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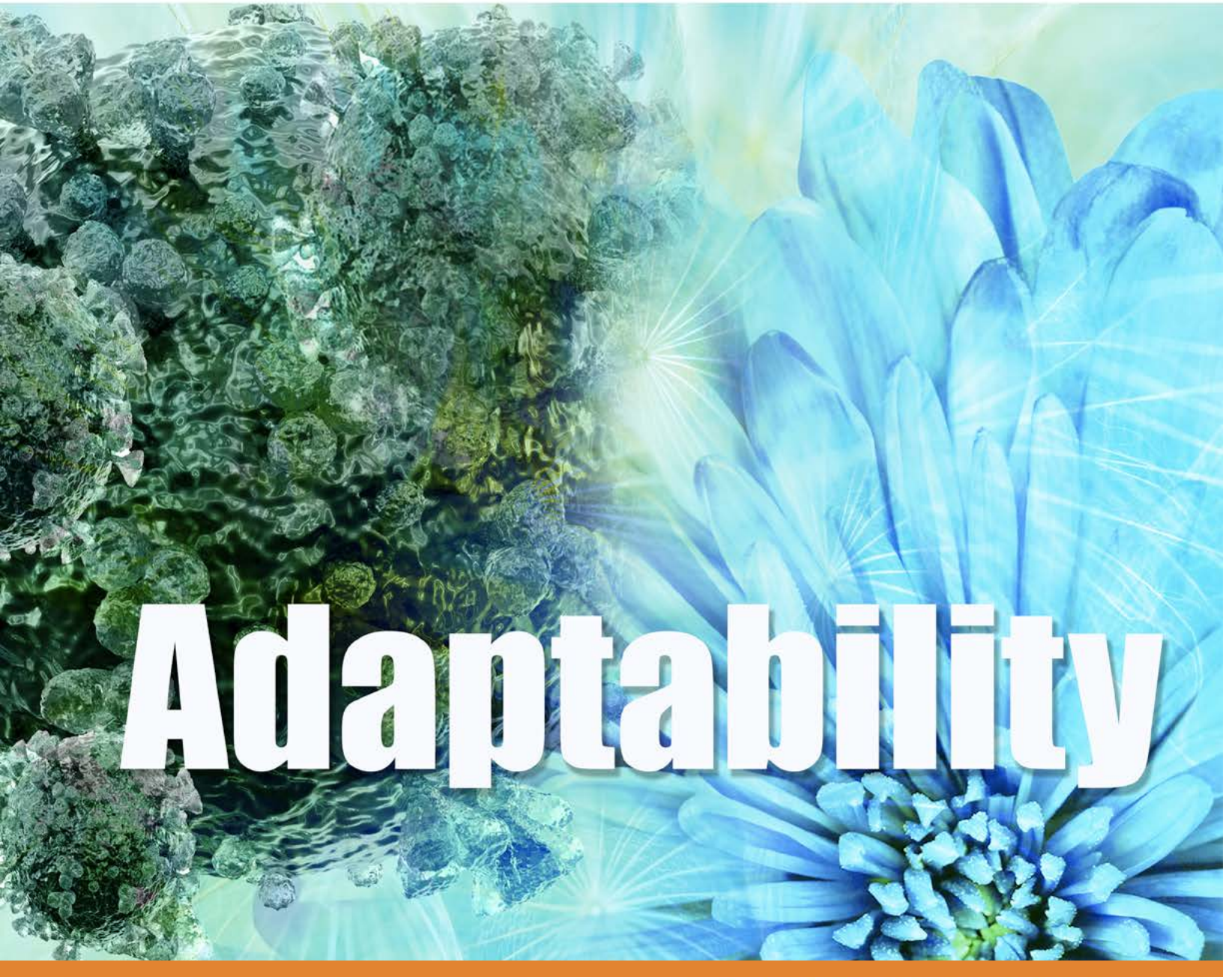

Adaptability

In this issue

CSPL Canadian Society of Physician Leaders
SCLM Société canadienne des leaders médicaux

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EDITORIAL

Pandemic emergence dysphoria

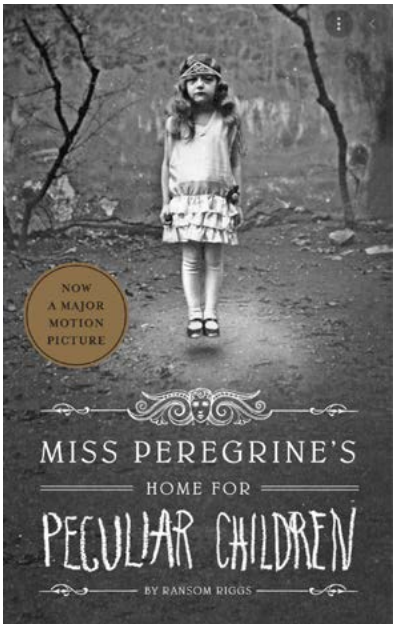
Sharron Spicer, MD, FRCPC, CCPE

I love leadership books. Sitting on my bookshelves, bold and stoic, they silently cheer me on through the challenges of leading. Sometimes I even open them up and read them! My mentors and fellow book-lovers, Dr. Johny Van Aerde and Dr. Rollie Nichol, have recommended many titles over the years. My collection grows faster than my ability to keep up.

Unfortunately, during the COVID-19 pandemic, many of those potentially inspiring books have stayed put. The effort to read about leadership when immersed in it is sort of like reading a camping manual inside a leaking tent. Instead, I have escaped pandemic reality by reading fantasy novels.

One of my favourite rediscovered books is Ransom Riggs' 2011 debut novel *Miss Peregrine's Home for Peculiar Children*, also released as a movie in 2016.[1,2] Each peculiar character has his or her own unique charm, "a recessive gene, carried down through families" that bestows upon them a supernatural ability. In a situation not unlike our pandemic experience, the main characters are trapped in a time loop that resets every 24 hours. And, as though forecasting the end of our pandemic, the movie theme song plays over and over: "There's a new world comin'."

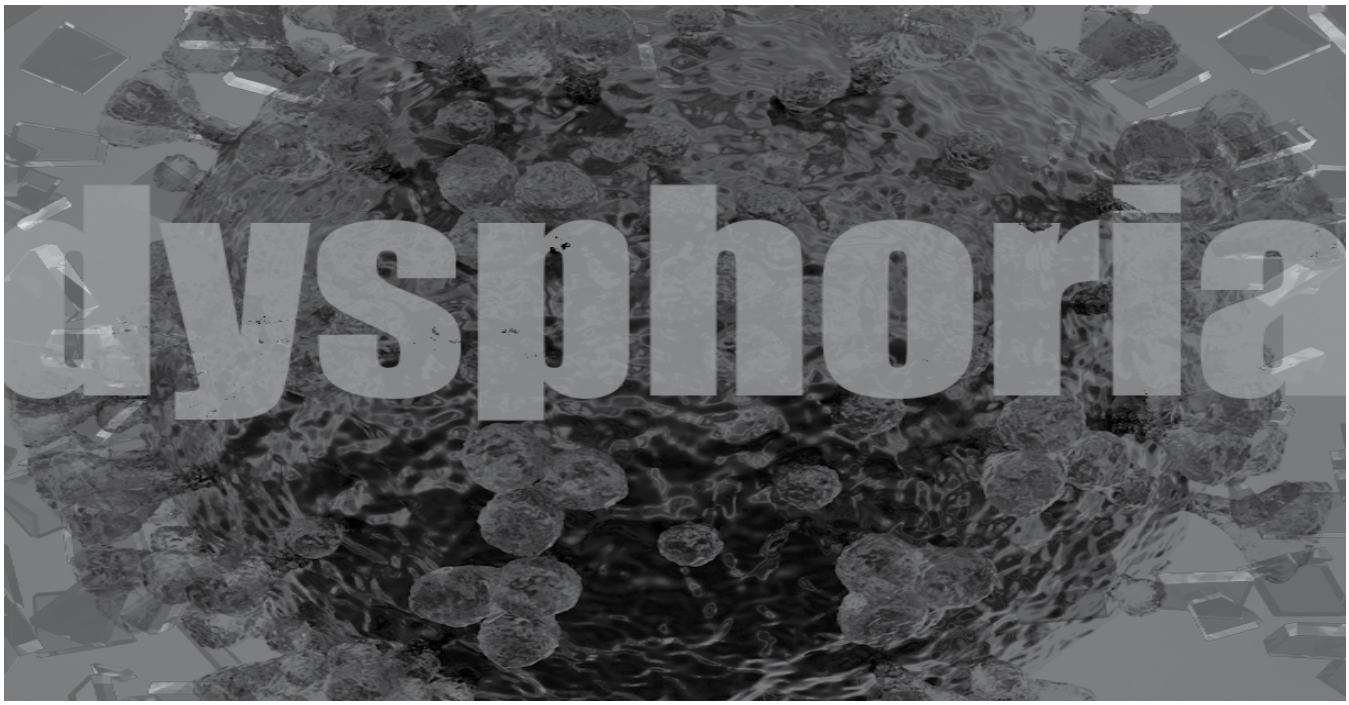
For us, as for Miss Peregrine's peculiar children, the new world will not be the same as the old one. Our pandemic experiences, both collective and individual, have affected us in ways that will shape our futures. We have witnessed suffering from illness and death, often exacerbated by the inequities already borne by those who are most vulnerable. We have humbly watched as racism – past and present – has been exposed in our systems of health care, housing, education, employment, and policing. Traumas over multiple settings and through generations have been revealed. The mood, as we emerge from this pandemic, is not entirely celebratory; for many of us, the moral residue of the past



18 months has left us with disquiet, a kind of "pandemic emergence dysphoria." Like the delirium that sometimes arises when emerging from general anesthetic, feelings of confusion and agitation accompany our emergence from the COVID-related restrictions. We are uncertain how – or if – we will return to "normal."

In Riggs' 2014 sequel, *Hollow City: The Second Novel of Miss Peregrine's Peculiar Children*,[3] he describes the sombre mood of the characters as they escape their tortuous time loop and enter a new reality.

> We rowed out through the harbor, past bobbing boats weeping rust from their seams… We rowed past the old lighthouse, tranquil in the distance, which only last night had been the scene of so many traumas… Finally, we rowed past the breakwater and into the great blank open, and the



glassy surface of the harbor gave way to little waves that chopped at the sides of our boats.

I heard a plane threading the clouds high above us and let my oars drag, neck craning up, arrested by a vision of our little armada from such a height.

This world I had chosen, and everything I had in it, and all our precious, peculiar lives, contained in three splinters of wood adrift upon the vast, unblinking eye of the sea.

Mercy.

I think back to how we coped as we entered the pandemic. We adapted. And we have continued to adapt. Sometimes more successfully than other times, but we have learned as we go how to do the things that are important. As medical leaders, this has truly been a time of adaptability as we have navigated complex and sometimes chaotic environments. Although our experiences may differ, I hope that we are all motivated to build a better post-pandemic world.

In this issue of CJPL, we share with you various experiences showing how leaders have responded to changing circumstances and evolving needs. Our articles highlight the importance of social connection: one shows how a group of hospital physicians created a peer support network and a virtual "physicians' lounge" during the pandemic, and another describes how to intentionally build a network of professional connections. We show an example of leaders supporting residents in their education and mental well-being. We also see a new perspective on how leaders might identify and support physicians struggling with attention deficit hyperactivity disorder. Two timely book reviews round things out with readers' insights: *Unconventional Leadership* and *The Psychology of Pandemics*.

I hope you enjoy this issue. I wish you all a safe and happy summer. And who knows – I may just open up a leadership book or two!

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Postgraduate medical education during the COVID-19 pandemic: lessons learned and calls to action for medical education leaders


Leanna S. McKenzie, MD, and Amonpreet K. Sandhu, MD

The COVID-19 pandemic has led to a rapid transformation in the delivery of postgraduate medical education, causing unexpected effects on the learning experiences of residents in training. Program directors, as educational leaders, are relied on to adapt an established curriculum and clinical experience into a virtual world while navigating the limitations imposed by the pandemic. In this article, we focus on the impact of the dramatic changes to medical education delivery on both learners and leaders and examine the challenges and successes of the new strategies employed. A reflection of the importance of leadership in medical education is discussed, along with a review of the strategies that have emerged as successful and worthy of integration into our new medical education paradigm.

KEYWORDS: medical education, COVID-19, pandemic, postgraduate, program directors

CITATION: McKenzie LS, Sandhu AK. Postgraduate medical education during the COVID-19 pandemic: lessons learned and calls to action for medical education leaders *Can J Physician Leadsh* 2021;7(4):145-152 https//doi.org/10.37964/cr24740

The global COVID-19 pandemic has significantly disrupted postgraduate residency medical education. After decades of minimal change to the basic structure of residency, a seismic shift in educational delivery occurred in a matter of weeks. The need to adhere to social distancing rules while learning and providing patient care has led to an emphasis on distance education, a delicate balancing of service and education, and the emergence of new and creative methods for medical teaching and learning. In Canada, educators and clinicians have been preparing for the advent of competency-based medical education for several years, unaware of a widespread societal change that was forthcoming.

