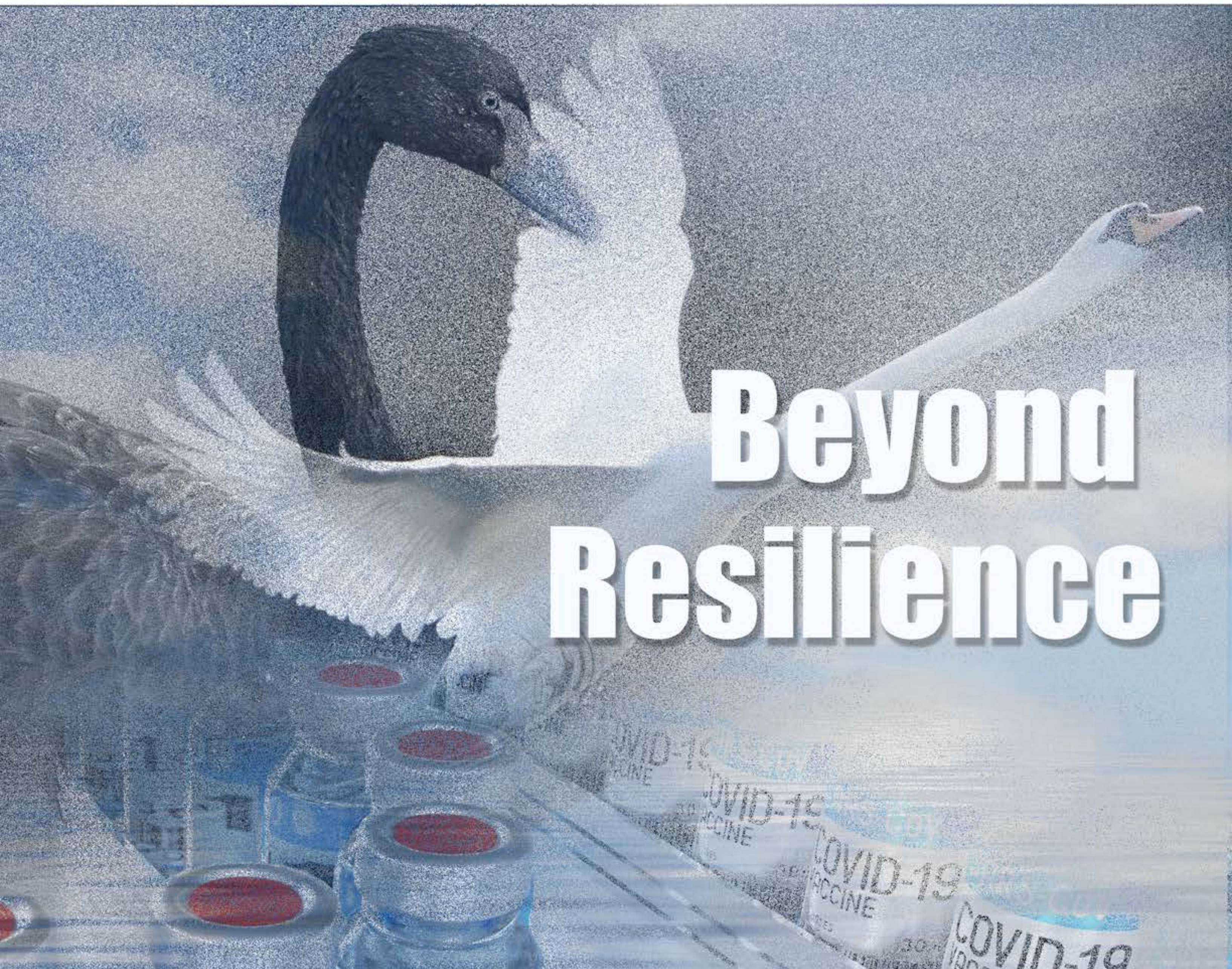
CANADIAN JOURNAL OF

Volume 7 Number 3
2021

Physician Leadership

THE OFFICIAL JOURNAL OF THE CANADIAN SOCIETY OF PHYSICIAN LEADERS



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ISSN 2369-8322

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EDITORIAL

Beyond resilience

Sharron Spicer, MD, FRCPC, CCPE

Note from the editor

This issue of *CJPL* marks a transition as its founding editor, Dr. Johny Van Aerde, passes the baton to the next runner. Many of you will know Johny as a pioneer in physician leadership in Canada over the past two decades. Like me, some of you will also consider him a mentor and friend. With much-appreciated encouragement and support from Johny, I humbly accept the baton and step into the role of *CJPL*'s next editor-In-chief. We'll continue to see much of Johny as he continues as executive medical director of CSPL and on the Editorial Board of *CJPL*.

I thought I'd share with you a little of my background. I have practised pediatrics in Calgary for over 20 years and have held various leadership roles in ethics, quality and safety, and physician health. I teach ethics at Calgary's Cumming School of Medicine and serve on the Committee on Ethics of the Canadian Medical Association. I am a collaborator with Well Doc Alberta and worked with the Alberta Medical Association's Physician and Family Support Program for five years. I am now a medical advisor in professional affairs with the Alberta Medical Association. I received the Canadian Certified Physician Executive (CCPE) credential in 2017. Having recently discovered a passion for writing and editing, I am pursuing a Professional Writing Certificate specializing in business and technical writing from the University of Calgary.

The pandemic experience has been a marker in time in all of our lives. In this issue, I share with readers my family's journey of illness, written one year ago as we were watching the pandemic gather speed around us (see "Career interrupted"). I had taken a leave from work, stepping into unknown territory. One year later, I'm grateful for my spouse's good recovery and the opportunity for me to return to work – although admittedly, becoming the editor-In-chief of *CJPL* was nowhere on my horizon at that time! Well, much can happen in a year.

I hope that you enjoy reading the articles in this issue as much as I have. I encourage you to write with your ideas, comments, and articles. I also hope to see you virtually at the 2021 Canadian Conference on Physician Leadership!

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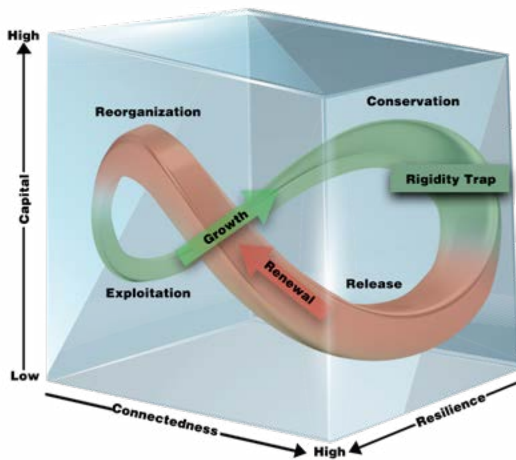
In organizational leadership, we are fond of the adage "Never let a good crisis go to waste." (Like many clever quips, this one is ostensibly credited to Winston Churchill.) One year into the COVID-19 pandemic, we are still responding to its disruptive change. Similar to other world events in the past – wars, 9/11, major natural disasters – the destructive effects are felt both individually and collectively. Its impacts will continue to appear and evolve over the next decades. One thing is certain: things will not go back to the way they were.

The pandemic peeled away the surface veneer of our health and social systems, revealing fragmented systems with gaps in services, coordination, and responsibility. The most vulnerable members of our society not only faced their ongoing struggles but also bore an uneven burden of pandemic-induced hardship and loss. The disparities in wealth, social advantage, and access to health care that were long recognized had never been fully addressed. The pandemic has given us a sobering awakening to the needs for urgent long-term care reforms; recognition of poorer outcomes of marginalized populations; demands for improved working conditions for front-line and entry-level workers in health care; and

greater advocacy for public health measures. To address the disparities in health outcomes, we need to deliver health and social services in vastly different and innovative ways.

We discovered, too, that the way we interact with patients – and how patients connect with their own health care information – has changed. We have seen the importance of improved system integration of health data across regions. We have witnessed the vast uptake of virtual health and e-prescribing. We note that patients need to have better access to their own health records. We have seen the resilience with which health teams have pivoted from providing one type of service to another. And we have humbly watched the enormous sacrifices of many health care workers as they substitute themselves for loved ones at the bedsides of the elderly and the dying.

Figure 1. The renewal cycle of complex adaptive systems



Innovations in science and technology have emerged. Remarkably, in just one year, we have seen the successful development and launch of totally new types of vaccines. International cooperation in genetics, epidemiology, virology, vaccine trials, and supply chain management have created a remarkable roll-out of therapeutic and preventive strategies for managing COVID-19; these will have lasting impacts on various clinical fields for years to come.

Transformative change like this is difficult to enact and is often preceded by a crisis event. In a 2016 article in *CJPL*, past editor-in-chief, Johny Van Aerde, shared an elegant panarchy model showing the renewal cycle of complex adaptive systems such as health care (Figure 1).[1] He further explained how the health care system in Canada had predictably become stuck in a "rigidity trap" and that some form of internal or external pressures would create a crisis to release the current state and create the conditions for change. Three years before COVID-19, Van Aerde noted that "the ultimate external crisis can be triggered at any time by an economic collapse or a global pandemic disease."[1] Further, he described, "Health care leaders, particularly physicians, need to… ensure that the substance of health care is not lost but renewed. As in a forest fire, creative destruction is designed to release nutrients so that new life can indeed emerge. Therefore, creative destruction is positive and not synonymous with devastation."[1]

Similarly, author Nassim Nicholas Taleb describes the outcomes of so-called Black Swan events – large-scale, unpredictable, and irregular events of massive consequence; in real time, they are experienced as random and disconnected, but in retrospect, we can see patterns, identify cause-and-effect relationships, and create predictability. Taleb coined the term *antifragile*. "Antifragility is beyond resilience or robustness. The resilient resists shocks and stays the same; the antifragile gets better."[2]

Crisis creates needs that require us to respond with urgency and innovation. The wind-down of the COVID-19 pandemic is a time for us to re-imagine and bolster our health and social systems. In this window of opportunity, let's not just return to normal – let's build *better*.

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Building belief: establishing credibility as a medical leader

Lara Hazelton, MD, MEd, and
Michelle MacDonald, PhD, MD

Credibility depends upon both an individual's personal characteristics and how they are perceived. Because a leader's credibility profoundly affects what they are able to accomplish, establishing credibility can be an important component of leadership development. However, while some factors that affect credibility may be modified through deliberate effort, others cannot. In this article, we explore steps leaders can take to increase their credibility and the limitations imposed by factors beyond the individual's control.

KEYWORDS: credibility, leadership, medical leadership, leadership education, communications, professional identity

CITATION: Hazelton L, MacDonald M. Building belief: establishing credibility as a medical leader. *Can J Physician Leadersh* 2021;7(3):101–107. https://doi.org/10.37964/cr24735

It may be that the credibility of leaders has never been more important than it is today. With the impact of the global pandemic continuing to reverberate, life is stressful and the future uncertain. According to attachment theory, we all have an innate desire to be protected and nurtured that begins in early life and continues into adulthood.[1] When anxiety levels are high, attachment needs may lead us to seek a greater than usual amount of reassurance and guidance from leaders and authority figures we feel we can trust.[2] Yet, knowing who we can believe in can be difficult, especially when news and social media are increasingly factionalized.

Credibility is defined as the power or quality of inspiring belief.[3] It is foundational to building trust, and leaders who are not seen as credible will struggle to accomplish their goals.[4] Many factors contribute to whether a person is seen as credible. Some pertain to the leader themself; competency, integrity, and caring are examples of qualities that form the basis of trust and credibility. However, simply possessing certain qualities will not be enough to build credibility if they are not perceived and acknowledged by others. For example, it is important that a leader not only cares about others, but clearly demonstrates this and effectively communicates this to those they work with.

Unfortunately, others may hold biases that lead them to base their assessment of credibility on irrelevant factors. For example, there are people who, consciously or unconsciously, make judgements about a leader's abilities, honesty, or integrity simply based on their gender or race, undermining the credibility of those who do not fit that mold. In this situation, establishing credibility may be difficult or impossible, regardless of the leader's credentials, qualifications, and ability to communicate.

Conceptualizing credibility as a combination of actual and perceived characteristics and abilities suggests two key strategies for becoming more credible. The first is through attaining a higher level of leadership expertise, either through formal training or informal experience. The second is by making that expertise visible to others in ways that convince them of your competence and trustworthiness. In this paper, we discuss the tenuous relation between formal training and

credibility, briefly explore how an individual's capacity to build credibility may be limited by external factors (including the biases of others and various forms of discrimination), and suggest steps current and aspiring physician leaders can take to increase their credibility.

