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Using Leadership to Improve Equity, Diversity and Inclusivity

In this issue

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EDITORIAL

Compassionate leadership fosters equity, diversity, and inclusivity

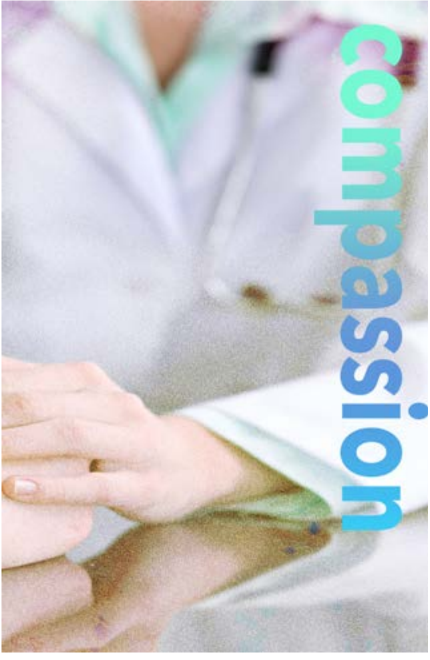
Sharron Spicer, MD, FRCPC, CCPE

If ever there was a need for compassion in health care, it is now. The far-reaching effects of pandemic-induced suffering have reached epic proportions for our patients, our colleagues, and our entire society. Compassion is at the heart of what we do. It is one of the core virtues of our professional identity. According to the CMA Code of Ethics and Professionalism,[1] "A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient."

Compassion is well understood in the physician–patient relationship. More recently, increased attention has been given to the role of compassion in health care leadership. Leading with compassion involves appreciating the unique and important characteristics of those we lead and serve, modeling respectful and inclusive behaviours, and encouraging others to develop their advocacy and leadership roles. Not surprisingly, therefore, compassionate leadership advances issues of equity, diversity, and inclusivity (EDI) within the organization.

I'm pleased that, in this issue of *CJPL*, we have curated encore and new articles that address principles to enhance compassionate EDI-focused leadership. In a book review of *Compassionate Leadership* by Michael West,[2] Johny Van Aerde notes the author's four steps for increasing compassion: attending, understanding, empathizing, and helping. Using this framework, we can see the value of revisiting historical events to identify and shift the mistreatment of certain groups. For example, in this issue, authors Shapiro, Levy, and Sommers describe how teaching about the Holocaust can enhance awareness of modern ethics principles in medicine.

It is sobering to recognize the roles that physicians played in perpetuating systemic racism in Nazi Germany. Closer to home, recent events have further revealed the systemic racism – past and present – that affects Indigenous people in this country. Sadly, the health system is directly implicated in some of these abuses. A Canadian Medical Association (CMA) produced film, *The Unforgotten*,[3] shares the experiences of Inuit, Métis, and First Nations peoples at various life stages and at different times in history. It is an excellent resource to spark reflection and conversation about creating needed changes in the health care system. As West's model suggests, attending to and understanding such events prepares the ground for change.



Compassion is deepened as we respond to others' experiences with empathy. Often, this emotional response is evoked with first-person narratives about lived experience. We honour those

who share their stories when we listen with curiosity, recognize our biases, and suspend judgement based on our own beliefs. We have included in this issue a number of first-person accounts of physicians addressing their own self-identified areas of diversity. I hope you take time to ponder their reflections.

Finally, to be effective, compassion leads to action. In this issue, we have provided an adaptation of the CSPL's interview with CMA President-Elect Dr. Alika Lafontaine.[4] He eloquently expresses how his leadership journey developed through a series of opportunities. In moving from advocacy to leadership, he realized the importance of filling the space with others. I would consider that to be a great lesson in EDI-based leadership! We have also included in this issue articles that address practical steps to support specific physician groups: women, those who identify as LGBTQ2S+, those with disabilities, and physicians across the age span. We have further highlighted the importance of ensuring leadership diversity in crisis management.

Like a forest regrowing after a fire, we have opportunities to see post-pandemic transformation arise in the aftermath of this COVID-19 experience. For us to achieve growth in personal, professional, and organizational realms, we would be well guided to ground ourselves in compassionate leadership.

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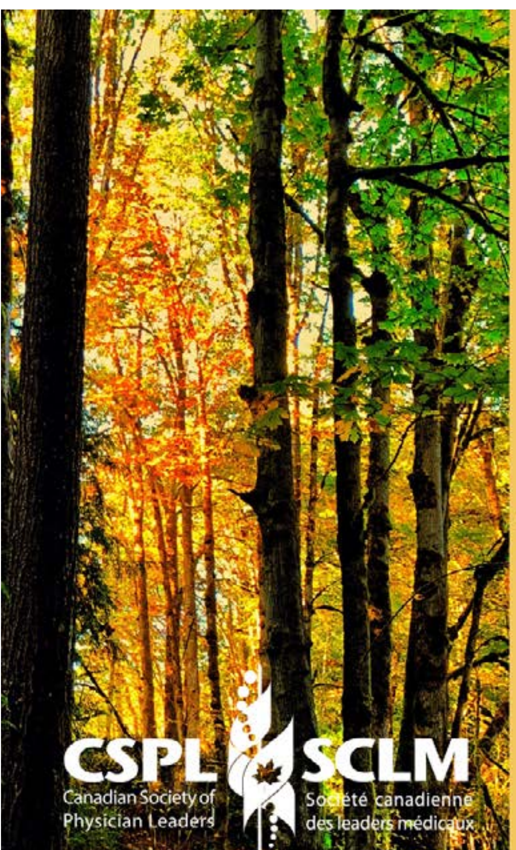

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Mind the gap: thoughts on inter-generational relations in medical leadership

Glen Bandiera, MD, MEd

Originally published CJPL 5(2)

Numerous models categorize, characterize, and explain differences among generations in society. Currently, four distinct generations are engaged in the physician pipeline from early training to late career. The distinct differences in how they view the world, their self-perceptions, and how they conduct relationships create real and imagined tensions. However, the significance of these differences is debated, as variability among those within a generation is likely larger than that between generations. Nevertheless, medical leaders and educators will be wise to develop an appreciation for generational differences to ensure that everyone may live up to their full potential. Opportunities exist to gain greater appreciation for how generational differences manifest in day-to-day interactions, adopt new approaches to interacting with those of different generations, and identify points of leverage across generations to optimize relationships and outcomes. Seizing these opportunities will require tough introspection and effort by leaders to overcome stereotypes and adapt to the challenges presented by those of generations ahead and behind them. This article looks at generational differences from a medical leadership perspective, offering observations and suggestions to address tensions in four domains: feedback, communication, collaboration, and problem-solving and lifelong learning.

KEY WORDS: Boomers, Generation X, Generation Y, Millennials, physician leaders, intergenerational differences

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Roughly four distinct generations are currently engaged in medical careers: Traditionalists (born roughly 1925–1945), Baby Boomers (1946–1964), Generation X (1965–1980), and Generation Y or the “Millennials” (1980–1996).[1-3] Howe and Strauss[4] argued to both popular acclaim and criticism that these are recent iterations of a repeating cycle of generational “archetypes” throughout the modern history of the developed world. The cycle starts with a high point after a crisis, creating an idealistic “prophet” generation adhering to an optimistic view of what the collective can accomplish with new opportunity, conformity, and dedication. These are the Boomers. Generation X comprises reactive “nomads” who begin to develop a consciousness about the implications of blind

conformity and the importance of questioning societal directions. They seek increasing personal autonomy and the erosion of institutional authority. The archetype of the "hero" typifies Millennials, who are more civic-minded and adhere to a need for security and belonging fed by their overprotected childhood and a sense of impending "social unraveling." Still to rise within the profession (and also represented by the departing Traditionalists) is the fourth archetype, the "artist." People in this generation also had overprotected childhoods during a crisis and seek security through due process, order, and fairness for all.

Millennials entered the workforce during a time of unraveling with serial financial downturns, the rise of terrorism, and rapid advancement of technology. They are products of overprotective home environments...

The experiences of each generation drive the archetypal characteristics. For example, the Boomers emerged after the crisis of two world wars. Their strong adherence to conformity and social change drove the expansion of corporate America, the sense of company loyalty, strong nuclear family values, and the expectation that hard work, calculated sacrifice, and dedication pay off in personal affluence and well-being.

Millennials entered the workforce during a time of unraveling with serial financial downturns, the rise of terrorism, and rapid advancement of technology. They are products of overprotective home environments, they seek a strong voice in matters related to them, believe strongly in their potential to influence people and outcomes, and see the power of the generation in the ability to collectively self-determine, rather than conform to existing norms. They have a strong affinity for sharing and collaboration. Manifestations of these perspectives, enabled by modern technology include the #metoo movement, the Arab Spring, crowdsourcing, and the long overdue increased focus on gender-based and other forms of equity within institutions.

One can see potential sources of friction between the generations. These may be amplified by the belief that each has in its own validity: while each generation self-identifies unique characteristics, with the Millennials seeing themselves as most distinct, each generation notably feels they are smarter than the others.[5] Millennials, although junior, feel that others have much to learn from them.

Although this framework might seem like a convenient way to make sense of professional relationships and related observations, it is important to consider dissenting views. Davey[6] outlines some risks of over-reliance on these models and encourages consideration of the individual first: "It's time to stop thinking about problems as 'generational issues.' If you have a problem with an entire generation, that's your problem and your prejudice. If you have a problem with one employee who happens to be of a different generation than you, then you have a problem with one employee, period." These cautionary words notwithstanding, there is some utility in exploring further the role of generational differences in leadership.

Implications for leadership

As Boomers make up the institutional senior ranks and early Generation X members the established mid-career cohort, most medical leaders arise from these groups. In contrast, those being taught, mentored, and overseen are predominantly late Generation X members and Millennials from Generation Y. If stereotypes are to be believed, current leaders are tenacious individualists with a high degree of practicality and a strong work ethic, who believe that resources are to be individually managed and you get what you earn. They are providing leadership and mentorship to a generation of overprotected, empowered collaborators, who believe that no individual has a lock on anything and that power exists in sharing and collective ownership. The tensions are obvious.

There is also a well-articulated leadership gap in medicine.[7] Current physician leaders often took on sequential leadership roles out of necessity, a sense of obligation, or personal interest in making a difference through administration. Many learned about leadership on the fly, some

adding formal education later. The currency for effectiveness is often personal impact and just portfolio stewardship. The allure of administration became muted as Boomers tended to hold on to power and influence, while Generation X exploited skepticism about organizational hierarchy and their need for autonomy and flexibility to avoid taking on leadership roles. The current health care climate and seemingly unending operational challenges do little to encourage mid-career individuals to step up.

Millennials, on the other hand, are connected and well-mentored. They have an invigorated energy to see a better future, one that depends on them. They formally prepare themselves for leadership roles and pursue opportunities to gain experience. They are motivated by social consciousness in leadership.[8] The typical Millennial would think nothing of jumping over a member of the preceding generation to take on a plum role, something that would be almost anathema to a Boomer. Again, more tension.

Finally, one need only look to medical leadership advertisements to identify one key desirable: the ability to influence others. This may pertain to one's impact on a group, such as setting a direction and achieving goals within an institutional framework, both of which require the ability to influence others and create alignment to a vision. Leaders are also expected to attend to individual needs through provision of personal mentorship, support, and advice, as well as creating an environment in which each and all can reach their full potential. An appreciation of generational differences and adoption of mitigating strategies will be key for success in both areas. Leaders are also often involved in mediating conflict between others experiencing these same tensions. Finally, generating consensus and commitment to certain directions within an age-diverse group can present challenges when differing perspectives cannot be reconciled.

So what to do? The following sections provide some ideas for turning generational tensions into opportunities for success.

Mind the "feedback gap"

As Busari[2] outlines, "While members of the Greatest Generation [Boomers] revere the institution of education as the source of all knowledge, conform to rules and regulations and tend to experience having failed if and when feedback is offered, members of the Millennial generation, and to a lesser degree the Gen Xers, thrive on immediate and continuous feedback, feel insecure without it and expect to be acknowledged based on how big their social network followers are." Millennials are so used to explicit feedback that they find it hard to make inferences about their performance in its absence. Nuanced and implicit feedback, through such means as body language, is often lost on Millennials, frustrating teachers who may assume the learner didn't listen or didn't care.

Leaders should remember that Millennials welcome feedback, rather than seeing it as an imposition. Feedback should be both more frequent and more explicit to effect change in a Millennial. In education, this is a key feature of the new competency-based models, which

involve frequent observation and feedback. For their part, Millennials, accustomed to constant validation, must be prepared for what they ask for: as one advances in a career, feedback is less uniformly positive.

