiality guidelines and recommendations
- maintenance and retention of a proper medical record

Transparency of VC involvement
Establishment of a clear and mutual understanding is important to all parties involved, including health professionals and learners, patients, caregivers, and the health care system.

This transparency should include:

- clear expectations about response times and "when the virtual office is open"
- licensure mechanisms to facilitate the process
- medicolegal protection

- clinical boundaries of acceptable VC care
- service reimbursement
- choosing appropriate software or infrastructure for appropriate VC use by the health system, health professionals, or patients with full understanding of the implications

Andragogic

Competency-based training
VC education for health professional trainees should consider a spiral curriculum, starting from simple cases (e.g., a single-image-based, one-on-one consultation) to more complicated cases (e.g., a team approach with several interdisciplinary colleagues participating simultaneously) and then to complex settings (e.g., providing VC to a remote community with low bandwidth and complex health service needs).

A variety of training options can be deployed, including:

- didactic learning of principles
- patient encounters for experiential learning
- standardized patients for simulation-based training
- scholarly projects to explore innovations or controversies

The planning and implementation of curriculum, training content, and educational methods would benefit from co-creation with and participation of patients, caregivers, and communities. Practising health care professionals would also benefit from continuing professional development in VC.

Harmonization with curricular priorities
VC training need not be done in isolation, but can be creatively harmonized with other competencies to generate strong synergy. For example, VC can be illustrated, taught, and experienced in combination with interprofessional collaboration, ethics, or rural and remote medicine.

Life-long learning commitment
VC education and knowledge exchange should take place in the continuum of undergraduate, postgraduate, and continuing professional development domains. Group-based dialogues,

such as forums, can provide opportunities for sharing of clinical pearls, lessons learned, latest innovations and research, and challenging controversies. It is also important to encourage mentorship provided by experienced clinicians well versed in VC to colleagues and trainees to perpetuate VC best practices longitudinally.

Social

Contextual sensitivity versus universality

Integrating VC into different aspects of health care services requires the meticulous consideration and selection of modes for use in special contexts to achieve equity of access and quality of care, for example, in rural and remote settings, urban isolated situations, mobility issues, socioeconomic constraints, etc. Health professionals providing VC must always be aware that not all patients have the same access to technology, because of variability and availability of resources or infrastructure in different communities and contexts.

Return on investment for all stakeholders

VC should be carefully deployed only in the appropriate context and situation to enable and enhance patient care, as not every aspect of health care services will fit. VC should not be chosen for expediency of care or convenience alone. Health professionals and involved health organizations must also be appropriately remunerated and compensated for the use of VC, but economic gains should never supersede excellence in quality of care.

Social reform and continuous quality improvement

Tomorrow's best practices in VC will certainly be different from those of today through technological innovation and evolution, and new understanding and lessons will be generated from expanding clinical applications. All stakeholders must be adaptive and flexible, as new technologies and VC approaches emerge. They must be effective change agents to promote sensible VC adoption, advocate evidence-informed VC to improve care, and engage in the co-creation of the future standard of care through continuous quality improvement.

Conclusion

We hope these principles will be helpful in guiding thinking toward the future evolution of VC toward high-quality best practices that also support convenience and equity of access. We welcome readers' feedback and further socialization to arrive at core principles that all stakeholders feel are important to illuminate on the path to future excellence in VC.

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Developing physician leaders: why, whether, and how good?

James K. Stoller, MD, MS

The challenges of providing high-quality, seamless access, and value in health care require great leadership; these needs are compounded by crises like the coronavirus pandemic. In the context that physicians often lead both in titled and informal leadership roles and that evidence associates effective hospital performance with physician leadership, leadership skills are widely needed by doctors. Yet, leadership competencies are not traditionally taught in medical school or during graduate medical training. Furthermore, some aspects of clinical training may conspire against physicians' developing optimal leadership traits. The tension between need and preparation highlights the imperative to develop physicians' leadership competencies. Increasingly, physician leadership development programs are being offered, e.g., by some health care organizations, professional societies, business schools, and consulting firms. Still, many unanswered questions beyond the "why" surround such programs: what is the best way to develop physician leaders and are such programs effective? This article considers the rationale for developing physician leaders as well as some leadership handicaps that physicians face by virtue of their clinical training. Attention then turns to considering the evidence regarding the effectiveness of such programs and framing remaining questions for further study.