Formal training and credentials

It is not uncommon for physician leaders to worry about their own credibility. In clinical settings, medical expertise is a major factor in establishing credibility, but this can lead to invitations to take on formal leadership positions requiring a different set of skills.[5] Characteristics that enable leaders to achieve credibility and success come naturally to some, but will need to be deliberately cultivated in others.[6] Thus, academic career advancement and leadership positions represent transitions that can lead physicians to pursue further education.[7]

Although clinical topics still form the basis of most continuing medical education, leadership education has become popular for physicians seeking to develop the knowledge and skills necessary to be effective leaders. Master of business administration (MBA) and other executive education programs associated with medical schools have proliferated, reflecting an increasing recognition of leadership as a key element in physician training.[8] In general, it appears that leadership education programs are regarded positively by participants. A recent Canadian study that looked at the return on investment of leadership development in health care found that the most commonly reported outcomes of training included improved communication, self-awareness, "personal qualities," confidence, and assertiveness.[9] A 2012 systematic review of faculty development initiatives designed to promote leadership in medical education found high levels of satisfaction among graduates.[10]

In addition to acquiring skills and knowledge, some participants may be seeking to enhance their credibility through acquisition of credentials. According to human capital theory, several forms of capital may be acquired through formal leadership programs.[11] Intellectual capital comprises the knowledge and skills that constitute the formal curriculum of most such courses, whereas social capital manifests in the relationships established through networking with other current and prospective leaders. In addition to these, participants may be motivated to take formal leadership courses to attain symbolic or cultural capital, which is the value generated by the prestige and status conferred by a formal credential. Although the possibility of increasing cultural capital is rarely made explicit in promotional materials for leadership courses, it is a potential benefit that may encourage participation. In a survey of Canadian physician leaders, standardized evaluation and accreditation, such as the Canadian Certified Physician Executive credential,[12] was believed to be useful for increasing physician leaders' credibility with peers and administrators.[13,14]

Overall, leadership programs seem to be a worthwhile investment of physicians' time. Nonetheless, there is limited evidence that having formal leadership credentials will actually make you more credible as a physician leader. In fact, placing too much reliance on one's credentials might lead to complacency about the other important aspects

of building credibility. In an article entitled "Beyond expert credentials: every aspect of credibility counts,"[15] Charlotte Morris, a trial consultant who works with expert witnesses, explains how credibility does not depend solely on formal credentials. Although an individual's competence can be determined by evaluating their training, experience, and reputation, their perceived trustworthiness, competence, and likeability — which includes warmth, empathy, humour, and listening skills — will greatly affect their credibility with the jury. The same is likely to be true of leaders whose actions may speak more loudly than their formal credentials when they interact with others.

Limitations on building credibility: the effects of bias and other systemic factors

When asked what makes a leader credible, a common response is to list characteristics of the individual, such as skills, character traits, or values. However, credibility is an essentially interpersonal phenomenon that is inextricably dependent on the judgements of others. Leader credibility can be defined as the degree to which followers perceive their leader is competent and worthy of trust.[16] Because it relates to perception, leader credibility comprises a range of factors that include, but are not limited to, the personal attributes of the leader.

We often conceptualize credibility solely in individual terms rather than seeing how it is constructed within relationships. This is a result of the fundamental attribution error, the universal tendency to overestimate how much another person's personal characteristics influence their behaviours and associated outcomes while underestimating the influence of situational factors.[17] The fundamental attribution error arises in medicine when, for example, we attribute poor patient outcomes to physician characteristics without fully considering the context in which they occur.[18] Similarly, if we ask why a leader has not been able to establish credibility, we may attribute it to their shortcomings without considering how they may be undermined by factors outside their control. These could include problems inherited from their predecessors, misinformation spread by others or simply bad luck. In addition, the impact of the values, expectations, and biases of colleagues cannot be overstated. For example, significant issues exist in our systems with regard to equity, diversity, and inclusion. Establishing credibility may be impossible when attitudes are negatively influenced by irrelevant factors, such as the leader's gender or race.

When credibility judgements are informed by prejudices, it is necessary for organizational development to complement the work done by individuals. Although professional development may enhance credibility, it is important to recognize that biases exist regarding what kind of leader is, or is not, credible. For women, racialized groups, people with disabilities, and others who may be targets of discrimination, these biases can undermine their credibility in spite of everything they have accomplished or are capable of doing.[19-21] To ask them to bear the full responsibility for building their credibility is unrealistic, and education and training that does not acknowledge this is not only likely to be less effective but is also fundamentally unfair.

In their 2016 paper "The great training robbery," Beer and colleagues[22] questioned the value of training programs in which participants learn skills that they are then unable to put into practice in their jobs because of systemic factors. They emphasize that organizational development that leads to changes in policies and incentives is essential to support the transfer of learning to the workplace. Although their criticisms are not specific to leadership education or health care, the assertion that education alone is insufficient for change to occur is equally true for medical leadership. Fortunately, many organizations and institutions are recognizing the systemic effects of bias and discrimination in medicine and are taking action. Simple steps that have been taken to address these biases include establishing diversity committees,[23] education around personal and unconscious biases, and mentorship. However, recent literature argues that more can be done at a systemic level.

Kang and co-workers[24] reviewed the management literature

to identify five "myths" that perpetuate gender bias and, subsequently, five strategies for mitigating it. The authors suggest that intervening at the level of the individual has not proven effective; instead, structural solutions are needed. Interventions must target organizational and systemic change. Five solutions are proposed: treat gender equality as an innovation challenge, change institutional norms, create a culture in which people feel personally responsible for change, implement behavioural guidelines and action plans, and create organizational accountability for change. Similarly, Raj and colleagues[25] suggest that achieving gender equality in academic medicine may be attained by establishing institutional support for family responsibilities, protections against harassment and discrimination, and institutional rewards for gender equality and advancement.

We are still in the early phases of implementing equity, diversity, and inclusion in academic medicine, and future research will determine whether these proposed interventions will be successful in changing culture.

Steps to building credibility

Although formal leadership education may be helpful to some and systems change is obviously required, these will require a significant investment of time and effort. Fortunately, there are steps that individuals can take today to increase their credibility.

Improve your communication

Not surprisingly, improving communication skills is a key component of leadership education.[9,26] The importance of communication in leadership has been recognized since ancient times, with Greek philosophers such as Plato and Aristotle among those who were interested in how persuasion could be used for positive – and negative – purposes.[27] There can be no leadership without communication, and even the most capable leaders will not be effective if their ideas and intentions are not conveyed effectively.

Although there are many aspects of communication that leaders should consider, one of the most powerful and controversial is charisma. Merriam-Webster online dictionary defines charisma as "a personal magic of leadership arousing special popular loyalty or enthusiasm."[28] People with charisma possess an interpersonal style of communication that is highly effective in attracting or influencing others through symbols, emotions, and ideology.[29] Charisma is one of the key elements of transformational leadership.[16] Choi[30] suggests that charismatic leadership has three core components: envisioning, empathy, and empowerment. In one leadership education program that attempted to teach charisma, researchers identified charismatic leadership tactics, which included rhetorical techniques (such as use of metaphors) and communication skills (Table 1). Through videos and intensive coaching on the use of these techniques, trainees were able to significantly improve the ratings they received on their perceived competence as leaders.[29]

However, it is important to note that charisma can also have negative connotations, and leaders may be reluctant to focus on developing charisma because it is seen as manipulative or unethical. Some authors have expressed reservations about the "dark side of charisma," which can enable narcissistic and psychopathic political leaders to inspire blind trust in their followers.[30,31] These concerns reflect the reality that, while good communication skills are essential for establishing the credibility of capable leaders, exceptional communication skills are so powerful that they can at times compensate for a lack of other factors required for truly effective leadership and inspire trust where it is not warranted.

Attend to relationships

In addition to the persuasive effects of charisma described above, communication skills enhance the leader's capacity to build relationships. At an organizational level, empathy on the part of the charismatic leader enhances group cohesiveness and collective identity.[30] On a personal level, skilled communicators can build one-on-one relationships that greatly influence how credible they are.

When others feel that a leader is invested in them, they become more motivated to achieve organizational goals.[6] In their classic book, *The Leadership*

Table 1. Charismatic Leadership Tactics[16]

Charismatic Leadership Tactics (CLTs)	
Verbal	**Non-verbal**
Metaphors	Body Gestures
Stories and Anecdotes	Facial Expressions
Moral Conviction	Animated Voice Tone
Sentiments of the Collective	
Set High Expectations	
Communicate Confidence	
Rhetorical Devices: contrasts, lists, rhetorical questions	

Challenge, Kouzes and Posner[32] identify five practices that are characteristic of credible leaders, two of which are enabling others to act and encouraging the heart. Hasel[2] writes that "creating a safe environment and showing enthusiasm for the group and the task, combined with the ability to understand how much the individual is able to shoulder, will lead to followers feeling greater levels of trust and motivation." Warmth and empathy of leaders meets the attachment needs of individuals under stress,[1] and leaders who provide nurturing and reassurance are likely to be seen as more credible.

Insights can also be gained from research into how medical residents make credibility judgements about their supervisors. During their training, residents receive regular feedback on their performance, but not all of it is equally accurate and helpful. When deciding which feedback merits attention and which does not, learners consider not just the content of the feedback, but also whether their supervisor is credible. This determination is based partly on the clinical acumen of the supervisor, but it is also highly dependent on relational factors, such as whether the learner believes the supervisor has a positive attitude toward them and a commitment to promoting their development.[33,34] This research suggests that subject expertise is not sufficient to establish credibility especially when providing disconfirming feedback. Although superior clinical knowledge and the ability to accurately assess a learner's performance play a role, supervisors must also understand how the learners perceive them. Then, taking into consideration all the factors that influence credibility, they must take deliberate steps, such as cultivating the relationship with the resident, to build their credibility. Thus, any leader who wishes to establish credibility must not forget the importance of the interpersonal relationship, since credibility is enhanced by strong connections.

Embrace your identity as a leader

Leadership training may also enhance professional identity formation. Research into medical professional identity suggests that professional identity is established in the formative years of medical education; developing the confidence to be a good doctor is as important as developing the technical competencies.[35] Maile and colleagues[36] argue that the same is true of leadership identity; opportunities such as leading ward rounds, support and feedback specific to leadership, and formalized training must be provided early on so that leadership identity formation can occur.

Identity formation may be useful for building confidence and overcoming the insecurity and self-doubt that can occur from medical school on into practice. The term "imposter phenomenon" was first used in 1978 to describe high-achieving women who struggled to own their accomplishments and felt as though they had "fooled" their peers.[37] Imposter syndrome is common among physicians of both genders.[38] As social identity theory suggests that an individual's identity is related to their membership in groups, leadership training with peers can help to develop a strong leadership identity[39] and lessen insecurity regarding whether one is entitled to claim membership in the group of "leaders." Leaders who project confidence are then more likely to be perceived as credible by their followers.[40]

Conclusion

In their interactions with others, leaders must always be attentive to how they are being perceived. While it is easy to be focused solely on tasks and actions they must take in their roles, leaders cannot ignore the question of whether those who work with them perceive them as credible,

since this will be key to inspiring action and motivating change. Avenues to increased credibility may include skill building and formal leadership training. In addition, the literature strongly supports building credibility by enhancing communication skills, cultivating strong relationships, and embracing your identity as a leader. Unfortunately, credibility is in the eye of the beholder, and conscious and unconscious bias can limit our control over others' perceptions.

Understanding the subjectivity of credibility is important for leaders and leadership educators. Even exceptional qualifications may not be enough for leaders who are members of historically disadvantaged groups to be seen as credible. This limits the pool of potential leaders and leads to missed opportunities for better organizational outcomes. Societal change will be necessary before all capable leaders, current and aspiring, will be seen as credible. Perhaps a good place to start is with our own biases, as we are also forming opinions of others based on a variety of factors of which we may not be fully aware. In addition to planning actions to build our own credibility, we should reflect on how we determine who we believe in.

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Author attestation: Both authors made substantive contributions to the article and approved the final version.