Challenges of residency education during the pandemic

The initial months of the pandemic led to a variety of changes to residency education. In-person teaching sessions, such as academic half-days and procedural skills and simulation sessions, were cancelled; outpatient clinic experiences were diminished or cancelled outright; certifying high-stakes examinations were deferred and reinvented in a remote format, all leading to significant emotional upheaval for trainees. Residents were on leave from clinical duties because of isolation or illness, out-of-province electives were cancelled, and research projects were stalled. All aspects of residency were affected. As educational leaders,

program directors (PDs) faced an insurmountable workload as they adapted their program administration to a virtual format while managing concerns about the wellness of their trainees. These duties weighed heavily on PDs as they faced parallel demands in clinical medicine and heightened personal responsibilities.

Further unanticipated challenges began to emerge as the COVID-19 pandemic progressed. With elective procedures cancelled during high COVID-19 peaks, residents in surgical programs found procedural opportunities lacking.[1-3] Outpatient experiences were dramatically reduced, and learners found it difficult to engage in virtual clinics. As educational experiences transitioned to electronic platforms, challenges in communication and interaction between resident physicians and staff became noticeable.

Although physician educators may have initially adapted to the transition to socially distanced education, a number of questions arose. Are the residents gaining adequate clinical experience? How has the pandemic affected their ability to learn team management skills? How has the significant decrease in outpatient interaction affected their training? How are residents coping in terms of emotional well-being?

As physician educators and leaders, we were curious about the impact the pandemic exerted on our residents and PDs. More specifically, we sought to identify how the changes in education delivery and clinical environments have affected learning and wellness for both residents and PDs.

Methods

To assess the educational and leadership impacts of the pandemic restrictions at our institution, a tertiary care pediatric hospital in Calgary, AB, Canada, we administered an informal, voluntary online survey (Survey Monkey; Momentive Global, San Mateo, Calif., USA) to pediatric residents, subspecialty residents, and PDs in September 2020. This survey was considered part of a rapid quality improvement project and, therefore, based on a Project Ethics Community Consensus Initiative (ARECCI) ethics screening tool; thus, formal ethics board approval was not sought.[4] The survey was distributed online via the deputy department head of education, and participation was completely voluntary and anonymous.

The aim of the study was to examine current perceptions of changes in the residency training program made in response to the pandemic. At the time of the survey, there was a widespread feeling in our hospital that both residents and PDs had shouldered a large burden in transforming and adapting to ad-hoc pandemic-style medical education. The information from the survey was intended to inform leadership regarding priority areas that required further support or attention.

The survey questions were created after a review of the literature and edited for clarity and brevity. The survey consisted of 10 questions related to residency training and examined the perceived impact of COVID-19 pandemic on three themes: clinical exposure, academic half-days and well-being. Resident participants were asked to rate how the pandemic affected various aspects of their experience on a five-point Likert scale: 1 = significantly worsened, 2 = slightly worsened, 3 = no change, 4 = slightly improved, 5 = significantly improved. PD participants were asked to rate the same questions in terms of their perceptions of how residents have been impacted in their training

Resident survey

Figure 1. How do you feel COVID-19 has affected your OVERALL training experience?

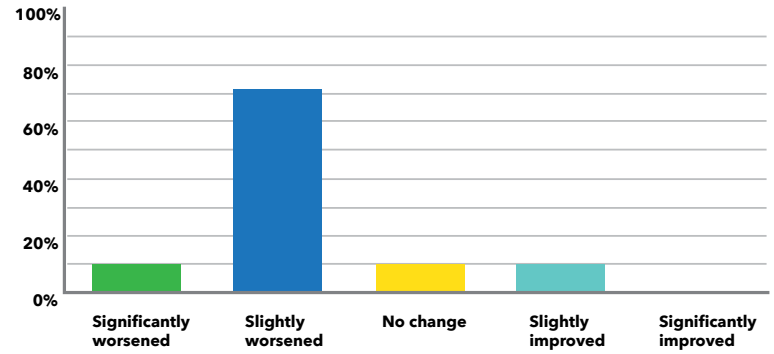


Figure 2. How has the pandemic affected your OUTPATIENT/CLINIC experience?

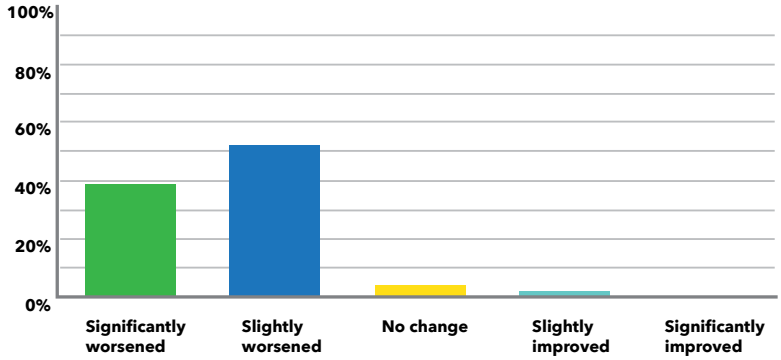


Figure 3. How has the pandemic affected your ACADEMIC HALF-DAY experience?

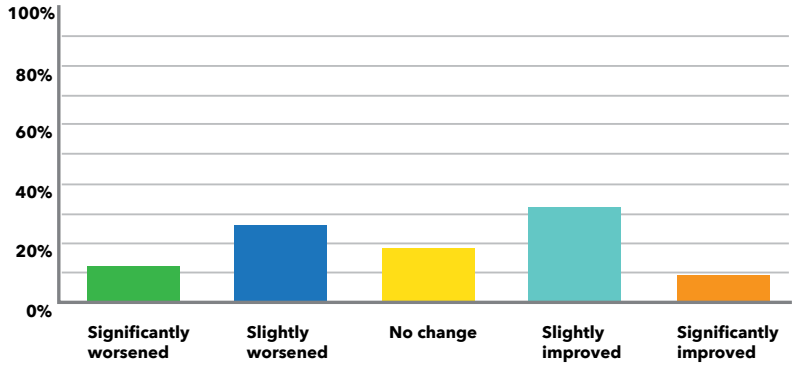
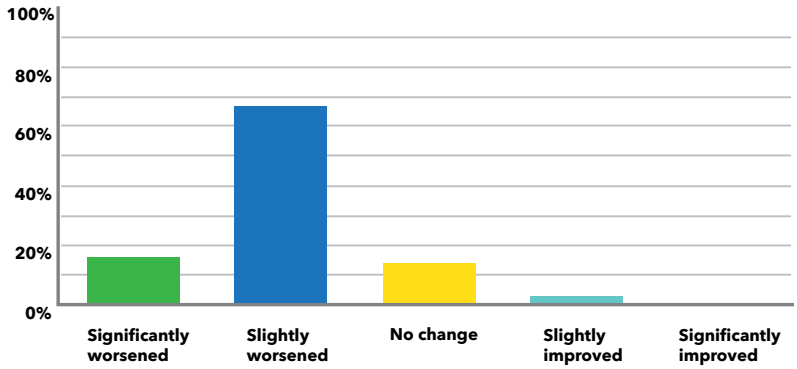


Figure 4. How has the pandemic impacted your OVERALL WELL-BEING?



and well-being; but, they were also asked to rate how the pandemic affected their own well-being. For each question, participants were able to add comments at their discretion. Minimal demographics were obtained; residents were asked to identify whether they were a general pediatrics or subspecialty resident.

Results

Of 81 residents, 43 responded for a response rate of 53%. Most trainees responding were general pediatric residents (n = 33, 77%), and a minority were subspecialty residents (n = 10, 23%). Of 16 pediatric general and subspecialty PDs, 12 (75%) responded to the survey. We report our results thematically along with corresponding figures.

Resident perspective

Resident training experience during the pandemic: Most residents stated that the pandemic had slightly worsened their training experience (Figure 1), in alignment with other studies in the medical literature.[2,5] Pediatric inpatient care saw a significant decrease in numbers of patients, which in turn has led to limited exposure to common problems, particularly respiratory ailments, which ironically decreased with the advent of COVID-19. Restrictions on entering the rooms of possibly infected patients led to further reduced clinical opportunities. Residents reported that communication issues were particularly strained at this time. Cessation of patient bedside

rounds, challenging interactions with patients and families wearing personal protective equipment (PPE), and lack of ability to connect with colleagues and health care providers through nonverbal cues were all identified as barriers to inpatient work. However, despite these challenges, residents found that the low-volume/high-complexity patient profile allowed them to focus on learning complex medicine and teaching junior residents.

Outpatient experience has also been profoundly affected by the pandemic, as reflected in resident feedback (Figure 2), and this is supported by other studies examining residency experience during the pandemic.[2,3,5] Specialty and subspecialty clinics were cancelled, and only the sickest or highest priority patients were seen. This led to a significant reduction in exposure to non-urgent but common pediatric problems, leaving deficits in resident training. Many clinics have transitioned to virtual or telephone clinics. Staff physicians, many of whom were unaccustomed to virtual care themselves, were asked to accommodate a resident learner on these electronic platforms. This could be challenging for both resident and staff physician, who had to simultaneously learn a new process while supporting education. PDs cited the adoption of this new practice while accommodating resident learning as a strain for faculty members. However, virtual visits did provide an interesting opportunity for direct resident observation. In our survey, residents indicated that they preferred virtual clinic visits where the staff physician could observe them throughout the entire appointment, from taking a history through to counseling the patient. The fact that residents welcomed being observed by a staff physician for an entire encounter was an unexpected advantage of this technique and a critical component of competency-based medical education.[6]

Impact of the pandemic on academic curriculum delivery: The effect of the pandemic on didactic learning, such as academic half-days and rounds, was one of the few areas that was not significantly negatively impacted, according to residents (Figure 3). Many enjoyed being able to attend academic half-days from home or watch it later if they were post-call. However, lack of team building and socialization amongst peers and less informal mentorship between residents and staff were frequently cited as negative impacts.

Impact of the pandemic on overall resident well-being: Not surprisingly, residents felt that overall, their well-being had suffered and was significantly worse because of the pandemic (Figure 4). The top pandemic-related factor cited as affecting mental health was social isolation, followed by lack of ability to participate in recreation and decision fatigue. Notably, fear of contracting COVID-19 was reported with less frequency, suggesting that social factors may weigh more heavily than medical factors. Most residents felt that friends and family were most helpful for emotional support during the pandemic, and many felt that peer support within the program was valuable.

Program director perspective

Resident training experience during the pandemic: Most PDs shared the view that overall residency training was slightly worsened as a result of the pandemic (Figure 5). Their responses were similar to those of residents, but perhaps slightly more pessimistic. Main themes in response to this sentiment were related to the reduction in ambulatory exposure, complexities of logistics for virtual clinics, and overall lower patient volumes in the pediatric setting.

However, PDs did note some unexpected "silver linings" in the altered clinical activity. As some staff mentioned, the direct observation of residents in virtual clinics has presented some excellent opportunities for feedback and coaching. Others feel that the pandemic is a once-in-a-lifetime opportunity to participate in an unprecedented public health event.

Impact of the pandemic on academic curriculum delivery: Most PDs felt the experience was neither better nor worse, mirroring the comments of the residents (Figure 6). Positive aspects of virtual learning cited were improved attendance and the chance to attend sessions from the comfort of home or out

of town clinical placements, such as electives and rural rotations; lack of social interaction, loss of community, and "Zoom fatigue" were identified as negative aspects.

Impact of the pandemic on overall PD well-being: As educational leaders, PDs have shouldered a large load during the pandemic. Most felt that their personal overall well-being was slightly or significantly worsened during the pandemic (Figure 7). Reasons attributed to the decline in their overall well-being included staffing issues, physical and mental health concerns for both self and residents, decreased interaction with trainees, and decreased sense of community. The importance of clear and timely communication was cited as critical to establishing an overall feeling of stability during these difficult times.

PDs also pointed to an increased workload for themselves and program administrators with the sudden need to adopt and navigate new technology. As one PD remarked: "Nobody added an 8th day of the week. But, we are getting it done!"

Discussion

Recognizing the strain and challenges of providing quality residency education during the pandemic, adaptations brought forward by education leaders may be divided into the following categories: short-term wins, medium-term modifications, and long-term transformations.

Program director survey

Figure 5. How do you feel COVID-19 has affected residency training OVERALL?