KEY WORDS: leadership development, rationale, effectiveness

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Great leadership is clearly needed in health care today. Daunting challenges of optimizing access, lowering costs, and assuring the highest quality care (i.e., enhancing value), all while maintaining caregiver well-being – the so-called Quadruple Aim[1] – surely require skillful leadership. Navigating decisions in resource-constrained environments, such as health care, and communicating these decisions to stakeholders are quintessential leadership competencies. Furthermore, crises, like the coronavirus pandemic, magnify the need. And leadership competencies matter. They are different from the clinical and scientific skills that physicians cultivate during training.

Physicians lead in a wide variety of contexts, e.g., on the wards, leading clinical and research departments, and sometimes in the executive suite. They are both "small l" leaders (who lack formal titles but lead change efforts to optimize care) and "big L" leaders (who have formal titles, such as department chair, dean, CEO, etc.).

Several lines of reasoning support the advantages of

engaging physicians in formal leadership roles in health care organizations. At the highest levels of leadership, observational data[2,3] show a significant association between the highest rating of health care organizations and having a physician as the CEO. An association between enhanced efficiency and financial performance when the CEO of the health care organization is a physician has also been shown.[3] As current supportive examples of this association, all five hospitals rated highest in 2019–2020 by *U.S. News and World Report* – Mayo Clinic, Massachusetts General Hospital, Johns Hopkins Hospital, Cleveland Clinic, and New York Presbyterian – are led by physician CEOs. Attribution of top hospital rating to having a physician CEO is clearly not possible from available studies (because correlation is not causality, of course), and there are many superb hospitals whose CEOs represent other disciplines. However, potential explanations for the benefit of physician leadership include physicians' enhanced core understanding of the health care environment, their enhanced interaction and relationships with other physicians based on the common experience of doctoring, and the clinical credibility that they uniquely enjoy, which enhances followership.[4] Beyond the executive suite, leadership by physicians without formal titles is critical in all clinical "microsystems" in health care organizations, e.g., in optimizing clinical care on the wards, contributing to review and search committees, etc.[5]

Further support for the importance of physician leadership in health care organizations comes from parallel observations in other sectors.[3,4] For example, universities that are led by presidents who have higher levels of career scholarship enjoy higher global rankings in research and scholarship. Similarly, in Formula 1 racing, the most successful racing teams are led by individuals who have been Formula 1 drivers, as opposed to non-driver mechanics, engineers, or managers. Synthesizing these observations from disparate sectors – higher education, sports, and health care – Goodall[4] has framed the "theory of expert leadership," which holds that "organizations perform most effectively when they are led by individuals who have inherent knowledge of the core business activity."

Just as physicians bring advantageous traits to leadership, so too do they bring unique challenges and potential handicaps as leaders. For example, although learning environments are evolving favourably in many academic medical centres, traditional medical training has selected for and cultivated "gladiator" or "Viking" behaviours, which have caused physicians to be described as "heroic lone healers."[6,7] To the extent that such "command and control" conduct conspires against optimal leadership and can undermine a collaborative spirit, emerging physician leaders must "unfreeze" these behaviours as part of their developing leadership competencies. Physicians must recognize that there are multiple leadership styles, e.g., democratic, affinitive, visionary, etc.,[8] and be able to adopt the right style for the right circumstances.