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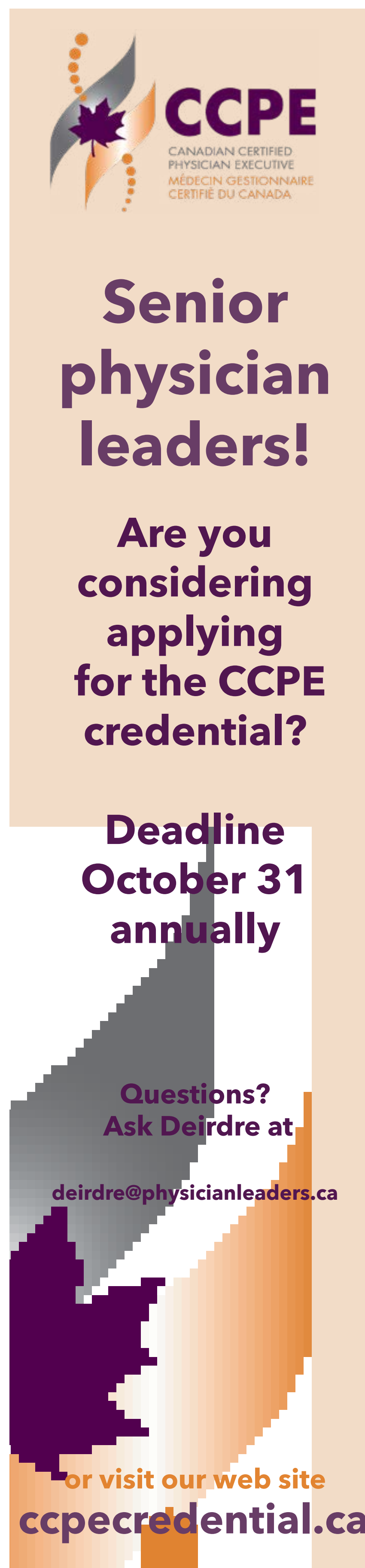
This article has been peer reviewed.



Improving physician diversity and inclusion benefits physicians and patients

Elizabeth Hillier, BSc, Kiera Keglowitsch, BSc, Marni Panas, CCIP, Blaire Anderson, MD, Sandy Widder, MD, and Debrah Wirtzfeld, MD

Note on language and bias
All authors of this article have taken implicit bias training and have based the points made here on empirical data rather than opinion. Throughout this article, the term "women" is used to refer to those who identify as women regardless of their sex at birth, to be as inclusive as possible within the scope of this project. Any person identifying as a woman can and likely does experience the discrimination outlined in this paper. We also acknowledge that concerns of transgender individuals within the health care system is an important topic in and of itself and should be further explored.

A diverse physician workforce in the Canadian health care system would result in more cultural competence, greater patient satisfaction, and improved population health. However, increasing representation and diversity does not automatically resolve issues of inequity, inequality, and discrimination. In this article, we discuss three broad areas of health care – the clinical environment, academic advancement, and leadership – that require intentional, systemic change if we are to make a lasting impact in terms of increasing the diversity and inclusion of underrepresented groups in medicine, and consequently, improve health outcomes. Inclusive and equitable practices to target pay inequity, unconscious bias, opposition to career advancement, and sexual harassment are integral to diverse physician recruitment and retention. Equity strategies and checks to remediate systemic biases in academic advancement through grant funding, academic criteria of merit for promotion, and the acknowledgment of differences of experience can be employed to improve equity in academic medicine. The long-standing culture, policies, and traditions of institutions within the medical establishment must be combated with a collaborative effort to foster equity through the engagement of academics and physicians from underrepresented minority groups, and the implementation of implicit bias training and meaningful accountability for creating a safe, equitable work environment for diverse physicians. Any proposed solution to improve equity and diversity should not be taken as a fixed principle to follow uncritically, but rather as a starting point for understanding and implementing the unique changes

required in various local contexts.

KEYWORDS: diversity, inclusion, equity, leadership, underrepresentation

CITATION: Hillier E, Keglowitsch K, Panas M, Anderson B, Widder S, Wirtzfeld D. Improving physician diversity and inclusion benefits physicians and patients. *Can J Physician Leadersh* 2021; 7(3):108-114. https//doi.org/10.37964/cr24736

A global viral pandemic, worldwide anti-racism protests, and a stance against overt sexism - each of these 2020 occurrences on their own should have been enough to give our society pause to reflect on what we value. Taken together, they should motivate us to create the changes we want to see in the world.

Over the past few decades, individual physicians, academic institutions, health care systems, and national physician groups, including the Canadian Medical Association, have committed to increasing diversity and inclusion.

Within the Canadian health care system, 2020 also brought sobering moments. In September, an Indigenous woman recorded racist slurs being directed at her before she died in a Quebec hospital. Tragically and ironically, this occurred days before the first anniversary of a report outlining systemic racism in the Quebec health care system.[1,2] A recent public health report described similar pervasive systemic racism and discrimination in British Columbia's health care system.[3] These problems are not isolated in Quebec and BC; racism in health care is a national crisis so ubiquitous that it not only impacts patient care and health outcomes, but also extends into our health systems' leadership and academic institutions. The recent events and reports are a wakeup call that there is still work to be done to improve diversity, inclusivity, and equity of patients and workers in the Canadian health care system.[3,4]

Data have shown that a diverse physician workforce results in more cultural competence, greater patient satisfaction, improved population health, and a more inclusive education and research agenda.[5-11] It also results in improved health care outcomes.

Over the past few decades, individual physicians, academic institutions, health care systems, and national physician groups, including the Canadian Medical Association, have committed to increasing diversity and inclusion. These commitments have been successful in improving some realms of diversity. Currently, over half of medical school graduates are women.[5]

Efforts have been made to increase the number of Indigenous students in Canadian medical schools.[6] Although no data are currently collected nationally, many faculties have recommitted to increasing the number of Indigenous students as a result of the calls outlined in the Truth and Reconciliation Commission's report to more accurately reflect populations being served.[6,7] The University of British Columbia has a target of filling 5% of its 300 seats with Indigenous students, and the University of Alberta and McMaster admit all Indigenous students who meet the rigorous standards of their admissions processes.[8,9] Similarly, the University of Toronto has been a national leader in implementing the Black Student Application Program, in response to a 2010 Association of Faculties of Medicine of Canada report that called for enhanced admissions processes to achieve desired diversity in the physician workforce.[10,11]

Increasing representation and diversity does not automatically resolve issues of inequity, inequality, and discrimination. Many groups still endure everyday experiences of sexist or racist jokes, sexual harassment, weaker or gendered reference letters for faculty positions, pay disparity, and higher representation in lower-paid fields of practice, despite increased diversity in the field.[12] Therefore, even as the management of the COVID-19 crisis takes priority, we must maintain a focus on improving the inclusivity and diversity of the physician workforce without reversion to previous, more familiar, modes of operating.

In this article, we discuss three broad areas of health care – the clinical environment, academic advancement, and leadership – that require intentional, systemic change if we are to make a lasting impact in terms of increasing the diversity and inclusion of

underrepresented groups in medicine and, consequently, improve health outcomes.

Clinical environment

Current models of health care delivery result in disproportionate negative health outcomes in marginalized and racialized communities. In Ontario during the first four months of the pandemic, those living in urban, ethnically diverse neighbourhoods had COVID-19 infection rates three times higher than predominantly white neighbourhoods and experienced more severe outcomes, including four times the rate of hospital admissions and twice the death rate.[13,14]

Inclusion of more women and underrepresented racial groups in medicine might help to alleviate this imbalance. Multiple studies have shown that female and racialized physicians bring added value through higher satisfaction rates, fewer emergency room visits, fewer subsequent admissions to hospital, and earlier detection of disease.[15-20] Furthermore, physicians from underrepresented minority racial groups are more likely than their peers to work in underserved communities and care for minority, low socioeconomic, or uninsured patients across all specialities and all racial groups.[21]

Despite important positive contributions to the Canadian health care system and patient care, physicians who are women and/or people of colour continue to face systemic inequity. Currently, 54% of Canadian physicians under 40 are women[22]; with a predicted even split among men and women physicians by 2030.[23] Yet, women physicians are five times more likely to experience opposition to career advancement and three times more likely to experience actions perceived to be disrespectful or punitive in the workplace when compared with their male counterparts.[15] Female physicians experience greater consequences than men for identical mistakes.[24] Furthermore, a mounting body of evidence has shown that physicians from underrepresented minorities face significant challenges in the workplace, such as sexual assault and harassment, unconscious bias, and pay inequity.[25]

The gender pay gap among physicians is not unique to Canada. A recent survey of primary care physicians in Brazil, France, Germany, Mexico, the United Kingdom, and the United States reported than women physicians earned 20–29% less than their male colleagues.[26] Remuneration disparities continue to exist after accounting for factors, such as years of practice, participation in clinical trials, number of publications, specialty, region, age, hours worked, and practice characteristics.[15] A recent Canadian study of surgeons in Ontario found that women earned 24% less than their male colleagues, when controlling for factors such as hours worked.[27]

The current schedule of benefits, fee-for-service structures, and billing codes supports higher remuneration for the styles of practice traditionally performed by men.[20] In addition, traditional referral systems may reinforce gender bias.[28-30] Different referral models, designed to increase efficiency, may also improve physician equity. For example, single-entry models create a single queue that will direct each patient to the next available provider

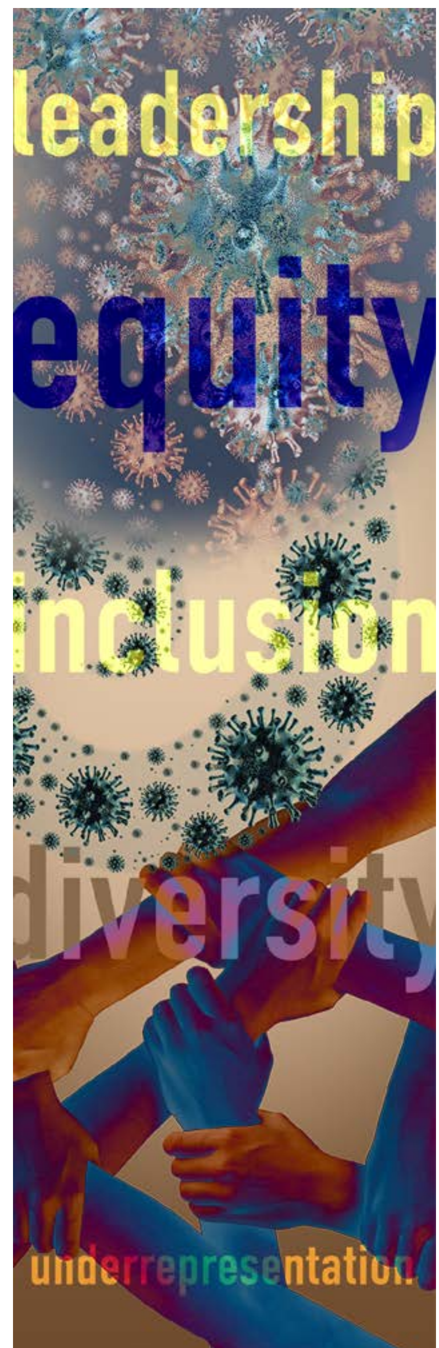
based on appropriateness and priority.[31] Team-based care allows a group of health care providers to share the responsibility of patient care; the provider who sees the patient for a consultation may not be the one to perform a procedure. Both single-entry and team-based models have been supported by providers and patients.[32,33] To be truly inclusive, however, these models must be inclusive of all of the providers' voices.

Academic advancement

Equity in academic medicine has been at the centre of public commitments by the federal government, granting agencies, and postsecondary institutions for over a decade.[34-37] Many health care bodies and faculties of medicine have set diversity targets as part of strategic plans in an effort to continue to improve diversity and inclusion.[9,37-40] The Canadian Institutes of Health Research (CIHR) published an equity strategy with the goal of identifying and remediating systematic biases in their grant system to create an equitably responsible agency for providing research funds to academic researchers.[35,41]

Gaps continue to exist. Not only do women and racial minority researchers receive less grant funding than researchers who are men,[42,43] but also, at academic conferences, women are less likely to be keynote presenters. One study found that, overall, only 21% of conference presenters were women, and only 28% of study authors were women.[44,45] Research in the United States on academic surgery has demonstrated that these disparities can be remediated through inclusion of more women among faculty and in leadership positions; for example, women who obtained National Institutes of Health research funding were more likely to come from institutions with a high proportion of faculty members or chairs who were women.[46]

Despite a recent increase in the number of women, racially diverse learners, and junior faculty in the positions of assistant or associate professors, this increase has not addressed the large gap that remains in academic leadership. A UNESCO report addresses what has come to be known as the "leaky pipeline" phenomenon.[23] That is, there is a progressive increase in gender inequity with each increasing stage of education and academic career advancement. The hierarchies of privilege inherent in the "meritocracy" of academic medicine, with their critical roles in determining promotion and appointments, have been established through histories of sexism, racism, and colonialism. As such, they are likely to reflect a limited perspective on what is considered valuable and to be imbued with implicit biases.[47] Therefore, what serves as "merit" in medicine should be re-evaluated to acknowledge more inclusive and diverse assessments and understanding of excellence, as suggested by Razack et al.,[47] such as, the participation of diverse individuals in the development and assessment of



new excellence criteria; an equity check intrinsic to the process of excellence assessment; and explicit, purposeful discussion of the foundational values and assumptions underlying excellence and merit criteria as they pertain to specific uses.