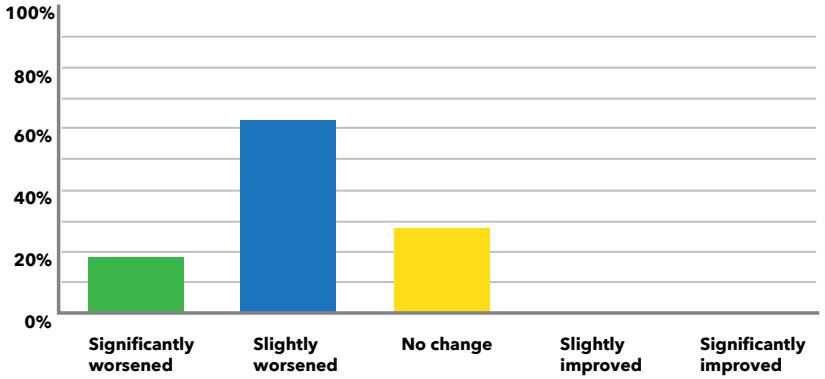


Figure 6. How has the pandemic affected your residents' ACADEMIC HALF-DAY experience?

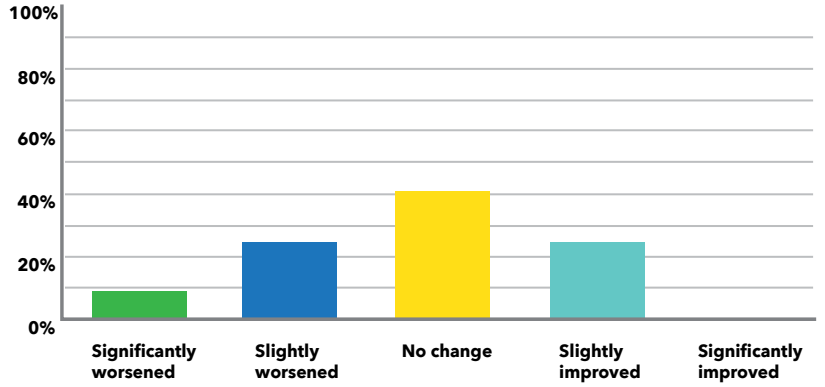
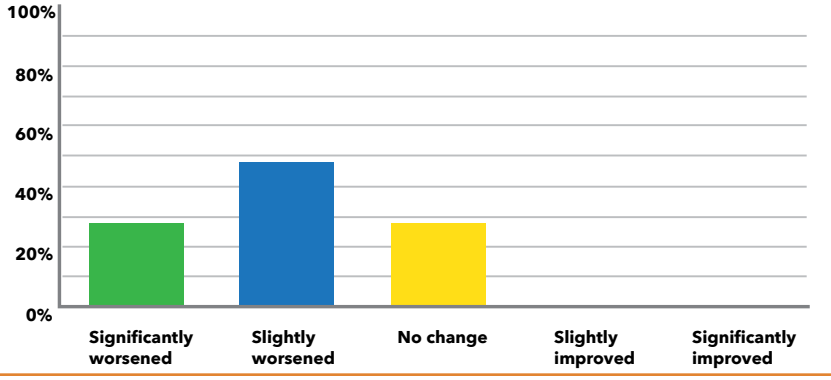


Figure 7. How has the pandemic affected your OVERALL WELL-BEING?



Short-term wins

Short-term wins, implemented in the first few months of the pandemic, are reactive, quick to implement, and may be very effective. They include moving lectures, academic half-days, rounds and webinars onto online platforms with recording capabilities to enable distance learning. Pre-existing online resources may also be invaluable for exam preparation, video learning, and community building. Simulation labs have been

essential in teaching residents the skills of resuscitation, PPE donning and doffing, procedural skills, and elements of teamwork/crisis resource management.

Virtual patient encounters have created new opportunities for direct observation and coaching for residents, although mastery of these skills takes time and experience. Effective and timely communication between educational leaders and residents has been essential to navigate changes and mitigate stress. Finally, consideration of resident wellness, as promoted and modeled by educational leaders, is critical in this trying time.

Medium-term modifications

As the pandemic has continued, more substantial modifications have been developed, many of which may be adopted on a permanent basis. Most high-stakes certifying exams have been transformed into new formats, including a digital written examination and a virtual applied examination. The use of virtual teaching sessions, meetings, and conferences, which increases convenience and facilitates attendance, is likely to continue with some frequency beyond this pandemic.

Resident wellness has emerged as a critical issue as the pandemic continues, and, although it is difficult to navigate during quarantines and social distancing, it cannot be ignored. Ongoing social isolation, long work hours, and lack of community negatively impacts mental health and, in turn, our residents' academic and clinical performance. Education leaders must actively check-in to support the wellness of individual learners and help them thrive academically. This can be achieved through one-on-one meetings, wellness virtual town halls, and the introduction of a resident wellness leader to acknowledge and validate resident concerns surrounding pandemic-related issues.

Long-term transformations

Medical education has been forced to pivot in light of the COVID-19 crisis, and programs have appropriately adapted. However, this has also generated questions around our pre-existing medical education framework and the need for long-term transformation. As educational leaders, we must consider lessons learned during the pandemic. Has the pandemic forced educators to reimagine the ways in which we deliver medical education? Should we modify how we assess our trainees? Is there a need for formal curricula and training around virtual patient encounters? If the pandemic continues for several years, will we graduate undertrained physicians? Will virtual and remotely conducted applied certifying exams be a fair and just model for certification?

The call to leadership has resonated throughout the pandemic. Department leaders have been expected to negotiate difficult and often conflicting positions of courage, advocacy, and humility in the face of great uncertainty. As educational leaders, PDs have been drawn into a position of trust and responsibility like never before. The challenges for PDs and educational leaders are unparalleled: advocating resident safety measures, including PPE and vaccination; ensuring quality education during high acuity; enabling access to virtual clinics and academic sessions; transitioning essential learning experiences to simulation; and, finally, recruiting faculty to champion education in the midst of an all-consuming public health emergency. PDs are expected to model professionalism while tending to the well-being of themselves, their families, and residents. Chief residents, technically learners themselves, have also found themselves in a state of heightened responsibility during the pandemic. Resident leaders have responded through advocacy, communication, instilling community, and modeling courage in the face of uncertainty.[7] Senior residents may find themselves learning critical leadership skills during the pandemic, which ultimately will give them confidence and experience when faced with future crises.[1,7]

As education leaders, we have a duty to our trainees to ensure the best possible work and learning environment, despite challenging situations. Our surgery colleagues

addressed these tenets at the onset of the COVID-19 pandemic as they pertains to their specialty; however, the themes are entirely transferrable to all areas of medicine, including pediatrics.[3] They include the promise to (a) prioritize trainee wellness and safety; (b) harness opportunities to learn from the COVID-19 pandemic; (c) restructure learning; (d) adapt current educational milestones; and (e) prepare for post-COVID-19.

Based on this paradigm, certain adaptations will be adopted into the long-term transformation of medical education. Examples include the use of simulation-based learning, virtual education sessions allowing for collaboration and sharing between centres, virtual patient encounters, the importance of trainee safety including PPE, and the firm incorporation of resident wellness into the curriculum. Teamwork and crisis management, residents-as-teachers, and leadership development have also developed as emerging themes critical to resident education.

There are many questions, but limited clear answers. However, one message remains: a reflexive return to the previous status quo after the pandemic means ignoring the important lessons learned and novel opportunities for medical education. As Dr. Lee Goeddel from Johns Hopkins shared: "This is a crisis of a lifetime. If students can learn from it in appropriate ways, it's going to make our future physician workforce better."[8] Educational leaders must reflect and learn from this crisis to continue to improve and advance the state of residency education.

Conclusion

The COVID-19 pandemic has presented a major challenge to the delivery, assessment, and administration of residency education. Despite the best intentions of educational leaders to provide a seamless transition to virtual and safe learning, there have been unexpected consequences, both positive and negative. Educational leaders have learned that excellent communication from leadership and attention to wellness for both residents and physician leaders is imperative. In addition, new areas for development in resident education have emerged.

All education leaders should reach out to their trainees to ensure well-being needs are being addressed and supported; reflect critically on local adaptations to the pandemic to identify initiatives that can and should be continued post-pandemic; and leverage this crisis as an opportunity to advocate funding and associated opportunities to build new curriculum and resources in the areas of wellness, teamwork, simulation, crisis management, and leadership development. As we move forward into control over the pandemic, it is clear that many educational strategies unexpectedly tested during this time in history will be integrated into our medical education framework for years to come.

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This article has been peer reviewed.

PERSPECTIVE

It's not what you know, it's who you know: diagnosing and healing your informal professional networks

Raphaël Kraus, MD

Traditional medical training fails to address the competitive realities of the job market and the critical role of informal professional networks in career development and advancement. Moreover, the concept of informal professional networking is scarcely represented in the medical literature. Borrowing from management science, I discuss the roles of informal professional networks; strategies to establish healthy and effective networks; and important barriers encountered by networkers, namely feelings of inauthenticity and inequities resulting from gender and race.

KEYWORDS: networking, professional networks, medical education, professional education, career planning, career advancement

CITATION: Kraus R. It's not what you know, it's who you know: diagnosing and healing your informal professional networks [perspective]. Can J Physician Leadersh 2021;7(4):153-158 https//doi.org/10.37964/cr24741

My own path across the landscape of medical training has been rather straightforward. Although not immune to self-doubt, I trod my way through medical school, residency, and a subspecialty fellowship with the naïve conviction that, at the end of the pipeline, I would be met with a neat blueprint for professional success. I have since learned that the shift from the linear structure of medical education – where the required steps are overt, concrete, and reproducible – to the thick bramble of the early-career physician is rife with anxious uncertainty. Many peers echo my experience. How, then, might we better prepare our trainees for this transition?

Although not unique to medicine, postgraduation existential angst among young physicians is amplified by the protracted nature and intensity of our training, which fails to address the competitive realities of the job market and the critical role of informal professional networks in career development and advancement. The focus of our clinical training is rightfully on what you know and how to apply this knowledge to the benefit of the patient. Lost in this pursuit is who you know and the immeasurable value of relationships – the concept of informal professional networking is scarcely represented in the medical literature.

Here, I draw from the expertise of our colleagues in management science to provide an overview – with the early-career physician in mind – of the roles of informal professional networks; proposed strategies to establish healthy and effective informal networks; and important barriers encountered by networkers, namely feelings of inauthenticity and inequities resulting from gender and race.

Why network?

First, let's distinguish formal from informal networks. Formal networks refer to specified, on-paper organizational relationships – between an attending physician and a trainee or between the hospital chief executive and the chief medical officer, for example. Informal networks bridge professional and social relationships and involve "more discretionary patterns of

interaction."[1,2] In other words, we get to choose what connections to forge, which to sustain, and which to break. Often, we cast these "discretionary" links based in shared interests or common ground.

However, unlike friendship, informal networking is not purely social. We strategically develop these relationships with people who stand to help us in our work and our careers. Management and organizational science literature have proven time and again that networking is a professional necessity, leading to more career opportunities, knowledge sharing, innovation, accrual of status and authority, in addition to improved quality of life and job satisfaction.[3] To network is to weave "a fabric of… contacts who will provide support, feedback, insight, resources, and information."[4] Ultimately, our networks' greatest power lies in their referral potential: our professional relationships are "valuable to the extent that they help us reach, in as few connections as possible, the far-off person who has the information we need."[4]

The healthy informal network

Not all informal networks are equal, and size appears not to be the lone – or even the most important – factor. In fact, the most effective "core networks," made up of those in your inner professional circle, typically range from 12 to 18 people.[5] Most impactful are structure and variety: "core connections must bridge smaller, more-diverse kinds of groups and cross hierarchical, organizational, functional, and geographic lines."[5] The results of this selective diversity and breadth are better opportunities for learning, decreased risk of bias, and greater personal and professional growth.

So, who are the key players in a diverse yet selective informal network? The most effective informal networks include people with new information or expertise, people wielding power, and people who dissent, those who challenge and push back. Beyond career advancement, healthy informal networks also nurture engagement and personal satisfaction. For this, our informal networks must include people to lean on for emotional support;

Figure 1. The six archetypes of dysfunctional networking. Adapted from Cross and Thomas.[5]

Wrong Structure

The ***Formalist*** lends too much attention to hierarchy and formal networks

The ***Overloaded Networker*** focuses on network size, spreading themself thin to the point of relationship burn-out

Wrong Relationships

The ***Disconnected Expert*** fails to build connections with those who push them to develop new skills outside their comfort zone

The ***Biased Networker*** seeks those with similar opinions thereby reinforcing their own

Wrong Behaviour

The ***Superficial Networker*** engages in shallow relationships with as many people as possible ("bigger is better")

The ***Chameleon*** changes themself for their audience

people who reflect back the broader meaning and impact of our work; and people who prioritize and hold us accountable for maintaining work–life balance.[5]

Finally, much like your muscles during a pandemic, professional relationships atrophy with disuse or neglect. The best networkers stick to an "exercise" regimen and "take every opportunity to give to, and receive from, the network, whether they need help or not."[4]

Diagnosing your informal network

The six archetypes of dysfunctional informal professional networking

Careful history and examination are key to diagnosing a networking illness. Rob Cross, professor of Global Leadership at Babson College, and Robert Thomas, executive director at the Accenture Institute for High Performance Business, argue that dysfunctional networkers broadly fit six archetypes boxed into three categories of impairment: wrong structure, wrong relationships, and wrong behaviour (see Figure 1).[5]

Mapping your informal professional network

Next, let's explore the self-similarity principle (or homophily), our natural tendency to gravitate toward those who resemble us in experience and opinion. Closely related is the proximity principle: as with the Disconnected Expert, we tend to fill our informal networks with people we see and speak to most often. This can be efficient – when we all speak the same language, information flows quickly. However, we risk cocooning ourselves in echo chambers, shielded from differing or dissenting information.[6] Mapping out your informal network can unmask any overinvestment in self-similarity (Figure 1).

