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IN THIS ISSUE

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

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Contents

Conference proceedings and (much) more

Abraham (Rami) Rudnick, MD, PhD

This summer 2025 issue of the Canadian Journal of Physician Leadership (CJPL) continues the tradition of highlighting the Canadian Society of Physician Leaders' annual conference by publishing summaries and more from its May 2025 conference as well as photographs from it. This issue also continues with regular as well as specialized articles, including those in theme sections.

The health economics article leverages previous articles on this theme to continue to provide much needed information on this important area of health leadership.

This issue also includes articles on artificial intelligence (AI) related to health leadership matters. As part of that, a conference proceeding as well as a book review are included. AI is expanding rapidly in relation to health leadership. In addition to its emerging and expected benefits, its challenges have to be addressed, such as those related to its impact on medical work scope. *CJPL* will continue to highlight these challenges and related opportunities, academically and practically, and initiate a health informatics section by 2026.

Input on *CJPL*'s content, process, style, and format is welcome. Feel free to share your comments and ideas with me and/or any of the *CJPL* team members. Your readership is much appreciated.

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Chronic condition: how or can the Canadian health care system be reformed?

A keynote address by Jeffrey Simpson

Giuseppe Guaiana, MD, PhD

In a candid and provocative address, veteran journalist and commentator, Jeffrey Simpson, critically examined the Canadian health care system, blending personal anecdotes, data comparisons, and policy reflections. He opened with humour, acknowledging the high trust Canadians place in physicians, second only to farmers, while journalists rank among the least trusted, alongside politicians, pollsters, and lawyers.

Central to his talk was the argument that Canada's health care system is structurally shaped by entrenched provider interests — doctors, nurses, administrators — while patients remain largely unorganized and without a collective voice. This dynamic, he argued, makes medicare the "third rail" of Canadian politics: any attempt to reform it is politically hazardous.

Benchmarking Canada internationally, Simpson highlighted that while Canada spends a comparable share of GDP on health care (10–12%), spending on access and outcomes lags behind. In Commonwealth Fund rankings, Canada placed 7th out of 10, while the United States ranked last. Canada's performance has been slipping over time. Organisation for Economic Co-operation and Development (OECD) data reveal that Canada has fewer doctors, nurses, hospital beds, and diagnostic equipment per capita than most peer nations. Simpson emphasized that while Canada spends more than average, only 56% of Canadians report satisfaction with the system, compared with 67% across OECD countries.

A key theme was access. Simpson argued that timeliness is part of the social contract of medicare, not a luxury, and delays erode both patient outcomes and trust. Although COVID-19 exacerbated pressures, he pointed to long-standing issues, such as population aging, increased immigration, and the opioid crisis, outpacing system capacity. He traced supply constraints back to policy missteps of the 1990s, notably the "de-doctorization" strategy, which deliberately cut physician training to control costs. Canada now lags in physician supply (2.8 per 1000 population), trailing countries like Germany (4.5 per 1000), Australia, and France.

Proposed solutions included:

- Expand medical school capacity and accelerate international recruitment of physicians and nurses, especially from countries with comparable training systems.
- Confront the "cartel-like" protectionism in the medical professions that limits entry and stifles competition.
- Explore private delivery models, such as clinics for diagnostics and surgeries, within the publicly funded system (e.g., the Calgary Eye Clinic).
- Support innovations, such as team-based family clinics (Jane Philpott's "pod" model) and Quebec's capitation-based primary care experiments.
- Establish a national drug formulary to leverage bulk purchasing power and reduce costs.
- Build a national medical pension plan for physicians, modeled after successful public pension funds.

In a closing exchange, Simpson addressed questions on administrative burdens faced by family physicians. He acknowledged the unintended consequences of excessive paperwork, fragmented referral systems, and technological inefficiencies, underscoring the need for streamlined processes in primary care.

He concluded with a call for bold, pragmatic reforms, urging physician leaders to "challenge vested interests, and catch the wave," leveraging current opportunities to attract talent, modernize the system, and deliver on the promise of universal, timely, high-quality care for Canadians.

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Leadership reset: leading with courage, connection, resilience and vision

A keynote address by Jody Carrington

Giuseppe Guaiana, MD, PhD

This powerful, raw, and engaging talk delivered a stark message: we are not facing a mental health crisis, we are facing a crisis of loneliness and disconnection. Jody Carrington, PhD, a clinical psychologist and public speaker who argues for authentic human connection, challenged the audience to rethink their assumptions about burnout, emotional health, and how we serve others. At the heart of the message is a simple but urgent reminder: humans are neurobiologically wired for connection. Yet, in a world flooded by noise, technology, and distraction, we are more disconnected than ever. The cost is staggering – rising rates of anxiety, depression, suicide, and a pervasive sense of futility.

Carrington painted a vivid picture of the everyday struggles of clinicians, parents, and leaders alike — juggling endless responsibilities, overwhelmed by data, and barely holding it together under the weight of expectations. She described the all-too-familiar cycle: a constant flood of notifications, stress, and emotional exhaustion that leads to compassion fatigue, and, eventually, burnout, not because of the work itself, but because the well of emotional resources has run dry. If the caregivers, doctors, nurses, teachers, parents, are not okay, those they care for cannot thrive.

Central to the talk was the concept of acknowledgement of our work as "holy." It is not about fixing problems, offering solutions, or apologizing. It is about bearing witness, holding space, and simply saying, "Tell me more." The act of truly seeing and hearing another person — without judgement, distraction, or the rush to fix — is rare and transformative. Although often dismissed as a "soft" skill, this is the core of leadership, parenting, health care, and community. Without it, we are reduced to transactional interactions that leave us and others feeling unseen and disconnected.

Carrington underscored that emotional regulation is the key: the ability to stay calm in times of distress, to model calm for others, and to restore the nervous system when it is overwhelmed. She offered practical advice: drop your shoulders, release your jaw, regulate your breath, and remember your capacity to connect. Small, consistent moments of acknowledgment can change lives, both those of the people we serve and our own.

The talk closed with a profound reflection: we are all just here walking each other home. No matter how skilled or educated we are, we cannot undo generational trauma or systemic inequity alone. But by being present, acknowledging the humanity of others, and tending to our own emotional regulation, we create ripples of healing in a fractured world. Carrington's final message: you matter more than you know. The work you do is holy. But remember, you are not superhuman. Care for yourself, because the people you love and serve are watching you, and learning from you, every step of the way.

> It is about bearing witness, holding space, and simply saying, "Tell me more." The act of truly seeing and hearing another person — **without judgement, distraction, or the rush to fix** — is rare and transformative.

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The insider's playbook: how to move fast in a slow health care system

A keynote address by Marlies van Dijk

Giuseppe Guaiana, MD, PhD

Marlies van Dijk began by asking the room to stand up, meet someone new, and share a story of how they'd hacked the system. Energy sparked instantly — laughter, confessions, and bold tales of bending rules and breaking barriers. That was the point: change doesn't happen by following the rules, it happens when someone decides to do what others won't.

This wasn't a talk about theory. It was a story about doing. Van Dijk, a nurse by training and a self-proclaimed rebel, had been thrown into the deep end during the Cargill meat plant COVID-19 outbreak, the largest in North America. The setting was brutal: 2300 workers, 78 languages, and a workplace so crowded and hazardous it felt like an island under siege. Rubber boots sloshed through blood, condensation dripped from hard hats, and the stakes were life and death.