It is also important to address the harmful argument of "colour-blindness" or inability to see racial

differences. This perspective is built on the notion that problems of inequality can be solved by seeing everyone as the same. What is problematic and dangerous about this approach, however, is that it fails to understand the role of unconscious bias in shaping perceptions and interactions. Furthermore, colour-blindness creates an impossible situation in which the very racial inequality the perspective is trying to address cannot be discussed or assessed because it would inherently involve "seeing" racial differences. Although race or gender, or any identifying feature, should never be used in assessing academic or professional performance, it is important to acknowledge differences and remain aware of how those differences influence inequities.

Leadership

Long-standing culture, policies, and traditions that result in inequity in institutions are built into the foundation of the medical establishment. Systemic institutional change is brought about by those who lead the institutions into the future.

Crucial in a collaborative effort to foster equity in medicine is engaging and consulting with academics and physicians from underrepresented minority groups, to understand their lived experiences, capacity to aspire, and opportunities to succeed.[12] The implementation of implicit bias training and meaningful accountability for creating a safe, equitable work environment for diverse physicians is a strategy that has previously resulted in success.[48] Allocating a certain percentage of funding to underrepresented groups is one way to hold academic and health care leadership to account for increasing diversity and inclusivity and move toward equity. For example, the CIHR has taken steps to increase diversity and inclusivity through the allocation of 4.6% of the COVID-19 Rapid Research Funding to Indigenous health research, to align with the Canadian Indigenous population (4.9%).[41,49] This example demonstrates how renewed commitments to diversity, equity, and inclusion must be met with new, intentional action.

Current leaders must be willing to create countermeasures to mitigate barriers to inclusion.[50] Tools for the retention and promotion of underrepresented physicians and faculty have been proposed by Doll et al.[50] and encompass a range of strategies:

- providing continuing education for faculty development
- becoming allies and advocates for underrepresented faculty through mentorship and leadership programs
- implementing institutional structural support in the form of time, funding, and clear expectations for new faculty
- dedicating local and national funding for underrepresented minorities

Conclusion

Diversity and inclusion policies and statements of support are ubiquitous today at nearly every organizational level. However, decades after national taskforces and diversity efforts began, there remains a striking lack of women and minority physicians in leadership positions.[51-53] The racial and gender inequity that is currently found in Canadian health care is a symptom of the historic design of the clinical, academic, and leadership environments. An equity-by-design model, supporting diverse physicians

and their inclusion, will lead to the enhancement of clinical practice and patient outcomes.

Any proposed solution to improve equity and diversity should not be taken as a fixed principle to follow uncritically, but rather as a starting point for understanding and implementing the unique changes required in various local contexts. For the health care system to address the issues of inclusion and diversity outlined in this paper, dedicated, informed, and ongoing action must be taken across all levels of organization and leadership. The COVID-19 pandemic should be perceived, not as a barrier, but as an opportunity for positive health care system restructuring.

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Author attestation: EH, MP, BA, SW, and DW were involved in the design, concept, and initial research for the article. EH, KK, and DW drafted the manuscript. All authors contributed to and edited the article and approved the final version.

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CANADIAN MEDICAL ASSOCIATION

CMA sending notice to federal political parties: Health is the ballot box issue in 2019

With mounting evidence that the health care system is failing Canadians, the Canadian Medical Association (CMA) is putting federal political parties on notice: It's time to put health back on the agenda. In its policy platform published today, the CMA is calling for decisive actions to address access to care across the country, seniors care and youth mental health — along with asking parties to commit to implementing pharmacare and making climate change a priority, recognizing its impact on the health of Canadians. MORE

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PERSPECTIVE

Learning to take care of ourselves

Nicole Boutilier, MD

Earlier this month, I read about the suicide death of Dr. Karine Dion, a 35 year-old Canadian emergency physician. I was so unbelievably sad to read this, and her husband's description of her death as pandemic-related. He said that she felt like she wasn't doing her part, like she was letting people down. For her, the stigma of being a physician who needed help was too much.

I couldn't stop thinking about her after I read that.

Was it because I was once a 35-year-old emergency department physician? Or was it because I haven't stopped worrying about all of you since the pandemic began and how I feel responsible for keeping you safe and well? The words her husband used just felt too familiar.

Physicians carry these things in their heads and their hearts. We somehow learn that we are supposed to work when we are ill, care more about our jobs than we do about our health, and then worry about the burden we place on others with our own illness. We forget that we are human with all the emotions, frailties, and vulnerabilities that come with it.

I want you to know that I have my own personal stories as I am sure most physicians do. I hope that any of you who are feeling alone or ashamed or stigmatized will feel comfortable to reach out for help if you need it.

I once miscarried in a call room during an ER shift and went back to work. During another injury, I was in a wheelchair – non weight bearing on both legs – had a deep vein thrombosis, and still held meetings in my living room. On other occasions, I didn't give myself time to grieve over the loss of a loved one or just carried on during an acute situational crisis in my personal life as though I had no choice.

In these stories, the theme is the same. With the physical illnesses, I kept quiet until I had no choice. I felt so guilty to miss time, as we were understaffed. I never once considered that I might need the time to recover and take care of myself. I worried about what people would think if I took time off, or that I was not doing my part.

The difference in the last scenario was that in my personal distress, unlike my physical health issues, I didn't share. I kept quiet and internalized the shame. As a result, there was no outpouring of support or visits. There were no check-ins or quiet moments of understanding. I was too afraid of

what others would think about me, and I felt that I should be at work no matter what else was going on in my life.

I don't know how Karine felt and I don't want you to think my examples are in any way comparable to what she or anyone is going through. I shared because I want physicians to know that it's okay to not be okay. It's okay not to be perfect. It's okay to show your vulnerability and talk about your fears. It's okay for the pandemic to be testing the limits of what you can emotionally handle.

As Karine's family wants us to know, there is no shame in asking for help. Talk to your colleagues. Ask your leader for a few minutes of their time. Reach out to each other. Check in. Take part in a wellness seminar. Notice if someone is struggling and ask how you can help. Let people you care about know that you are there for them.

Let's show that we are learning that, as a profession, we can do better at taking care of ourselves and give ourselves permission to be simply human. Tell someone your stories and what you hope would be different for them.

Stay safe. Stay well.

Author

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Leading through COVID-19: understanding and supporting grief and loss

Ethan Kutanzi, Kathleen Fraser, MC, and Debrah Wirtzfeld, MD

The COVID-19 pandemic has created an environment in which grief and loss are being experienced collectively. This grief can lead to increased burnout, decreased productivity, and increased likelihood of job turnover. With health care workers already facing increased risks because of their frontline pandemic responsibilities, it is important to provide leaders with knowledge and tools to support their grieving team members. Understanding the Kübler-Ross grief model, as well as grief-related concepts such as anticipatory grief, disenfranchised grief, moral injury, and complicated grief, will help leaders provide normalizing support. This approach may include building and fostering trusting relationships, engaging in self-reflection, participating in supportive conversations, and, when appropriate, sharing information around grief-support resources. There is no universal timeline for the resolution of grief; mental health impacts can last for many months and can continue to resurface for years. During the COVID-19 pandemic, we educated health care workers around the issues of grief and loss by focusing on the relationship side of the Wheel of Change, interviewing people with expertise in the area, holding town hall meetings, and hosting online "coffee and chat" sessions for physicians. We recommend relying less on policy development and, instead, focus on strengthening workplace relationships and creating opportunities for connection and discussions.

KEY WORDS: COVID-19, grief, leadership, support resources, Kübler-Ross, leading during COVID-19

CITATION: Kutanzi E, Fraser K, Wirtzfeld D. Leading through COVID-19: understanding and supporting grief and loss. *Can J Physician Leadersh* 2021;7(3):118–124. https://doi.org/ 10.37964/cr24737

"We can't work on [it]; it works on us," Sigmund Freud said, speaking of grief.[1] No matter where or who we are, all of us experience grief. When speaking about grief and loss, we often think of death, but grief encompasses much more than reactions to death. Grief is the "normal and natural reaction to any type of loss."[2] Whether that loss be the death of a loved one, the disappearance of one's customs or traditions, or changes to daily routines, it triggers many emotions that affect our well-being in multiple ways. Because of its enduring presentation, grief can feel bigger than our efforts to manage it.[3] In addition, given its individualistic presentation, we will perceive our own loss as the worst.[4] The process of

grieving often provides support as we endeavour to integrate the loss (and change) we have experienced into our new normal.[5] As we grieve, we may look to find meaning in the relationships or experiences that we have lost.[4,5] This meaning-making, which is now suggested as an additional sixth phase in the Kübler-Ross model, can fuel personal growth toward a place of strength and resilience.[5,6]

Grief doesn't stay contained within one's personal space; grief comes to work with the griever.[7] If a grieving worker does not receive support, they will have an increased chance of experiencing "compassion fatigue,… increased burnout, absenteeism, decreased productivity, and increased likelihood for turnover."[7,8] With health care workers already facing increased risk of these variables in the work environment,[9] it is prudent to provide leaders with knowledge and tools to support grieving team members. In this paper, we explore the components of grief that health care workers may encounter and how leaders can effectively support those they lead during this challenging time.

Shining a light on the grief experience — important foundational considerations for leaders

The Kübler-Ross grief model

As described by Kübler-Ross, grief has five stages: denial, anger, bargaining, depression, and acceptance.[4] A depiction of what these might look like in a pandemic can be seen in Figure 1.

It is important to remember that these stages are non-linear and not everyone is in the same phase at the same time.[4,10]

Denial presents as a lack of acceptance of the loss. Anger may be toward others, oneself, or a spiritual being. When bargaining, the griever may experience regret and ask themselves "what if" statements. Bargaining can also involve negotiations with a "higher power." Depression can present as sadness, emptiness, loss of motivation, and, at its extreme, suicidal ideation. Acceptance refers to the griever's awareness that although the loss has occurred and had an impact, the griever will be okay. David Kessler, who worked with Kübler-Ross, later added one additional phase to this model: finding meaning.[6] For Kessler, this refers to finding meaning in the relationship to whom or what was lost. A COVID-19 related example could be, "The quarantine brought the members of my family closer together."

Application of Kübler-Ross' grief model to COVID-19

The COVID-19 pandemic has created an environment in which grief and loss are being experienced by everyone. For some, the loss may be the passing of a loved one. For others, it may be loss of their regular routine, their job, or their social interactions. Collectively, everyone in the world is experiencing the loss of the old normal.

By applying the Kübler-Ross model of grief, we can gain insights into our reactions. Denial may present as not accepting the seriousness of COVID-19. Anger may be toward regional health authorities and the measures they have put in place, which affect our workplace. It may even manifest as displaced anger directed toward those we care for the most, be they patients, family members, or friends. When bargaining, we may say to ourselves, "If I can just go visit my friend, I won't interact with anyone else outside of work for the next week." Depression can present as feeling like our efforts at work are futile or in a disruption of sleep cycles. Finally, acceptance may present as the recognition that, although we can't visit friends and family as we did in the past or interact with patients as we used to, we can find other ways to have meaningful interactions.