Coaching frameworks have been championed as ways to make feedback more palatable for both participants: "Exciting research in recent years has moved medical education closer to an enlightened perspective on assessment and feedback. Robust assessment of learner competence and coaching for learner development are increasingly recognized as necessary partners in effective clinical education."[9]

Frequent, explicit feedback and coaching in leadership relationships will help Millennials feel more welcome and support their development. Getting to know and understand their perspectives through focused questioning will also help to bridge the gap and may result in a more senior leader learning how to best optimize a Millennial's role in the organization.

Davey,[6] writing from a perspective outside medicine, offers suggestions: "Where have you seen great ideas that we could apply here?" "What can you teach me that would help me keep up with the digital age?" "Given what you've just told me… what advice would you give me to make this work?" "What do you see as the strengths you bring to the team?" She concludes, "For most people, young or old, seeing their ideas in action will reduce their resistance and start to bridge the divide."

Embrace different communication styles

Bernard Shaw reputedly said, "The single biggest problem in communication is the illusion that it has taken place." This rings truer now than ever. Many emphasize the importance of not jumping to conclusions about motives or character based on one's manner of communication.

One obvious example is technology use. Millennials grew up connected and are accustomed to instantaneous, abbreviated conversation segments. Older folks, less so. Citing Erikson,[10] "The crux of most technology-based team misunderstandings is not the technology per se – it is how team members interpret each other's intentions based on communication approaches."

Ellaway[11] offers a label in her paper, "The informal and hidden curricula of mobile device use in medical education," emphasizing problems with misguided assumptions about mobile technology. One should avoid assuming Millennials are detached or pre-occupied when they focus on their device; they may be involved in problem-solving or bringing others into the conversation.

A barrage of emails with explicit demands and expectations of a rapid response can seem intrusive. This, however, is how Millennials communicate with each other. More senior leaders should set an early pattern of when and with what urgency they will respond to emails, advise when a response will be delayed, follow-up with a verbal conversation at a next meeting, or send an auto-reply something akin to, "I check emails infrequently, if this is urgent please call or visit my office."

E-communication may also seem impersonal or distant to an older generation, sometimes to the point of offense or worry about the lack of interpersonal contact. Those afflicted should reassure themselves that this is a style issue rather than a personal slight.

Explicitly stating one's communication preference may help, as Millennials may not realize they have "permission" to approach superiors directly rather than digitally. Conversely, Millennials would do well to understand that tardy delays are not dismissive, as others are not tied to devices as they are. They should try to avoid feeling frustrated or rejected by a delayed response. Everyone in the modern workplace should develop

multi-modal communication strategies suited to purpose.

Accept greater collaboration but proceed with caution

Millennials were told their opinions matter, they should express them freely and they would be listened to. This generation is, thus, very collaborative and open with their opinions. They see knowledge as available for everyone, not something to be hoarded. Their view is that real power lies in the collective and the ability to consult, engage, and involve others quickly and liberally.

In medical circles, these propensities play out in several ways. Millennials prefer to collaborate widely rather than take a sole role in academic endeavours, a practice that may make their CVs hard to interpret for more senior academics.[7] In a clinical teaching session such as questioning on ward rounds, seeking out information "on the fly" is smart to a Millennial but may be seen by their teachers as "cheating" or being underprepared.

Similarly, sharing information may have different meanings; Hopkins et al.[12] provide an excellent example of the tensions that may arise when Millennials liberally share information that their supervisor took to be protected. A key principle seems to be: encourage collaboration to maximize input and impact, but be sure everybody is comfortable with it.

Boomers and Generation X members would do well to become comfortable with embracing the democratization of information and increased open collaboration. Encouraging Millennials to share their strategies or to explain where and how they got information can have a positive effect on a relationship. Millennials should use caution when sharing information provided by their teachers and leaders and ask for permission or guidelines.

Think about problem-solving and lifelong learning differently

When problem-solving, the Boomer perspective would bring a small group of key individuals together in a formal, scheduled meeting to talk things through, whereas the Millennial perspective would involve more people accessed asynchronously and quickly via electronic means. Erikson[10] frames this dichotomy as such: "[Millennials may view] work as 'what you do' vs. 'where you go'" and asks some challenging questions: "Is someone who arrives at 9:30 necessarily working less hard than other team members who are there at 8:30? Is it okay for some members to work from alternate locations? Is adherence to time and place norms important for the team to accomplish its task? Is it viewed by some as an important sign of team commitment?"

Boomers should recognize that Millennials' reluctance to commit to structured meetings is not reflective of detachment or lack of commitment, rather it represents a different manner of engagement in which as many opinions as possible are valued and meetings are unnecessarily rigid in terms of both scheduling and structure. Leaders should consider creating some space for Millennials to collaborate in this way, perhaps between formal meetings scheduled less frequently. Millennials, in turn, should recognize that some initiatives must be contained to fewer individuals and check on the appropriateness of more general consultation before engaging in it.

Given Millennials' expectations of rapid responses and direct interaction with their leaders, it might be advisable for leaders to create a forum for such interchange.

They may also consider embracing the structure of meetings as a way to engage in the details of a topic and more fully appreciate the perspectives of others. Boomers and Generation X members are more likely to accept "packaged" education products with a firm plan and structure, and the focus is likely to be on learning facts and skills. Classrooms, lectures, traditional conferences, and reading papers and chapters resonate with them. Millennials typically do not respond well to some traditional instructional methods, such as public inquisition (being put on the spot in ward rounds), single-moded information sources (listen to the expert), and large group lectures with one-way communication. This has implications for faculty and organizational development.

Those looking to reach early-career learners should consider newer educational models, such as e-modules, flipped classrooms, and gamification.[3] Flipped classrooms involve providing learners with materials in advance and using an in-person environment to discuss issues, answer questions, and interact with the materials through such things as case studies, simulation, and Q&A sessions. This may prove uncomfortable with previous generations who may be reluctant to "leak" the content and risk reducing the value-added of the session. Millennials can help by providing input into the design of interactive sessions, preparing as required in advance, and demonstrating appreciation for the perspectives of more experienced individuals.

Millennials are highly skilled at accessing information. So much so, that they fuss far less about remembering vast amounts of information than their predecessors did.[10,12] Erikson[10] refers to this generation as "largely 'on demand' learners" who "figure things out as they go." They will take advantage of their networks and electronic information sources to figure out a course of action and expect others to do the same.

Again, tolerance is foundational to creating a way forward. Older generations have had to face the reality that they cannot know or remember everything and should accept that Millennials are demonstrating how to manage information in a different way. The value-added by older generations may be to demonstrate how to be better curators or brokers of information, how to be appropriately critical of information, and how to use information to eventually make wise decisions.

Given Millennials' expectations of rapid responses and direct interaction with their leaders, it might be advisable for leaders to create a forum for such interchange. Certainly having individual simultaneous email conversations with each member of a large group is not a palatable endeavour, nor are group email discussions that serve only to clog inboxes. Setting up a discussion forum or blog or setting aside time for open web-based sessions to discuss topics may be helpful strategies that allow leaders to manage their time while also providing frequent access to those they are leading.

Summary

Intergenerational differences are well described and, to a degree, real. Recognizing that interpersonal differences are still paramount and can be larger than group differences, leaders should consider how to use the described generational differences to advantage as they develop as leaders. The key principles for success seem to converge on the following: strive to understand, be slow to assume, validate perceptions, and look for common ground. These, along with some of the more specific strategies outlined in this paper, may be helpful to all within the profession as they struggle with how to best seek synergy among generations.

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This article has been peer reviewed.

Fostering inclusion of physicians with disabilities at The Ottawa Hospital

Camille Munro, MD, Michael Quon, MD, and Kathleen Gartke, MD

Physicians with disabilities can offer unique insight into their hospital institutions. Their lived experiences can enrich the learning and clinical environment, increase empathy for patients, and improve care for patients with disabilities. Unfortunately, barriers to full inclusion of these physicians often develop because systems in place are inadequate to meet their needs. The Ottawa Hospital (TOH) recently identified a void in policy for physicians with disabilities that aligns with the goals of both the Physician Wellness and the Equity, Diversity and Inclusion (EDI) offices. Since then, TOH's Medical Advisory Committee (MAC) unanimously voted on a position statement created for physicians with disabilities. It includes principles that value these physicians and recommendations to promote their accommodation and provide them with equitable opportunities. To our knowledge, this is the first position statement designed specifically for physicians with disabilities at any Canadian hospital institution. This type of statement is important because most practising physicians are not protected by the employer/employee relationship at their hospitals. Our work is also an important call to action: the statement provides recommendations for all departments at TOH to create inclusive policies and practices for physicians with disabilities. Achieving full inclusion of physicians with disabilities requires that institutions take action to reduce structural barriers, improve their culture toward disability, and provide training on the potential for reasonable accommodations. This position statement could be adopted at all Canadian hospital institutions to improve inclusion of our colleagues with disabilities.

KEY WORDS: accommodations, barriers, disability, equity, inclusion, physicians

Medicine is a field that should be accessible to people with diverse backgrounds, experiences, and abilities. Although progress has been made to reduce systemic barriers to full participation for all individuals in medicine, challenges remain with respect to equity, diversity, and inclusion when considering disability. The *Accessible Canada Act* defines disability as "any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment – or a functional

limitation – whether permanent, temporary or episodic in nature, or evident or not, that, in interaction with a barrier, hinders a person's full and equal participation in society."[1] A barrier may be defined as "anything physical, architectural, technological or attitudinal, anything that is based on information or communications or anything that is the result of a policy or a practice – that hinders the full and equal participation in society of persons with an impairment."[1]

Under the Human Rights Commission, employers have a duty to accommodate the needs of people with disabilities to ensure they have equal opportunities, access, and benefits.[2] However, in Canada, physicians are usually not employees of their hospitals or other institutions. Barriers develop and then persist because current systems and processes are inadequate to meet the needs of physicians with disabilities. They can face structural barriers related to lack of policies and procedures, clinical accommodation, and disability/wellness support services. Examples of accommodations in the workplace can include, but are not limited to, flexible work arrangements or scheduling; attendant services; adaptive technology; changes to work sites; modifications to workspace and furnishings; media conversion and/or interpreters appropriate to the nature of any sensory disability. Many physicians with disabilities also face cultural barriers related to the attitudes, beliefs, and values of their hospital leadership or colleagues. Ableism is widespread within our medical culture and remediation is increasingly urgent.

Recent survey data from the United States showed that 3.1% of physicians self-identified as having a disability. The most common disability reported was a chronic health condition (30.1%), followed by mobility (28.4%) and psychological (14.2%) issues.[3] The most recent data from the Canadian Survey on Disabilities in 2017 reported that 22.3% of all Canadians 15 years of age and older self-identified as having at least one disability.[4] There is a lack of current data on the number of physicians with disabilities in Canada. In 2012, Moulton[5] reported data from Statistics Canada, showing that 9000 physicians with disabilities were working in Canada (11.2% of the profession), compared with 13.7% of all Canadians who self-identified as having at least one disability.

Physicians with disabilities are more likely to provide care for patients with disabilities and contribute to improvement of health care disparities and their outcomes.[6] Their lived experiences of disability increase empathy for patients, enrich the learning environment, and can improve the working conditions of colleagues, learners, and patients.[7] Achieving full inclusion of physicians with disabilities will require that institutions take action to reduce structural barriers, improve their culture and climate surrounding disability, and provide training on the potential for reasonable accommodations.[8]

To our knowledge, no other teaching hospitals in Canada have a position statement or accommodation policies designed specifically for physicians with disabilities. Given that physicians with disabilities are frequently not employees, they require unique

consideration and protection at the institutional level. At The Ottawa Hospital (TOH) the Medical Advisory Committee has formally endorsed a position statement on physicians with disabilities (see orange tet). It is more than a mission statement that merely suggests inclusion of physicians with disabilities.[9] It commits to the creation of policies and the implementation of best practices to build an inclusive environment for all physicians with disabilities who work at TOH. It recommends that all departments develop a plan to identify, eliminate, and prevent barriers for such physicians. A position paper was chosen as a first step, for expediency. As a process, its endorsement at the senior leadership level can be achieved within a couple of months as opposed to the more extensive, time consuming process of policy development. Rejection of a such a position paper is unlikely. Instead, it will result in more immediate socialization of the concepts and sensitization of leadership to the issues.

Further faculty development education about the accommodations process will follow along with implementation of formal policy. Survey data before and after implementation of our policy will then assess the accommodations provided to our physicians with a self-disclosed disability. In addition, we are considering further qualitative evaluation of the perspectives of physicians with disabilities to determine any ongoing perceived barriers or inequitable opportunities they are still facing. Through implementation of such a policy and education leading to systemic change, health care can be rehabilitated into a more safe and equitable space for both physicians and patients with disabilities.[10] This serves as an important call for the inclusion of physicians with disabilities.