Her team couldn't wait for committees or policies. They acted. They built relationships, found translators, lobbied politicians, and set up pop-up vaccine clinics in meat plants, tents, and parking lots. They worked until midnight, jabbing 1638 arms in a single day, with a 98% uptake rate. They cut through bureaucracy, ignored absurd rules (like facing chairs toward fire exits), and just did the work. A CEO handed out $100 bills at the door. It was messy, chaotic, and utterly effective.

This, van Dijk argued, is what health care needs. Not more steering committees, not five-year plans that take four and a half years to draft. It needs small teams of people with fire in their bellies, the "13%" who care enough to push through obstacles and get things done. The rest? They follow the rules, sit in meetings, and kill ideas before they breathe.

She made no apologies for her blunt message: health care is a 150-year-old business model that hasn't changed much since 1917. Hospitals still look the same. Care is still delivered in ways that ignore the realities of patients' lives. Meanwhile, other countries are leaping ahead: in the Buurtzorg model in the Netherlands, nurses run self-managed teams and deliver community care on bicycles. In Canada? Most patients still die in hospitals.

She also warned that AI is coming, fast. Virtual physicians may soon handle the first point of contact. Data will dominate decision-making, and, unless we push back, clinicians risk becoming support staff for algorithms. The future is being built, with or without us.

Her final plea: stop asking for permission. If you have an idea, don't bring it to a meeting, just do it. Use the principles of design thinking: build a prototype, test it, and prove it works before anyone has the chance to say no. Avoid the "hippos," the highest-paid person in the room whose word shuts down all others. Find your "wolf pack," the people who get it, who will back you up when the system pushes back.

Change doesn't happen by climbing the ladder. It happens on the edges, in the chaos, in the urgency, in the refusal to accept the status quo. And it's not safe. You'll get told no, a lot. You'll feel like quitting. But if you care — about your patients, your colleagues, your community — you'll keep going. Because in the end, we are the system. And if we don't change it, who will?

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She also warned that AI is coming, fast. Virtual physicians may soon handle the first point of contact. Data will dominate decision-making, and, unless we push back, **clinicians risk becoming support staff for algorithms.** The future is being built, with or without us.

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Mantra:

"Leadership starts with leading yourself, both inside and outside the office."

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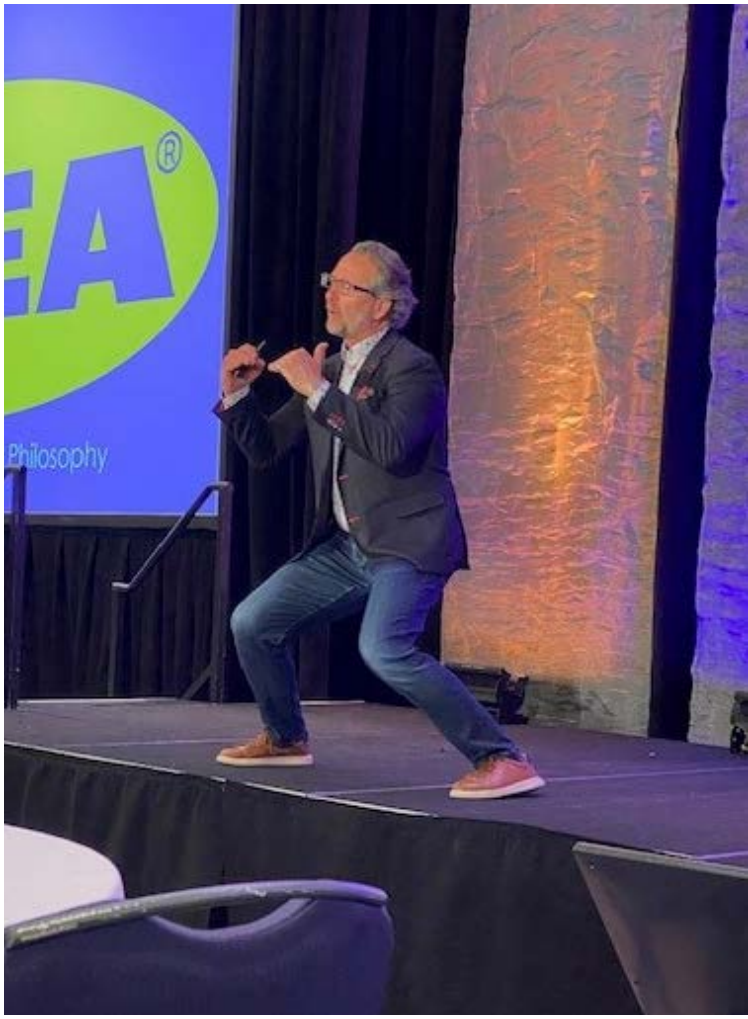
Wholehearted leadership: the HEART of a leader

A keynote address by David MacLean

Giuseppe Guaiana, MD, PhD



David MacLean's powerful address, delivered with humility and humour, challenged physicians to reimagine leadership as an act of service and courage. Speaking as both a leadership coach and a patient living with multiple cancers, MacLean underscored the life-saving power of health care professionals while urging them to embrace wholehearted leadership.

MacLean opened with gratitude for the care he received during his cancer journey. This personal story framed his core message: leadership is influence, and, in health care, influence is an everyday act. Drawing from diverse examples, from the Winnipeg Jets to a chance encounter with a pizza delivery musician who helped shape a rock anthem, MacLean illustrated how passion, purpose, and conviction transform ordinary roles into extraordinary impact.

He presented the seven commitments of wholehearted leadership, summarized by the mnemonic HEART.

- **Humility:** It's not about you. Acknowledge limits, seek others' perspectives, and remember that no one is indispensable.

- **Empathy:** Understand others' stories before judging; leadership is about connection, not command.
- **Authenticity:** Be genuine, act with integrity, and have the courage to say what needs to be said.
- **Risk:**
  - » **Courage:** Push through fear and embrace vulnerability; courage is action, not absence of fear.
  - » **Vulnerability:** Open up to build trust; depth in relationships is impossible without it.
  - » **Fail:** See failures as first attempts in learning; true innovation requires risk.
- **Tenacity:** Sustain effort toward a worthy goal; grit distinguishes those who persevere.

MacLean's message to physician leaders was clear: health care's challenges — burnout, bureaucracy, and fragility — demand a shift from command-and-control models to heart-centred leadership. Physicians must become "risk-takers" and "spenders of themselves for others," challenging outdated systems and breaking free from paralysis by analysis. Echoing Angela Duckworth's work on grit, MacLean argued that passion, persistence, and courage, not perfection, are the real hallmarks of leadership.

He closed with a simple yet profound takeaway: leadership is not about titles or hierarchy. It's about the daily, human work of helping others become better than they thought possible.

MacLean's message is a call to action: for physicians to lead not just with their heads, but with their hearts.

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Bridging policy and practice to build a health care system that works for all

Hosted by **Scott McLeod**, Registrar and CEO of the College of Physicians and Surgeons of Alberta, the Panel included **Sarah Yassami**, MD, UBC IMG Principal LEAD; **Michael Ertel**, MD, Chief of Staff, Kelowna General Hospital and **Connie Paul** (Teltitelwet), RN, Primary Care Medical Manager, Snuneymuxw Hulit Lelum

Giuseppe Guaiana, MD, PhD

This panel brought together diverse voices in health care leadership to focus on mentorship, workforce sustainability, rural care innovation, and systemic transformation. The conversation highlighted mentorship as a core responsibility across disciplines, including nurse practitioners, residents, occupational therapists, social workers, and international medical graduates (IMGs). The panelists emphasized that mentorship must extend beyond clinical skills and also foster leadership, cultural safety, and resilience within health care systems.