Let's take the example of Ken (see Table 1). First, Ken lists out his key contacts in the leftmost column, those he relies on most for advice, information, and support. Next, he thinks back to how he met each person, placing the name of the person who introduced them, or the "broker," in the centre column; notably, one can serve as one's own broker. Then, he jots down the name of someone to whom he introduced his key contact in the rightmost column – these

Table 1. How to map your informal network.

Name of contact	Who introduced you to the contact (i.e., the broker)?	To whom did you introduce the contact?
Yvan	Me	Pete
Bob	Larry	
Guy	Me	Doug
Jacques	Serge	
Steve	Bob	

Source: Adapted from Uzzi and Dunlap.[6] Names chosen from the 1977–78 Montréal Canadiens roster.

are times he acted as the broker. Finally, Ken tabulates the number of times his own name is listed in the centre column: two of five, or 40%. If you've served as your own broker more than 65% of the time, your informal network is likely "inbred" and you risk becoming the *Disconnected Expert or the Biased Networker*.[6]

Cross and Thomas recommend further classifying your relationships by the benefits they provide, whether information, political influence, personal development, personal support, sense of purpose, or work–life balance as described above.[5] This shows where your informal network needs bulking and where you can trim the fat.

Healing your informal network

"Building a leadership network is less a matter of skill than of will."[4]

Having completed the diagnostic exercises, it is time to lay out a treatment plan. Within the described classes of benefits (information, political influence, personal development, personal support, sense of purpose, or work–life balance), what do you have too much of, and who asks too much of you? The *Overloaded* and *Superficial* networkers are particularly vulnerable to the accumulation of redundant network contacts. This is the most diplomatically challenging step: excising the superfluous, the overdemanding, and the toxic.

Next, where do you need to invest? Recall the diverse yet selective network. Look to fill the holes in your informal network with deliberate attention to diversity across hierarchy, organization, function, and geography – most applicable to the *Formalist*, whose scope must be broadened beyond formal organigrams, and the *Disconnected Networker*, who must deliberately seek out those with skills and interests outside their comfort zone. Cross and Thomas remind us to prioritize "positive, energetic, selfless people," and to seek the recommendations of people both inside and out of our existing informal network.[5] As you rebuild, remain mindful of the dangerous allure of self-similarity and proximity (the plight of the *Biased Networker*). Perhaps the most effective way to evade these hazards is through the "shared activities principle."[6] The most impactful relationships grow not only from common background, but through shared, *meaningful* experiences. I stress meaningful, as not all activities carry the same networking weight. They should be relatively "high-stakes" (e.g., competing for a research grant) and should demand interdependence.[4] Such activities cross many spheres – sports, charity and community work, interdepartmental projects – and, most important, gather people around a central goal (e.g., advocating a health policy initiative) rather than common background.[4]

Finally, "the best way to get invited to the party is to host the party."[7] Borrowed from the concept of "inbound marketing," a commercial strategy focused on creating valuable content that draws customers to the product directly in lieu of advertising, "inbound networking" aims to attract valuable people to you.

In essence, writes Dorie Clark, professor at Duke University's Fuqua School of Business, "make yourself interesting enough that

they choose to seek you out."[7] First, Clark suggests that we target what sets us apart. For the *Chameleon*, this means representing oneself genuinely and with confidence rather than trying to fit in. This is easier said than done – we tend to overlook what makes us unique. Asking those who know us best (e.g., friends, family) to identify the most exceptional things about us, while admittedly awkward, can be a great way to suss this out. Next, become a connoisseur – true expertise, especially if outside what is expected of your field, is powerful fodder for conversation and connection. People like people who know things. Finally, place yourself at the centre of your informal network – have the gumption to host a dinner party or organize a lecture. "The best strategy is to make them come to you."[7]

Although medical culture is slowly evolving from rigid hierarchies to flatter structures of leadership that foster collaboration, networking with your "superiors," those likely to open the most doors, is intimidating.

Barriers to effective informal networking

These strategies alone are unfortunately not a networking panacea. Although medical culture is slowly evolving from rigid hierarchies to flatter structures of leadership that foster collaboration, networking with your "superiors," those likely to open the most doors, is intimidating. It can feel inauthentic, disingenuous – even dirty.[3,8] To overcome this aversion, focus on the opportunities for learning and discovery in your networking interactions; think not only about what you stand to gain from them, but also what you can give – trainees and early-career physicians are often better at having their finger on the pulse of emerging clinical and research trends; and "find a higher purpose" – should your networking efforts land you that dream job, what contributions, beyond your own career advancement, would you stand to make to your community, society, academia?[3]

Most important, inequities and prejudice pervade informal networking as they do all facets of society. In a mixed-methods study of gender differences in science, technology, engineering, and mathematics (STEM) disciplines, researchers found that informal professional networks frequently lack women, are generally composed of only one ethnicity (think back to self-similarity or homophily) and are exclusionary.[1] Most striking, although most men in the study reported that gender did not impact network access (failing to acknowledge their privilege), 40% of women described their gender as influential and a quarter reported their minority status as a major obstacle.[1] Perhaps it is not surprising that women were found to have more diverse informal networks than men. Despite this greater diversity, women may not feel as empowered to leverage their professional networks: "Women may view asking for something as transactional, so they miss out on the value of the relationships," says Sally Helgesen, best-selling author, speaker, and leadership coach.[9] According to Helgesen, women in the professional context have traditionally been taught to "keep their heads down, do their jobs and expect that others will notice."[10]

What's more – and further compounded at the intersection of gender and race – racialized professionals experience unique, marginalizing barriers to informal professional networking, and are misperceived as lacking power, credibility, or resourcefulness.[11] The results can be professionally and personally isolating.

In the enduring wake of the Flexner Report (1910),[12] the seminal framework for North American medical education forcing the closure of all but two historically Black medical schools, Black physicians remain heavily underrepresented – while Black Americans represent roughly 13% of the United States' population, they represent only 5% of the physician workforce.[13,14] Similar disparities are described in Canadian medicine.[15] Moreover, many Black faculty are leaving academic medicine, citing inadequate mentorship, barriers to promotion and advancement, and a lack of supportive work environments.[16] Quoting a Black venture capitalist, Laura Morgan Roberts, professor at the University of Virginia's Darden School of Business, and Anthony Mayo,

senior lecturer at Harvard Business School, write: "They don't know us. They don't have a rapport with us. They haven't heard us talk about what we've accomplished. Then we're not going to come up in the conversation when they decide who's going to get the next high-level job."[11] When marginalized groups are ignored in medicine and other professional spheres, they are disconnected from the informal networks underpinning essential processes both inside and outside academia.[17]

Conclusion

"The alternative to networking is to fail – either in reaching for a leadership position or in succeeding at it."[4]

The existential angst of the early-career physician is partly a failure of our training to emphasize informal professional networks as vital to career development and advancement. Borrowing from the wisdom and experience of management science, I outline strategies to dissect, diagnose, and design your informal networks, cognizant of the important barriers encountered by networkers – by some inequitably more than others. With these tools, as health system leaders, you will "purposefully build partnerships and networks to create results."[18]

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Understanding attention deficit/hyperactivity disorder in physicians: workplace implications and management strategies

Maryna Mammoliti, MD, Christopher Richards-Bentley, MD, Adam Ly, MScOT, and Mary Nguyen, MD

Physicians with attention deficit/hyperactivity disorder (ADHD) may have unrecognized workplace difficulties because of inattention and impulsivity. If these behaviours interfere with patient care or organizational functioning, leaders may erroneously attribute the physician's actions to unprofessionalism. As such, corrective efforts with punitive measures may be ineffective. ADHD is a neurodevelopmental disorder that responds to evidence-based treatments, including medications, accommodations, and supports. Physician leaders who understand the unique presentations of ADHD in physicians may better identify when this condition may be contributing to workplace behaviour. Furthermore, physician leaders may have a professional or legal duty to accommodate or support physicians with underlying medical and/or psychiatric conditions, such as ADHD. Using our own clinical experience, we provide a general overview of ADHD in physicians and guide physician leaders on how to help physicians who may be struggling with ADHD in the workplace. We hope that our clinical experience and observations of this hidden problem will spur discussion, awareness, and action for further research and support.

KEYWORDS: physician health, physicians with ADHD, workplace health, mental health management strategies, performance

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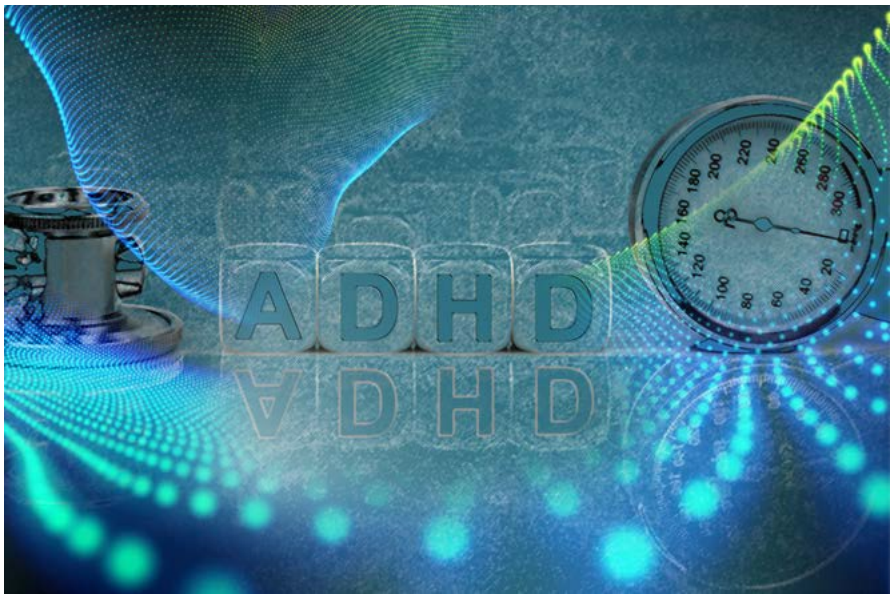
Do you know a physician colleague who is always late to patient appointments or meetings? Do they submit their billings months late? Are they constantly behind in charting? Do they seem overwhelmed all the time? Have colleagues or patients complained that they were "impatient," "rude," or "interrupting"? Do they excel and focus on one area of practice very well, but other responsibilities are forgotten? Perhaps they are not prepared for the reality of medical practice, lack practice management or coping skills, or experience chronic stress. Perhaps they were always like that. Perhaps you ignore it, provide some tips or suggestions, or think they are just not up for the job.

From our clinical experience and practice as psychiatrists and an occupational therapist, we have observed an increasing proportion of physicians who struggle with some of the above difficulties. These physicians recognize that these problems are having a



significant functional impact on their personal and professional lives and, consequently, seek professional help. They may have completed coursework, remediation programs, or coaching with little resolution. Through their family physicians, the provincial physician health program, or social media interest groups, these physicians enter our practice, where their life history and presenting problems fit the criteria for a diagnosis of attention deficit/hyperactivity disorder (ADHD). Once given a diagnosis, they are comforted by the fact that their professional challenges can be explained as a neurobiological condition rather than a character flaw. They become motivated to seek and accept appropriate help to improve their professional and personal performance.

In this article, we aim to review what is known about ADHD in physicians, how to recognize the possible presentations of physicians with ADHD in the workplace, and how physician leaders can help guide these physicians in seeking professional help and make changes in the workplace if necessary. We hope that our clinical experience and observations of this hidden problem will spur discussion, awareness, and action by physician leaders toward further research and support for this niche population. In turn, this can improve patient care, physician well-being, and organizational functioning.

What we know about physicians with ADHD

ADHD is a neurodevelopmental disorder that presents as impairment in executive functioning with inattention, hyperactivity, impulsivity, and emotional lability/dysregulation inconsistent with developmental age.[1] *The Canadian ADHD Practice Guidelines* (4th ed.) provides a comprehensive assessment and diagnostics framework.[2]

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.) lists ADHD as present in most cultures in about 5% of children and about 2.5% of adults.[1] Various reports suggest that a substantial proportion of children with ADHD grow into adults with continued impairment.[3,4] Most ADHD diagnosed in childhood persists into adulthood, with persistence rates of up to 70% when using partial remission criteria.[5] A longitudinal perspective of the disorder is warranted to truly understand ADHD and the phenotypic presentations seen across the lifespan. As a lifelong condition, ADHD has an impact in occupational, social, and personal areas of functioning. Thus, ADHD symptomology can persist or be diagnosed later in adulthood during medical school or in a practising physician.