The Ottawa Hospital's Medical Advisory Committee position statement on physicians with disabilities*

Being inclusive of physician with disabilities at The Ottawa Hospital (TOH) may improve conditions for all physicians, learners and patients. It would create a more collaborative, respectful, just professional and learning culture and practice of medicine. Physicians with disabilities are likely to provide care for underserved and disability-concordant populations, therefore reducing disparate population health outcomes and inform health care practices for patients with disabilities. The lived experiences and patient perspectives of physicians with disabilities can inform research and quality improvement from patient-centred perspectives.

The MAC abides by the CMA Policy for Equity and Diversity in Medicine, December 2019.†

The MAC recognizes there is no employer/employee relationship between TOH and the physicians of the medical staff.

The MAC promotes the inclusion of physicians with disabilities and recognizes they contribute to positive outcomes for all physicians, learners and patients.

The MAC fosters the value of physicians with disabilities as part of diversity within its organization.

The MAC advocates identifying and eliminating barriers to accessibility.

The MAC supports treating physicians with disabilities in a way that values and respects them.

The MAC promotes providing equitable opportunities to physicians with disabilities to allow then to realize their full potential while maintaining their dignity and independence.

The MAC recognizes the importance of educating leaders and members on reasonable accommodations for physicians with disabilities.

The MAC recommends all departments create inclusive policies and practices for physicians with disabilities. These policies and practices should:

- meet the needs of physicians with disabilities including support to assist physician access to appropriate work that respects their accommodations
- destigmatize disability
- aid in recruitment and retention of diverse applicants
- include a plan to prevent and eliminate barriers
- be available for all physicians who are working or will be working at TOH
- be reviewed and updated regularly

Disability – Ontario's accessibility law adopts the definition of disability that is in the Ontario Human Rights Code.‡ It defines disability broadly:

1. "any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or a wheelchair or other remedial appliance or device,
2. a condition of mental impairment or a developmental disability,
3. a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
4. a mental disorder, or
5. an injury or disability for which benefits were claimed or received under the insurance plan established under the Workplace Safety and Insurance Act, 1997."

The definition includes disabilities of different severity, visible as well as non-visible disabilities, and disabilities with effects that come and go.

*How to create an accessibility plan and policy. Toronto: Government of Ontario; 2019. Available: **https://tinyurl.com/wz58vh2e**

†Equity and diversity in medicine. Ottawa: Canadian Medical Association; 2019. Available: **https://tinyurl.com/4sud6rbs**

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LGBTQ2S+ diversity: leading and celebrating pride

Derek Puddester, MD

Originally published CJPL 5(2)

Organizations that actively promote diversity tend to be learning and practice environments of choice, excellence, and innovation. However, despite all our hard work and successful social equity efforts, discrimination still exists in Canadian health care and medical education. Leaders can influence diversity in their organization by taking four urgent actions.

KEY WORDS: diversity, LGBTQ2S+, health care, education, harassment, discrimination, leadership

CITATION: Puddester D, LGBTQ2S+ diversity: leading and celebrating pride *Can J Physician Leadsh* 2021;8(1):16-20 https// doi.org/ 10.37964/cr24746

Diversity promotes leadership success

The Harvard Business Review[1] has identified diversity as a source of power, influence, and success that organizations ought to nurture and support. In particular, organizations that actively promote LGBTQ2s+ (lesbian, gay, bisexual, trans, queer, two-spirited, and other) diversity tend to be learning and practice environments of choice, excellence, and innovation. Promoting and enhancing LGBTQ2S+ environments are associated with three practical outcomes: recruitment and retention of top talent, improved quality of service and engagement with critical stakeholders, and enhanced creativity and innovation.

It simply makes good sense for Canada's health care and education sectors to develop best practices that leverage diversity and inclusion to promote excellent clinical outcomes and outstanding workplace health and wellness. Fostering pride serves all members of the health care sector well and sends a powerful message of inclusion to the communities they serve.

Canadians are rightfully proud: a brief primer on LGBTQ2S+ history

Canada is among the most advanced nations of the world when it comes to human rights. Indigenous peoples held cultural norms and descriptors long before that; the land on which we live, work, and practise is rich in respect for diversity, inclusion, and equity. Canada's post-colonial population declared same-sex sexual activity legal since 1969 when then Justice Minister Pierre Trudeau declared: "There's no place for the state in the bedrooms of the nation." In 1985, section 15 of the *Canadian Charter of Rights and Freedoms*[2] came into effect, protecting sexual minorities from discrimination and, in the same year, the *Canadian Criminal Code* began to forbid hate-crimes against homosexuals. In 2005, Canada became the fourth nation on earth to allow same-sex marriage with equal rights for adoption quickly following.

Last year, Prime Minister Justin Trudeau, on behalf of the nation, formally apologized to the LGBTQ2S+ community, an apology worth considering carefully:

> It is with shame and sorrow and deep regret for the things we have done that I stand here today and say: We were wrong. We apologize. I am sorry. We are sorry... To members of the LGBTQ2 communities, young and old, here in Canada and around the world: You are loved. And we support you. To the trailblazers who have lived and struggled, and to those who have fought so hard to get us to this place: thank you for your courage, and thank you for lending your voices. I hope you look back on all you have done with pride. It is because of your courage that

we're here today, together, and reminding ourselves that we can, and must, do better. For the oppression of the lesbian, gay, bisexual, transgender, queer, and two-spirit communities, we apologize. On behalf of the government, Parliament, and the people of Canada: We were wrong. We are sorry. And we will never let this happen again.[3]

Canada is, without doubt, a global leader when it comes to human rights and freedoms. But there is much more for us to consider, particularly in health leadership.

Contemporary opportunities and challenges for the LGBTQ2S+ community

Last year, the Fondation Jasmin Roy commissioned a report[4] on the values, needs, and realities of LGBTQ2S+ people in Canada. One of the first contemporary studies of sexual minorities in the country, the foundation reported many critical findings, including:

- Generation and gender matter; there are more self-reported pansexual, asexual, and non-binary people among 15–24-year-olds, particularly women, than any other age group.
- Having safe spaces and assertive positive role models is associated with more positive mental and physical health outcomes.
- 45% of respondents viewed Canadian society as still not open to sexual diversity, particularly in schools and workplaces.
- 75% of respondents reported bullying in the workplace or educational setting (compared with 45% of members of sexual majorities); sadly, this seems to increase the more open a person chooses to be, suggesting that tolerance, not acceptance, is a strong Canadian value.
- A vast majority of respondents identified the health and education sectors as having the greatest capacity to influence ongoing integration, equity, and fairness.

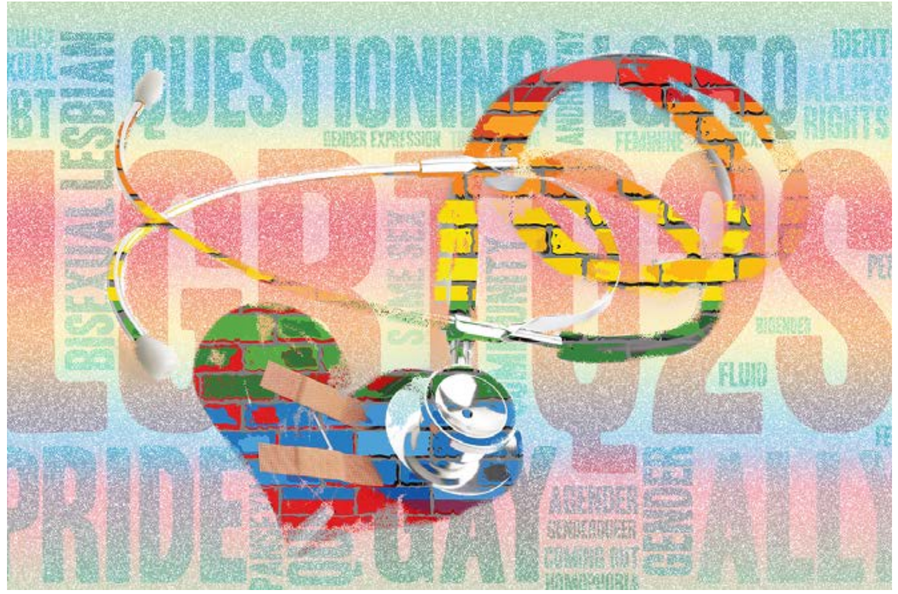
The report also concluded that members of Canada's LGBTQ2S+ community hold several core values in levels that distinguish them from the greater population: a great desire for fulfilment and authenticity and intentioned practice to find ways to express their true selves, a more developed creativity, which makes them more apt to think outside the box and adapt more easily, and heightened social and environmental awareness. This unique blend of authenticity, adaptivity, and social consciousness suggests that many members of the LGBTQ2S+ medical community have naturally developed leadership skills that can serve the greater good of the profession in Canada.

Opening medicine's closet door

A recent study[5] looked at sexual disclosure among sexual and gender minority students in the United States and Canada. Almost a third of them reported choosing to conceal their identity in medical school, with a marked difference between sexual minorities (67.5% out) and gender minorities (34.3% out). On the positive side, the rate of being "out" in medical school appears to have doubled in the past two decades.[6] However, much work needs to be done to promote safety, respect, and inclusion for gender minorities. Indeed, almost half of respondents reported a strong fear of discrimination and lack of support, particularly during the matching process and in accessing mentorship and career advice.

In 2016, the British Medical Association[7] looked at the experience of lesbian, gay, and bisexual doctors in the National Health Service in detail: 70% of respondents reported being subject to homophobic or biphobic abuse, more than 12% reported at least one form of harassment or abuse and more than 12% suffered some form of discrimination. Only 25% of victims reported maltreatment to their senior leadership, and only 20% chose to seek resolution. This study also found that fewer than 40% described their place of study or practice as encouraging of openness, and 33% chose their specialty based on their belief that it would be LGBTQ2S+ friendly. Finally, respondents identified senior medical or clinical colleagues as the most likely people to initiate harassment or abuse, with the next most likely sources peers, non-clinical managers, patients' families, and fellow learners.

Tackling such complex issues will require more than legislation,



policies and procedures, and codes of conduct. Developing and implementing named, staffed, and funded LGBTQ2S+ inclusion programs is a practical strategy used by many of North America's largest and most successful enterprises.[8] These programs typically advise leadership teams regarding recruitment, professional development, network building, and succession planning. Not only do such programs promote diversity across organizations, they are also associated with improved problem solving, enhanced sustainability and collaboration, and establishment of the organization as an employer of choice. The BMA study[7] identified a number of practical action strategies for leaders to consider, such as ensuring that sexual-minority-themed diversity training is mandatory in all training programs, hospitals, and clinics; addressing bullying and intimidation of sexual minorities studying and practising medicine; and taking active part in pride celebrations in their communities.

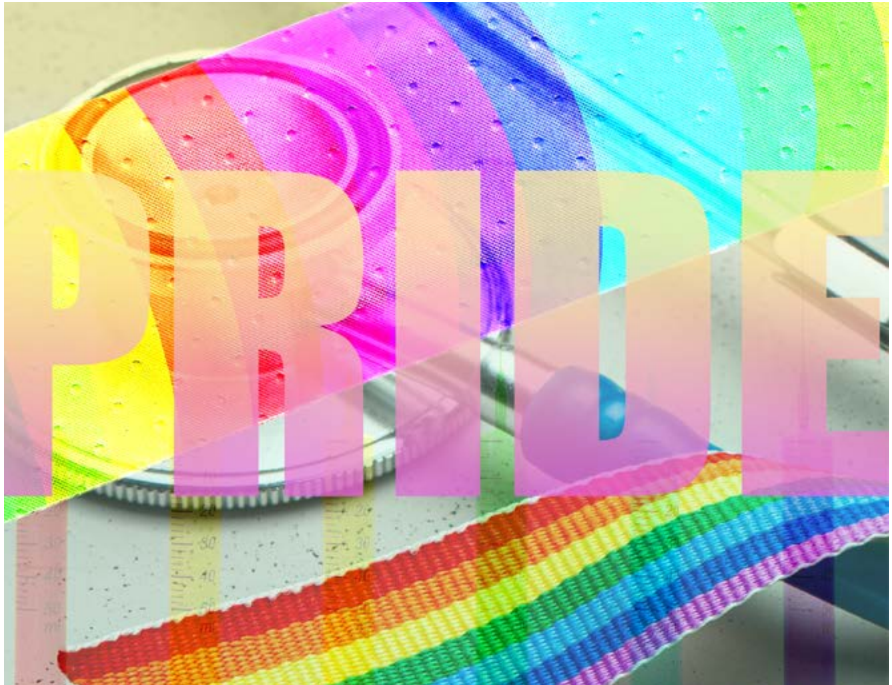
Leaders may be well-advised to familiarize themselves with emerging best-practices in health care for the LGBTQ2S+ community. Rainbow Health Ontario (www.rainbowhealthontario.ca) is a province-wide program of Sherbourne Health that creates and disseminates clinical and educational resources, conducts research, and informs health policy. Its "safe-space" symbols are exemplars worth posting in any clinical or medical education setting in Canada.