Virtual care, especially in rural and Indigenous communities, emerged as a transformative solution. Panelists described successful models, such as virtual emergency departments staffed via iPads that enable family physicians to rest while still maintaining care continuity. Such models reduce physician burnout, support rural nurses and IMGs, and maintain high standards of care. Virtual collaboration among paramedics, rural hospitals, and specialists is now vital in transporting critically ill patients from remote areas. The paradigm shift to the use of virtual care, once unthinkable, has become a cornerstone of care delivery in underserved regions.

Panelists agreed that retention is a deeper challenge than recruitment. Connie Paul shared personal reflections on why she stayed in a remote First Nations community for over 16 years, despite systemic barriers and limited access. She emphasized the importance of shared vision, community connection, and a culture of mutual respect. High retention rates in their community stem from strong leadership, cultural alignment, and long-term investment in building local health infrastructure, dental care, occupational therapy, Indigenous medicine, and more. The discussion underscored the need to understand why people stay, not just why they leave. Panelists advocated "stay interviews" over exit interviews.

A physician in the audience asked how health care systems can better support the "silent majority" of doctors who are currently doing the bulk of the work. Although efforts often focus on recruitment, she stressed the importance of retaining and recognizing these experienced physicians, ensuring their professional satisfaction and support through effective policies and programs.

Discussion shifted to the need for physician advocacy at policymaking levels — engaging ministries of health, associations (e.g., Doctors of BC, the Ontario Medical Association), and divisions of family practice. Panelists urged physicians to understand governance structures, join leadership tables, and push for realistic, system-wide solutions that balance resources and needs across facilities. Collaboration with other health professions and Indigenous governance was seen as essential for systemic change.

The panel concluded by emphasizing collective action, empowering clinicians across disciplines to advocate change, challenge systemic inertia, and build inclusive, sustainable health systems that meet the needs of all communities.

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Panelists urged physicians to understand governance structures, join leadership tables, and **push for realistic, system-wide solutions** that balance resources and needs across facilities.

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Leading with purpose: **Liberating Structures** in action!

In this dynamic session facilitated by Carolina Almeida and Fernando Murray, participants experienced a series of Liberating Structures. Liberating Structures are simple, adaptable facilitation techniques designed to promote inclusive participation, creativity, and shared leadership in groups of any size. This session combined peer learning and structured engagement to create a direct bridge between inspiration and practical application.

Attendees engaged with the widely adopted Liberating Structures methods of:

- **Impromptu Networking** - A quick series of one-on-one conversations to build connections and surface ideas around a shared question.
- **UX Fishbowl** - A small group discusses a topic while others observe, then reflect or join in—ideal for exploring diverse perspectives. Three physicians shared how they have successfully integrated these approaches into their clinical and organizational contexts, bringing credibility and relevance.
- **15% Solutions** - Participants identify small, immediate actions they can take using the resources and authority they already have.

By linking lived experience with hands-on practice, the session supported participants in moving from reflection to action — inspiring purposeful leadership and more inclusive engagement within their teams and organizations.

Concurrent **workshops**

The 2025 Canadian Conference on Physician Leadership featured 18 90-minute workshops offered at various levels: introductory, intermediate, advanced, and suitable for all participants. A summary of these workshops follows. Please note that the descriptions have been condensed for the purposes of the journal. To view the full, detailed workshop descriptions, see the conference website: https://physicianleadershipconference.com/ccpl2025-program

Fostering co-production through distributive leadership: realizing the transformative value of patient engagement

Holly Harris, MA; Sophie Soklaridis, PhD

This workshop explored how physician leaders can create meaningful patient engagement through distributive leadership and multidirectional learning. Participants examined how intentional power-sharing and collaborative learning can elevate patient voices, challenge tokenism and promote health equity.

Learning objectives

- Articulate the value of patient engagement in health care programs and research
- Apply distributive leadership to foster shared decision-making
- Use multidirectional learning to empower patients and reduce power imbalances

Advancing equity in health care leadership through strategic intelligence

Ruth Vilayil, MD, FRCSC; Erica Phelps, MD, FRCSC; Ariella Zbar, MD, CCFP, MPH, MBA, FRCPC

This workshop introduced participants to a four-part strategic intelligence framework for leading with equity. Using foresight, partnering, visioning and motivating, participants explored how to align leadership behaviour with

equity-centred outcomes and increase awareness of implicit bias in strategic decision-making.

Learning objectives

- Identify the components of strategic intelligence
- Conduct personal gap analyses related to leadership behaviour
- Use bias awareness tools to improve inclusive leadership practices

From advocacy to influence: using negotiation skills to achieve outcomes

Amanda Brisebois, MD, Med., MMgmt (IMHL), PPC (ICF), AoDI

This session guided physician leaders in using negotiation and mediation principles to translate advocacy into influence. Participants practiced issue framing, stakeholder analysis and goal articulation through the development of impactful briefing notes and SMART-E action plans.

Learning objectives

- Describe common gaps in influencing health care change
- Apply a negotiation process to move from advocacy to influence
- Develop briefing notes integrating negotiation techniques

The interaction of leadership style and calling orientation: a novel approach to mitigating and predicting burnout in physician leaders

Gary P. Ernest, MD, CCFP, FCFP, MBA, EDBA Candidate; Catherine Loughlin, PhD

This workshop explored how physician leaders' sense of calling interacts with leadership style to affect burnout. Participants reflected on their personal pathways, analyzed peer experiences and applied evidence-based insights to support sustainability in leadership roles.

Learning objectives

- Assess participants' own calling orientation in relation to leadership roles
- Gain insight into peer strategies for managing stress and burnout
- Identify correlations between calling and burnout
- Apply calling orientation as a burnout mitigation tool

Applying the Psychosocial Hazards Manifesto: a new system tool for medical leaders to manage disrespect and incivility*

Andrea Lum, MD, FRCPC, CCPE, FCAR; Kelly McShane, PhD, CPsych

Participants examined disrespect and incivility in medicine through a systems lens, using occupational health and safety principles. They applied the Psychosocial Hazards Manifesto to identify root causes and develop structured interventions to create safer work environments.

Learning objectives

- Describe psychosocial hazards affecting physicians
- Use root cause analysis to address incivility
- Apply a hierarchy of interventions to improve workplace culture

** A more detailed article based on this workshop is included in this issue of CJPL.*

Building leadership influence with purposeful relationships: curiosity, connectivity, community, collaboration

Anne McNamara, MBChB, FRACP, FRCPC, CEC

This interactive session supported leaders in strengthening relational influence using curiosity, collaboration and the Allyship Framework. Participants developed practical skills for trust-building and created action plans for more intentional leadership engagement.

Learning objectives

- Reflect on relationship dynamics within leadership ecosystems
- Explore the impact of allyship principles in leadership
- Practice curiosity-driven communication techniques
- Identify purposeful changes to improve leadership connectivity

Leading with humility: modeling culturally safe leadership

Jennafer Wilson, MD; Atussa Behnam-Shabahang; Katie Alexander; Amanda LaBoucane

This workshop guided participants in developing culturally safe leadership practices. Through self-reflection and case study analysis, leadership plans grounded in humility and reconciliation were designed.