Females with ADHD are often underdiagnosed and untreated, compared with their male counterparts.[6] In fact, experts have suggested that this discrepancy results from a lack of recognition of the condition or referral bias in females with ADHD and have developed clinical guidelines to highlight the unique presentation in this group across the lifespan.[7] Nonetheless, ADHD prevalence has increased among females across all age groups.[8] These studies suggest that ADHD symptomology in female physicians may be more likely to be unidentified or untreated, present itself differently compared with males, and be more prevalent than historically measured.

To review the existing literature on this phenomenon, search terms, such as "physicians with ADHD" and "ADHD in physicians,"

Table 1. Attention-related symptoms of ADHD and possible presentations in clinical and occupational settings.

Symptom	Possible ADHD behavioural presentation by physicians and physician learners
Makes careless mistakes/lacks attention to detail	• Makes mistakes in reports, charting, orders (e.g., orders the wrong medication or dose because of distraction) • Makes inattentive mistakes during exams (knows the material but inattentively picks the wrong answer thus scoring poorly)
Has difficulty sustaining attention	• Is distracted in patient interaction/assessment, missing vital information • Appears distracted and bored in meetings, team rounds, discussions, and social settings
Does not seem to listen when spoken to directly	• Appears to be bored, dismissive, unprofessional, and disinterested
Fails to follow through on tasks and instructions	• Does not follow up on assigned tasks, organizational initiatives, team goals, goals for patient care, annual paperwork renewals, tracking of continuing medical education (CME), licence payments, and paperwork
Avoids/dislikes tasks requiring sustained mental effort	• Avoids or delays "boring" tasks, such as CME tracking, preparing teachings, charting, grant proposals, and late call schedules
Loses things necessary for tasks/activities	• Loses patient lists, patient charts, research lists/laptops, hospital badge/ID • Loses own car in parking lot, wallets, important personal documents
Is easily distracted (including unrelated thoughts)	• Is distracted in meetings when presenting cases in rounds and appears to be tangential when speaking or conveying ideas or patient presentations • Written submissions appear to be tangential and disorganized, disjointed emails and communications that are hard to follow • Becomes stuck in research/charting because of distraction from one idea/concept to the next and delay of complete product (i.e., research paper, abstract)
Is forgetful in daily activities	• Forgets obligations, meetings, patients waiting in the examining room • Forgets to pick up own children, pay taxes/insurance, leaves stove on or doors unlocked
Is poorly organized	• Is chronically overwhelmed, cannot prioritize tasks and patient cases or make call schedules • Cannot prioritize multiple requests coming at once (at nursing station, parenting) • Appears angry and unprofessional when overwhelmed by cognitive demand

were used to search the Omni database, an academic search tool that gives access to high-quality resources from 16 Ontario university libraries. Of the 97 journal articles found, only three pertained to this topic. Inclusion criteria included any journal article from 1990 to 2021 that cited ADHD in physicians in the article title or abstract. Exclusion criteria included article titles that pertained to general adult ADHD, general ADHD with co-morbidities, and general ADHD treatment for both children and adults. References from these three articles were also scanned by two of us, but only one article was found by both that included ADHD in medical students.

A research study[9] conducted among medical students in 2016 showed that ADHD was the most common self-disclosed disability: 33.7% of the 1547 students with disabilities. School-based testing accommodations were most frequently used (97.8%) and clinical accommodations were less frequent (34.8%). Testing accommodations included extra time to complete examinations (i.e., one and a half or double the time), environments with reduced distractions, and breaks. Clinical accommodations included leaves of absence, deferred clinical years, and releases from overnight call.

A case report[10] documented the course of ADHD and its impact on resident training. It detailed the challenges faced by an anesthesiology resident (e.g., recurrent lateness, time management issues, task prioritization issues, and fixation on minor issues that were considered less important to patient care) and how educational accommodations, cognitive behavioural therapy, and pharmacological treatment had a significant positive impact on his performance of clinical work.

In another study,[11] four recommendations were found to be helpful for psychiatry residents with ADHD: documenting the accommodations, ensuring confidentiality, measuring core knowledge, and not altering the core curriculum of the program.

Finally, a retrospective cohort study[12] looked at medical students with and without disabilities protected under the American Disabilities Act to determine if there were differences in the effect of accommodations on medical admission test scores, clinical performance, graduation rates, licensing exam scores, and residency matches between the two groups.[12] Clinical performance indicators included medical knowledge assessment scores, communication skills, data gathering, and professionalism across clerkships. Of the 59 students with protected disabilities, five had a diagnosis

of ADHD. The authors found that in general, most students with protected disabilities performed generally well; however, compared with students without protected disabilities, these students were less likely to graduate and had lower academic scores. Unfortunately, no studies on the impact of ADHD in staff physicians were found in our literature search. As the literature is so scant, we hope that our clinical experience can be a starting point for further investigation and action.

Recognizing potential ADHD in physician colleagues

Distinguishing between potential ADHD in physician colleagues and unprofessional behaviour caused by non-ADHD factors can be difficult. First, it can be challenging to identify patterns of hyperactive, inattentive, and impulsive behaviours over time and, instead, view them as individual incidents of problematic behaviour. Second, it is tempting to blame the symptoms on personality traits. Third, ADHD is often comorbid with anxiety, depression, substance use, and personality disorders.[13] Fourth, symptoms or behaviours may be a result of other causes, such as burnout. Fifth, some physicians may overcompensate for their symptoms such as by spending excessive time at night completing their work.

The presentation of ADHD can vary depending on the environment. For example, hyperfocus is the ability to focus on a task for hours without interruption or breaks.[14] A surgeon may benefit from hyperfocusing when completing a lengthy surgical procedure and have difficulty managing a busy clinic schedule that requires shifting focus repeatedly. The presentation of ADHD can also depend on life stage. For example, we have seen ADHD symptoms cause impairment when a physician takes on more responsibility, such as starting a family, changing jobs, or being promoted into management or leadership positions.

Tables 1, 2, and 3 outline what we commonly see in our practice and can serve as a guide. These tables provide explicit, clear, and descriptive examples of how possible ADHD-related occupational impairments can be observed in physician colleagues.

Table 2. Hyperactivity/impulsivity-related symptoms of ADHD and possible presentations in clinical and occupational settings.

Symptom	Possible ADHD behavioural presentation by physicians and physician learners
Fidgets with or taps hands or feet, squirms in seat	• Leaves seat in situations when remaining seated is expected • Body movement perceived as "annoyance" by colleagues and patients; may be distracting to people working in the same office space • Fidgeting/movement seen as a sign of "boredom," i.e., personal choice rather than a symptom of a disorder • Often unaware or ashamed of this behaviour or has been criticized by others
Is on-the-go or acts as if driven by a motor	• Cannot sit still, on the go and moving a lot • Has difficulty engaging in quiet, leisurely activities • Forgets obligations, meetings, patients waiting in the examining room • Seen as disruptive, will not sit still in meetings, gets up to get snacks/eats loudly in gatherings • Interrupts to speed up the duration of presentations or teaching workshops
Talks excessively **Blurts out answers**	• Dominates meeting by speaking excessively, causing colleagues and patients to feel shut out, changes dynamics of the group/meeting • Talks excessively in patient encounters leading to extended appointments and running late as well as potentially oversharing and boundary crossing
Has difficulty waiting their turn **Interrupts or intrudes on others**	• Seen as impatient and rude by colleagues because of interrupting or forgetting what they were going to contribute • Seen as narcissistic or self-absorbed by others because of interrupting and inability to delay own idea

The strengths of ADHD

Although we have described the impairments of ADHD in physicians, ADHD symptoms can also confer many strengths. Our patients have been described as creative, "outside of the box thinkers," quick decision-makers, passionate, big-picture thinkers, and entrepreneurs. These labels are a more socially appropriate manifestation of the same underlying emotional dysregulation and impulsivity. We have noticed that the hyperfocus symptom allows physicians with ADHD to thrive in particular medical specialties, such as emergency and intensive care unit settings. ADHD symptoms are conducive to fast-paced environments, high acuity, and the unpredictable nature of this work. This symptom can also be useful in medical settings that require long hours performing tasks that interest the physician, such as surgery. These symptoms/strengths allow physicians to be respected experts in their fields.

The role of physician leaders

Physician leaders can guide

Table 3. Other symptoms of ADHD and possible presentations in clinical and occupational settings.

Symptom	Possible ADHD behavioural presentation by physicians and physician learners
Variability of performance	• Performance varies across job requirements, leading to appearance of disinterest or not caring about certain aspects of the position • May be hyperfocused and interest-driven versus reward-driven (e.g., may spend hours on one activity but procrastinate another activity with greater reward) • May have preference for clinical, procedural, teaching aspects of the job but struggle with sustained attention-demanding, "boring" tasks like meetings and charting
Poor time management	• Is late for meetings and appointments • Forgets how long it has been since call/page while peers and patients wait • Forgets how long has been talking in meetings, social gatherings, or presentations • Overcommits to tasks and is late for meetings/operating room /clinic/appointments/ exams; misses meetings/events
Emotional dysregulation	• Deficient emotional self-regulation • Seen as quick to anger and frustrated; cannot regulate degree of emotion for situation • Seen as emotional, unpredictable, hot-headed, angry, "he/she has a temper" • Colleagues may be afraid of them • Quick mood changes incongruent with situation leading to shame after an event or lack of insight in terms of impact on others and failure to repair relationships; seen as difficult interpersonally • Easily frustrated during meetings or by changes

physicians with suspected ADHD to seek professional help, offer support, and reinforce coping strategies. Leaders can implement workplace accommodations, capitalize on strengths and help compensate for weaknesses, decrease the use of ineffective disciplinary actions, welcome neurodiversity, and promote mental health and well-being. Leaders can also advocate funding for treatment to help cover the costs of psychotherapy, occupational therapy, and coaching.

As with any colleague struggling on the job, it is important to try to understand their perspective rather than judge their behaviour. Our physician patients have told us that they are asked by management or colleagues to use simple strategies, such a planner or to-do list, or to complete a task right away, e.g., charting immediately after seeing a patient. However, they have stated that colleagues have made complaints against them without first seeking to understand. This approach fails to acknowledge the physician as a person with potential mental health issues and increases feelings of guilt and shame. Guilt and shame further impair performance, lead to worsening mental health, and create a vicious cycle.

We recommend opening up the conversation by describing the behaviours that have been noticed, asking the physician their thoughts on the potential causes, and stating concern for their mental health and ability to complete their job tasks. If the person is receptive, you may suggest that they might benefit from speaking to a mental health professional. This approach can help decrease potential defensiveness in the physician, maintain a safe and professional boundary, and lead to further exploration. For example, a leader might say, "I have noticed that you are easily distracted in meetings, lose things around the office, and have difficulty organizing your paperwork. Is everything okay? I am concerned about your mental health and how these tasks are affecting you. Perhaps we can talk further about your struggles if you're comfortable sharing. May I suggest that perhaps speaking to a mental health professional might help? I read a paper on ADHD in physicians, which might be worth looking into and discussing with your doctor."

As required by the Accessibility for Ontarians with Disabilities Act[15] and the Ontario Human Rights Code,[16] physician supervisors have the legal obligation to implement workplace accommodations and environmental changes. These can include, but are not limited to, setting up large digital clocks on walls to help with time management, providing checklists and templates, and reducing distractions by offering quiet spaces. Physician leaders can also reinforce coping strategies, for example by sending a friendly reminder on a task item, encouraging breaks and exercise, and developing and following a simple organizational system.

Conclusion

The clinical presentation of physicians with ADHD is often missed or mistaken for unprofessional behaviours, poor communication, and unsatisfactory work performance. Physician leaders are optimally positioned to detect, support, and accommodate physicians with ADHD in the workplace. Treatment strategies, such as connecting the affected physician with appropriate medical care and service providers in the community and providing targeted support in the workplace, will

allow the physician with ADHD to thrive. With physician leaders aware of the hidden problem of ADHD, these changes will ultimately improve patient care, organizational functioning, work performance expectations, and social relationships.

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Author attestation

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Building community during the COVID-19 pandemic: a system level approach to physician well-being

Serena Siow, MD, Carmen Gittens, BMBS, Janet M. de Groot, MD

Before the COVID-19 pandemic, physician burnout was identified as reaching crisis proportions, and the pandemic is expected to worsen the already perilous state of physician wellness. It has affected physicians' emotional health, not only by increasing workload demands, but also by eroding resilience under increasing pressures. The mental health consequences are expected to persist long after the pandemic subsides. With physician wellness increasingly recognized as a shared responsibility between individual physicians and the health care system, system-level approaches have been identified as important interventions for addressing physician well-being. In this article, we describe two evidence-guided initiatives implemented in our hospitalist network during the current pandemic: a trained peer-support team and facilitated physician online group discussions. These initiatives acknowledge the emotional strain of physicians' work and challenge the "iron doc" culture of medicine. Our efforts build community and shift culture toward improved physician wellness. We suggest that the pandemic might be an opportunity for our profession to strengthen our support networks and for physician leaders to advance physician wellness in their work environments.