Valuable work has also been done by the Canadian Federation of Medical Students[9] on improving health care for LGBTQ2S+ populations. This study offers several practical suggestions to medical schools and teaching centres on promoting collaboration with LGBTQ2S+ peers and professionals, promoting excellence in the care of patients identified as sexual minorities, and ensuring a hate-free practice and learning space. The Royal College of Physicians and Surgeons of Canada[10] has an excellent bioethics case module on sexual minorities that leaders and leadership teams may find helpful. Canadian leaders may also find it useful to attend the Gay and Lesbian Medical Association Annual Conference on LGBTQ2S+ Health at some point in their tenure; its focus on professionalism, system-based practice, leadership, and quality improvement may trigger useful insights and generate ideas for implementation at their home sites.

What will you do in your leadership practice?

I have served hundreds, perhaps thousands, of children and youth presenting with suicidal ideation, depression, anxiety, substance use, and trauma-related suffering. A disproportionate number of these patients are either questioning their sexual or gender orientation or have already identified as sexual minorities.[11] Even in Canada, with all our hard work and successful social equity efforts, children and youth suffer, some fatally, from homophobia. We must continue to make all sectors of our health care system sensitive, respectful, and welcoming to sexual minorities across the lifespan. This demands ongoing diversity training, monitoring, and quality improvement efforts.

I have also cared for many medical students and physicians over the past 20 years. Every year, I am asked by medical students about how "out" they should be during the CaRMS match.



Physician-patients have shared stories about their experiences with discrimination, stereotypes, and lack of positive role models. Many disclose how their careers were curtailed or derailed in the absence of any clear feedback about their performance or productivity, raising the possibility of active discrimination. Several felt forced, often under duress, to participate in "conversion therapy," i.e., an unscientific and unethical psychological and pharmacological "treatment" designed to reprogram their orientation to heterosexual and/or cis-gendered — a form of medical abuse that has been banned by many provinces and all major medical organizations.[12] These are but a few of the tragic stories that our learners and colleagues struggle with in contemporary Canadian medicine.

In that spirit, I encourage leaders to consider taking four urgent and important actions:

- Acknowledge that it is shameful that conversion or reparative therapy hasn't been banned in each province and territory and do everything possible to ensure that it is banned at your clinic, hospital, and university.
- Host a lunch-and-learn session for your leadership team to review Rainbow Health Ontario's fact sheets on bisexual, gay, lesbian, and trans health needs, and deeply reflect on your organization's capacity to meet and exceed them.
- Identify, appoint, and appropriately resource an LGBTQ2S+ senior leader in your facility and seek their advice on recruitment, retention, and celebration.
- Ensure that your organization promotes and participates in your local LGBTQ2S+ pride celebrations: your community will be delighted with your presence and develop a deeper sense of commitment and connection to your mission.

Canada is, without doubt, a world leader in LGBTQ2S+ diversity. However, there must also be no doubt that hate, both conscious and subconscious, is very much alive. What are you doing to influence diversity in your institution?

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Author

Derek Puddester, MD, MEd, FRCPC, PCC, is an associate professor of psychiatry at the University of Ottawa. He is proud partner to his husband and father to their adopted son. He is very grateful to live in a democratic, inclusive, and innovative country that has been incredibly supportive. That said, he won't quite forget being called a faggot in medical school, listening to homophobic jokes in residency, fabulously checking off the box on a marriage license form as a bride and on a birth certificate as a mother (the other guy checked the only groom and father boxes). He is incredibly proud of his son, who sees his family as no different from any other.

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Web-based resources for Canadian Leaders

Gay and Lesbian Medical Association: **www.glaad.org**

Association of LGBTQ Psychiatrists: **www.aglp.org**

Gay and Lesbian Association of Doctors and Dentists: **www.gladd.co.uk**

Rainbow Health Ontario: **www.rainbowhealthontario.ca**

Royal College of Physicians and Surgeons of Canada, 2.4.5. Respect for difference – sexual orientation: **https://tinyurl.com/hbrj4kt6**

College of Family Physicians of Canada, Resources: Gay and lesbian health

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The Canadian Society of Physician Leaders has developed a

"Coaching for Physician Leaders"

resource website

The site will provide you with contact information for various coaches and their areas of expertise.

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Our coaches will cover a variety of topics, including career planning, wellbeing and leadership.

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A framework for inclusive crisis leadership in health care

Javeed Sukhera, MD, Lisa Richardson, MD, Jerry M. Maniate, MD, Ming-Ka Chan, MD
Originally published CJPL 7(1)

In a crisis, leadership is often driven by a sense of urgency. Leaders find themselves looking inward with a narrow focus and surrounding themselves with those who share similar values and ideas. We propose an empirically informed framework for maintaining inclusive leadership and creating an environment that fosters inclusion throughout a crisis situation. Its three components are rooted in constructive tensions that inclusive leaders can leverage to bring balance, predictability, and moderation to their teams and organization.

KEY WORDS: crisis leadership, inclusive leadership, framework, equity, inclusion, belonging

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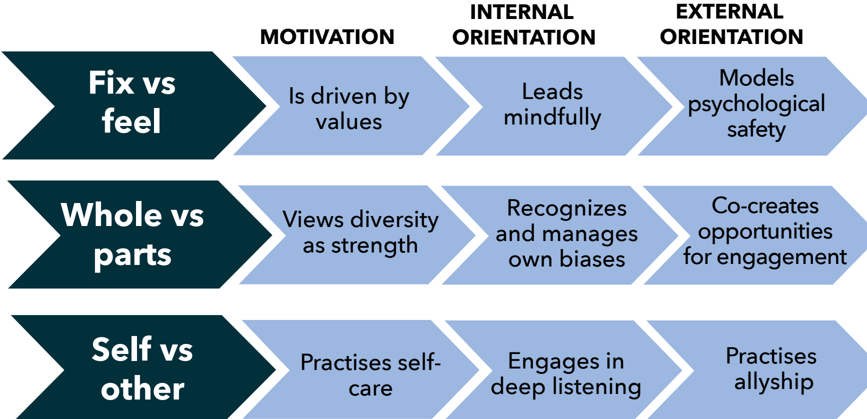
Most leadership theory is built on predictability and moderation.[1] Crisis leadership, on the other hand, is often driven by a sense of urgency and the need for a narrow focus. Times of crisis can unintentionally precipitate and perpetuate an exclusive approach to leadership. Policies are developed quickly. Timelines are tight. Urgency drives decisions. In these situations, we tend to look inward to our "known allies" and surround ourselves with those who share similar values and ideas. Crises pose a unique challenge to the formation of diverse teams, as problems with communication and shared understanding may result from differences in status and training, as well as professional norms.[2]

Consider the example of health care leaders who have always strived to be inclusive by avoiding tokenism and seeking meaningful input from patient/family partners while developing policy. Despite their best efforts, policy decisions made quickly during a crisis have alienated their patient/family partners and eroded trust. How can such leaders adapt their inclusive leadership to times of crisis? As a group of scholars who have been involved in equity, diversity, and inclusion in both principle and practice, we propose an empirically informed framework for inclusive leadership.

A framework for inclusive leadership

Our framework is designed to guide health care leaders in maintaining inclusiveness and creating an environment that fosters inclusion throughout a crisis situation. Each component of the framework is rooted in a constructive tension that inclusive leaders can leverage to bring balance, predictability, and moderation to their teams and

Figure 1. Inclusive leadership framework



organization. We identified three such tensions: fix versus feel, whole versus parts, and self versus other (Figure 1).

Constructive tension 1: fix versus feel

When encountering a crisis, many leaders are hard wired with an implicit impulse to fix things. This response is often accentuated or even sought out during a crisis. However, inclusive leadership requires stepping back from the urge to fix and being prepared to sit with complex emotions. Moments of crisis highlight that there are many problems outside a leader's control that cannot be solved by simple fixes. Therefore, inclusive leaders can be role models by explicitly describing these moments for their team, encouraging others to share, and creating psychologically safe environments for others to experience and process heavy emotions.

Inclusive leaders should also recognize that others may cope with crises in diverse ways. There may be challenges that a leader has overcome, but with which their team members are still struggling. In these contexts, leaders are at risk of falling into the trap of toxic positivity. It can be profoundly invalidating for others to be told to have gratitude or be kind when they might be struggling to meet basic needs, in survival mode, or facing grief and loss. Sometimes, the greatest challenge for a leader is to step back and simply emphasize that they are present and truly listening and offer unconditional support. Crisis leadership is about having compassion and being able to take another's perspective.

Constructive tension 2: whole versus parts

During a crisis, our threat response becomes activated and we tend to narrow in on specific details. It can be challenging to prevent our amygdala from overriding our brain and hindering our ability to step back to distinguish "the forest from the trees." Narrow thinking can prevent diverse ideas from being considered. Inclusive leaders can engage in active reframing for their teams. For example, a crisis can be reframed from threat to opportunity, diversity from dangerous to driving excellence, and engagement from time to presence.

Leaders can create mechanisms to ensure dialogue around complex problems while considering a wide range of possible solutions and being mindful of unintended consequences. The use of online tools to solicit engagement with teams can be useful for rapid feedback. Inclusive leaders should ask themselves if they feel the need for such activities to be anonymized or not. If a team prefers anonymity, leaders might ponder whether they are truly creating the kind of psychological safety where diverse ideas can thrive. The actions of a leader directly influence whether people on their team are willing to speak up.[3]

Team leaders are often in a unique position of being able to see a crisis situation as a whole rather than in parts.[4] Sometimes leaders have more access than other members of their team to information from those with more power and status in the organization. Inclusive leaders must find ways to bridge this divide of power and hierarchy by distributing power within their team, while not diminishing the agency and control of others. In doing so, these leaders often break down historical or organizational

silos by drawing on expertise, resources, and perspectives not usually accessed to create innovative solutions.

Constructive tension 3: self versus other

Times of crisis may make it difficult for leaders to introspect and reflect on their own performance. Leaders may also amplify self-blame and self-doubt. During a crisis, inclusive leaders should model humility and empathy for others, as well as for themselves. During any crisis, all members of the team (including the leader) are sharing the experiences of suffering and distress because of the shared nature of the crisis situation.

Another challenge in the context of a crisis is that our ability to engage in empathic listening is constrained. To maintain a sense that leadership should be collaborative and distributed, listening is simply not enough. Some listening involves confirming what we already know, some requires presence and empathy;[5] however, deep listening requires listening to what is not being said. It requires listening to the emerging story that has not yet been written.[6]

Although leadership theories emphasize the concepts of mentorship and followership, inclusive leadership requires allyship. Inclusive leaders recognize their own privilege and start their journey toward inclusion by looking in the mirror at themselves.

Conclusion

Leadership in crisis can feel like both a burden and a gift. Health care leaders are asked on a daily basis to demonstrate character and engage in critically, contextually aware judgements.[7] By understanding the challenges that arise during times of crisis, we can also identify leadership strategies that build on inclusive principles. Inclusive leadership may provide us with some guidance on what steps we need to take individually and collectively with our teams, organizations, and community at large.

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Useful resource

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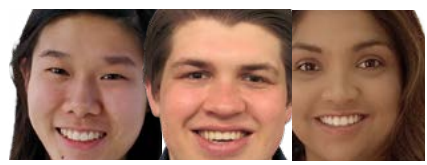
Re-thinking conferences in medicine: opportunities and challenges of virtual delivery



Hilary Pang, MSc, David Wiercigroch, MPA, and Abi Sriharan, DPhil
Originally published CJPL 7(1)

As the COVID-19 pandemic underscores the need for physical distancing, an opportunity to reimagine conference design and delivery has emerged. Conferences should consider widespread adoption of virtual strategies to support professional connection and knowledge exchange driven by thoughtful design and implementation. Although virtual conferences represent a significant paradigm shift, opportunities to improve systemic inclusivity, increase financial accessibility, reduce environmental impact, and increase engagement and interactivity present compelling arguments for change. Challenges include minimizing digital exclusion, providing technical support, supporting participant wellness, and facilitating opportunities for networking. We reflect on these themes through experiences and lessons learned when transitioning the inaugural Conference on Health Advocacy Toronto to a virtual model during the COVID-19 pandemic.