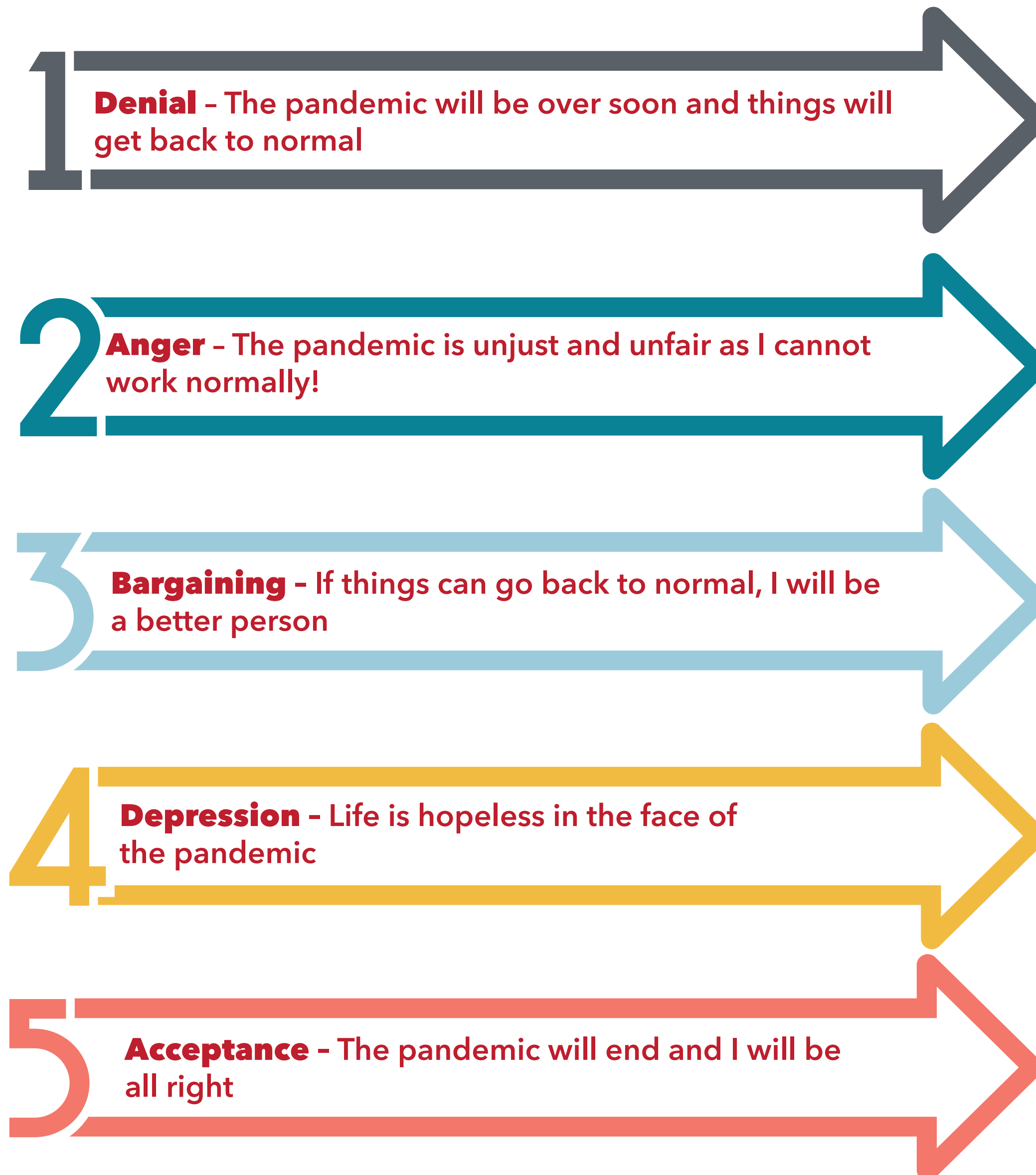
Anticipatory grief

Anticipatory grief is based on anxiety and fear for the future.[10] We anticipate and start to grieve losses that have not yet happened. Our anticipated losses may be something physical — an object or person, such as a parent with a life-limiting illness. We can also anticipate the loss of future opportunities or important rituals, for example, attendance at a ceremony or event.[4,5] For health care workers, anticipatory grief may sound like, "What if I am exposed and put loved ones, colleagues, and friends at risk?"[5] The concept is much broader than just fear for the potential loss of a loved one.

Disenfranchised grief

Disenfranchised grief comes when our losses occur within a context

Figure 1. Kübler-Ross Five Stages of Grief



that is not seen by our culture as a legitimate loss.[1,2,5] It is often seen in situations where the loss and grief are not the result of death.[5] For example, someone going through a divorce or family estrangement may feel that their loss does not warrant feelings of grief, as the individuals involved are still alive. Disenfranchised grief may also be relevant in situations where loss is seen to be a normal part of daily experience; in this situation, people may feel increased pressure to meet expectations that they remain professional and "keep it together."[1] This form of disenfranchised grief can be seen in the health care environment. For example, an ICU physician who experiences grief after the death of a patient may feel that their grief is minimized, or not validated, as our culture sees patients' deaths as an expected and normal occupational experience.

Moral injury

Health care workers often experience moral distress, which can lead to moral injury. Moral distress may be caused by "actions…, inactions…, or other people's actions or inactions."[11] As an example, during the COVID-19 pandemic response, moral distress can be caused when health care workers are unable to provide care to those who need it because of external factors, such as restrictions on visiting multiple care sites or lack of hospital resources to meet the needs of patients.[5,12,13] Physicians might also experience moral distress when they feel

compelled to work despite feeling unwell.

Complicated grief

At times, an individual's internal capacity is insufficient to deal with their grief and they may require additional support. This presentation of grief is termed complicated grief, where the symptoms of grief interfere with one's ability to meet the requirements of daily life for a prolonged period.[14] Although grief is very individualized, there are predictors for complicated grief, including childhood adversities and a previous history of anxiety disorders.[15] If leaders see team members who appear to require additional support, they can provide information and/or referrals to mental health professionals.

Leading our teams through loss and grief

Given that grief is a universal human experience, amplified during COVID-19, leaders benefit from understanding ways to approach grief and loss within their team. Discussing grief in the workplace is often avoided, which can accentuate the harm caused by the initial loss.[1] Self-reflection is critical. It is tremendously important to understand our own experiences with grief, as well as our thoughts, feelings, beliefs, and biases about how to manage loss and grief.[2,5,16] These crucial reflections also allow leaders to be appropriately vulnerable with their teams, which may help normalize grief by showing team members that it is an accepted and encouraged practice to ask for understanding and support.

Building and fostering trusting relationships as an integral part of our workplace culture is a proactive practice. Having these relationships firmly in place before a crisis strikes will enable grieving team members to seek "just in time" help.[2,16] Through transparent and frequent communication, leaders develop team trust, which also reduces the fear and anxiety that accompanies anticipatory grief.[5]

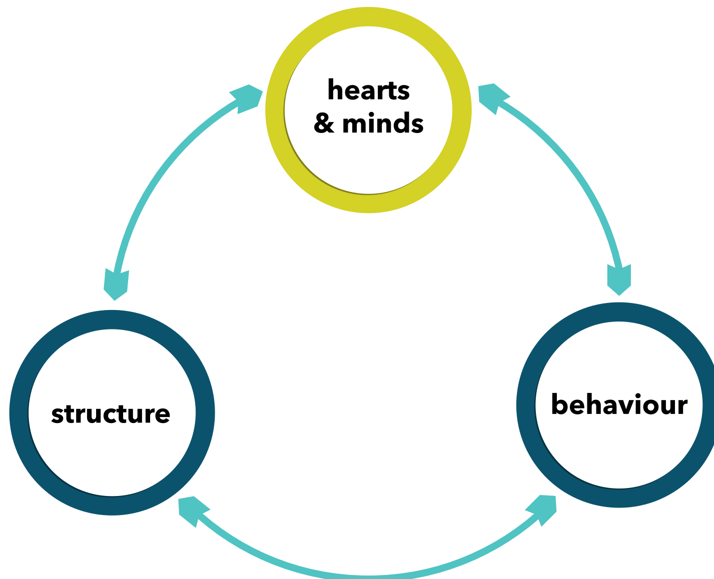
As grief is an individual experience, every griever will exhibit different signs.[2,5,17] It is important that leaders understand the complexity and variety of grief processes, so that, as team members experience them, leaders can help name and normalize them. Leaders can reference the Kübler-Ross model as a framework for potential grief responses. Grievers will demonstrate experiences that look like both progression and regression, and, at times, it might appear that grief is absent.[1,16] During the COVID-19 pandemic response, it is safe to assume that almost all humans are experiencing some loss and grief.[4,5] Team members acting or reacting differently than they ordinarily do may be an important indicator that they would benefit from some grief-related leadership support.

When engaging in grief-related support conversations, leaders may find the following principles helpful.[2,4,5]

- Be conscious of both privacy and safety of the space when determining where the conversation will take place.
- Allot adequate time for discussion.
- Resist the urge to problem-solve the griever's loss during the conversation.
- Realize you are helping them by listening and creating an uninterrupted safe space.
- Be curious in your dialogue, by asking open-ended questions, such as, "Can you tell me more about that?"
- Acknowledge and validate the griever's experience, without comparing it to your own.
- Understand that each griever is the expert in their own grief.
- Recognize that you are not a grief counsellor. Although you are providing an open space to listen, be aware of available grief support resources in your community and be prepared to share those with your colleagues early in the conversation. These supports may include those provided through medical associations, universities, or formal peer-to-peer support programs where individuals have acquired specific training around supporting peers.

There is no timeline for the resolution of grief. Emotional impacts can last for many months and can continue to resurface for years.[1] Leaders can offer valuable support as grieving team members seek a restorative balance between processing grief and moving forward with resiliency – in other words, finding meaning. Finding

Figure 2: Wheel of Change depicting the three domains involved in guiding change.[20]



meaning does not suggest that we find meaning in the death or loss. Rather, that we can find meaning in the life of, or in our relationship with, the person we lost or, in the case of non-death losses, recognize transformative opportunities to create something new. The recent COVID-19 selfie project at the University Health Network is an excellent example of this.[18] The purpose of this initiative was to provide meaning by showcasing the team's evolving strength and dedication during a challenging time as well as to commemorate the story of their service.[18,19]

In times of loss, leaders can facilitate and support their team as they navigate into a "new normal," the re-imagination phase. Leaders can hold space for both grieving and creating, by balancing empathy for their team's losses with inspiring hope by embracing the possibility of what comes next. Throughout this approach, leaders should adopt effective change management techniques through engagement, communication, and consistent messaging. In health care, physicians have used telehealth to increase workplace safety by ensuring that patients can quarantine and seek medical support. Some patients will want to continue with changes that were necessitated by the pandemic, whereas others will want to return to the "old way." By sticking to the principles and guidance above, leaders will be a helping hand for both team members and patients who are navigating grief.

Our approach on educating leaders around these issues

Robert Gass created the Wheel of Change model as a facilitative tool to guide transformational change by considering three domains: hearts and minds, behaviour, and structure (Figure 2).[20] The model emphasizes that change often requires a focus on relationships and discussion rather than a shift in policy and procedure. It demands a focus on the human side of change and evokes the principles of change management.

This is the approach we have focused on during the pandemic. We educated physicians around issues related to loss and grief, rather than invoking a strictly systems approach. In other words, we did not create any new policies or processes. Rather, we focused on relationship components of our environment, through interviews with grief experts in town hall meetings and virtual "coffee and chat" sessions.[5]

On 30 April 2020, a virtual conference was held where a leader with focused education and experience in grief and loss (KF) shared her knowledge through non-didactic teaching, responding with empathy as difficult questions were posed by the participants. The leadership practices outlined in this paper were reviewed and discussed in a safe setting. Because of her expertise, KF was able to be responsive to the participants' questions. Some of the questions included: "Can you talk a little bit about loss and grief of individuals and teams when they describe feeling a sense of moral harm from not being able to care for their patients as usual?" and "Can you talk about anticipatory grief, and how leaders can support their teams when it is present?"[5] The facilitator shared her own leadership vulnerabilities in addressing loss and grief with team members and this created an atmosphere that allowed the

participants to feel safe in asking their own vulnerable questions.

The essential aspects of the domains of behaviour and hearts and minds represented by the Wheel of Change were used by JT Sanford in her leadership following the loss of a faculty member at JMU School of Nursing, who passed away as a result of an infection while receiving chemotherapy in 2015.[16] She focused on creating an atmosphere of care and compassion.[16] She dedicated time and courage to telephoning each employee individually to inform them of their colleague's death. She also solicited the support of the university's counseling centre. She visited classes of students who were impacted by the loss, providing opportunities to discuss feelings, as well as offer support. After the funeral service, faculty met with students and debriefed. By approaching this situation with a relationship focus, loss and grief were effectively managed and supported.