KEYWORDS: physician wellness, system approach, social support, peer support, culture change

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Physician wellness in peril

Before the COVID-19 pandemic, physician burnout was already identified as reaching crisis proportions. In 2018, 30% of Canadian physicians reported high levels of burnout and 8% reported recent suicidal ideation.[1] The adverse psychological impact of COVID-19 predicts worsening of the already perilous state of physician wellness. Health care workers providing care to patients with COVID-19 experience increased mental health symptoms, including depression, anxiety, insomnia, and distress.[2] A recent Canadian Medical Association survey shows high levels of anxiety and increased fatigue among physicians one year into the pandemic.[3] The chronicity of the pandemic threatens

physician resilience as strain accumulates over many months. Concerns about worsening post-pandemic burnout and post-traumatic stress disorder exist, and the mental health consequences of the pandemic are expected to persist long after the pandemic subsides.[4]

Emotional impact of health care work

The emotional burden associated with health care work is heavy, and there are many real and perceived barriers to seeking help. Physicians have individual emotional responses to clinical experiences. The nature of the work is demanding, often wrought with uncertainty and the pressure of high-stakes decisions. Physicians routinely witness suffering, death, and grief. They are prone to secondary trauma and have been called the "second victims"' of medical errors and adverse patient events.[5] Furthermore, there is a long-standing "iron doc" culture of medicine where physicians uphold stoicism and perfectionism to prove competence. As a result, they may come to deny and minimize their feelings to avoid emotional distress.

The pandemic has added layers of complexity to providing patient care, while also eroding factors that maintain resilience under pressure. Relentless workload demands and the continuous flow of patients without moments of reflection can be barriers to processing emotions and grief. Furthermore, physicians feeling distress may feel alone in their experiences, especially in a culture that denies or minimizes the importance of recognizing one's own emotions. The pandemic has furthered social isolation, with many physicians providing virtual care from home or working in different settings than usual. Adherence to public health recommendations has led to physical and social distancing from colleagues, friends, and support networks. Unfortunately, the stigma against physicians seeking help for emotional concerns is pervasive, with shame and fear often preventing those needing help from seeking it.

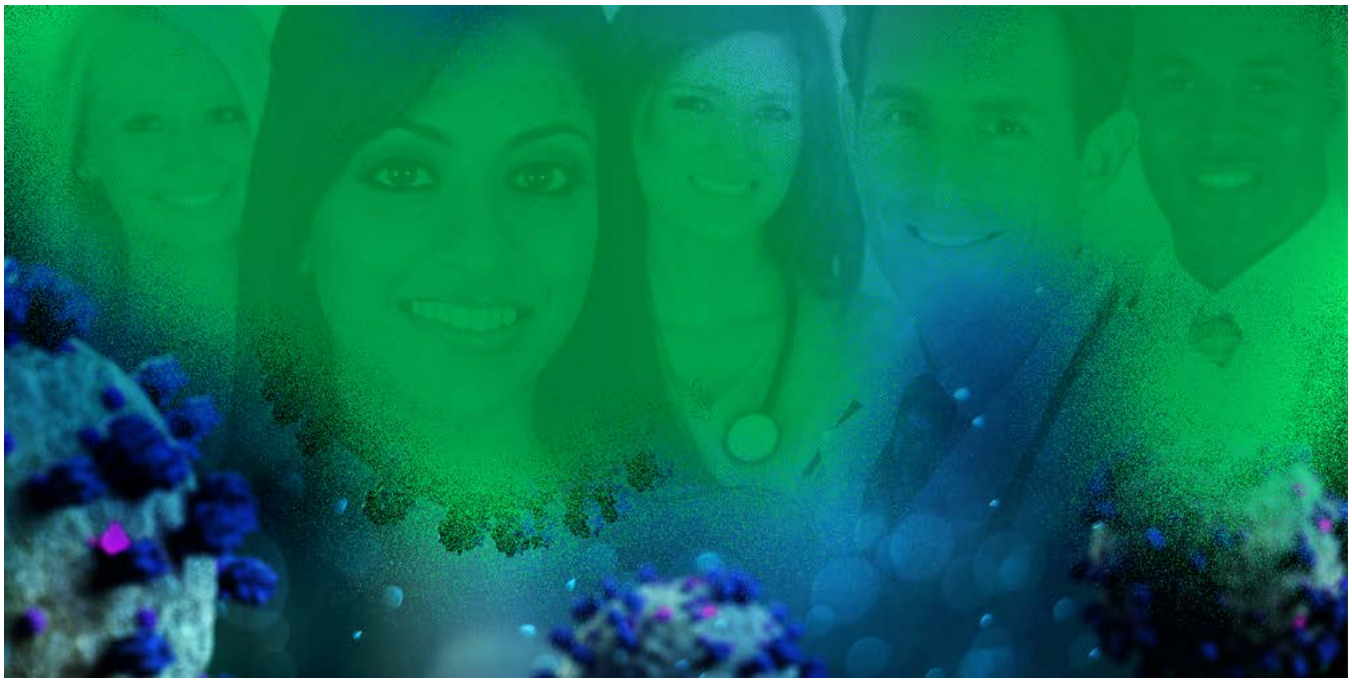
The emotional burden associated with health care work is heavy, and there are many real and perceived barriers to seeking help.

Left unchecked, attempts to cope using dysfunctional mechanisms can have detrimental effects on emotional well-being. Prolonged detachment, for example, potentiates cynicism, depersonalization, and burnout. "Working harder" can take the place of dealing with internal turmoil and exhaustion. Feeling isolated, some may become "hyper-independent" doing multiple tasks themselves, adding to the sense of isolation. Keeping busy and helping others provides distraction and avoidance from self-connecting. Failing to address emotions and grief compounds chronic stress and drives burnout. Burnout is associated with disrupted personal relationships, addictions and substance use disorders, and death by suicide.[6-8] Meanwhile, patients suffer from decreased quality of care, increased medical errors, and poor outcomes.[9,10]

System approach to emotional and social support

Physician wellness is increasingly recognized as a shared responsibility between the individual physician and the system.[11] Previously, physicians were expected to manage the demands of medicine through personal strength and resilience alone. Recently, 83% of Canadian physicians reported high levels of resilience[1] and physicians demonstrate higher resilience compared with the general population.[12] Recommendations to improve physician wellness often emphasize the need for greater personal resilience. However, system approaches to wellness show greater benefit than efforts targeted at individual physicians.[13]

Having a sense of community at work is a priority for physician wellness, particularly during a crisis. Social support during a pandemic lowers stress and anxiety, and improving support is critical to well-being.[14] A randomized trial showed that connecting with physician colleagues improves engagement and reduces burnout.[15] Physicians are more willing to seek support from fellow physicians than from formal assistance programs or mental health professionals.[16] Physician support is thought to be the most effective support system, as "peers have the unique qualification of having



'been there'; experiencing similar stressful situations… in the past."[16]

Sharing experiences with colleagues was identified as a factor associated with resilience after adverse events.[17] Relating to others enriches our lives in various ways: "groups that provide us with a sense of place, purpose, and belonging tend to be good for us psychologically. They give us a sense of grounding and imbue our lives with meaning. They make us feel distinctive and special, efficacious and successful. These effects can buffer wellbeing when it is threatened."[18] Viewing experiences as a collective "we" instead of as an individual "me" supports resilience and well-being.

Initiatives developed during the pandemic

Our hospitalist team of 170 physicians provides care to a large proportion of COVID-19 patients in Calgary hospitals. An assessment of Calgary hospitalists revealed that emotional and social connections were important to maintaining a sense of community at work during the pandemic; therefore, members of our team quickly developed a system-level approach to support physician wellness based on social and emotional support. These strategies included trained peer support and facilitated online group discussions.

Peer support

We launched a peer-support team to support our hospitalist colleagues during difficult times. Well Doc Alberta provided training and guidance, with 21 family physicians attending a 4-hour training workshop to build empathetic listening skills, identify supplemental resources, and recognize when a peer may be at risk of harming self or others. Peer-support team members volunteer to support their colleagues with any issue at any time: for example, work-life imbalance, adverse events, workplace inequity, personal conflicts, financial concerns, professionalism matters, or career track indecision. A list of provincial resources was distributed, including contact information for the Alberta Medical Association Physician and Family Support Program. Psychological safety was preserved by asking peer-support team members to track the number of contacts and general category only. This initiative challenges the stigma associated with asking for help, recognizing that we all need help at some point in our careers.

Six months following initiation of the peer-support program, five formal contacts and multiple (over 40) informal contacts were reported. An anonymous survey conducted at the same time showed that knowing peer support is available supports the well-being of 83% of the hospitalist physicians who responded.

Physician group discussions

We created an online space

– called Virtual Doctors' Lounge – for physicians to connect with each other, share experiences, and maintain resilience. Group discussions explore the emotional impact of practising medicine and support recognition that we are not alone in our challenges. We discuss coping strategies and explore solutions to system issues. This preventative approach to recognizing day-to-day stress mitigates chronic stress and might keep physicians from reaching crisis states. Discussions are facilitated by psychiatrists and mental health clinicians.

Our pilot sessions with hospitalists (n = 12) reported increased connection and less distress, with 92% willing to attend again. We completed our second phase with Calgary physicians of all specialties and are planning a next phase.

Discussion

We build community through initiatives that bridge informal support (e.g., hallway conversations) and formal support (e.g., provincial physician health program). We each have the responsibility of normalizing the emotional strain of our work while challenging the existing "iron doc" mindset. Seeing ourselves as the "imperfect but good doctor" involves compassionate awareness of our own experiences, so that we can connect meaningfully with our colleagues. As a culture, acknowledging our humanity while practising medicine may eliminate the stigma attached to seeking help. Further, allowing oneself to be vulnerable in communities of practice has the potential to support personal growth and greater resilience.[19]

Our initiatives allow physicians to share experiences without fear of judgement and acknowledge lived experiences with mental health, bias, and microaggressions. We promote civility and compassion for each other and, above all, acceptance as human beings. Fostering a sense of community moves us from isolation toward connection. The existence of our system-level initiatives enhances visibility of physician wellness as a priority and accelerates culture change.

Conclusion

Our views align with physician leaders who believe that targeting culture change is necessary to advance physician wellness. We experienced the benefits of strategies to support physician wellness through peer support and facilitated online discussions. We recognize the limitations of using these approaches alone and emphasize that these are only two of many strategies in our comprehensive framework to improve physician well-being. We also advocate strategies that improve practice efficiency, address workload demands, and advance wellness as an organizational priority. Nevertheless, we believe that a system-level approach to offering social and emotional support builds community and culture change. Nurturing our capacity for connection advances an ideal medical culture that promotes compassion and supports physicians as human beings. The pandemic is an opportunity to strengthen our support networks and do better than merely survive. With social and emotional support from our colleagues, we hope for progress toward positive growth and improved well-being, together.

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The opinions expressed in this article are the authors' own and do not represent those of their institutions or organizations.