KEY WORDS: virtual conference, medicine, opportunities, challenges, professional development, collaboration

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Accelerated adoption of virtual communications will be a legacy of the COVID-19 pandemic. As physical distancing measures preclude us from large in-person meetings, many academic conferences have been cancelled or postponed. Although we must act collectively to "flatten the curve," virtual conference design and delivery emerges as a promising and enduring approach to supporting professional connection and idea sharing. Experiences have been positive so far: more than 80% of attendees of a recent virtual conference were willing to attend another one in the future.[1]

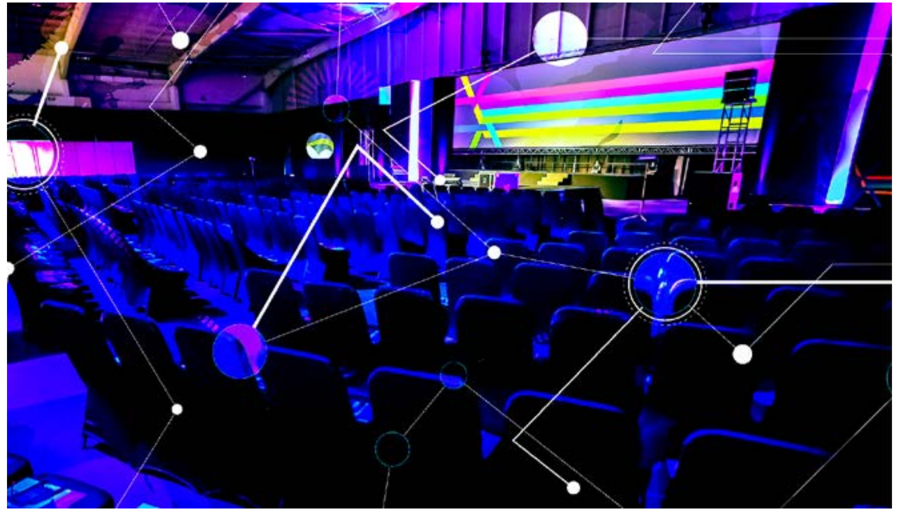
Recently, the Conference on Health Advocacy Toronto (CHAT)[2] fully transitioned from an in-person meeting in Toronto to a virtual forum within two weeks. CHAT was launched by University of Toronto medical students to highlight initiative- and research-based advocacy at the local, provincial, and national levels.[3] This grassroots academic forum brought together almost 200 medical students, students in allied health programs, and physician leaders from across the country to establish a community of support, share best practices, and identify opportunities for collaboration.

Here we discuss the opportunities and challenges of virtual conferences informed by our personal experience and broader consideration of pertinent literature.

Opportunities

Accessible costs

Virtual conferences are markedly



less cost-prohibitive than physical meetings. Many virtual conferencing platforms, including Zoom, Cisco WebEx, Google Hangouts, and Skype, have basic packages that are available free-of-charge. Expanded features required for larger meetings, such as hosting more than 100 attendees, may require payment of a monthly, but still cost-friendly, subscription fee. For example, CHAT 2020 spent less than $200 for two virtual conferencing packages that allowed a maximum of 500 participants. In comparison, upwards of $5000 is needed for a 100-participant in-person meeting with estimates of $1000 for the venue rental fee and $4000 in food expenses. These significant cost-savings can be transferred to the sponsors and attendees so that registration fees for various major conferences can be reduced or waived.[4,5] A low cost also makes the conference financially viable at a broad range of registrant volumes, thus providing certainty to the conference team early in the planning process.

Further, there are no added costs for participants to physically attend a virtual meeting, such as travel, accommodation, food, or poster-printing expenses that could otherwise add up to hundreds or thousands of dollars across the group.

Systemic inclusion

Virtual conferences not only increase financial inclusion, but also break down geographic, health, and social barriers. Current in-person conference design may be a systemic barrier that excludes certain groups, including people with physical disabilities,[6] acute or chronic health considerations, travel restrictions, or caregiving responsibilities.[7,8] Women are disproportionately affected by family inclusion policies, which vary among medical conferences; dedicated lactation spaces, free childcare, and admission of children into conference venues is often not available.[9] Allowing participants to attend virtually, from the comfort of their selected space, presents a solution that addresses these barriers and aligns with objectives to achieve equitable representation in academia. Conference attendance has critical implications for career advancement, professional networking and mentorship, and knowledge sharing. Using virtual technology as a vehicle to improve accessibility at professional academic forums is a strategic move toward fostering diversity and inclusion in medicine.

Environmental savings

Virtual conference delivery is eco-friendly. The adverse consequences of climate change on health are widely recognized and, as leaders in our communities, physicians should take action in environmental stewardship and emission reduction. Given their substantial environmental footprint, conferences should not be exempted.[10-13] Event materials, such as printed programs, conference merchandise, non-reusable dining utensils, and uneaten food, result in unnecessary added waste. In addition, frequent work-related air travel among ecologists and conservation scientists has been shown to be associated with carbon footprints 10 times the global average.[14] Conferences have an inherent role in facilitating career advancement, but increased air travel has been shown to not be associated with academic productivity in terms of H-index.[15]

Frameworks to design greener conferences have been developed. The Nearly Carbon-Neutral conference model[16] is one approach that recommends prerecorded talks with interactive online discussion over a 2–3 week period. This model produces less than 1% of greenhouse gas emissions of traditional fly-in conferences. During the COVID-19

pandemic, webinar models via videoconferencing software have emerged as another popular approach. At CHAT, the move to a virtual interactive seminar model eliminated printing needs and food catering and minimized any need for air or ground travel to a physical venue.

Elevated engagement

Hosting a virtual conference holds great potential to increase engagement and attendance. For CHAT, registration volume increased 4.5-fold after the announcement that it would be adapted to a virtual format. Major international conferences have also seen registrations soar.[17] Virtual delivery expands the breadth of interest and expertise in attendance, which can allow for richer discussions and more satisfying networking opportunities.

Harnessing interactivity

Virtual conferences can be delivered interactively. Novel approaches to engage participants can be harnessed to stimulate conversation, networking, and connections. Video conferencing platforms allow for group discussions via video, audio, and chat functions. Likewise, groups can be divided into breakout rooms or separate meetings to facilitate more intimate, focused conversations.

Setting an interactive tone and encouraging video participation are important ways to engage participants in a virtual setting. In an email sent to guests before CHAT, we asked them to consider enabling their audio and video for a full, interactive experience. We also addressed possible participant anxieties over participation, including conference dress code in a virtual setting, and highlighted the opportunity to use virtual backgrounds if desired. Our opening keynote speaker also encouraged interactivity by asking participants to contribute ideas and experiences verbally or through the chat box.

Approachable poster sessions

The traditional conference poster session can be greatly improved with virtual delivery. Many conferences typically include a large volume of poster presentations in condensed sessions set in large, noisy, busy halls – a challenging environment for participants to navigate. At CHAT, we adapted the poster session to take place in virtual "breakout rooms" with a variety of research and advocacy initiative presentations in each room. Presenters were scheduled a specific time to present their project followed by a moderated question-and-answer period.

Rather than printing expensive single-use posters, presenters produced slide decks that were displayed via the screen-sharing function on our conferencing platform. Slide decks can also be uploaded to an online repository where the audience can download and view them on their screens.

At CHAT, despite more than 40 slide decks and speakers, clear instructions at the beginning of each session and the availability of a preconference audiovisual check allowed for smooth transitions throughout the conference with minimal technical challenges.

Flexible document sharing

Cloud storage, widely recognized and accessible to participants, can be leveraged to support virtual conference delivery. A conference "drive" on Google Drive, Dropbox, or other open-access cloud system can be distributed to participants with changes made in real time, allowing the organizing committee the flexibility to make last-minute program changes,

modify schedules, and share resources in real-time. Collection and dissemination of contact information among participants is also possible.

For CHAT 2020, we created a conference drive that included the conference program, presentation schedules, and conference meeting links. Feedback forms and online resources shared by attendees could also be easily accessed after the conference, enabling longitudinal communication and knowledge sharing. We displayed web links to this drive and associated QR codes at the start of each session for easy access. We also created a second drive for presentation judges only, which included a modifiable scoring spreadsheet and presentation rubric. Judging scores were inputted in real time directly onto this spreadsheet. This allowed for a quick turnaround time of only a few minutes to announce the competition winners after the conclusion of the last presentation session.

Challenges

Virtual conferences represent a novel approach with many opportunities. Although there are challenges, they are surmountable with careful planning.

Minimizing digital exclusion and providing technical support

As not all participants may be comfortable using a virtual platform, digital exclusion may be a barrier to access.[18,19] The COVID-19 situation has challenged academics and physician leaders across the world to familiarize themselves with virtual tools.[20] Although use is broadly increasing, CHAT 2020 was the first time some participants used our conferencing platform. To address this, an instructional package was emailed before the conference and a primer was provided at the beginning, during opening remarks, in anticipation of possible technical concerns during the day.

Despite best efforts, virtual conferencing may still be affected by technical issues, such as muted microphones, malfunctioning cameras, low Internet bandwidth, or platform crashing. These issues can be mitigated by having a telephone (dial-in) option as an alternative to a poor Internet connection, having multiple team members available for back-up to take over moderating and other event-management tasks, and having a dedicated audiovisual check for participants and presenters before the conference start time. At CHAT, we also had a dedicated IT lead to whom participants could reach out privately to resolve IT challenges.

Facilitating networking and unstructured conversation

The temptation to structure all components of a virtual conference can limit self-directed opportunities for informal discussion, which is an important benefit of physical meetings. However, organizers can facilitate small breakout sessions that allow for unstructured conversations. As participants get more comfortable with virtual sessions, there may be interest and acceptance of virtual breakout groups for mealtime, allowing informal dialogue among colleagues. In addition, encouraging use of the text chat function, which can be used for whole group or private conversations, may allow discussion to continue throughout the conference.

Supporting virtual wellness

In recent months, increased reliance on virtual tools for professional and social communication has precipitated widespread wellness concerns related to "Zoom fatigue."[21] Physician wellness is a national priority: the Canadian Medical Association's 2019 data show that one in three Canadian physicians is experiencing burnout and more than one in three screen positive for depression.[22]

Principles of design thinking should be applied when developing virtual conferences. Thoughtful consideration of flexible programming, event duration, and rest breaks are strategies to promote engagement and wellness. During CHAT, we incorporated a few structured breaks into the program, but also recognized that participants might wish to take additional breaks throughout the day. We limited the conference duration to less than six hours and encouraged participants to join for as much of the program as they were able to but normalized the option to take additional breaks if required.

Coordinating schedules

Timing of a real-time event is an important consideration, as participants may be located in

multiple time zones. However, virtual conferences allow sessions to be recorded (with the consent of presenters) and watched at a later time. One conference, designed under a flipped classroom model, pre-uploaded recorded talks, and participants joined an online conversation afterward to discuss the content.[23]

Conclusion

In-person conferences have been the norm in medicine for many years. However, technological innovations allow academic collaboration to be more resilient against the constraints of physical distancing. With likely gains in equitable and inclusive access, it is time to consider the opportunities for virtual conferences in medicine.

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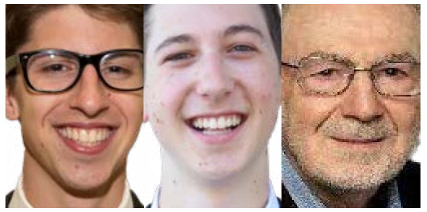
OPINION

Using Holocaust education to teach medical ethics and leadership



Justin Shapiro, Ben B. Levy, and Frank Sommers, MD

Holocaust remembrance remains critical in our society as we eternalize the lessons learned from this terrible time in history. Seventy-six years after the liberation of Auschwitz, this still holds true.

Indeed, the medical community is uniquely situated to provide Holocaust education. Many people remain unaware that physicians played significant roles in committing and perpetuating Holocaust atrocities. It is our assertion that Holocaust education provided to the medical community — and medical students in particular — creates an important context in which to explore the principles of medical ethics and leadership.

The Holocaust was unique in that it was the only genocide in which health care leaders were enthusiastically involved in the conceptualization, design, and implementation of an apparatus for extermination, which led directly to the systematic torture and killing of millions of Jewish people.[1] Although political polarization, racism, and xenophobia are all on the rise, combatting anti-Semitism is not the only reason to educate medical students about the Holocaust. Nearly every ethical issue in health care, from inherent power imbalance to eugenics to inhumane research, can be better understood by examining direct evidence of abuse by physicians during the Holocaust.[1]

Physicians wield great power in society. Impressionable medical students enter an extremely hierarchical and obedient profession and become socialized to its norms.[2] It is only fitting that the next generation of physician leaders should receive Holocaust education to demonstrate that, from time immemorial, power has always been susceptible to abuse.