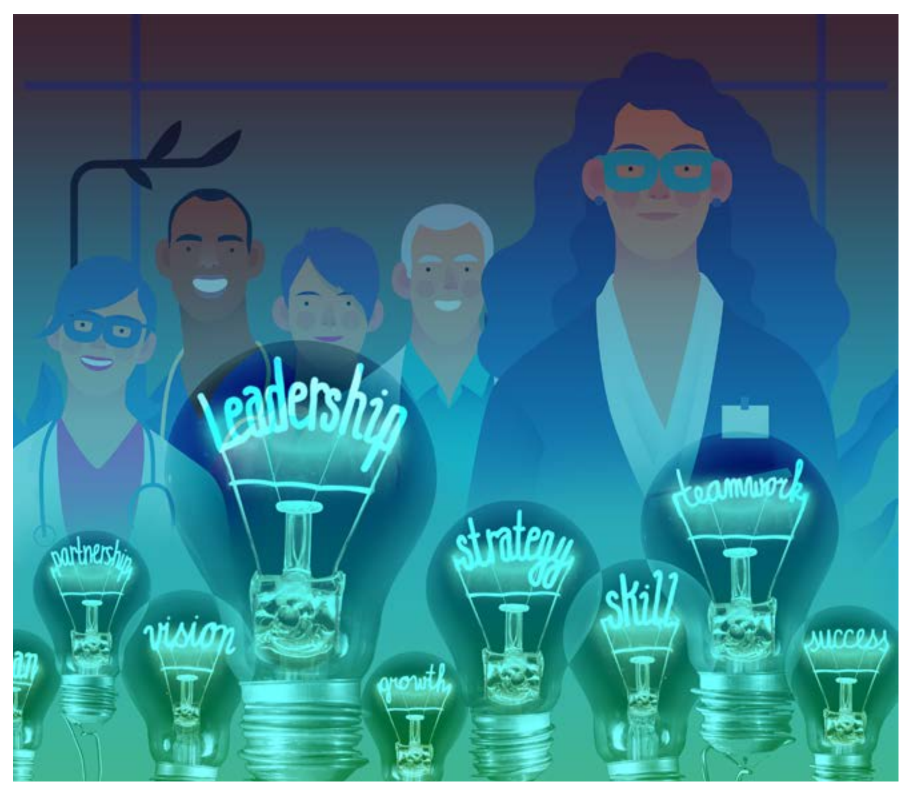
In a similar vein, physicians are trained clinically to be "deficit-based thinkers," i.e., clinical reasoning sees symptoms as problems to be solved by generating a list of potential causes in service of a solution.[9] Indeed, deficit-based thinking is core to the time-honoured practice of differential diagnosis, which is essential in clinical reasoning. Yet, organizational thinkers espouse the antithesis of deficit-based

thinking – so-called "appreciative inquiry"[10] – as a better way to think about and lead organizations. The notion is that "words create worlds" and that the way an organizational question is framed informs the answer. Issues framed through a strengths-based lens are likely to generate more informed, stickier solutions that unleash discretionary effort in an organization. Physicians who create cultures based on classic virtues – trust, compassion, hope, courage, temperance, wisdom, justice – instead of "carrot and stick" compliance-based cultures are more likely to engage caregivers and unleash discretionary effort, leading to enhanced organizational performance.[11] Thus, to both function as clinicians and to lead optimally, physicians must be situationally mindful and nimble to invoke differential diagnostic reasoning when they are practising medicine but to embrace appreciative inquiry when they are leading.

Finally, physicians are also trained to be "dichotomous thinkers."[9] The practice of medicine routinely calls on doctors to translate continuous biologic variables (blood pressure measurements, electrolytes, etc.) into yes/no decisions. For example, we might treat with an antihypertensive medication if the diastolic blood pressure is 91 mm Hg but might not if it is 89 mm Hg. This penchant to dichotomize the world can predispose physicians to what Collins[11] has called "the tyranny of the *or*" rather than the "genius of the *and*," the latter deemed an important leadership competency. As such, as physicians learn to lead, they must learn and be intentional about embracing the "and." As F. Scott Fitzgerald said, "The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time and still retain the ability to function." Although dichotomously minded in their clinical practice, physician leaders must learn to embrace seemingly conflicting realities (e.g., we can provide optimal care and anchor on value) and still function.

Taken together, the impetus for physicians to lead – whether from the executive suite or on the wards[5] – and the need to develop leadership competencies among physicians begs two questions: are we developing physician leaders today, and what is the evidence that such leadership development is effective?

Outside health care, leadership development programs have been signature and longstanding features of successful multinational corporations. Corporate universities are offered by IBM, Toyota, Motorola, and many others. Health care organizations have generally been slower to embrace leadership programs for physicians and, although such programs are increasing in recent years on the strength of supportive observational data, their adoption remains incomplete. In 2012, Davidson *et al*.[13] reported that 57% of surveyed health care institutions offered no such leadership development programs; a 2015 survey of members of the Association of American Medical Colleges[14] found that, although 65% reported offering faculty development programs of some type, 88% sent faculty away to other organizations for training. To the extent that leadership training in an academic medical centre is perhaps best taught locally with attention to organizational culture and by faculty who enjoy local



"street credibility," organizations are encouraged to develop intramural leadership programs. Examples include programs at Emory, Harvard, Stanford, McLeod Health, Hartford Healthcare, Cleveland Clinic, and Mayo Clinic. Still, health care organizations with well-developed intramural leader development programs are currently in the minority.