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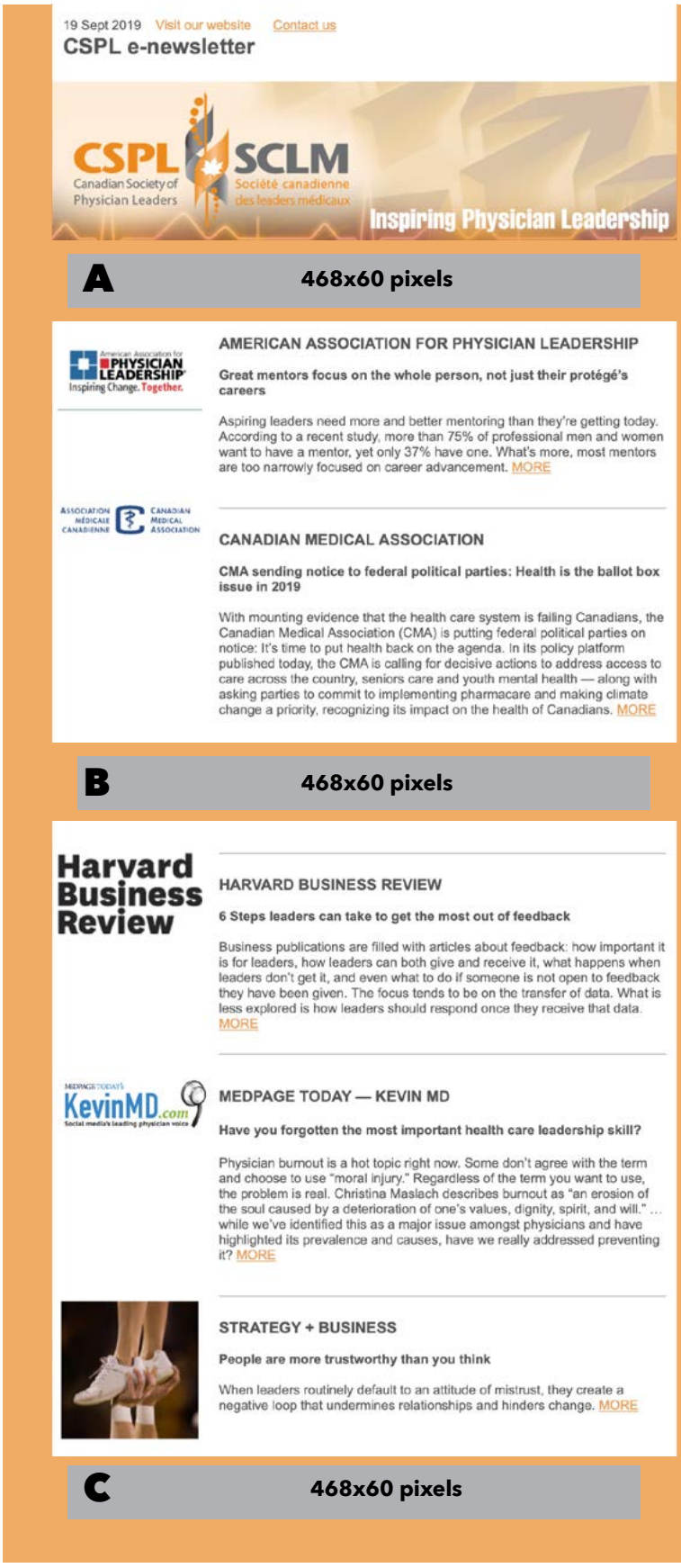

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Leading in an uncharted future

Pat Rich

As the third wave of the COVID-19 pandemic crested in many parts of the country, the annual Canadian Conference on Physician Leadership, aptly named "An Uncharted Future," was held on 26–29 April 2021. This virtual gathering gave delegates a forum to refresh their leadership skills and discuss the post-pandemic future.

It was a testament to the Canadian medical profession's commitment to the values of leadership that more than 450 people attended the totally virtual conference hosted by the Canadian Society of Physician Leaders (CSPL) and the Canadian Medical Association's Joule, despite many suffering from Zoom fatigue and the stress and the anxiety of dealing with the pandemic.

The conference featured six outstanding keynote speakers, 21 workshop sessions, and four in-depth masterclasses as well as opportunities to network. The conference was accredited by both the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, and this year delegates were able to choose between four different tracks; wellness and medical culture, digital health, leadership, and health features. The conference was chaired throughout by CSPL president Dr. Rollie Nichol who also chaired the conference planning committee.

"I am pleased to see the breadth and depth of topics on the conference agenda, from core physician leadership to digital health, wellness and medical culture, and the future of health – all areas of critical importance as we navigate these uncharted waters," CMA President Dr. Ann Collins reflected during her introductory remarks for one session.

Many of the sessions were created to support physicians in their ongoing need for social and practical information, and many participants selected "feel good" workshops or those dealing with how to survive. A masterclass hosted by Dr. Jill Horton, who recently wrote *We are All Perfectly Fine*,[1] delved deeply into just these issues. Although they were unable to share the usual coffee breaks and other direct person-to-person interactions, delegates still had an opportunity to feel a sense of belonging at a welcome reception and virtual cocktail hour.

The stated learning objectives of many of the sessions underlined the focus on leadership:

- Demonstrating "simple habits" leading to greater personal happiness, thriving teams, and a more positive work environment
- Building systems of resilience to protect physicians and allow them to lead with confidence and competence
- Exploring the importance of indigenous allyship as a component of physician leadership
- Aligning leadership strengths and leadership effectiveness

In her keynote address, former CSPL president and president and CEO of St. Joseph's Health Care in London, Ontario, Dr. Gillian Kernaghan, provided a wealth of insights on physician leadership as she traced the various phases of her leadership journey.

"Diversity, inclusion and engagement," which was the formal theme of the last CCPL conference in 2019 was continued by certain presenters at this year's conference, such as Dr. Faisal Khosa, associate professor at the University of British Columbia, who discussed existing disparities in academic medicine and how to overcome them.

In his plenary address, Dr. Brian Hodges, chief medical officer at

the University Health Network in Toronto, specifically referenced some of the learnings that have come from dealing with COVID-19 at arguably the heart of tertiary care medicine in Canada. Dr. Hodges noted that he and his team had learned many lessons from helping support long-term care homes during the early phase of the pandemic and in helping to operate a mobile vaccination clinic earlier this year.

Sessions on digital health allowed a variety of perspectives on one of the most radical shifts in practice caused by the pandemic – the move to virtual care. Dr. Alexandra Greenhill provided a rapid-fire overview of the exponential changes occurring with medical technology, while Dr. Tasleem Nimjee talked about the way the Humber River Hospital is transforming hospital care with the "command centre" approach to using data and delivering digital care. As an early adopter of digital health, Dr. Mark Dermer was well-positioned to trace how he saw digital care evolving after the pandemic.

A long-standing tradition at the CCPL is the formal debate on a high-profile issue, and this year's conference closed with an outstanding panel discussing whether medicine is a calling or a job. Drs. Sandy Buchman, Melanie Bechard, Victor Do, and Susan Shaw each delivered heartfelt perspectives from the positions they had been assigned in a debate that was well-received by delegates.

"It's in my soul, in my heart, in my DNA," said Dr. Sandy Buchman, past-president of the CMA and expert in palliative care, in arguing for medicine as a calling. For her part, Dr. Susan Shaw, chief medical officer in the Saskatchewan Health Authority stated, "I see medicine as my job and something I am very passionate about, and my calling is to make the world a better place." Speakers on opposite sides of the debate came together with a common view that physicians need to know what is important to them and to not allow the system to take advantage of their altruism.

The conference also saw Drs. Douglas Bell, special advisor to the CEO at the Canadian Medical Protective Association, and Neil Gibson, associate zone medical director, Acute Care Coverage, Edmonton Zone, Alberta Health Services, receive the CSPL Excellence in Medical Leadership (Chris Carruthers) Award. Dr. Karen Shaw, registrar of the College of Physicians and Surgeons of Saskatchewan, was also acknowledged as the 2020 winner, as no conference was held last year because of the pandemic.

As an additional bonus for registering, delegates have been able to access recorded sessions for three months after the four-day meeting concluded, allowing the learning to continue as we track toward the next CCPL conference scheduled for 6–7 May 2022 in Toronto.

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Chief Medical Officer, Northern Regional Health Authority / Medical Director, Primary Care Clinics, NRHA, Thompson / Physician Champion, Physician Health and Wellness Community of Practice Project, Doctors Manitoba Thompson, MB

Dr. Darija Vujosevic
Primary Care Lead, Niagara, N-ESON Ontario Health Team / Lead Physician, Niagara North Family Health Team, St. Catharines, ON

CSPL Excellence in Medical Leadership Award (Chris Carruthers Award) 2021

The CSPL presents this award annually to a physician who has made an outstanding contribution to the development and mentorship of medical leaders in the field of health services leadership and management. The nominee should demonstrate outstanding abilities in one or more of the following categories:

- Commitment to enhancing the role of physicians in the management of health care delivery organizations
- Leadership in a hospital or health region management role
- Significant contribution to leadership development within CSPL or any related organization, hospital or program of local, provincial or national in scope

Edward Douglas Bell, MD, FRCSC

Doug Bell has dedicated much of his notable 41-year medical career to the provision of professional development and medical risk management education, leadership and mentoring. This began early on during his years in clinical practice in the field of obstetrics and gynecology and continued throughout his 27 years in progressively senior leadership positions within the CMPA. He has provided decades of guidance and leadership to the team of physician advisors on staff at the CMPA, as well as medical-legal advice and education to thousands of CMPA members and physician leaders in clinical practice. Additionally, he has led the CMPA's collaborative efforts in advocacy and stakeholder engagement for over two decades. When he retires this June, Doug Bell will have left his indelible mark of excellence on all aspects of the CMPA's work, and the essential role it plays in the Canadian healthcare system.

A few excerpts from the letters of recommendation…

"To borrow an old business adage, Doug "walks the walk". The basis of Doug's leadership abilities rest with a logic-based intelligence which allows him to be decisive when required. He is keen to take input from colleagues and staff and equally able to change directions upon reflection. He has always impressed us with his ability to totally separate business disagreements from the social environment, a skill very few senior leaders enjoy. Doug does not beat around the bush, communicating clearly and directly but always respectfully. There is never any doubt with his verbal or written messaging.

If we have not yet led you to interpret what we see as obvious, Doug is one of the most honest and ethical persons we have ever met. He has established a high bar for himself and lives it; however, he does place great value in compassion and this contributes to fairness. There is no "mean" streak in this man.

These character traits combine to make up "respect" as it applies to Dr. Doug Bell and it is why we are so convinced he is deserving of the CSPL Excellence in Medical Leadership Award.

John Gray, MD and Pat Ceresia, MD

Doug's good humor and fine temperament have been tremendous assets to the international medical profession in the numerous initiatives and educational programs he has organized and led for many years. His experience as a physician, combined with his talents as a business executive, make Dr. Doug Bell one of the most widely respected and admired individuals within the global medical professional liability community.

Brian K. Atchinson, President & CEO, MPL

Neil E Gibson, OMM, CD, MSc, DOHS, DTMH, CTropMed, CCPE, MD, FACP, FRCPC, Founder in GIM

Dr. Gibson has had a distinguished career as a military officer serving for a total of 32 years. He held numerous leadership positions within theCanadian Armed Forces eventually retiring at the rank of Colonel. He has deployed overseas to multiple countries including Cambodia, Eritrea, and Ethiopia. He has served as the overall specialist advisor to the Surgeon General providing leadership within the Department of National Defence.

In 2006 he was made an Officer of Military Merit of Canada for his "outstanding meritorious service in duties of responsibility" awarded by the Governor General of Canada.

On an international level, he has served as a past governor for the American College of Physicians. He was responsible for the revival of our provincial chapter of the American College of Physicians. He has also served as the president of the Canadian Society of Internal Medicine.

At the University of Alberta, Dr. Gibson has served in many roles including most recently Associate Dean, Clinical Faculty. During his tenure he was instrumental at raising the profile of our clinical faculty within the university. He has also achieved the rank of full Clinical Professor of Medicine. I would also note his multiple clinical teaching awards indicating the importance he places on preparing the next generation of physicians.

A few excerpts from the letters of recommendation…

In my observation of "The Colonel's" leadership style, I characterize him as the rarest of medical leaders: a physician with a consistent "can-do" attitude. I learned from him not to be deterred by perceived organizational barriers, but rather to embrace hidden opportunities. He demonstrates innovation, flexibility, and broadmindedness to evolving medical practice and healthcare system dynamics. Nevertheless, he is principled and resolute, when required. These insights continue to guide my approach to medical leadership.

Gurmeet Singh, MD, Medical Director
Adult ECMO Program, Mazankowski Alberta Heart Institute

Dr. Gibson's humility is probably one of his greatest strengths and one that can sometimes be hard to find in health care. He always has the best interest of his patients and the team around him at heart. He stands by his personal values and respects all members of the health care team. He is inquisitive and open to hearing many perspectives in complex problems and I have always known him to be open to considering all options to address challenging issues.

Scott A. McLeod, MD, Registrar
College of Physicians and Surgeons of Alberta

The acceptance of Physician Assistants in Canada and their continued importance in the delivery of quality health care has been in no small part due to Dr. Gibson's quiet and steady leadership. The development of/and organization of PAs from an essentially military entity, at least in Canada, to a National Organisation can be attributed to MWO (ret) Tom Ashman and others. Tom was a medic deployed with us in Somalia. Very early in the PA movement, Neil became a champion for them and has advocated for them tirelessly. Recently he was recognized by CAPA (Canadian Association of Physician Assistants) for his hard work and commitment.