The case for educating medical students about the Holocaust was bolstered when Richard Horton, editor-in-chief of *The Lancet*, endorsed the idea. In his editorial, "Medicine and the Holocaust — it's time to teach," Dr. Horton argues that teaching medical students about the Holocaust could "instill lessons about the equal worth of human beings, the limits of human experimentation, the importance of ethical regulation of research, and the balance between notions of public health and the duty of health professionals to the welfare of individuals."[3] Dr. Horton also cites preliminary evidence from the Autónoma University of Madrid, demonstrating that the professional values of medical students were enhanced after the introduction of a course entitled The Holocaust: Lessons for Medicine.[3]

According to Reis et al.,[4] learning and teaching about the Holocaust can be a meaningful tool for enriching the formation of professional identity. It can also endow medical students with a moral compass to navigate inherent ethical challenges in their careers and to combat unethical behaviours. In this vein, in November 2020, the University of Toronto instituted a mandatory course for second-year medical students entitled, Physician Obligation: Lessons from the Holocaust. Most recently, *The Lancet* editorial team has continued to show support for this initiative by launching The Lancet Commission on Medicine and the Holocaust: Historical Evidence, Implications for Today, Teaching for Tomorrow.

The accelerating pace of advances in medicine may give rise to a myriad of ethical impasses. Fields such as artificial intelligence and genomics can achieve great triumphs for humanity in fighting a plethora of diseases, yet also carry the potential for flagrant abuse. The Holocaust represents the most egregious example of racism being both medicalized and systematized.[1] This was only possible with the

willing participation of medical leaders. Indeed, Nazi physicians supervised the selections of which individuals would live or die on arrival at concentration camps, oversaw the operation of gas chambers disguised as showers, and tortured subjects with barbaric medical experiments.[5] Just imagine how much more destructive the Holocaust could have been had Nazi physicians been privy to the knowledge and technological capabilities of our era. Implementing Holocaust education will not only enrich medical education at large, but it will also fortify the ethical backbone of medical trainees and empower them to confront the moral challenges they will face throughout their careers.

There may have been German physicians who protested against the crimes perpetrated by the Nazis. However, doctors joined the Nazi party in greater numbers than any other profession.[3] They also benefited from their political affiliation through promotions and the ability to carry out ethically unsound research. These physicians began a tortuous journey down a dark path. The murder of six million Jews during the Holocaust did not happen overnight; it did not start with genocide. Rather, the Holocaust began as a series of seemingly small ethical compromises that ultimately led to devastating consequences. Each concession silently ate away at the collective soul of ordinary people.

Some might argue that the current ethics and professionalism curricula within Canadian medical schools is sufficient to ensure that medical students appreciate the evils perpetrated by German physicians during the Holocaust. However, Nazi physicians were rigorously inculcated with scrupulous ethical codes. Ironically, Germany was also the first country to enforce a mandatory ethics curriculum in all of its medical schools.[1] Thus, merely teaching medical ethics is not enough to ensure that physicians remain faithful to the Hippocratic Oath. If physicians in an advanced society – physicians who sought to pioneer medical ethics education – could implicate themselves in the greatest moral lapse in the history of our profession, we would be demonstrating hubris to assume that the same fate could not befall us as well.

Given the indispensable role the medical community played in orchestrating the mass extermination of millions of people during the Holocaust, physicians bore much responsibility for the flames of the crematoria of Auschwitz.[1-3,5-7] Today, we are at a crossroads: in the face of rising anti-Semitism, racism, and xenophobia, we must ensure that these flames serve as a stark warning of the perils of unchecked power and moral corruption. Although it can be emotionally challenging to delve into the horrors of the Holocaust and the

role physicians played in enabling such atrocities to occur, we believe it is necessary for all medical learners to do so.

Sadly, the forces of human nature that unleashed the Holocaust have not gone away. Physicians are still susceptible to the racism, corruption, and disregard for human life and dignity that served to instigate the horrors of the Holocaust not so very long ago.[7] Educating medical students about the Holocaust will bring our profession one step closer to ensuring that the lessons learned through blood, tears, and sorrow will never be forgotten. As the number of Holocaust survivors continues to diminish, the burden has never been greater on medical education to eternalize the lessons of the Holocaust.

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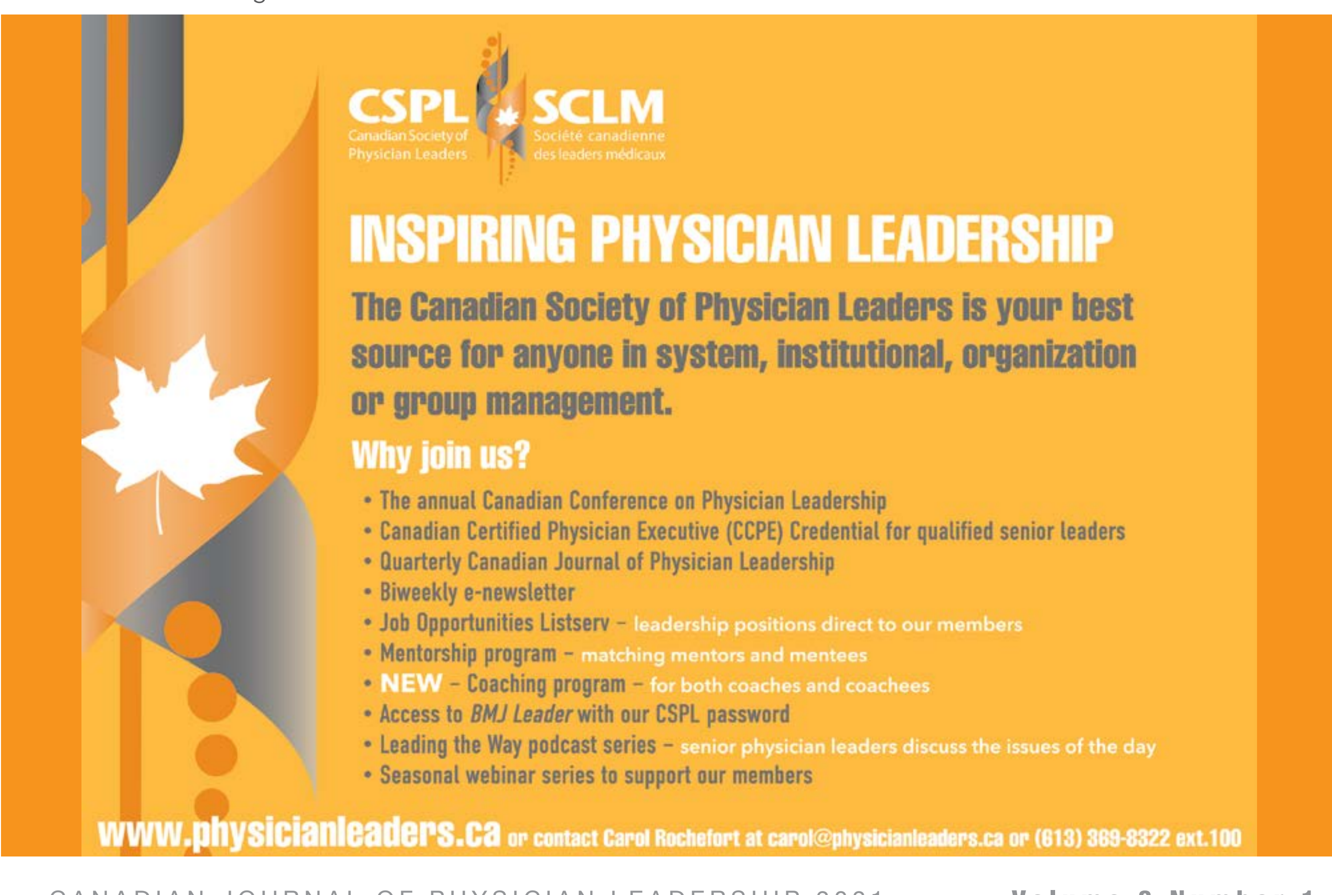

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CMA sending notice to federal political parties: Health is the ballot box issue in 2019

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

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HARVARD BUSINESS REVIEW

6 Steps leaders can take to get the most out of feedback

Business publications are filled with articles about feedback: how important it is for leaders, how leaders can both give and receive it, what happens when leaders don't get it, and even what to do if someone is not open to feedback they have been given. The focus tends to be on the transfer of data. What is less explored is how leaders should respond once they receive that data. MORE

MEDPAGE TODAY — KEVIN MD

Have you forgotten the most important health care leadership skill?

Physician burnout is a hot topic right now. Some don't agree with the term and choose to use "moral injury." Regardless of the term you want to use, the problem is real. Christina Maslach describes burnout as "an erosion of the soul caused by a deterioration of one's values, dignity, spirit, and will." ... while we've identified this as a major issue amongst physicians and have highlighted its prevalence and causes, have we really addressed preventing it? MORE

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INTERVIEW

The journey from advocacy to leadership

This article has been adapted from an interview in the Canadian Society of Physician Leaders' Leading the Way podcast series.* In episode 29, recorded on 30 Jan. 2021 and aired on 4 Feb. 2021, Dr. Johny Van Aerde (executive medical director of CSPL) spoke with Dr. Alika Lafontaine about his personal leadership journey and his views on advancing equity, diversity, and inclusiveness.

Dr. Lafontaine is an anesthesiologist in Grand Prairie, Alberta, and an acknowledged advocate for improving Indigenous health care. He is of Cree, Anishinaabe, Métis, and Pacific Islander heritage. Dr. Lafontaine is president elect of the Canadian Medical Association, the recipient of various advocacy awards, and a member of the board of several nonprofit organizations.

Your leadership journey has been accelerated and diverse. How would you describe it?

Leadership, from my own experience, is a mix of opportunities. I knew early on in my leadership journey that I had specific individuals who looked at me differently than I looked at myself. I never thought that I'd be in a leadership position. I never thought that I'd have all the leadership experiences I've had over the last two decades. Individuals like Dr. Tom Dignan, who was a family physician and champion for Indigenous health, who passed away [in January 2021], was one of the people who saw the way that I looked at things and decided for whatever reason that he was going to give me the opportunity to enter into some of these spaces that he carved out through his own advocacy and work.

I think when you look at leaders, some of us have been on the path our entire lives to eventually get there, and others of us were placed in the path by other people. My accelerated and diverse journey has really been eclectic: opportunity after opportunity that's come up because of others' work. As a result, I've had the great blessing of walking this path, learning the things that I've learned, living these different experiences. It's brought me to a place in leadership where I think I've realized that my job is to create that space for others.

At the beginning of leadership, you really look at it as an advocate, instead of as a leader. I think you want to fill the space with your lived experience, your pain, your priorities. But as you walk down the path, and you start to realize the way that change actually works, you recognize that there comes a point where you can't fill it with yourself anymore. You've got to bring other people into it. I think that's what Tom felt when he first brought me into this. And that's how I feel now, which just brings everything full circle. It's kind of a nice bookend to my relationship with him.

The picture you portray of going from advocacy to leadership ties in with a question that I've been thinking about. For political advocacy, primarily for your work on Indigenous health, do you fear being pigeonholed as an advocate in this area, because of your heritage and this type of work?

I think if the spaces that you lead in are only filled with yourself, then it's inevitable that eventually you're going to get pigeonholed because there's only so much lived experience that you can pour into that space. If you start to see it as a way of bringing other people into those spaces, amplifying their voices, making sure that they feel like they're heard, and then teaching them how to navigate and lead them along so they can avoid some of the bumps and pitfalls that you went through as part of your own leadership journey, [that's leadership]. There's a lateralization of leadership experience that occurs. I don't see myself any more

as exclusively within the realm of Indigenous health. At the beginning, I thought that a lot of the things that happen in Indigenous health were unique to Indigenous health systems, but they were really a magnification of problems that everyone was going through. If you go through trust and communication issues with your care team or if you have problems with continuity of care and fragmentation, they're just magnified within the Indigenous health context. Understanding that and reframing my role – not filling the space with myself, but with the lived experience, pain and priorities of other persons working in other areas – has been a wonderful journey to now bring other people with other expertise and lived experience into this space. It broadens your mind to what you can achieve. I don't feel pigeonholed any more, but that's really because of the other people I've connected to on this path.

COVID-19 has exposed many cracks in our health care system and in society in general. With regard to equity, diversity, and inclusion (EDI), do you think we're going to make real progress this time?