Notwithstanding a growing volume of supportive observational data, the other burning issue is whether leadership development programs work, i.e., has institutional performance been rigorously shown to be enhanced because physician leaders have received leadership training? High-quality evidence here is woefully thin. Meta-analyses regarding the impact of physician leadership development have consistently identified few controlled studies or observational studies that assess, no less show, that participants in such programs exert a favourable organizational impact.[15] Furthermore, to my knowledge, despite the expense of organizing such programs (e.g., faculty costs, food and facility costs, and most notably, the opportunity costs associated with taking physicians off-line for such training), no study has formally addressed the cost-effectiveness or return-on-investment of such programs.

All in all, the need for effective leadership in the current challenging health care environment remains indisputable. To the extent that physicians bring distinctive benefits to health care leadership; that leadership competencies matter; but that leadership training is not part of traditional medical curricula, either in medical school or during graduate medical education, greater attention to developing physician leaders is needed. At the same time, while designing and offering such programs, a keen focus on assessing optimal training strategies, determining when such training is most needed in a physician's career,[16] and rigorously assessing the objective impact of such programs, including their cost-effectiveness, is urgently needed.

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BOOK REVIEW

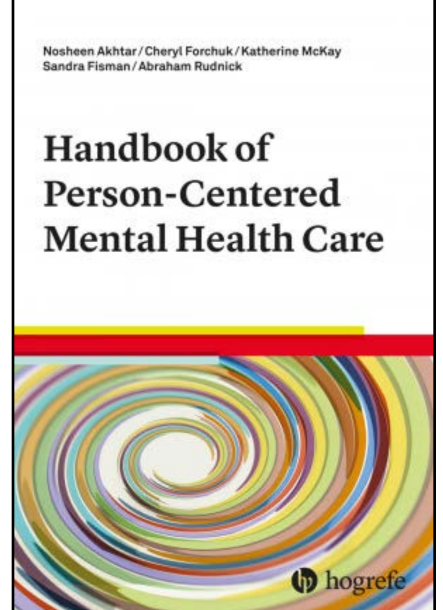
Handbook of Person-Centered Mental Health Care

Nosheen Akhtar, Cheryl Forchuk, Katherine McKay, Sandra Fisman, Abraham Rudnick
Hogrefe Publishing Boston, 2020

Reviewed by Marilyn Baetz, MD

Person-centred care is authentic, compassionate, and built on respect toward individuals with various health problems. It is the foundation of working with people with mental health challenges and beyond. This book expands on the multidimensional construct of care for mental illnesses introduced by Abraham Rudnick and David Roe.[1] This treatment approach focuses on the person, is sensitive to their needs, allows them to make choices on their care, and considers their current and past context. The purpose of this book is to provide a comprehensive, hands-on guide on how to provide such care and how it can be implemented by mental health professionals and students. As noted by the authors, the book can also be used as an educational tool for service users, so that they may actively participate in their own care.

Chapter 1 of the book discusses the foundations of this approach and introduces the terminology "service user" and "service provider." The benefits, challenges, and applications are briefly introduced.



Chapter 2, the lengthiest section of the book, is a compilation of knowledge and practical skills needed for working with those with mental health challenges. It discusses a person-centred approach to the clinical encounter with the individual or family, addresses culturally sensitive care, different challenges for adolescents and older adults, as well as the unique aspects of forensic mental health and dual diagnoses. Each scenario is complemented with a case study along with useful cognitive and behavioural worksheets, which are "answered" through the case study. All of these provide further understanding of the process. The worksheets and potential responses can be a very helpful additional resource when one faces challenges in a particular difficult area with a client.

Chapter 3 turns the focus to patient-centred research. The case studies give clear examples of how service users help to initiate and refine the research question and play an imperative role throughout the process. Participatory action research is highlighted as a method that ensures that action and outcome are of real benefit to the service users. As patient-oriented research is a main thrust of the Canadian Institutes of Health Research, these principles are timely and align well with current needs.

Chapter 4 is about person-centred education for the service user, family members, health professionals (at all levels), and public at large. The importance of learning to share decision-making, reflecting on the therapeutic alliance, and considering adult education approaches are discussed within the context of optimized care. Although many of the health professions will have their own curricula for teaching person-centred care, the core content remains comparable.