Learning objectives

- Define and discuss the concept of cultural safety
- Model humility and lateral kindness within the participants' sphere of influence
- Design a personal, culturally competent leadership plan
- Develop actionable commitments to incorporating culturally safe competencies into leadership practice

Social media: amplifying voices and shaping the future of health care

Shazma Mithani, MD, FRCPC

Participants explored how to use social media to share health expertise, counter misinformation, and build professional presence. The session focused on platform differences and best practices for responsible engagement.

Learning objectives

- Identify the role of social media in health information dissemination and advocacy
- Define the demographic characteristics of each major social media platform
- Compare and contrast content types across different platforms
- Explore best practices for using social media to champion key issues in health care

Supporting physicians in the aftermath of a critical incident

Heather Murray, MD, MSc, FRCPC; Keleigh James, MD, CCFP, FCFP

This workshop provided evidence-informed strategies to support physicians recovering from critical incidents. Participants assessed intervention barriers and discussed building resilience through case-based scenarios.

Learning objectives

- Describe the impact of repeated exposure to critical incidents and recognize signs of trauma in the workplace
- Evaluate strategies for fostering individual and team resilience following a critical incident
- Compare barriers and assess the feasibility of incorporating resilience-building strategies in diverse health care settings

Health system transformation requires authentic co-design with primary care

Marilyn Crabtree, MD, CCFP, FCFP; Nicole Nitti, MD, CCFP (EM), FCFP; Kim McIntosh, MD, CCFP, FCFP

This workshop explored strategies to engage family physicians and primary care teams in system transformation. Participants examined ways to strengthen leadership, improve collaboration and support more equitable, community-based care.

Learning objectives

- Explore the difference between co-design and stakeholder engagement through the "Heard, Seen, Respected" exercise, highlighting the impact of tokenistic engagement
- Discover the value of connecting family physicians and primary care teams through self-determined governance and leadership, followed by "Wise Crowds" discussions to share strategies
- Learn how formal leadership education equips family physician leaders to drive system change, reduce burnout and collaborate effectively

Finding the sweet spot of personal leadership edge: personal, philosophical, pragmatic and political

Anurag Saxena, MD, M.Ed., MBA, FRCP, FCAP, CHE, CCPE; Graham Dickson, PhD

Leaders examined four dimensions of leadership — self-awareness, values, decision-making and influence — and explored how these align with their leadership styles. The session focused on reflective integration for personal growth.

Learning objectives

- Explain the four dimensions of effective leadership: personal, philosophical, pragmatic and political
- Appraise structures and processes conducive to leadership success within participants' spheres of responsibility
- Integrate these practices into their leadership repertoire to help develop a personal leadership brand

Leadership in the era of AI: skills for 2025 and beyond*

Mamta Gautam, MD, MBA, FRCPC, CCPE, CPE; Kathleen Ross, MD, MSc, MCFP

Participants examined the leadership skills needed to ethically and effectively implement artificial intelligence (AI) in health care. Using the LEADS framework, they identified opportunities to build innovation-ready, trust-based teams.

Learning objectives

- Define AI and discuss its applications in health care
- Identify key leadership competencies — using the LEADS framework — required to lead change, remain agile, communicate effectively, build trust and create a positive culture of innovation
- Describe how to integrate AI tools into the health care system in an ethical, transparent and accountable manner

** A more detailed article based on this workshop is included in this issue of CJPL.*

Creating a culture of connection through informal peer support

Alexis Botkin, MD, FRCPC; Holly MacLean, RN, BN

This session emphasized informal peer support as a driver of clinician well-being and team cohesion. Participants practiced communication and listening skills to foster psychologically safe environments.

Learning objectives

- Articulate a personal vision for a more inclusive and collaborative culture of medicine through reflection and dialogue
- Identify and analyze everyday opportunities to apply informal peer support in interactions with colleagues
- Practice informal peer support skills through role play and prepare for future application in professional settings

Transforming health care: a paradigm shift toward Whole System Quality

Raymond Dong, MD, ABIM, FRCPC; Erica Phelps, MD, FRCSC

Participants applied a Whole System Quality framework to integrate planning, control and improvement. They engaged in stakeholder-based exercises to enhance learning culture and quality-driven leadership.

Learning objectives

- Define what quality means to patients and the health care workforce and craft strategies to achieve it sustainably
- Adopt leadership principles to support problem identification, experimentation and codification of effective solutions
- Integrate quality planning, quality improvement and quality control to deploy strategies that reliably meet prioritized needs
- Describe how all levels of staff can meaningfully participate in quality improvement efforts
- Assess the current stage (stages 0 to 3) of participants' organizations' progress in implementing a whole system quality approach

Meeting whisperer: taking your meetings from "meh" to magic

Jennie Aitken, MA, MADR; Maria Kang, MD, FRCPC

This practical session helped leaders address common meeting pitfalls and apply tools to improve time management, participation and decision-making. Participants left with techniques for leading more efficient and engaging meetings.

Learning objectives

- Analyze the "current state" of meetings in health care, identifying key challenges and inefficiencies that affect productivity and engagement
- Assess and justify whether a meeting was necessary using specific criteria, supporting informed decisions about when to meet and when to consider alternative communication methods
- Synthesize and apply practical tools and techniques, such as agenda setting, time management, and participant engagement strategies, to improve meeting outcomes

Tall poppy syndrome: an organizational blind spot driving talent from your organization

Jodi Ploquin, MSc, TIC, CWT, CHE; Callie Bland, BSc, BSN, Certified Professional Co-Active Coach (CCPN)

Participants examined how tall poppy syndrome undermines high achievers and contributes to poor retention. The workshop offered strategies to build psychologically safe, inclusive cultures that support talent and innovation.

Learning objectives

- Define tall poppy syndrome
- List key traits of "tall poppies" and describe the behaviour of "poppy cutters"
- Identify how to recognize tall poppy syndrome in the workplace
- Outline tangible organizational actions to create cultures that attract, support and retain high-performing individuals

Finding joy in practice

Andie Bains, MD, CCFP; Leah Malazdrewicz, RN

This session supported physician leaders in reconnecting with joy, managing challenges and fostering positive team cultures. Strategies focused on resilience, well-being and sustaining a meaningful medical career.

Learning objectives

- Identify ways to reconnect with joy in the practice of medicine
- Describe strategies to cope with challenging encounters and difficult periods
- Explain how team leaders can take action to cultivate a healthy, joyful work environment

Developing leadership for health care resiliency: adaptation to extreme heat, "the silent killer"

Diane de Camps Meschino, BSc(H), MD, FRCPC; Ming-Ka Chan, MD, MHPE, FRCPC; Myles Sergeant, MD, FCFP, P.Eng.

Participants explored health care risks associated with extreme heat and climate change. The session provided strategies for EDIA-focused (equity, diversity, inclusion and accessibility) planning, crisis leadership and preparing vulnerable communities for climate impacts.