A leader can use the Wheel of Change model to support change during the pandemic in a way that recognizes both relationships and structure.[20,21] Key considerations for each domain can be found below.

Hearts and minds

- Create a common purpose within teams, through open dialogue and a vision for a successful future.
- To foster a sense of belonging, allow everyone to be involved in the change process. This will include spaces for creative thinking outside regularly scheduled meetings and without structured agendas.
- Allow people to identify limiting beliefs or concerns without fear of reprisal by creating safe spaces. This may involve the use of facilitators or consultants.
- Recognize the stages of grief and support team members through active listening and early referral to resources to support grief.
- Provide education around emotions and emotional intelligence to yourself and team members.

A leader can use the Wheel of Change model to support change during the pandemic in a way that recognizes both relationships and structure.[20,21]

Behaviour

- Establish clear norms and behaviours for how the change will take place that are accepted by everyone and support the diversity and inclusion of group members.
- Communicate widely with respect to the change by using whatever media the team agrees on.
- Be transparent in what is expected of all members of the team to reach the vision of future success. Ensure that everyone knows their role in getting the team through the pandemic and that there is adequate time to achieve goals.
- Provide a forum for bidirectional feedback through the creation of safe spaces.
- Provide adequate support in the form of mentoring, educating, and coaching.
- Provide an environment where people can "fail" and be supported in using this as a learning experience.

Structure

- Develop appropriate and documented strategies, including performance metrics and impact assessments, to support the vision of a successful future.
- Adequately resource and support the structures for necessary change. This will require an assessment of the role of existing structures to adequately support the change.
- Develop and implement processes that support the change initiative. This will require an assessment of the role of existing processes to adequately support change.
- Ensure that the change supports the values of the team and that core competencies are present. If additional core competencies are necessary, these must be supported.

Through careful consideration of each of the three domains, a leader and their team can understand and support grief and loss during the pandemic and develop a vision for a successful future.

Conclusion

Returning to Sigmund Freud's

words, "We can't work on [it]; it works on us," although we cannot work on grief, we can have effective leaders who enable the griever to progress through its stages. After first self-reflecting on the meaning and impact of grief in themselves, leaders can then turn outward and use the concepts and strategies discussed in this paper to approach grief in their teams compassionately and effectively. Whether the grief is anticipatory, disenfranchised, or evolves into complicated grief, effective leaders can have a lasting impact on individuals facing painful losses.

Our approach to educating leaders about grief and loss focused on the relationship portion of Gass' Wheel of Change. Although some policies and structures needed to be developed or modified to support and accommodate health care workers during the pandemic, a focus on building relationships and providing safe spaces for discussion was equally important. This balanced model allows leaders to guide their teams and organizations through the darkest night.

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Sponsorship and funding: None

Author attestation: All authors contributed to the conception and design of the work, drafting, and revisions to reflect intellectual content; Dr. Wirtzfeld approved the final version to be published. All authors agree to be accountable for all aspects of the work related to accuracy and integrity.

Training and certification for hospital medicine programs support the essential role of hospitalists for complex multi-morbid patients in acute care

Vandad Yousefi, MD, William Coke, MD, and James Eisner, MD

The current COVID-19 pandemic has resulted in significant strain on acute care delivery in Canada and around the world. It has highlighted the importance of hospitals rapidly increasing their resources to meet the capacity demands brought on by a disruptive change. Hospital medicine teams have become central to many acute care sites, caring for increasingly complex hospitalized patients. We believe that the ongoing implementation of hospitalist teams of generalist physicians is critical in ensuring that health care organizations are well positioned to provide high-quality care in uncertain times. We also highlight the need for adequate training and certification for physicians who aim to work as part of such programs.

KEY WORDS: hospital medicine, hospitalist, training programs, certification, COVID-19

CITATION: Yousefi V, Coke W, Eisner J. Training and certification for hospital medicine programs support the essential role of hospitalists for complex multi-morbid patients in acute care. Can J Physician Leadersh 2021;7(3):125–131. https://doi.org/10.37964/cr24738

In the last few decades, the Canadian health care system has seen seismic changes in the care of patients in hospitals. With the rapid proliferation of new knowledge and technology, the management of many clinical conditions has changed profoundly, often with dramatically improved outcomes. Much of this success has occurred because hospital care has become increasingly interprofessional, relying not only on the expertise and input of highly specialized physicians, but also on the unique knowledge and skills of other health care professionals.

This shift to team-based care is the result of a number of systemic drivers; patient populations, care providers, and the health care system have rapidly evolved in the face of increasing medical acuity, care complexity, and the emergence of novel illnesses. Arguably the greatest pressures have resulted from the rapidly rising prevalence of chronic illnesses.[1] Patients with one or more chronic medical conditions have become the largest group requiring admission to acute care hospitals.[2-4] As the population continues to age, the challenge of caring for complex patients is expected to continue.[5-7] During the COVID-19 pandemic, for example, patients with co-morbidities and increasing age were most likely to require hospital admission and have a longer length of stay.[8]

Health care providers have also experienced significant changes in their scopes of practice over the past decades, including ongoing trends toward subspecialization and the expanding roles of various health professions.[9-11] Physician burnout and the need

for better work–life balance is increasingly being recognized as a priority, particularly among newer graduates with new (and perhaps healthier) attitudes and expectations.[12] At the same time, the health care system is facing ongoing resource constraints, with growing pressures to control the rising costs of services.

Within this evolving environment, many medical admissions no longer fit into discrete diagnostic categories or even specialty areas. Physicians serving as most responsible providers (MRPs) for hospital patients today are working under unprecedented pressures to effectively diagnose and treat patients presenting with a range of acute and chronic conditions, while at the same time responding efficiently to meet ongoing capacity issues. Surgeons and subspecialists are increasingly finding it difficult to manage complex patients admitted under their care with multiple comorbidities outside their areas of expertise. Community-based family physicians and specialists are similarly facing increasing difficulties in continuing to serve as MRPs for complex patients while maintaining busy office practices.[13,14] The net effect is a steady decline in the number of physicians who provide traditional MRP coverage for medical inpatients across the health care system.

In response, over the past two decades, a growing number of organizations across Canada and internationally has been adopting new models for physician coverage. These models (broadly referred to as "hospital medicine") involve groups of physicians ("hospitalists") working in teams to provide 24/7 MRP coverage for medical inpatients.[15] Many hospital medicine programs also support the care of increasingly complex patients admitted to other services (most commonly orthopedics, neurosurgery, and psychiatry) through formal or informal co-management agreements.[16]

During the COVID-19 pandemic, many patients were admitted to acute care with a hospitalist as the MRP.[17-19] Having hospitalist teams already established as an integral component of the multidisciplinary care model demonstrated that

hospital medicine programs are valuable in the acute care of complex patients.[19] For example, across the network of acute care hospitals operated by Fraser Health in British Columbia, hospitalists quickly became the default providers for non-critically ill hospital patients with COVID-19 pneumonia, caring for 80% of inpatients across 10 facilities.

Having hospitalist teams already established as an integral component of the multidisciplinary care model demonstrated that hospital medicine programs are valuable in the acute care of complex patients.[19]

The value of hospital medicine programs

Studies have found that hospital medicine programs in the United States are associated with shorter length of stay, higher patient satisfaction, variable impact on select clinical measures of quality, and similar performance regarding mortality and readmissions.[20,21] Studies from Canada also suggest that, although hospitalist care does not result in shorter length of stay, it may be associated with reductions in mortality and readmissions.[22-24] In both countries, hospital medicine programs have generally demonstrated that they can not only provide effective inpatient coverage, but also produce real savings for the health care system without compromising standards of care, quality, and patient satisfaction.

Hospital medicine programs can also facilitate standardization of services based on best evidence/best practices and promote interprofessional collaboration. By allowing more predictable workloads and, in turn, better work–life balance, they can also help prevent burnout and facilitate physician retention.[25-28] Moreover, hospitalist programs can play an important role in improving teamwork and help retention of other health professionals in the acute care setting.[29]

Finally, hospitalists have increasingly become key players in a range of non-clinical activities, such as organizational leadership, quality improvement, and teaching.[28,30-32] For example, 80% of hospitalists surveyed in Canada in 2012 indicated that they participated in non-clinical activities in addition to caring for patients.[33]

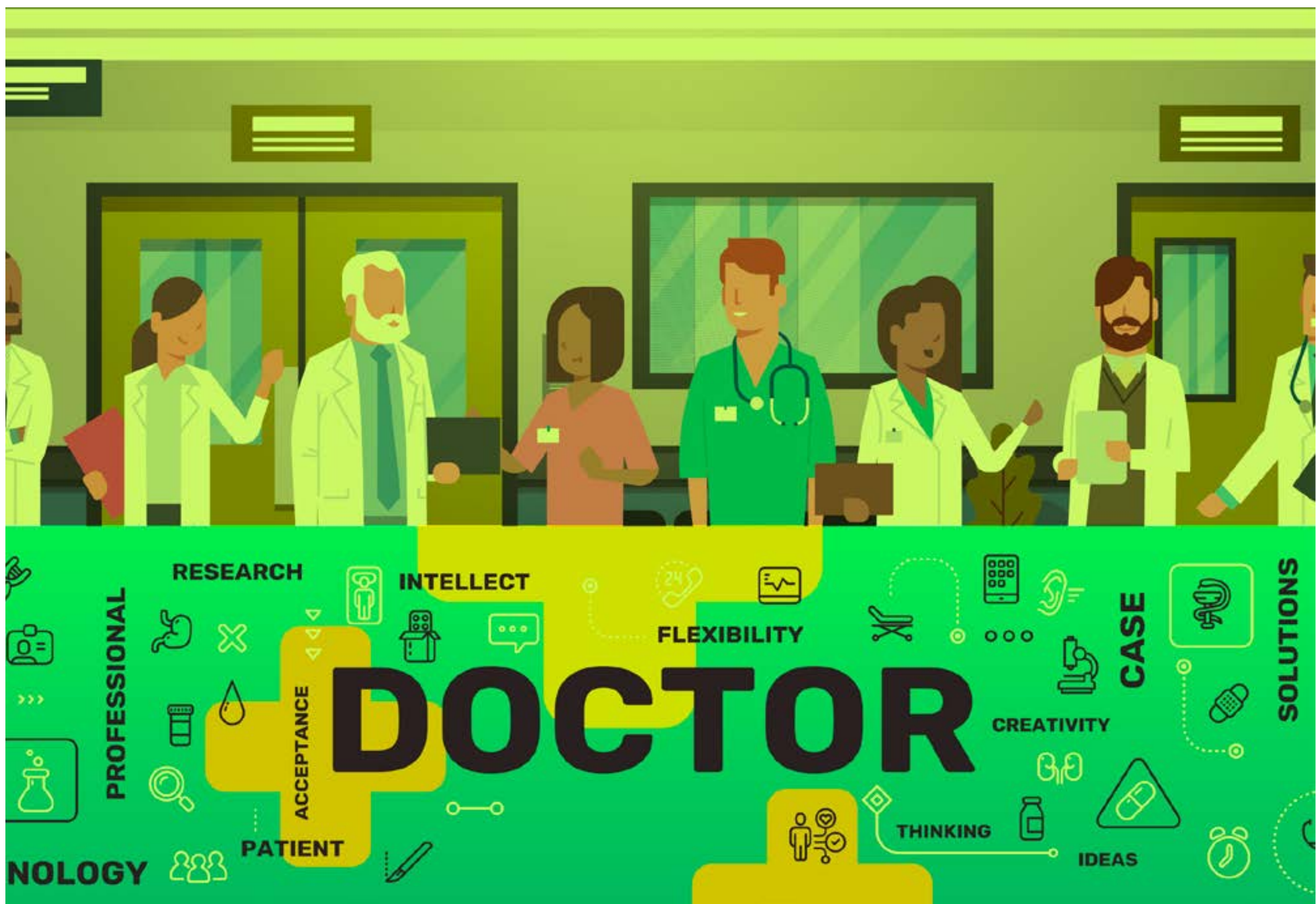
Generalist physicians function as hospitalists

To be effective, most hospital medicine programs require physicians who can function as generalists and are able to care for patients with a wide range of acute and chronic medical conditions. Both internal medicine and family medicine specialties have the potential to provide the training and experience needed to acquire the competencies of hospital-based medicine.