The final chapter is on a person-centred approach to leadership. It uses a case study of the personal development of a physician and an administrator co-leaders, as they bring system change to an outpatient mental health program. The example walks through numerous established leadership concepts, programs/theories, such as reflected best self, strengths based, emotional intelligence, appreciative inquiry, and SWOT (strengths, weaknesses, opportunities, and threats) analysis. These approaches and tools are used to make plans in a consultative,

person-centred approach that includes collaboration with teams that incorporates service users at each stage. This chapter covers both theory and practice (the case study) in attempts to pull the many approaches together to make the process easily understandable.

The authors have backgrounds in occupational therapy, nursing, psychiatry, and philosophy. Their expertise includes psychosocial rehabilitation, leadership, treating serious and persistent mental illness, programming, and policy. Authorship is more heavily weighted to psychiatry but does provide expertise from a mental health team perspective.

The book is well structured and written in a very easy-to-read style. The content flows well and the case examples are in grayed boxes in handwriting type, making them clearly distinguishable from the theory. There are 33 examples of forms that service users can work on together with the health care worker. The forms are available at the end of the book and for free download from the publisher's website.[2]

The authors of Handbook of Person-Centered Mental Health Care took on an ambitious agenda, writing for a wide range of mental health care workers and service users too. A lot of information is packed into this handbook, but, given the number of topics and the breadth of the intended audience, some readers may find it to be only a primer. There is, however, a reference section at the end of each chapter for further study. This book would be a good educational resource for mental health trainees, including psychiatry residents, and a useful resource for practitioners who want to begin to advance their journey in person-centred care.

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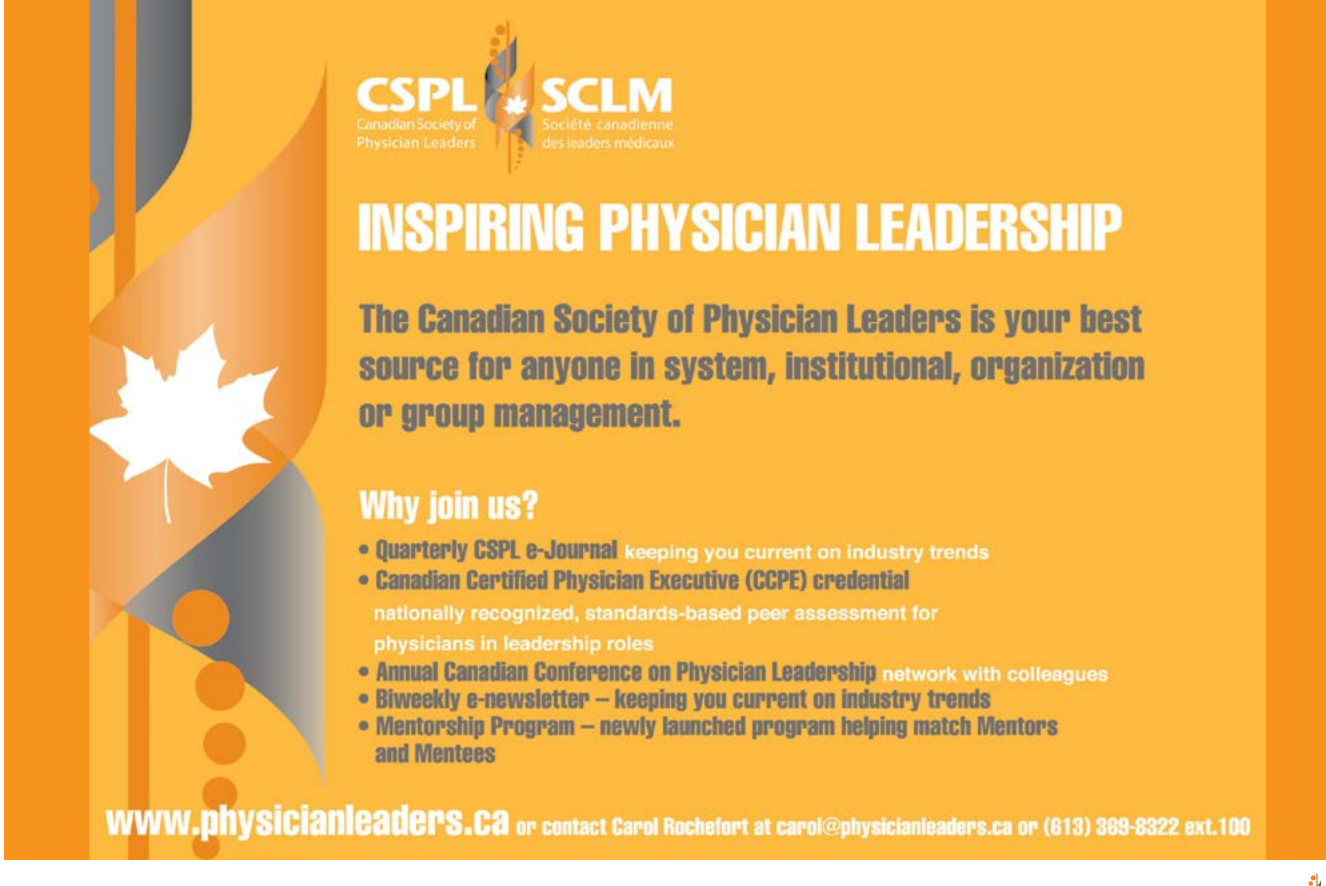