Learning objectives

- Use change leadership techniques to stimulate innovative ideas for building climate-resilient health care systems
- Develop EDIA-focused adaptation strategies for patients and communities facing high exposure and low adaptive capacity
- Apply a crisis leadership framework to support emergency response planning and system preparedness

LEADING WITH PURPOSE

TO BUILD A BRIGHTER HEALTHCARE FUTURE

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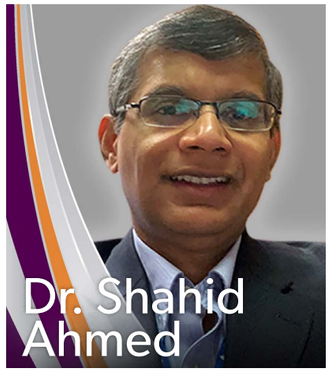

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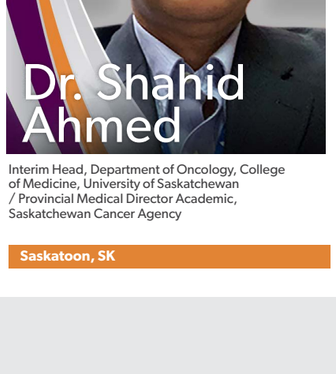

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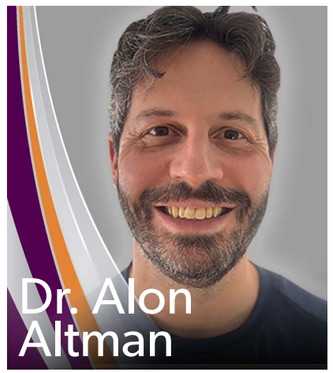

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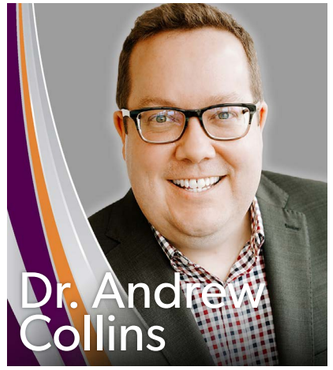

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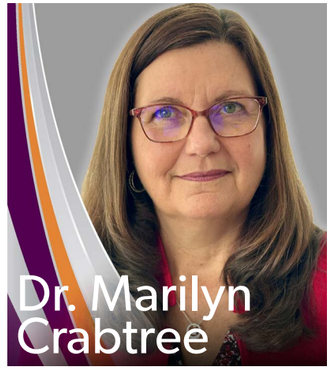

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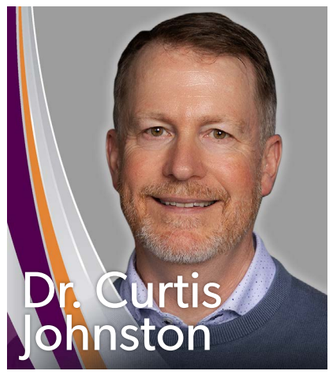

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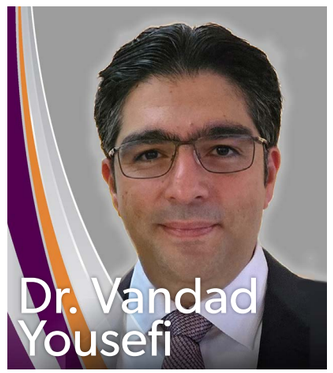

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2025 Chris Carruthers Excellence in Medical Leadership Award

Dr. Mamta Gautam

Assistant Professor of Psychiatry, University of Ottawa, and President and CEO, PEAK MD

Dr. Gautam embodies the qualities of a visionary leader, strategic thinker and compassionate advocate. At her core, she is a deeply caring and genuine person who uplifts those around her.

– *Dr. Jerry Maniate and Dr. Lyn Sonnenberg*

Dr. Mamta Gautam has made an extraordinary impact on physician health, leadership development, and healthcare management. With over three decades of pioneering work, she has developed and implemented strategies to address the systemic challenges healthcare professionals face, both individually and as teams.

Dr. Gautam founded the University of Ottawa's Faculty of Medicine Wellness Program, which inspired similar initiatives across Canada. She was instrumental in establishing the Canadian Medical Association's Centre for Physician Health and Well-being and the development of its national Mental Health Strategy for Physicians. Her continued leadership has improved workplace satisfaction and physician retention nationwide.

A passionate advocate for women in medicine, Dr. Gautam co-leads Momentum, a retreat for women physicians, and founded The Raft, an accredited online leadership and peer support platform. She played a key role in leadership development initiatives globally, through PEAK MD, the LEADS Global program, and a wide range of workshops focused on social justice and equity in healthcare. During the COVID-19 pandemic, she was the founding Chair of the Canadian Physician Coaches Network and launched online support forums to assist physicians. Her books, *Irondoc: Practical Stress Management Tools for Physicians* and *The Tarzan Rule: Tips for a Healthy Life in Medicine*, have become essential resources for navigating the challenges of medical practice.

In addition to her many professional accomplishments, Dr. Gautam is admired for her warmth, generosity, and integrity. She exemplifies the power of leadership grounded in kindness and humanity.

Incivility and disrespect as a workplace hazard: a new framework from occupational health and safety

Kelly E. McShane, PhD, and **P. Andrea Lum**, MD

This article was inspired by the workshop Dr. P. Andrea Lum and Kelly McShane, PhD hosted at the 2025 Canadian Conference on Physician Leadership in May.

Disrespectful behaviour of physicians is increasingly recognized as a significant problem in health care, contributing to a dysfunctional culture, decreased staff well-being, and compromised patient safety. Regulatory approaches frequently focus on individual actions or conduct, treating such behaviour as isolated issues rather than hazards in the workplace. Such approaches are long and slow and fail to address the broader systemic impacts of incivility and disrespect. We advocate reframing incivility and disrespectful behaviours as workplace hazards, drawing heavily from the workplace-specific principles of occupational health and safety (OHS). This approach would encompass accurate detection of harmful behaviours; root cause analyses of workplace conditions that perpetuate incivility; and a hierarchy of interventions. Successful implementation of this paradigm shift would require few changes to regulatory statutes and would signify recognition of physician-oriented OHS concerns. Implementation would draw on existing foundational approaches, including just culture, patient safety, and continuous quality improvement. The Psychosocial Hazards Manifesto is a call to action for all of us to incorporate an OHS lens that recognizes the workplace context, as well as the obligations of both employers and physicians to address such hazards. It will also support effective assessment strategies and a robust tiered intervention approach.

KEY WORDS: disrespect, incivility, physician, psychosocial hazards, occupational health and safety

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Disrespectful physician behaviour is proposed as a core underlying factor in the dysfunctional culture in health care and a significant contributor to the limited progress in patient safety.[1] It is also linked to decreased well-being and increased stress and burnout among health care providers and physicians.[2,3] Most interventions have failed to focus on systemic factors in addressing disrespectful behaviour in favour of individual skills-based interventions.[4]

We have overlooked an established approach to addressing incivility and disrespect — one that is simultaneously systems-driven and locally directed. Occupational health and safety (OHS) provides a unique conceptualization of incivility and disrespectful behaviours, which are regarded as *psychosocial hazards in the workplace*. An OHS perspective would enable more systematic approaches to prevent, address, and manage disrespectful behaviours in the local workplace of physicians. It would offer proactive bench-strength to complement disciplinary and regulatory measures through the inclusion of additional legislation, regulations, and policies.

Furthermore, we contend that physicians have a workplace, and disrespect and incivility are workplace hazards. Physicians are workers in need of protection and mitigation of such hazards. Our purpose is to change to a more nuanced consideration of interventions to address physician incivility and disrespectful behaviours.

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How do existing regulatory and disciplinary solutions operate?

Ontario’s *Public Hospitals Act* defines the governance role of the Board of Directors and the Medical Advisory Committee (MAC). The MAC is responsible for recommending to the Board of Directors the annual appointment of physicians’ medical staff privileges. Where “incompetence, negligence or misconduct” is determined, the board has the authority to suspend or revoke privileges.[5] Recent cases have documented how the MAC intervened because of a physician’s documented use of fear and intimidation in interactions with colleagues; a physician’s inability to

collaborate with other staff, which presented a risk to the delivery of safe patient care; and a physician's inability to maintain civil interactions with other health care professionals.[6,7]

In these cases, regulatory solutions took 15 years to achieve, and both physicians filed a series of false and inaccurate counter-complaints against their colleagues, including complaints to the College of Physicians and Surgeons of Ontario and the Human Rights Tribunal of Ontario.