The interesting part about EDI from an historical context is that we often think that we're the first ones who went through this problem. We obviously know that we're not, but we think we're the first ones to gather people together, create a common narrative, or say that this can't continue.

If you look at racialization, for example, there have been several cycles even the last five years where we've had crises that have broken out in, say, Northern Ontario with the suicide pact. There was the mental health crisis in northern Saskatchewan; in northern Manitoba, there are problems with access to care.

There are more and more stories that are coming out about persons who live in these systems and have unequal power and lack of equity, diversity, and inclusion, who are having really negative health outcomes.

If we can find a way to link today with yesterday and bring in those experiences and those learnings, I think we really do have a chance to create a new sort of story. Social media has changed the way that we communicate. You can go on Facebook, you can have something go viral, you can get on Twitter and share your story, something that's shared thousands of times. Getting these stories out is really how we trigger change. Looking back, in the [Truth and Reconciliation Commission] when we talked about truth and reconciliation, I wish we had said, "truth before reconciliation." It's getting the truth out of what's happening right now in the system in a way that keeps the integrity of the experience, not worrying so much about the palatability of the pain that we're sharing, but saying the honest truth.

People are harmed because of inequities. Voices are excluded because of a lack of diversity and a lack of inclusion. That's wrong, not just from a moral standpoint. It's also wrong from the point of good system design. If you don't have people sharing what's actually going on with them, how are you ever going to make the right choices when it comes to how the system should evolve? And so we have these new opportunities, new ways of sharing these ways of establishing truth, where we really create a firm foundation of lived experience that has integrity, that's linked with reality, and that we're not trying to make more palatable.

Our challenge is then creating that environment where people feel like change can happen. The real power of the status quo is keeping us in this space, where we feel that no matter what we do, we actually can't change our future. And I'm really heartened by conversations I have with colleagues, especially new colleagues who have just

finished residency and medical students, that there's this hope there. I think that as a medical profession, we really need to feed that until it becomes a norm.

I'm fascinated with your reasoning, because I recognize the four steps of compassionate leadership: awareness (becoming aware that there is a problem); coordination (the facts and stories that need to be told); closely linked is empathy (feeling what other people are going through); and action (doing something about it).

One of the things that we're taught in Indigenous philosophy and worldview is that all truth takes us to the same place. I do believe that those four steps are very similar, if not the same, as what I just shared in Indigenous health. Things are magnified if you take those four steps and then you take them beyond and imagine if they became even bigger, where they almost swallowed up the system. I think that that's how we need to amplify and magnify those four steps in areas that traditionally have been intractable and use them to unwind what we're really doing. I think in all of this is we're humanizing each other in the process of achieving system change. Intuitively, I think we all feel like that's a message that belongs to us and that's a part of us.

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How full is the glass? A perspective on women in medical leadership in Canada

F. Gigi Osler, MD
Originally published CJPL 5(1)

What do we really know about the representation of female physicians in medical leadership in Canada? Female representation on the current boards of the Canadian Medical Association and provincial/territorial medical associations is 23% and 40%, respectively. Identified barriers to female medical leadership include gendered organizational and workplace culture, gender bias, inflexible work practices, unequal childcare and domestic responsibilities, and biased performance assessment criteria and recruitment practices. Identified enablers include flexible tenure policies, systematic parental leave policies, greater inclusivity in the workplace, and formal mentorship structures. More has been written about the costs of leadership for female physicians rather than the benefits. Reinforcement of the positive aspects of leadership may serve as a motivator, particularly if the message is delivered by other female physician leaders. The negative consequences of the existing gender gap in medical leadership may have implications not only for physicians, but also for patients and the health care system. Further study on diversity and equity in medical leadership in Canada is needed to identify areas for improvement and ongoing work to address and correct gaps.

KEY WORDS: female physician leadership, barriers to leadership, enablers, benefits and costs of leadership, tracking women's leadership

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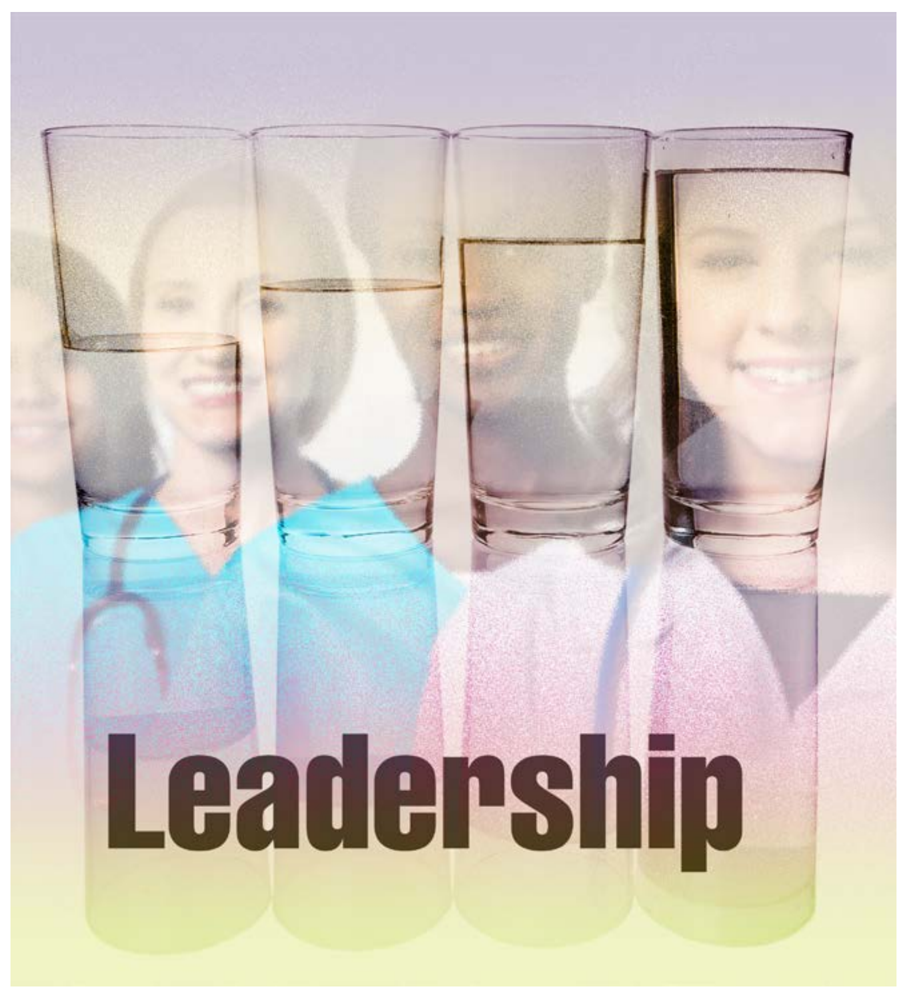
"If you can't measure it, you can't improve it," or some variation thereof, is a frequently cited quotation of the late legendary management scholar, Peter Drucker. What do we really know about the representation of female physicians in medical leadership in Canada? What do we know about the barriers and enablers that female physicians experience in pursuing medical leadership positions? And what do we know about the benefits and costs to female physicians of taking on medical leadership positions? The short answer to all three questions is simply not enough. And if we are not measuring and tracking female physician leadership, how can we improve it or even recognize where it needs to improve?

How represented are female physicians in medical leadership in Canada?

Despite the lack of commonly accepted typology of medical leadership positions in Canada, I suggest three large categories:



elected positions in organized medicine, clinical/administrative positions in hospitals, and faculty appointments in academic health sciences centres. Organized medicine includes the national medical organizations, national specialty and special interest societies, and the provincial/territorial and local medical associations. In the absence of systematic data collection, I will review selected examples in each category based on data availability. Although there are hundreds of medical organizations in Canada, I only have ready access to current data for the Canadian Medical Association (CMA) and the provincial/territorial medical associations (PTMAs).

As of January 2018, 42% of the 84 260 practising physicians in Canada were women.[1] This percentage is projected to reach 50.1% in 2030.[2] The 42% figure will serve as the benchmark of comparison for each of the categories that follow.

Organized medicine

In August 2018, I was installed as the eighth female president of the CMA. I am also the first woman of colour and the first female surgeon to serve as CMA president. It took more than 100 years after the CMA was established in 1867 for the first female president, Dr. Bette Stephenson, to be installed in 1974. She went on to have a distinguished political career in the Ontario government and cabinet. Although eight female presidents might not seem like many over a 151-year history, I will be the fourth female CMA president in less than a decade; clearly the pace is picking up. The rapidly increasing number of women in the Canadian medical profession is a contributing factor. At the time of Dr. Stephenson's installation, just a fifth of the MD degrees awarded in Canada were received by female graduates; by 2017, this proportion had nearly tripled to reach 57%.[3]

A more robust indicator of the changing representation of female physicians in organized medicine leadership can be seen in the gender composition of CMA/PTMA boards of directors. Although female representation on the CMA board is just 23% of the 26 directors, as of June 2018, females represent 40% of the 179 physician directors serving on the PTMA boards. In New Brunswick and Newfoundland and Labrador, female physicians outnumber the male board members. This compares favourably with the 42% representation in the practising profession and highly favourably with the data for corporate Canada, which show that women occupied just 14% of board seats in 2017.[4]

This did not happen by accident. Since the 1990s, the CMA and the PTMAs have all drawn attention to the issue and promoted better representation of female physicians. In 1990, the CMA Board of Directors appointed an ad hoc Committee on Women's Issues, chaired by Dr. May Cohen

from McMaster University. This became formalized as the Gender Issues Committee and met throughout the 1990s to advise the board. On the recommendation of this committee, the CMA established a Leadership Workshop for Medical Women that was offered for several years. In 2001, Dr. Cohen became the inaugural recipient of the CMA's May Cohen Award for Women Mentors, which continues to be presented annually to a female physician mentor who has demonstrated outstanding leadership abilities in enhancing mentorship opportunities for female physicians.[5] In 2015, Joule's Physician Leadership Institute (PLI) began offering a two-day course: Leadership for Medical Women.[6] Female physicians are participating in leadership development and represented 48% of the physicians who enrolled in one or more of the PLI's offerings in 2017.

Aside from recognizing the importance of gender composition, the CMA/PTMAs have taken measures to encourage and facilitate the participation of female physicians in leadership positions. The New Brunswick Medical Society has adopted a specific intent to make its board and committee structure more reflective of the future composition of its membership and has made gender a specific consideration in its recruitment strategy. In an effort to promote inclusivity at its annual General Council meeting, the CMA began offering a child care subsidy for delegates (both female and male) several years ago and, at the 2018 meeting, welcomed breastfeeding in the plenary sessions and offered a wellness/ breastfeeding room.

It would be useful to collect data on the representation of female physicians in elected and staff leadership positions across the full range of medical organizations in Canada at all levels. Prospective data collection is necessary to monitor the gender gap, follow trends, and formulate strategies.

Clinical/administrative roles in hospitals

No database in Canada captures information on the numerous leadership roles that physicians play in hospitals. Physicians occupy positions, such as clinical division head, committee member/chair, chief of staff, president/vice-president of the medical staff, and CEO, but numbers are not known. Most regionalized jurisdictions no longer have hospitals, per se, and it is not easy to find information about medical staff structures across the acute care facilities within a region.

Ontario still has hospitals with individual boards; the CEO, chief of staff, and the president and/or vice-president of the medical staff association are typically included as ex officio non-voting members of the board. The Ontario Hospital Association represents virtually all hospitals in Ontario and lists its hospital members on its website.[7] A review of the current gender composition of 133 hospital boards reveals that, of the 327 physicians serving in one of the abovementioned capacities, only 28% are female. Although this is double the representation of women on Canadian corporate boards, it still falls short of the reference point of 42%. Also, while 327 is a robust sample, it would be useful to round out the picture by being able to capture the full breadth of medical leadership roles in health facilities across Canada.

Faculties of medicine and dentistry

The underrepresentation of female physicians among the senior ranks of academic leadership is a longstanding issue. Gender-based data are not published systematically in Canada as they are in the United States by the Group on Women in Medicine and Science of the American Association of Medical Colleges (AAMC), which produces annual tabulations for a report: The State of Women in Academic Medicine. The most recent version, for 2015,[8] shows that the percentage of MD faculty who are women declines steadily with increasing rank, from 51% at the instructor level to 20% at the full professor level.

Statistics Canada's university and college academic staff system has a code to capture clinical full-time staff in faculties of medicine (including veterinary medicine) and dentistry. In 2016/17, women represented 50% of the faculty at the assistant, 41% at the associate, and 23% at the full professor levels.[9] This is similar to the findings from the United States. Again, it would be useful to be able to monitor trend data.