Hospital medicine programs in Canada are often made up of internists and family physicians working collaboratively as part of the same teams. For example, at Trillium Health Partners in Mississauga, Ontario, 55 internal medicine hospitalists currently work with 15 family medicine hospitalists to provide MRP coverage for over 13 000 acute medical admissions per year, involving up to 400 inpatient beds at a time. With admission volumes continuing to increase markedly year after year, recruitment for additional hospitalists (from both training backgrounds) will continue. At Fraser Health in British Columbia, hospitalists are responsible for over 50 000 admissions per year. Most are trained initially in family medicine; however, in recent years, an increasing number of internists have joined the program, and now account for almost 20% of new recruits. In the Calgary Zone of Alberta Health Services, the hospital medicine program is responsible for over 14 700 admissions a year, or 61% of all medical admissions in the zone. The program is staffed entirely by family medicine hospitalists. Over the past 6 years, admissions to the program have shown progressive increases in comorbidity and complexity, requiring routine collaboration with internal medicine providers to help ensure optimal care.

Hospitalist programs enhance system leadership

Hospitalists are uniquely positioned to take on leadership roles within the acute care setting. The enhanced on-site availability of hospitalists, where physicians are present continuously in the



hospital throughout the day (and, in many cases, located in specific care units) is a defining core feature of the hospital medicine model.[25] Although this enhanced presence and engagement may help explain improvement in outcomes associated with the introduction of the hospitalist model, it has also been shown to result in improvements in collegiality and interprofessional collaboration.[34,35]

As a result, hospitalists have the opportunity to not only better integrate into interprofessional acute care teams, but also to take on a leadership role within the care unit.[36] Indeed, in some organizations, hospitalists have assumed formal leadership roles as part of physician–nursing dyads with significant positive impact on care outcomes.[37] More broadly, hospitalists have also been increasingly involved in transformation throughout their organizations, for example, by leading quality improvement and patient safety initiatives.[38] These leadership functions correlate well with the leadership domains described in the LEADS framework: Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation.[39]

Hospital medicine is an evolving specialty

In 2012, Smith and Sivji[40] identified a number of pressing challenges in the evolution of hospital medicine in Canada. These included the development of core competencies for hospital-based generalist care, clarification of scope of practice, measuring outcomes associated with hospitalist care, the need for formal training, and formal certification in hospital medicine.

Since then, there has been progress on some of these issues. For example, in 2015, the Canadian Society of Hospital Medicine (now the Society of Hospital Medicine – Canada Chapter) created a document defining core competencies required for those caring for hospital patients with acute general medical conditions.[41] Similarly, various organizations have attempted to define hospitalist scopes of practice by developing guidelines and interdepartmental agreements[42]

or through credentialing and privileging standards.[43] In addition, an increasing number of publications have aimed to assess outcomes associated with hospitalist care.[22-24] However, challenges remain with regard to hospitalist training and certification in Canada.

Hospital medicine practice needs training

Based on our collective experience, we believe there will be an ongoing need across the country for physicians with comprehensive generalist training to provide MRP coverage for hospital patients, not only to fill current vacancies, but to also meet future physician resource requirements.

General internists in Canada complete extensive clinical training in inpatient care, including substantial experience on inpatient and critical care units. As a result, they are well trained to provide comprehensive care for inpatients. However, with fewer than 3500 general internists in active practice across the country, compared with over 42 000 family physicians,[44] the latter constitute the largest group of generalists working as hospitalists.[45]

In contrast with general internalist training, that for family medicine is shorter and is focused on primary care in the community, including chronic disease management and preventive health care. We have found that gaps in knowledge and expertise between internal medicine and family medicine hospitalists clearly diminish over time as physicians gain clinical experience by focusing their practices on inpatient care. However, some family medicine trained hospitalists can initially face a steep learning curve, and many are reluctant to participate in acute care as they feel underprepared after graduating from residency. If core family medicine training remains unchanged in duration and educational focus, there will be a growing need to provide additional enhanced training related to inpatient care for family physicians who wish to participate in hospital medicine services.

Precedents for certification and formal recognition of medical specialties, defined by how care is delivered as opposed to historical organ-body systems, have already been established.

Indeed, a number of postgraduate hospital medicine training fellowships currently exist across Canada. These include non-accredited clinical fellowship programs that are administered by various academic hospitals[46,47] as well as some category 2 enhanced skills programs offered by a few family medicine university departments that provide additional training opportunities for graduates.[47-50] However, progress has been limited, and a standardized curriculum and many more training programs are still urgently needed to ensure that physicians wishing to pursue careers as hospitalists have the needed clinical competencies to take on these challenging roles regardless of their initial training.

Hospital medicine should have certification

Similarly, there is a pressing need for formal recognition and certification of hospitalists. The lack of formal certification for hospital medicine, particularly for family medicine graduates who currently make up the majority of the workforce, continues to be a major barrier to developing sufficient training opportunities and for motivating family physicians who want to practise as hospitalists to pursue additional training.

Precedents for certification and formal recognition of medical specialties, defined by how care is delivered as opposed to historical organ-body systems, have already been established. Both emergency and critical care medicine employ physicians from diverse training backgrounds. Like hospital medicine, these specialties have evolved around the setting where care is provided. More recently, palliative medicine has emerged as a specialty encompassing physicians with backgrounds in internal medicine, family medicine, and other disciplines.

Close collaboration between the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada has allowed for the development of certification and common standards, in turn helping to define these evolving fields. To date, this kind of cooperation among relevant stakeholders has

been elusive for hospital medicine. Until it exists, establishing sufficient training programs to meet the growing need for physicians with the knowledge, skills, and experience required to work in hospital medicine programs will remain a challenge.

A national certification program for hospital medicine can be an important enabler of more widespread and standard training for prospective hospitalists.

Conclusions

As the complexity of inpatient care increases, the need for qualified generalist physicians who can help both the patients and the health system navigate hospital admissions has become important. The COVID-19 pandemic made the valuable role of hospitalist teams even more apparent. To meet this demand, postgraduate family medicine training programs must either more fully incorporate acute care opportunities or implement dedicated training fellowships to allow for acquisition of the core competencies and skills that have been identified to be critical in providing care to general medical patients in hospitals. A national certification program for hospital medicine can be an important enabler of more widespread and standard training for prospective hospitalists.

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Author declarations: Vandad Yousefi is co-founder and CEO of Hospitalist Consulting Solutions, Inc. William Coke and James Eisner have nothing to declare. This work is unfunded.

All authors contributed substantially to the conception and design, the acquisition of data, or analysis and interpretation of data. All drafted the article or revised it critically for important intellectual content and approved the final version.

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This article has been peer reviewed.

PERSPECTIVE

Embracing plan B

Sharron Spicer, MD, FRCPC, CCPE

It was a day that started as any other for our family, but by bedtime our world had changed. Cancer had entered our home as an unwelcome house guest.

In early September – the first week back to school – our morning routine was not yet smoothly choreographed. As we were all heading out the door with lunches and backpacks in hand, my husband gave himself a self-congratulatory pat on the belly. "Can you feel this?" he asked me. Anticipating a hernia or some other minor malady of middle age, I had him stretch out on the couch. His flanks spilled over their previous margins. *Why hadn't I noticed this girth before?* I ran my hand over his abdomen. In the right upper quadrant, just below his ribcage, a grapefruit-sized mass rose up to meet my fingers. This was no hernia. We both instinctively knew that this was bad. It was a quiet drive to the family doctor's office that morning. By afternoon, we were sitting with a radiologist in a small room, listening to his opinion. Everything on the differential diagnosis was a malignancy.

It would be another four weeks before we had a definitive diagnosis. Bloodwork, multiple scans, and a biopsy confirmed an aggressive lymphoma. The recommended treatment was chemotherapy with a stem cell transplant in first remission. With this approach, his prognosis for recovery is good. As I write, he is nearing the end of his chemo and preparing for his "Day 0" of transplant. He will be, as the doctor puts it, part of the new cohort for "rewriting the textbooks" on this cancer.

Having worked in pediatric palliative care for over a decade, the world of oncology is not totally foreign to me. I have been witness to suffering caused by cancer as well as other life-limiting conditions in childhood. Like the families of my patients, we had not signed up for this journey, yet here we were on an unexpected detour – an exit ramp from the highway, not shown on the map.

How has the experience of cancer affected me as a physician? It has been a deeply profound and personal journey. I humbly share with you some of my experience, hoping that it might encourage you in some way.

I made the decision early to take a leave of absence from my work as a physician. My husband had been the *de facto* at-home parent for the past few years and I knew I was needed by my family. Granted, this transition was made easier because my clinical load was small with some recent changes to my practice. I am grateful to my department head and colleagues who graciously pulled together to cover for me during my absence.

For the initial weeks after finding the tumour, my husband and I were both deeply introspective. Having cleared our work schedules, we lingered over morning coffee with conversations about life's meaning, suffering, regrets, and hopes. As the fall mornings grew crisp, our dog happily accompanied me on many long walks. My emotions were labile, as was my outlook about the future. I kept oscillating between the positive and negative; for every good bit of perspective, there was a balancing negative and vice versa. "It's cancer… but he's otherwise healthy." "It's already spread… but he's young." I was overwhelmed at the thought of losing my spouse. I felt like I was in a Credit Karma commercial, waiting for the dial to land on a number that would somehow define our cancer score. I still don't have that Credit Karma score, but with time and reflection, I have become more comfortable with uncertainty, not needing to grasp at the outcome but allowing it to unfold as I sit with palms open to what comes.

Jann Arden, the singer, songwriter, and author, wrote these words following the death of her father and while caring for her mother

with advancing Alzheimer's:

> *Losing people is what happens to humans. Like the constant drip of an old tap. To try to avoid that loss only leads you to avoid true happiness. When you don't argue with grief like a drunk husband, much good can come from its stillness. Reflection is so important, time alone, reckoning. You can't be your best self when you're submerged in useless busy-ness. Most people choose not to stop long enough to think about how they feel… Change is taking hold of me and morphing me into a much better version of myself, and that morphing comes with some discomfort. And yes, sometimes it feels like I'm being crushed by that boulder.*[1]

As time went by, we became more pragmatic. There were appointments to keep and medications to organize. We moved from the questions of "why" to "how." Our philosophic questions were replaced by a more simple understanding that shit happens, let's deal with it. We resolved to keep cancer as our "day job," trying not to have its influence spill over into family time. We kept up with friends and hobbies. When he was feeling well, my husband hiked and played badminton. To his credit, even when he was breathless with a flight of stairs, he continued to do the family's laundry. And I took seriously the instructions to thoroughly clean the house before his transplant. It is amazing how cathartic cleaning can be!

At times, I have wondered how I might manage if I lose my partner – not just emotionally, but with practical household things. My husband, sensing this, became a patient teacher as he narrated for me the subtleties of changing car tires and fixing furnace fans. Friends and family have walked alongside. We have had our freezer filled with food, words of encouragement sent in cards and e-mails, and offers fulfilled of dog-walking and errands to be done. We have appreciated all the thoughts and prayers made on our behalf. And I know that somehow everything will be okay.

At the centre of our thoughts, always, is our teenage daughter. More than anything, our goal is to have her continue to be a teenager without shouldering adult burdens. No doubt cancer will cast its shadow upon her, but we do everything we can to create memories of happy times. Adolescence is a developmental stage that is profoundly egocentric – necessarily so to enable the launch toward independence – and her initial questions reflected her worries of how her world might change. Frightfully honest, she would ask lots of things that

began, "If Dad dies…": "will we move? will we be poor? can we get a puppy? will you remarry?" (No, no, yes, let's just stick with a puppy.) Over time, she has become more indifferent as she integrates this new reality into her life.

I have learned much about supporting myself and my family from Facebook COO and author Sheryl Sandberg. Known by many for her 2013 best seller, *Lean In: Women Work and the Will to Lead*, she went on to write *Option B: Facing Adversity, Building Resilience, and Finding Joy* following her husband's sudden death in 2015. Along with some funny words of advice for responding to other's bad news ("When life gives you lemons, I won't tell you a story about my cousin's friend who died of lemons"), she describes how she fostered resilience for herself and her young children. As she says,

> Option A is not available. So let's just kick the shit out of Option B. Life is never perfect. We all live some form of Option B.[2]

Whether you are living a Plan B, or C, or D, or walking alongside someone who is, I hope that you, too, find support along the way. Taking time away from work has been a part of my coping and resilience. It has allowed me to be fully present for my family and for my own reflection and growth. I do not know what my future holds, but I know I will be a healthy, stronger, and more compassionate medical doctor when I return to work.