An alternative regulatory approach involves the use of inspectors to bring about awareness and action. At one hospital, a group of anonymous physicians hired legal counsel to submit a claim of unprofessional behaviour by hospital administration, which prompted the Minister of Health to appoint an inspector to conduct a review. The subsequent report[8] included recommendations, which the hospital's Board of Directors stated would require leadership to implement. At another hospital, inspections stemmed from the Ministry of Labour following staff safety incidents, which then linked staff safety and patient safety. In this case, hospital administration was compelled to address the safety issue from an organization-wide approach.[9]

… a physician's inability to collaborate with other staff, which presented **a risk to the delivery of safe patient care;** and a physician's inability to maintain civil interactions with other health care professionals.[6,7]

Does this effectively address incivility and disrespect?

Such investigations result in physicians losing their licenses and reports being written. However, accountability often rests with the Board of Directors. Few are willing to nudge leaders (i.e., gently force compliance) to implement the recommendations. Also, given the lengthy timelines, aggrieved physicians have often left the organizations before resolution and likely do not experience any benefits.

We contend that there are three fundamental issues with these approaches. First, they fail to recognize the widespread impact of incivility and disrespect in a workplace. Often, the perpetrator or respondent is referred to as a "rotten apple." However, rotten apples spread problems and directly impact all those around them. A rotten apple emits a gas, which sets off a chain reaction that results in rotting the other apples.[10] Just as one rotten apple can spoil a barrel, a workplace can be impacted by only a few people.

Second, the approaches are ill-fitted to address disrespect and incivility; in fact, some might call them sledgehammer approaches. Sledgehammers are used for demolition, not reparations or improvements. A tiered approach to interventions is often described, but this has not truly been applied at the organizational level.[4] Key suggestions for additional strategies have been cited in inspector reports following investigations.[8] For example, addressing issues locally by minimizing formality and focusing on de-escalation; employing a third-party arbitrator to oversee individual complaints; and implementing "just culture," a system-wide orientation based on the goal of optimizing safety through effective learning systems.[11]

Third, the root causes of disrespect and incivility are not addressed. In cases reviewed previously, colleagues spoke of how the physician's ongoing behaviour created a lack of trust and collegiality among their colleagues and adversely affected their ability to provide safe patient care.[6] Nurses feared having to inform the physician of mistakes, because the physician would then make derogatory comments about staff.[7] The two investigation case examples (both Ministry of Health and Ministry of Labour) revealed that fear of retaliation or punishment for speaking up was commonplace among physicians and staff.[9,12] Essentially, there was a cited lack of psychological safety.[13]

Time for a paradigm shift: the Psychosocial Hazards Manifesto

We propose conceptualizing incivility and disrespectful actions as psychosocial hazards in the workplace. In doing so, we seek to highlight the role of the workplace in managing physician behaviours that impact patient safety, staff experience, and overall organizational culture. This approach incorporates fundamental aspects of OHS, including best practices listed in ISO45003: Occupational health and safety management — psychological health and safety at work — guidelines for managing psychosocial risks.[14]

Physicians as partners in OHS

According to the Public Services Health and Safety Association,[15] physicians are workers (or independent contractors) when they provide services in a hospital or clinic. Thus, they are afforded the protection of the OHS act in the province or territory where they work. They are also afforded protection outlined in workplace safety bills. In Ontario, these include Bill 168 (*Occupational Health and Safety Amendment Act; Violence and Harassment*

"

The approaches are **ill-fitted to address disrespect and incivility;** in fact, some might call them sledgehammer approaches. Sledgehammers are used for demolition, not reparations or improvements.

in the Workplace[16]) and Bill 132 (*Sexual Violence and Harassment Action Plan Act [Supporting Survivors and Challenging Sexual Violence and Harassment]*).[17]

Under the OHS act, physicians have an opportunity to be active members of the internal responsibility system, which guides safety in workplaces.[18] Accordingly, Joint Health and Safety Committees (JHSC) would include physician contributions, thereby ensuring that their safety issues are identified and addressed (e.g., advocating an investigation of workplace harassment by the Ministry of Labour). An engagement strategy of JHSC would require incorporation of relevant physician-oriented items and MAC endorsement would be required via appropriate stipulation in professional staff by-laws.

Accurate detection of psychosocial hazards

Organizational culture must be an active process, whereby the implicit is stated as set expectations, where supposed "shared assumptions" are verified and corrected, and the protection and maintenance process of culture is active and negotiated on an iterative basis. Without set expectations, any change is hard to detect, and normalization of deviance (NoD) is inevitable. NoD occurs when individuals' actions deviate from what is known to be acceptable behaviours (or performance) to such an extent that this "new way" becomes the norm.[19]

NoD as applied to patient safety culture underscores the benefits of placing organizational structures and culture as central driving factors that prevent the new way from emerging when faced with individual actions.[20]

We contend that it is imperative to view the display of disrespect and unprofessional behaviour by a physician as an opportunity to restate and reinforce expected standards of behaviour. We believe that there are many missed opportunities to do so, in part because of reluctance and fear of retaliation. The opportunity for early, non-blaming interventions is underused. As well, the introduction of evidence-based systems that use "nudges" toward expected behaviour is recommended.[21,22] Furthermore, tracking the implementation of early nudges and impact will ensure monitoring of any shifts overtime, ensuring identification of NoD. Building on the existing framework of continuous quality improvement that underpins the safety literature will ensure that detection and management of psychosocial hazards is a long-term, iterative process and not a passing phenomenon. In essence, disrespectful interaction could

be an opportunity for quality improvement, where nudges are used to protect organizational culture.

System lens for root cause analysis

Adopting an OHS lens necessitates a shift in the system's failures in prevention, recognition, and management of the psychosocial hazard. A big leap is required! This means individuals are not solely to blame for their disrespectful action, and, likewise, it is not solely an individual's responsibility to intervene to address it. We argue that denying the role of the workplace as a conduit for psychosocial hazards amounts to perpetuation of the careless work myth.[23]

The careless work myth is a concept from OHS which suggests that some workers are accident prone, careless, or even reckless, which explains the injuries.

Root cause analysis shows that safety and care for patients is reduced in workplaces where unprofessional behaviours are present.[24] Such behaviours are fostered by harmful workplace processes (e.g., lack of role clarity, high job demands, managers' reluctance to address unprofessional behaviours).[25] It is necessary to underscore the links between civility and psychological safety.[3] In fact, research in the United States has shown that physicians in strong protective systems report experiencing less mistreatment.[26]

> We contend that it is imperative to view the display of disrespect and unprofessional behaviour by a physician as **an opportunity to restate and reinforce** expected standards of behaviour.

Apply a hierarchy of interventions

OHS interventions are designed according to a hierarchy of hazard controls,[27] constituting a five-tiered view of interventions, ranging from complete elimination of a hazard to personal protective gear to minimize impact. Australia has developed a guide managing psychosocial hazards, which specifically states that control measures (i.e., interventions) must predominantly be considered at an organizational, work, and system design level, instead of at an individual level.[28] This is consistent with recommendations from previous reviews and investigations, such as third-party dispute resolution[8] and implementation of just culture to promote employee engagement.[29]

Ombuds offices have recently been used in academic workplaces to address faculty-to-faculty conflict, including bullying and harassment.[30] The services are confidential, and staff are often skilled at coaching individuals and groups in conflict management, alternative dispute resolution,

mediation, and restorative justice. Many are governed by a code of ethics from the International Ombuds Association.