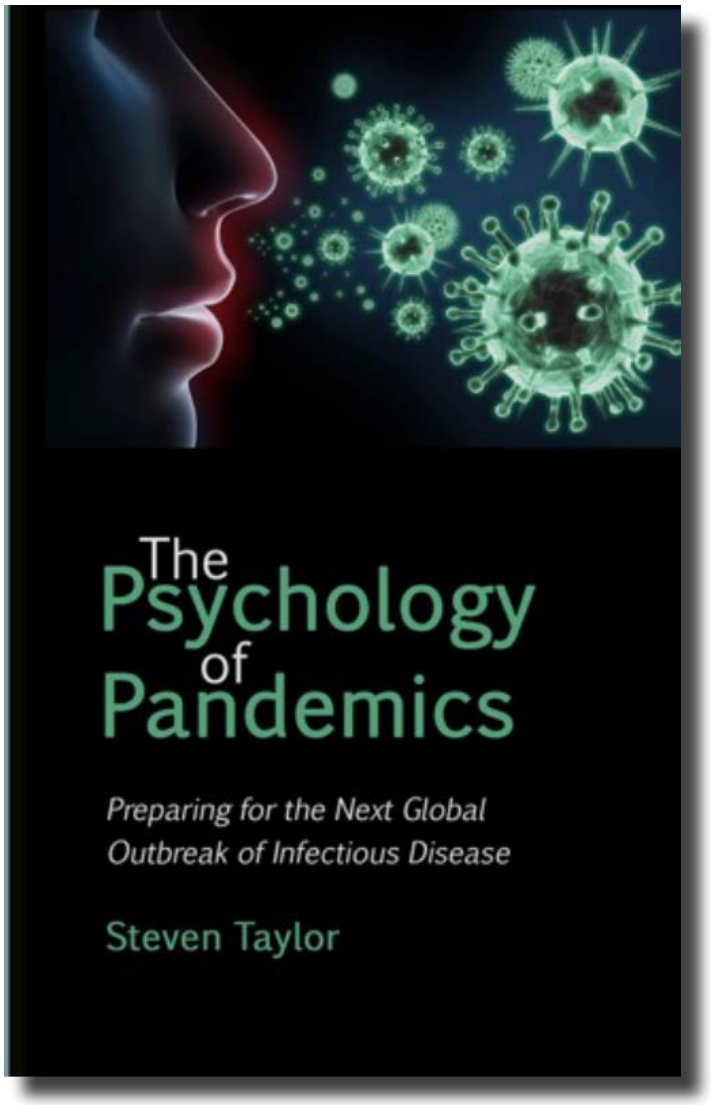
I believe I have seen Dr. Gibson as few others have. He is a superb doctor. His concerns for patients encompass so much more than medical management. He is a compassionate physician who is always looking to make the system work better for all patients. During all of our interactions I have found him to be insightful, dedicated and passionately engaged.

Colonel (ret) Russell James Brown, CD, MD, MA
Associate Clinical Professor (retired)
Dept. of Anesthesiology and Pain Medicine
University of Alberta

BOOK REVIEW

The Psychology of Pandemics: Preparing for the Next Global Outbreak of Infectious Disease

Steven Taylor, PhD
Cambridge Scholars Publishing, 2019



Reviewed by Johny Van Aerde, MD, PhD

With uncanny foreshadowing, in December 2019, University of British Columbia professor Steven Taylor published *The Psychology of Pandemics* describing the course of previous pandemics and their behavioural and psychological impacts. The book highlights the threats that worldwide pandemics pose, not only to governments and health institutions, but also to individual people dealing with day-to-day consequences. In an interview with Dr. Brian Goldman,[1] Taylor acknowledged that the timing of the publication, on the cusp of the COVID-19 pandemic, was purely coincidental.

Taylor sheds light on the relevance of the psychological factors that play a role in creating adaptive and disruptive behaviours during pandemics. By analyzing the data of previous pandemics, Taylor explains the implications of psychological reactions and behavioural problems for health systems that arise in these times. Reading *The Psychology of Pandemics* is like reading a book about today's COVID-19 pandemic rather than pandemics of the past, as most of the book's evidence-based content is consistent with what we have been living through since the spring of 2020. Based on what we see as responses to the current pandemic, we seem to have learned little over the last decades or centuries, as we are still no better equipped to prevent, deal with, and resolve a pandemic than before.

The first chapters deal with basic facts of pandemics and available methods used to deal with them. Previous reactions to pandemics have focused on immediate concerns, neglecting to anticipate potential future dangers. As such, health care agencies and governments have focused on limiting the spread of infection, at the expense of other important elements, such as the psychological consequences people may experience. This happened during the plague

pandemics, the 1918 influenza pandemic, SARS, and now COVID-19. This oversight might hinder positive efforts to contain and fight spread by failing to treat emotional distress and maladaptive and socially disruptive behaviours.

The focus of the second part of the book is on those psychological consequences of pandemics. Different personality traits cause people to differ in the way they react to psychosocial stressors. Although some can minimize or control their reactions, others may experience negative emotions, the most common being anxiety and fear. Mental disorders may also be triggered by pandemic-specific stressors. These reactions might also be linked to the emergence of socially disruptive behaviours, such as riots (read anti-mask gatherings during the COVID-19 pandemic), or even conspiracy theories.

These two types of reactions emerge because of uncertainty during a pandemic. People tend to believe in conspiracy theories when they are trying to understand the new environment they are living in, asserting some control over it, or maintaining the security and positive image provided by their group. Taylor accurately describes what supporters of conspiracy theories post in social media every day: (1) proponents typically make great efforts to cite supposedly authoritative sources to support their claims, even if such claims are vague (e.g., "Research at Harvard has shown that…"); (2) the theories themselves are often vague; and (3) proponents frequently use leading questions – a "just asking" style in which they raise rhetorical questions to challenge mainstream views. The tendency to believe conspiracy theories is related to certain types of psychological disorders, such as narcissism.

One of the final chapters of *The Psychology of Pandemics* is dedicated to risk communication, which becomes inherently relevant to reducing the negative reactions or defences against a pandemic. Proper risk communication by government, health, and other credible sources should aim to inform people about the best actions to take to protect their health and safety. Risk communication should, therefore, include information about coping methods and guidance on managing stress and emotional reactions, such as anxiety, depression, or anger. Direct communication with the public can lead to positive behaviours, such as good hygiene, social distancing, or even vaccination, if health authorities are perceived as trustworthy.

Providing a sense of stability during and after the pandemic and psychological support, such as cognitive behavioural therapy in higher-risk cases, will be necessary as a response to the psychological needs of people around the world. Yet, as for so many aspects of this pandemic, we are little prepared to support our citizens psychologically during and after the COVID-19 crisis.

This book is an easy and fast read. Hopefully, Taylor's knowledge will be used in what can still be salvaged during this pandemic. As for the next pandemic, judging by Taylor's book, the French might be right when they say, "Plus ça change, plus c'est la même chose."

Reference

1.Goldman B. The psychology of post-pandemic life – why you might feel anxious about re-entry. The Dose (podcast); 19 May 2021. tinyurl.com/t947b4td

Author

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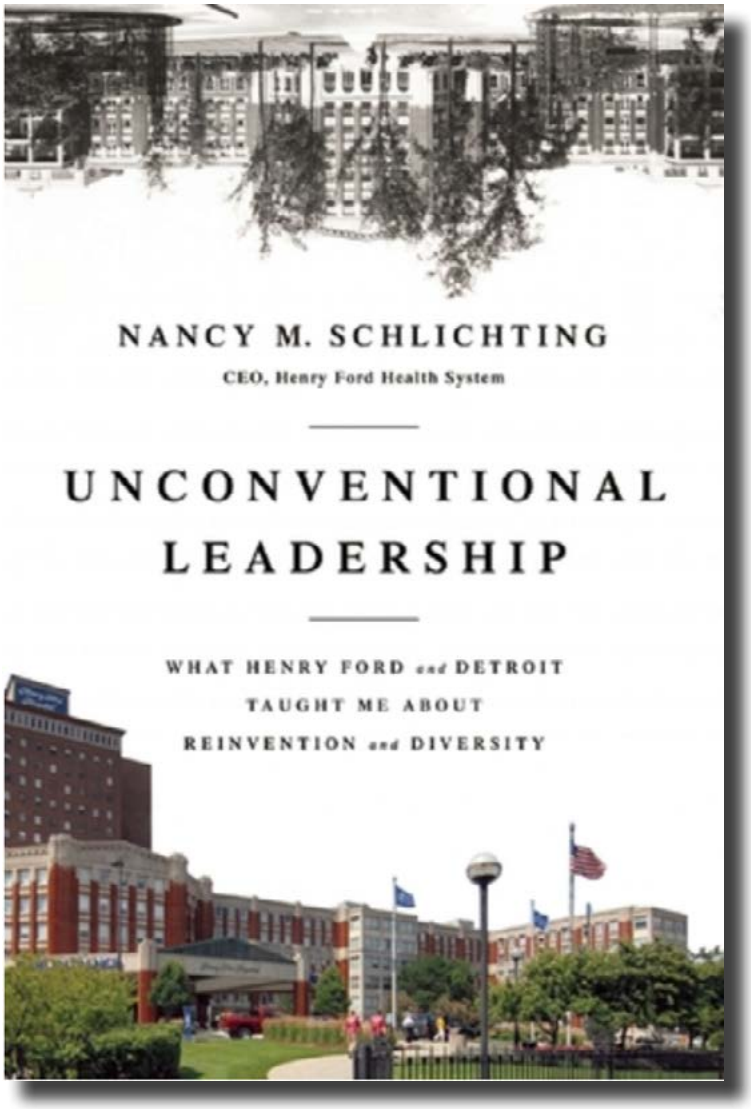
BOOK REVIEW

Unconventional Leadership: What Henry Ford and Detroit Taught Me About Reinvention and Diversity

Nancy M. Schlichting
Bibliomotion, Inc., 2016

Reviewed by Justin Shapiro

Nancy Schlichting's *Unconventional Leadership* provides unique insight into the career of an illustrious American health care executive. Schlichting



recounts the triumphs, setbacks, and surprises that occurred as she rose through the ranks of health care, culminating in her appointment as chief executive officer of Henry Ford Health System (HFHS) at age 48. While tracing her professional journey, Schlichting shares her experience in leading successful turnarounds throughout her life. She offers poignant accounts of the struggles she faced as a female and LGBT CEO in a male-dominated industry.

Unconventional Leadership is split into eight chapters that focus on three unconventional strategies for driving long-term success: putting people first, fostering a culture that is conducive to innovation, and embracing diversity in all its forms. In the contemporary health care landscape, disruption is the norm. Schlichting clearly illustrates how leaders can harness the power of disruptors for the benefit of patients, workers, and communities alike. She credits Henry Ford himself for providing a paradigm of innovative leadership. As Ford pioneered a living wage by paying his employees $5 a day, HFHS offers a formula to rejuvenate a community in distress while working toward profitability.

When Schlichting became CEO of HFHS, the organization was bleeding cash. Detroit was in economic, cultural, and population decline, and government regulation was disrupting traditional models of health care delivery. However, Schlichting reinvigorated the culture and fiscal outlook of the organization within two years by slashing inefficiencies and cutting costs, while investing in quality improvement and innovation.

Schlichting offers an insightful case study of an intended merger between HFHS and a neighbouring health system. The cultural differences between the two organizations were deemed too large to amalgamate seamlessly, and the deal was abandoned at the last moment. Despite the hardships of rescinding the merger, the experience provided HFHS with the opportunity to gain a deeper understanding of a large competitor's business model, reaffirm its own core values, and appreciate its unique mandate as a not-for-profit health system serving Detroit's most vulnerable populations.

Schlichting also expounds on the role of HFHS in helping Detroit emerge from its current decline. She outlines the many efforts, including redeveloping real estate around its flagship hospital and co-founding an innovation hub, that HFHS undertook during her tenure to spark a renaissance in Detroit. Schlichting came to Detroit in the middle of the exodus from the city, and she recounts how many of her new colleagues were perplexed by her

decision. However, from her first day in Michigan, she intended to be immersed in the community. As Schlichting demonstrates, building a trusting working relationship with stakeholders is crucial to effecting meaningful change within any industry, including health care.

Schlichting also focuses on the importance of diversity. HFHS is located in a city that was 83% Black, but the board and leadership team were unrepresentative. As CEO, Schlichting changed the identity of the organization to reflect the surrounding community. Schlichting brilliantly explains how placing people with varied life experiences in decision-making roles helped the organization better address the needs of patients and employees. She also posits that diversity does not stop at race or socioeconomic status; cognitive diversity is equally important for an organization to thrive. Diversity of thought is often overlooked when discussing diversity at large. It is crucial to create a culture that encourages the healthy clash of ideas. If employees do not offer dissenting perspectives, organizations will not fulfill their creative potential, and disruptors will work against their organizations rather than with them.

One illustrative account was how Schlichting championed a urologist who had been trying unsuccessfully for years to secure funding to pioneer robotic surgery at HFHS. Despite the dire financial situation, Schlichting acquired the necessary equipment. HFHS is now a world leader in robotic surgery because of investment in the organization's human capital and ideas.

Unconventional Leadership offers invaluable insight for any student of leadership. Schlichting does not purport to offer a panacea for the complex issues that health care leaders face, but rather an unorthodox mode of operating and a method to evaluate an organization's strategic landscape. This is a must-read for anyone interested in creating a culture of innovation, collaboration, and ethical leadership.

Author

Born and raised in Montréal, Justin Shapiro is a third-year medical student at the University of Toronto. He is concurrently pursuing an MSc in health system leadership and innovation.

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