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Sharron Spicer, MD, FRCPC, CCPE, is a pediatrician in Calgary. Her husband and daughter gave their permission to be referenced in this article, although Sharron did receive a scolding from her daughter for her use of profanity.

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This article previously appeared in Vital Signs, a publication of Calgary and Area Medical Staff Society, in April, 2010.

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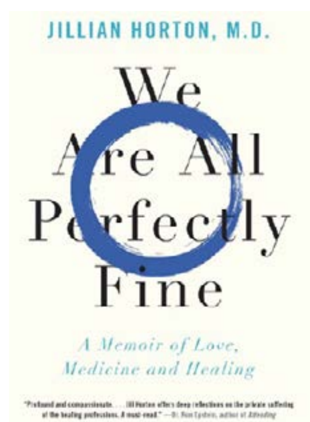
BOOK REVIEW

Since last fall, many books have been published by Canadian physicians. We chose four to review in this issue: *We Are All Perfectly Fine* by Jillian Horton; *Without Compassion There Is No Healthcare* by Brian Hodges, Gail Paech, and Jocelyn Bennett; *Hardwired* by Robert Barrett and Louis Francescutti; and *Stress in Medicine* by Nina Ahuja.

We Are All Perfectly Fine: A Memoir of Love, Medicine and Healing

Jillian Horton, MD
HarperCollins, 2021



Reviewed by J. Van Aerde, MD, PhD

The title of Jillian Horton's new book is misleading, because, simply, we are not fine at all. Horton is a multi-talented internist from Winnipeg, who has a Joni Mitchell-sounding CD to her credit, as well as many podcasts, columns in the *Globe & Mail*, *Macleans*, and the *Los Angeles Times* – and now a 300-page book.

In a journey of self-discovery, Horton explores her fatigue, disappointment, and misery in medicine and how her own mental models and painful experiences are as much at fault for her pain as "the system." Horton loves medicine; she is grateful for the privilege of serving patients, relieving their suffering, and being present for them. The disappointment and misery are related to medicine as an institution – how it eats up its trainees and physicians, no matter what gender, colour, or age.

Using what initially seems to be the reluctant experience of a five-day retreat as the common thread throughout the book, Horton goes back and forward in time and space, connecting her own struggles with the deep conversations and stories of physicians she met during that week. In that supportive environment, Horton peeled away the many layers of her moral distress, guilt, and self-blame, shaking her belief that she was not the parent she should or could have been, the perception that she didn't do enough for her patients, and the unfairness of what happened to her siblings and parents. All of that, plus the never relenting demands on her as a clinician and academic administrator, had pushed her into a pit full of burnout symptoms.

Writing this book was part of Horton's own healing and rediscovery. It also serves as a mirror, not only for each of us as individual physicians, but also for all of us as a profession. Reading the book compels us to go on our own journey of self-discovery, to find the demons of perfectionism and work addiction that never allow us to really "turn off" unless we are willing to accept the guilt that comes with that.

The richness of metaphors and descriptions create images and bring feelings to life. For example, "How many times in our lives do we have a pager that felt like a live grenade?" Horton said she was fine in so many different ways and so many times when she wasn't fine, that she came to believe it. As a result, she was not really in her life anymore and needed to find a way back into it. Her autobiography is for all physicians who have suffered in silence and need to find a way back into their own lives.

In the process of self-discovery, Horton understood the importance of self-compassion, particularly after she came to realize that the only person she seemed to be totally unwilling to help was herself. Her learning helps us realize that medicine should be neither a hero's journey nor a Stanford prison experiment. Both

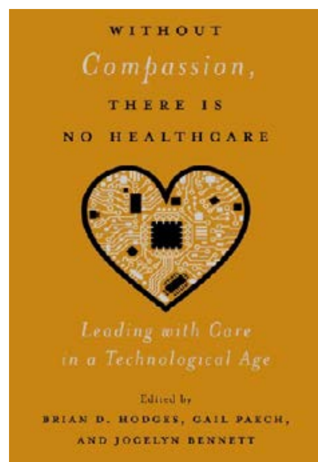
mental models explain the high rate of burnout among physicians; the culture and the structure of the health care system and our own self-concepts as physicians lead to burnout. This means that we cannot change the system without dealing with our own beliefs and behaviour, but also that mindfulness alone can never fix systemic and organizational malformations in structure and culture.

The book finishes with a reflection on the times before and during the COVID crisis: "These are frightening times, when we are all struggling to keep the pieces of our lives from shattering into fragments, wondering what's left if they do shatter, and how we will ever return to the life we had before. We're never, ever going back. The minute we accept this is when our next life begins." This is one of the most important quotes of the book. It applies to any complex adaptive system – from the individual human who learns and changes continuously to the natural and human-made complex systems transforming and adapting in a never-ending process.

Listen to a CSPL podcast interview of Dr. Jillian Horton with Dr. Van Aerde
https://leading-the-way.simplecast.com/episodes/interview-with-dr-jill-horton
Dr. Horton will also be a masterclass speaker at the 2021 Canadian Conference on Physician Leadership
https://physicianleadershipconference.com/ccpl2021.html

Without Compassion, There Is No Healthcare: Leading with Care in a Technological Age

Brian D. Hodges, Gail Paech, and Jocelyn Bennett (editors)
McGill-Queen's University Press, 2020



Reviewed by J. Van Aerde, MD, PhD

More than two dozen authors have contributed to *Without Compassion, There Is No Healthcare*. They explore and champion the importance of compassion from many angles, including artificial intelligence, virtual care, patient engagement, equity, relationships, burnout, leadership, education, and systemic compassion.

Compassion means "suffering with" and comes from the Latin "com" (with) and "pati" (to suffer). That means that compassion requires human presence; it is a relationship. If we value presence, it becomes problematic when technologies distract, displace, or diminish humans in their connections with each other. Compassionate care has always been vulnerable when threatened by the constant imperative to be efficient, the mountains of scientific publications, and the rapid expansive logic of automation. That vulnerability is now bigger than ever. The authors make a strong argument that when compassion is diminished, health care becomes ineffective or even harmful to those who receive treatment, as well as those who provide it.

This book makes us rethink many of our assumptions, beliefs, and mental models. The definition of compassionate care itself is challenged. We assume that we practise compassionate care, but the book asks us to think again. By whom was compassion defined and how does it apply to different situations? It was defined mostly by those at the giving end of health care, mostly without various situational contexts in mind, particularly inequity. What does compassion mean for those who were not involved in that definition, and is the care then truly experienced as compassionate?

Compassionate care has four elements: being aware of suffering (others and self); the knowledge or cognition of that suffering; the feeling of how that suffering is experienced by the other, i.e., empathy; and the

action to relieve the suffering. The difference between empathy and compassion is the action. The integrated understanding of the physical, biochemical, physiological, psychological, mental, social, cultural, and spiritual aspects of the other is an additional key element in compassionate care in the health care setting.

The changes in professional work in health care, which had started before and were accelerated by the COVID-19 crisis, will likely run deep, extending beyond routine tasks. They will disrupt the very foundation of the professions. After it is all over, will AI play a meaningful role in listening empathically, understanding deeply, or offering comfort? And if technology can't do that, perhaps not ever, then how can it serve us to improve our relationships, our compassion, and our care? If compassion is fundamental in health care, then what deployment of human abilities and what technologies together will be most effective? Can AI ameliorate relationship-centred care and, if so, how? What are the implications for stress on the providers who are already stressed by EMRs? Will we need AI engineers as team members? What would be the impact on our professional liability insurance?

The connections between relationships, compassion for self and others, and burnout are described with the pandemic in the background. The current epidemic of burnout among health professionals is described as largely driven by diminution of human contact in our work environment. Relationships are integral to fostering resilience and protection against burnout. Health care work will face an enormous crisis if there is continued erosion of human presence and interaction. The physical distance between professionals and the people they care for has been growing, as more and more technologies become intermediaries between clinician and patient. It started with the stethoscope, followed by the X-ray machine, then MRIs, and now the computer for virtual appointments. What is the effect on the patient, on the relationship, and on clinicians' own well-being?

The book finishes with compassionate leadership – what it takes to lead oneself, others, and organizations to make compassion a way of being within a safe work environment. Finally, embedding compassion and compassionate care into the structure and culture of health care organizations is also explored.

The book would have been more complete with a final chapter on how to change our complex health care system to see compassion in all its corners, levels, and connections.

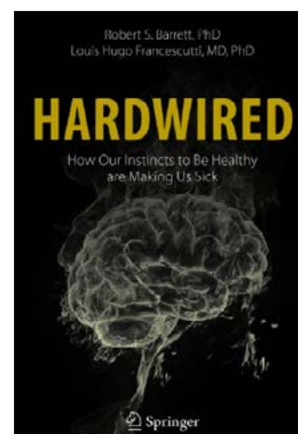
Our biggest challenge is to decode the foundational elements of health care that will remain true, now and after the pandemic, even if AI takes over specific tasks of delivering that work. This book is a must read.

Dr. Brian D. Hodges will be a keynote speaker at the 2021 Canadian Conference on Physician Leadership **https://physicianleadershipconference.com/ccpl2021.html**

Hardwired: How Our Instincts to Be Healthy Are Making Us Sick

Robert S. Barrett and Louis Hugo Francescutti
Copernicus Books, 2021

Reviewed by J. Van Aerde, MD, PhD



In *Hardwired*, Robert Barrett (PhD, behavioural and group dynamics) and Louis Francescutti (MD, PhD, emergency and preventive medicine) explore why our evolutionary predetermined habits and fixed-action patterns, intended to protect cavemen, are now negatively affecting wellness and even longevity in modern humans. Although inequity is part of the wellness decline, the decline has even more to do with behaviour. The authors provide plenty of

evidence suggesting that we have entered a public health emergency in which our physiological and psychological well-being are failing to keep up with the fast pace of societal and technological change. Our survival instincts served us well until sometime in the last century. More recently, particularly in the last decade, those same hardwired survival instincts have been working against us as they have become immersed in an intoxicatingly rich environment of overstimulation and overindulgence. To survive, evolution linked instant gratification with items we needed to survive. But how does our biology deal with a new environment (in the western world) where stimuli are never ending, where the offerings of food and social bonding are endless?

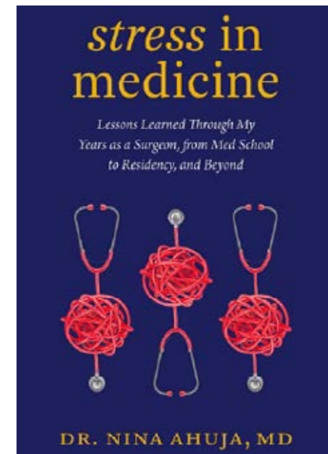
With a richness of examples and evidence-based references, Barrett and Francescutti describe how our behaviour makes hospitals dangerous places and how our nutrition-related cravings affect our health negatively. Some less well-known information is found in the chapters "Raising children on war, cartoons, and social media" and "Are we hardwired for risk?" For those who tend to skip introductions to books, please read the very well written introduction summarizing the content of this one.

Building adaptive solutions to these modern challenges requires a combination of social and medical awareness. First, we need to understand why we do the things we do. Only after acquiring that awareness can we take action, holistically, by seeing our social and biological worlds as an integrated complex system.

Humans have a prefrontal cortex, the executive part of our brain. It allows us to control our self-destructive urges, by being aware, and by planning and strategizing to manage them. It is our way of overcoming short-term urges to achieve long-term goals. It is the evolutionary part of our brain that can help us reverse the recent destructive trend in health and wellness. The question is, do we have the will to use that uniquely human capacity to postpone immediate gratification for future health and wellness?

Stress in Medicine: Lessons Learned Through My Years as a Surgeon, from Med School to Residency and Beyond

Nina Ahuja, MD
Docs in Leadership, 2020



Reviewed by J. Van Aerde, MD, PhD

This small book is practical and contains reflections from Nina Ahuja based on her experiences during residency, in her personal life, and as a clinician and established academician. She provides many gems to reflect on, particularly for the emerging physician leader who is looking for something that resonates.

She developed her own framework for dealing with the stresses we physicians feel in professional and personal life. Her mnemonic ADMIT stands for: adapting to new ways, doing the work, measuring success, introspection, and transformation. The book finishes by highlighting the importance of a social support system. A quick worthwhile read.

Author

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

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