Some of these services might be offered through hospitals. For example, the Ottawa Hospital recently posted positions in its Office of Conflict Resolution. Together, these early intervention approaches ensure that there is a focus on the organizational and systems designs, and not simply about training individuals to respond to incivility and disrespect.

Conclusion

We require a systemic and psychologically safe approach beyond "command and control" (e.g., sledgehammer) approaches, such as licence revocation.[31] OHS offers a paradigm with relevant legislation and is premised on joint responsibility between physicians and employers. As well, the focus on detection of incidents through clear expectations and careful monitoring is central to this paradigm. Finally, the application of root-cause analysis and a hierarchy of interventions means that we can achieve a responsive approach that appropriately addresses the system issues that contribute to such psychosocial hazards. This is important given that group-oriented organizational culture has been found to enable the successful implementation of just culture training.[32]

If we are to truly walk away from "name, shame, and blame" and other similar sledgehammer approaches that underlie the rotten apple verbiage, we must simultaneously acknowledge the widespread impact of disrespect and incivility, while uncovering what system characteristics tolerate (or even reinforce) such actions. The cost of incivility and disrespect is much more than we can imagine; it impacts individuals, teams, patients, organizations, and the entire health care system.[33]

The Psychosocial Hazards Manifesto will enable all of us together to move toward the responsive obligation and regulation of incivility and disrespect as workplace hazards, consistent with international approaches and best practices in OHS.[14]

We hope you accept this call to action — to reframe incivility and disrespect as workplace issues, issues that are, in fact, occupational hazards. These hazards must be detected, in collaboration with physicians, and root-cause analyses are required to identify system issues. We envision interventions that are responsive and are drawn from a hierarchy of control for psychosocial hazards, with dedicated emphasis on prevention and early interventions offered at the organizational level.

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Author attestation: *Both authors participated in the conceptualization of this article, writing of the original draft and revisions, and approval of the final version.*

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Leadership in the era of AI: skills for 2025 and beyond

Mamta Gautam, MD, and **Kathleen Ross**, MD

This article was inspired by the workshop Dr. Mamta Gautam and Dr. Kathleen Ross hosted at the 2025 Canadian Conference on Physician Leadership in May.

As artificial intelligence (AI) transforms the fabric of health care, physician leaders face an urgent call to lead with vision, nimbleness, and a deep sense of ethical responsibility. AI is not a silver bullet; it is, however, here to stay. How we lead through disruption in this era of AI will shape the future of medicine.

KEY WORDS: Leadership, Artificial Intelligence, Ethics, AI

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Physician leaders will be asked to address competing priorities of innovation, ethics, and implementation. Physician leadership will be crucial, steering us toward outcomes that serve both efficiency and the humanity of our profession.

Setting the stage

AI is not new technology; however, its potential in health care became more tangible following the release of ChatGPT in 2022. From enhancing decision-making to optimizing workflows, AI is poised to disrupt traditional medical models.

This is not the first time health care has been redefined by technological advancements. The shift from paper and pager-based systems to digital

solutions, such as electronic medical records and secure messaging, was already significant. Today, AI promises to further accelerate innovation, making it essential for health care leaders to understand its implications. Remember though, that for something to be truly innovative, it must be new and it must generate value.

Physician leaders will be tasked with navigating this evolving, complex landscape with vision, curiosity, and a commitment to improving patient care, while keeping an eye on both financial costs and environmental impact. As clinicians, it will be our professional responsibility to ensure AI use meets established safety and practice standards.

Understanding the technology

John McCarthy defined AI in 1955 as the intelligence demonstrated by machines. We now consider AI much more broadly as a technology that can learn, make decisions, and act. AI, however, is not just one entity and cannot be applied to every task.

Machine learning (ML) is a type of AI that learns from experience, without being explicitly programmed. ML uses algorithms, step-by-step procedures, or sets of rules that a computer follows to achieve a specific task. ML can discover patterns in data and use them to make predictions or decisions.

Deep learning (DL), a type of ML, automatically learns complex patterns across multiple layers of large data sets. Given enough data of good quality and parameters, DL will create its own strategies for action. It makes its own way to the conclusion. Data drives, modifies, and improves the model without direct human commands. A great example would be support vector machines, such as those applied to imaging to detect breast cancer. These algorithms excel at differentiating between normal and abnormal without supervision, but within clear, human-defined planes of differentiation that are then compared with human interpretations to achieve rapid improvement.

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These algorithms excel at **differentiating between normal and abnormal without supervision**, but within clear, human-defined planes of differentiation that are then compared with human interpretations to achieve rapid improvement.

Large language models (LLMs) enable computers to understand, interpret, and generate meaningful human language, driving such innovations as AI scribes and chatbots. LLMs interpret our questions — even emotional ones — as data, to generate more helpful human-sounding responses.

Generative AI (Gen AI) can create novel content based on patterns and structures. It learns by extracting useful text from a variety of data sources

and then generating insights to inform decisions, predictions, or better optimization of its own performance. Text, images, music or even entire video simulations that mimic or resemble novel human content are created. Applied to medical imaging, Gen AI can process millions of images, compare them with a database of known outcomes, and provide a highly accurate diagnosis that rivals or even surpasses human experts. AI applied to calculating bone age is one such example.

Despite all the hype and hope, AI today largely focuses on specific, single, defined tasks. AI output, based on data input, responds to a single query — even if that query is complex and crosses silos of data. Essentially, today's AI transforms large amounts of data inputs into actionable information.

From large language models and predictive analytics to ambient scribes and robotic-assisted surgeries, AI tools are no longer hypothetical in health care.

AI offers us an opportunity to improve our own productivity and the quality of care we deliver to patients through implementation of a series of specific tools. Those supporting clinicians will generally address repetitive tasks, including AI scribes, clinical decision pathways, image interpretation, and chart review and summary, even building differential diagnoses. AI-driven system-level efficiencies, such as triage, scheduling, and predictive staffing tools, will scan data from multiple sources, summarize, and implement improvement plans much more quickly than human data analysts. Patient-empowering AI resources, such as education tools, consult visit summaries, wearables, home monitors, and chatbot-driven disease management

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Gen AI can process millions of images, compare them with a database of known outcomes, and provide a **highly accurate diagnosis** that rivals or even surpasses human experts

supports, will drive substantial change in how and where care is delivered, truly enabling personalized medicine.

As these technologies evolve, leaders must understand both the AI resources' technical capabilities and their limitations. This includes how AI models are trained and validated, where biases may exist, and how data privacy is protected.

Key leadership skills for the AI era

While AI introduces unparalleled opportunities, it also brings challenges that demand careful leadership. Several key areas must be addressed as we integrate AI into health care systems. Exploring how LEADS, a time-tested Canadian leadership model, remains essential in today's AI-era will help navigate these increasingly active agents in our clinical and administrative settings.

Lead self

With so much evolving at pace, leaders must develop digital literacy to understand AI and continue to engage in lifelong learning, increasing knowledge of this topic as part of their ongoing professional development.