Summary

The underrepresentation of women in medical and health care leadership is a global

phenomenon. The World Economic Forum has reported that while women constitute 61% of employment in health care worldwide, over 2007–2017, they accounted for less than 40% of hiring in health care leadership positions.[10]

...we cannot overlook the lack of women in medical leadership without considering the current status of racialized, disabled, LGBTQI physicians, and other underrepresented groups as well.

What are the barriers and enablers to seeking leadership positions?

Most of the literature on this topic has concentrated on female physicians in academic settings. Almost 30 years ago, Dr. Wendy Levinson and colleagues[11] reported on a survey of academic female physicians in the United States regarding their experiences of combining career and family life. Clearly, time management associated with juggling family and career responsibilities was a challenge, if not a barrier, to career advancement. Almost seven in 10 respondents reported that having children had slowed their career progress either markedly (12%) or somewhat (56%). Levinson et al. recommended strategies including flexible tenure policies, systematic maternity leave policies, and role models and mentors.

In 2016, Drs. Paula Rochon, Frank Davidoff, and Levinson[12] revisited this paper, asking "has anything changed in 25 years?" They noted the continued underrepresentation of female physicians in the senior ranks of academic medicine and recommended greater flexibility in structuring career paths and the use of metrics, such as those published by the AAMC.[8]

In 2018, Pattani et al.[13] published a survey of full-time faculty members at a large university department of medicine in Canada. Most participants were aware of the existing gender gap in academic medicine and described social exclusion, reinforced stereotypes, and unprofessional behaviours as consequences of this gap in terms of organizational effectiveness and culture. Suggested improvements included:

- better processes for recruitment, hiring, and promotion
- greater inclusivity in the work environment
- formal structures for mentorship
- ongoing monitoring of the gap

Female physicians take on a greater share of the responsibilities of raising children and maintaining a household. Although not current, the findings of the CMA's 2002 Physician Resource Questionnaire showed this very clearly.[14] Among physicians with children under age 18 at home, female physicians reported almost three times the number of hours a week with primary responsibility for children compared with male physicians (42.2 versus 15.0 hours). Female physicians also reported spending more than 1.5 times as many weekly hours maintaining the household as male physicians (12.5 versus 8.0 hours). Anecdotal evidence suggests that a gap still remains.

In conversations with other female physicians, some comment on having to choose between the "mommy track and the tenure track." A commentary on the Rochon et al.[12] paper concluded with the following: "we do not wish our sons and daughters to grow up believing that women have to follow a different career path than men because they have greater responsibilities at home. We want them to grow up thinking that men and women equally share both domestic and work responsibilities."[15]

Most recently Mangurian et al.[16] highlighted additional barriers beyond inflexible leave polices, including unconscious bias against female physicians and sexual harassment, which is gaining overdue attention through the #MeToo movement. They identify a number of policies and actions in the categories of:

- instituting family-friendly policies
- mitigating bias, discrimination, and sexual harassment
- improving mentorship, sponsorship, and targeted funding for women

Costs and benefits

Based on a quick review of the literature, it would appear that more has been written about the costs of physician leadership than the benefits, in particular,

the costs for female physicians. In a qualitative study of 35 female physicians at The Ottawa Hospital,[17] participants clearly assessed leadership as costly in terms of both time away from their personal and family lives and time away from clinical practice. Other concerns included being perceived as depriving others of leadership opportunities, having to get their colleagues to cover their absences while executing their leadership responsibilities, fear of rejection among those who self-identify for a leadership position, a perceived lack of respect for leadership by physician peers and a perceived lack of support by nursing leaders. As the authors summarized their results, "on the whole, participants perceived that to be a leader in their current work context would be burdensome and unrewarding."[17]

The negative consequences of the existing gender gap in medical leadership may have implications not only for physicians, but also for patients and the health care system. Implementation of gender equity strategies could benefit all physicians along with improving workplace culture and effectiveness.

I believe there is benefit in leadership and value in service. It would be useful to know how other physicians and medical leaders define the benefits of leadership. Reinforcement of the positive aspects of leadership may serve as a powerful motivator, particularly if the message is delivered by other female physician leaders. In 2015, the Royal College of Physicians and Surgeons of Canada renamed the original CanMEDS manager role to leader.[18] I look forward to seeing research around the measurement and acquisition of the competencies for the leader role and whether it subsequently affects the uptake of leadership opportunities by both female and male physicians alike.

Conclusion

It is heartening to see increased attention to improving equity, diversity, and inclusion in medical leadership across Canada. This commentary has approached the gender gap from a non-intersectional perspective, yet a key component in improving equity and diversity lies in taking an intersectional approach: we cannot overlook the lack of women in medical leadership without considering the current status of racialized, disabled, LGBTQI physicians, and other underrepresented groups as well. There is growing evidence to suggest that the interplay of these factors creates even greater barriers to career advancement and certainly warrants further discussion and exploration.[19]

In a *Toronto Star* commentary in September 2017 entitled "Canadian medicine has a diversity problem," Dr. Adam Kassam[20] illustrated his point about the health care system with the observation that, of the 39 federal health ministers since Health Canada was established in 1919, only nine have been women, one was First Nations, and one was from a visible minority.

Medical school is the logical place to begin growing this diversity, and it is encouraging to see recent developments in the universities and medical faculties across Canada. In June 2017, the University of Manitoba Rady faculty of health sciences launched the Indigenous Institute of Health and Healing (Ongomiizwin) under the leadership of Indigenous physician, Dr. Marcia Anderson.[21] In 2016, the Admissions Review Committee of the faculty of medicine of Dalhousie University put forward recommendations to the dean intended to increase the number of African-Canadian and Indigenous medical students[22]; Dalhousie graduated six students of African descent in each of 2017 and 2018. The University of Toronto's faculty of medicine has appointed Dr. Lisa Robinson as chief diversity officer.[23] These measures will all contribute to a more diverse profession that is more fully representative of the patient population that we serve.

The negative consequences of the existing gender gap in medical leadership may have implications not only for physicians, but also for patients and the health care system. Implementation of gender equity strategies could benefit all physicians along with improving workplace culture and effectiveness. Furthermore, some studies have suggested that the gender gap may have implications for patient care and health outcomes.[24,25] Finally, the experience of the corporate world suggests that diversity would be beneficial for the health care system. As the federal government's Advisory Council

for Promoting Women on Boards reported, "studies in Canada, the United States, Australia and Europe demonstrate that businesses with more women on their boards and in senior management outperform those with fewer women."[26]

The CMA believes in a vibrant medical profession. With the increasing number of women entering medicine, we see the increasing need to encourage and support female physician leadership in Canada. It is needed, and now is the time.

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This article has been peer reviewed.

BOOK REVIEW

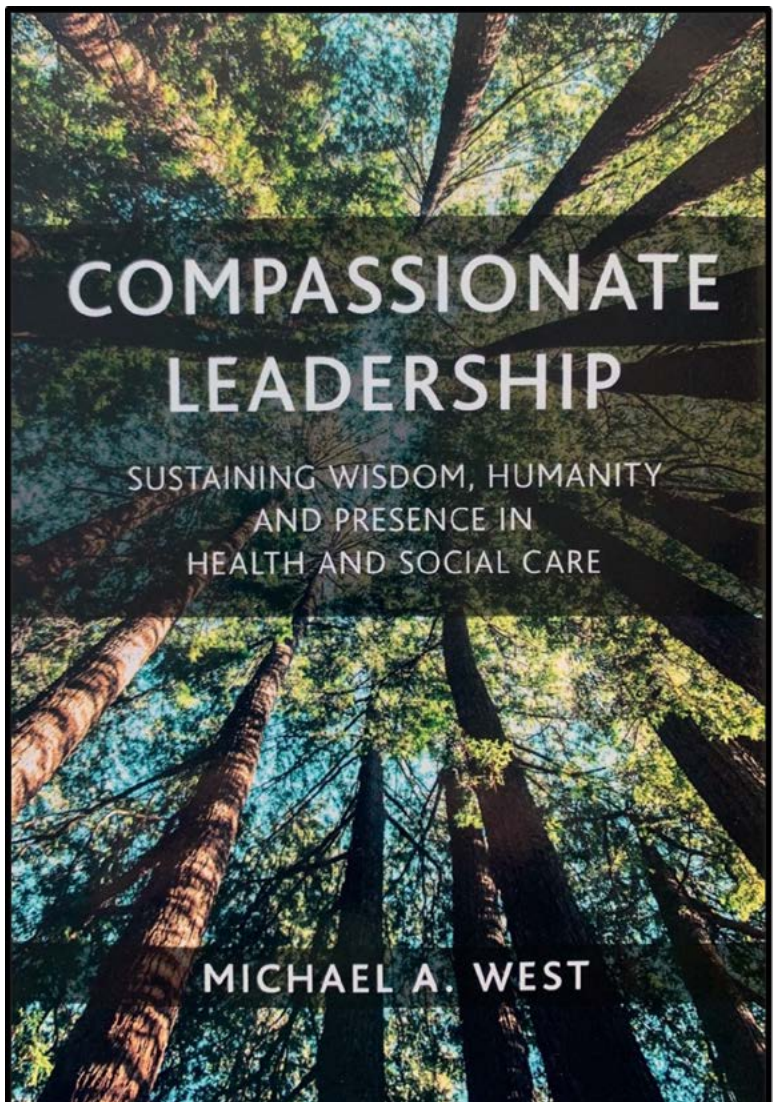
Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care

Michael A. West
Swirling Leaf Press; 2021

Reviewed by Johny Van Aerde, MD, PhD

Compassionate Leadership by well-known British researcher and author, Michael West, is a must-read. Professor West has written extensively on health care leadership. This latest work provides a great companion to Dickson and Tholl's classic textbook *Bringing Leadership to Life in Health*,[1] which aptly outlines the well-known LEADS framework of health care leadership. West's book rounds out Dickson and Tholl's work by adding "distributed leadership" and "caring" as realms within health care leadership. Along with other recent works, such as *Without Compassion, There Is No Healthcare* by Dr. Brian Hodges et al.[2] and *Compassionomics* by Trzeciak and Mazzarelli,[3] this new book gives us knowledge and tools for developing compassionate leadership, including practising self-compassion and building compassionate teams and organizations.

The first chapters of the book align with the domains Lead self, Engage others, and Achieve results domains of the LEADS framework[1]; the last chapters align more with Achieve results, Develop coalitions, and Systems transformation. In the first chapter, West defines the four steps of compassion as a universal human value: being aware of suffering,



attending; having cognition of the cause, *understanding*; mirroring the other's feelings without being overwhelmed, *empathizing*; and taking action to relieve the suffering, *helping*. Looking at it differently, we start with the brain (understanding), then add the heart (empathizing) and finally the hands (helping).

Chapters 6 to 9 describe compassionate leadership with collective, inclusive, and systemic lenses. By paying attention to people's autonomy, belonging, and contribution, their needs at work are respected and that, in turn, ensures high levels of trust, motivation, and well-being. This increases alignment with and commitment to the direction of the organization or teams. Chapter 6, one of the greatest chapters of this book, covers many fundamentals of team leadership, while the next chapter deals with equity, diversity, and inclusivity. Without genuine curiosity and inquiry about differences and challenges for those we lead and serve, it can be difficult to find the motivation to treat people fairly and differently according to their specific needs. West provides evidence of how the four elements of compassionate leadership can help us effectively deal with the issues of equity and fairness. Chapter 9 extends the scope of compassionate leadership across the boundaries of one's own team or organization by building new relationships with other teams or organizations in the larger community of health and social care.

Most chapters include examples of how the book's principles have been applied during the COVID-19 pandemic. Given the crisis in the health care workforce and leadership, West provides evidence of the importance of compassion even in the context of resource shortage. There is a good summary of "compassionomics," with evidence of improved outcomes for patients, providers, and organizations when compassionate leadership is embedded in health care culture. Delving deeper into culture and psychological safety, West goes on to provide excellent, practical tools on how to safely remove barriers and introduce enablers to incorporate compassionate care in the culture at all levels of organizations.

The last section of the book is on self-compassion and might be one of the best pieces ever written on the topic. In the LEADS framework, leadership starts with Lead self; thus, West's book might have benefited from moving the final chapter to an earlier section. Nonetheless, it is an important addition to the literature in this area. To share just a few gems, "Our relationship with ourselves is the basis for our relationships with others. How we relate to ourselves determines how we relate to others." Also, "When we help ourselves and have a warm, accepting sense of ourselves, we are better able to have a warm and accepting appreciation for all those we lead, work with and encounter, thereby enabling us to show them compassion more easily. This is the most important message of this book to all of those who work in health and social care."

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Note: All three of these books have also been reviewed in CJPL: see issues 7(2):91-2, 7(3):136-7, and 6(2):74-5, respectively.

Reviewer

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