BOOK REVIEW

Bringing Leadership to Life in Health: LEADS in a Caring Environment 2nd edition

Graham Dickson and Bill Tholl, editors
Springer Nature Switzerland, 2020

Reviewed by Johny Van Aerde, MD, PhD

The first edition of this book focused on the evidence and research methods used to develop the LEADS framework. For those unfamiliar with the framework, LEADS is an acronym for the five domains of physician leadership: L for Lead self, E for Engage others, A for Achieve results, D for Develop coalitions, and S for Systems transformation. Each domain comprises four "capabilities."

In this second edition, Dickson and Tholl add new information, collected over the last six years, about how LEADS has been used in many organizations, regions, and provinces, with dozens and dozens of national and international examples. Anecdotal evidence of the framework's usefulness from the perspectives of patients, different cultures, and various health professions has also been added. Reflective learning moments, each with its own set of questions, make the book one large learning experience for the reader.

The book is almost double the size of the previous edition, with a whopping 330 pages. If this is your first exposure to LEADS, I suggest you start with chapter 3, which explores the essence of LEADS, and then move on to chapters 5–9, which each cover one domain. These chapters are well structured and clear. The danger lies in reading them too fast; go slowly, one capability at a time, keeping in mind that all 20 capabilities are intertwined.

Once you are familiar with the framework, chapter 10 would be an interesting continuation of your journey, as it shows how LEADS can not only be used as a framework for leadership development, but also for change management (in this context, it should really be called change leadership). All remaining chapters can be read in a sequence of your choice.

While chapters 1 and 2 are aimed at the theoretical and academic reader, chapters 11–16 use a set of lenses to focus on different parts of our health care system. Chapter 14, "Seeing with two eyes: Indigenous leadership and the LEADS framework," by Dr. Alika Lafontaine and colleagues, uses a double lens, as it not only highlights different worlds of experiences and thinking around health, but also provides food for thought on how the content of that chapter could be used across the entire health care system. The authors also give specific examples of how the L, E, and D domains can be applied to Indigenous leadership and culture.

In Canada's health care system – which is highly fragmented constitutionally, geographically, and structurally – LEADS might serve as a common language across silos. How can it be used to improve continuity of care across

those silos? How can we embed LEADS in the structure and culture of the health system, such that we will practise real distributed leadership by advancing diversity and inclusion. How can we use LEADS to help improve physician well-being systemically?

Finally, the LEADS framework can be used as the foundation to professionalize leadership and leadership development across the health care system and to measure and evaluate individual and organizational leadership capacity. The Canadian Certified Physician Executive (CCPE) credential, for example, is based on the LEADS framework. Introduced 12 years ago, it is the only certificate in Canada recognizing a standard for professionalized physician leadership. (See **ccpecredential.ca**)

One final piece of advice: don't buy the electronic version of this book; get the printed one, as you will grab your copy from the shelf many times, to re-read or highlight a section, or to delve further into the abundance of references. This book is a keeper for anyone who touches the health care system — which means all of us.

Author

Johny Van Aerde, MD, PhD, FRCPC, is co-editor-in-chief of the *Canadian Journal of Physician Leadership* and executive medical director of the Canadian Society of Physician Leaders.

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