AI is best seen as a support tool rather than a replacement for critical decision-making. Leaders must be self-aware, understanding their own comfort levels with AI while supporting staff in flagging mistakes or biases. Encouraging open communication and feedback loops will foster a collaborative environment where AI serves as an extension of the physician's capabilities.

There is no doubt that we will be approached by many purveyors of this technology as AI's applications in health care strive to address our collective pain points related to managing increasingly complex patients in an increasingly fragmented and complex care system. Fortunately, we don't all need to be data scientists; however, we must understand the capabilities and limitations of AI, the ethical considerations, and the potential impact on our organizations and the broader industry.

Ethical decision-making, bias recognition, and curiosity have never been more important. Being aware of knowledge gaps in ourselves and in the technology, which potentially undermine equity and social justice, will lessen unintended harms.

AI is best seen as a **support tool rather than a replacement for critical decision-making.** Leaders must be self-aware, understanding their own comfort levels with AI while supporting staff in flagging mistakes or biases.

Engage others

One of the cornerstones of effective AI integration is building trust among frontline health care providers. Leaders need to foster education on AI technologies, ensuring that staff understand the capabilities and limitations of these tools. Clear communication and explainability of AI processes are critical to engender confidence and transparency.

Leaders must develop and share a clear vision and articulate how AI fits into the broader strategy of their organization. This vision should be patient-centric, focused on AI-driven outcomes improvements, enhanced patient experiences, and more efficient and effective care delivery models. But vision alone is not enough; being adept at implementation is required. Turning our vision into reality demands careful planning, investment, and forging partnerships with technology innovators in ways we are not accustomed to undertaking.

AI has the potential to upend traditional models of care, reallocate roles and responsibilities among health care providers, and shift the balance of productivity toward those who embrace these new technologies. Therefore, communication and advocacy skills are vital. Focusing on both our people and the culture of innovation in our workspaces, while simultaneously addressing concerns over equity, privacy, and trust, will lead to successful adoption and spread. Jobs will change and we will need to understand how.

This is all positive. However, before jumping to AI as a solution, it is important to step back and ask, "what problem are we trying to solve?" Clearly defining for our teams how AI will augment workflows and encourage employees to inform themselves, while providing opportunities to support their learning, will require a mindset shift.

Communicating our sense that, while AI can be used to enhance human judgement, capabilities, and expertise, it is not a replacement for human compassion in care settings. Although AI may predict clinical deterioration, only humans can comfort a family in distress. AI may generate a care plan, yet humans are best poised to explain it with compassion. As humans, we continue to have our best outcomes when we connect — human to human.

Accuracy remains an issue, as generative AI does, at times, fill in gaps in data with information that it determines fits the situation — the so called "hallucinations." Current tools quote references that do not exist. Key to

… while AI can be used to enhance human judgement, capabilities, and expertise, **it is not a replacement for human compassion in care settings**. Although AI may predict clinical deterioration, only humans can comfort a family in distress.

the transition to AI is trust, and trust is currently lagging. Adoption remains slow because of concerns over accuracy and responsibility.

In 2023, the American Medical Association first highlighted that earning clinician trust is critical to accelerating the adoption of AI into patient care.[1] Establishing standards and revisiting regulatory systems is needed. Who is responsible if AI makes an error? Application of ethical frameworks, such as the World Health Organization's Ethics and Governance of Artificial Intelligence for Health[2] will further trust for both patients and clinicians.

Achieve results

Change often brings fear, and the transition to AI is no exception. Leaders must acknowledge and manage the resisters to change, which include not only systemic concerns but also personal fears, such as career security or retirement uncertainty. Leaders will need to manage not just the change (the external aspects that will be modified), but also the transition (people's internal reactions to the change). All change creates a loss, as we let go of what we used to do and embrace the new way. Recognizing the stages of grief that often accompany this loss as people transition from old systems to new ones is an essential aspect of empathetic leadership.

In some cases, AI is a solution in search of a problem. To meet with success, AI should not be implemented for its own sake, but to address tangible issues, such as clinician burnout, inefficiency, inequity, or clinical gaps. The financial costs and environmental impacts are not negligible. We need to be clear that the effort to incorporate AI into a specific process is something needed or wanted by those in the system. "Readiness to change," a careful examination of risks, liability, privacy, and implementation plans, should all be considered in our communications, including what clinician upskilling or increased physician engagement will be required to adopt new technologies.

Implementation science skills become indispensable. Setting goals and directions, aligning with our values and evidence, and measuring outcomes are as vital as tracking measurable outcomes. If our teams can see the gaps

and tangible solutions, they will be incentivized to build on their own skills and measure improvement, making change management a great deal less onerous.

For example, AI scribes have demonstrated the ability to reduce documentation time by up to 90%, according to a recent OntarioMD study.[3] The same study noted a significant improvement in clinician cognitive load, job satisfaction, and work–life balance. Yet this "heavenly" advancement raises equally critical questions: How are recordings stored? Who ensures data deletion? Can patients truly offer informed consent when the technology is opaque even to providers? This duality of promise and peril is at the heart of AI leadership.

In addition, leaders must drive change while maintaining critical thinking skills. Humans tend to quickly become reliant on evolving technology. How many of us can navigate a new city without the assistance of Google Maps? Normalizing active involvement with AI tools, including regularly reviewing outcomes with our teams, should help to limit automation bias, maintain clinician autonomy, and reduce the risk of deskilling our health care workforce.

Ethical considerations are paramount in deploying AI in health care. Leaders must ensure that AI models are designed with accountability and responsibility, accepting the possibility of errors and building awareness about biases. Tools, such as reflexive AI, which identifies its own biases, and adversarial AI, where one AI interrogates another, can help highlight gaps and biases in decision-making processes. In addition, it is vital to ensure patient consent when AI tools are used, equipping clinicians with the knowledge to address questions about data handling.

Implementing AI solutions requires **robust change-management strategies.** Leaders must identify internal and external stakeholders, recognize barriers to adoption, and align behind a common vision and shared goals.

Develop coalitions

Implementing AI solutions requires robust change-management strategies. Leaders must identify internal and external stakeholders, recognize barriers to adoption, and align behind a common vision and shared goals. Engaging patient advisors and health care providers in the AI resource development process ensures that tools are inclusive, accessible, and designed to meet diverse patient needs. Tailored interaction methods for patients, such as verbal phone bots or video AI, can help address varying levels of digital literacy while ensuring that patients are informed when interacting with AI. Building collaborative networks across sectors, including health care

professionals, information technology specialists, and policymakers, has always been essential in health care.

Leadership in this new space means more than just enthusiasm for innovation. It demands building trust. Leaders must emphasize patient feedback and data to continuously improve AI tools. Ensuring accountability in design, implementation, and outcomes reinforces trust while aligning AI advancements with patient care standards. Including patients in the development process enhances the relevance and effectiveness of AI interventions. Patients and providers must believe that AI systems are accurate, equitable, and secure. Yet public AI tools remain largely unregulated, and professional organizations are only beginning to issue guidance.

Leadership in this new space means more than just enthusiasm for innovation. **It demands building trust.** Leaders must emphasize patient feedback and data to continuously improve AI tools.

AI vendors are not clinicians. Leaders must evaluate them as they would any industry stakeholder — applying rigorous scrutiny to ensure that AI tools serve patient and provider needs, not just commercial interests. Yet, there is an inherent need to form partnerships between publicly funded care delivery teams and technology partners in ways we may not be accustomed to undertaking.

The ethical landscape is complex. From algorithmic transparency and data bias to environmental impact and cybersecurity, the path forward requires careful navigation.

Busy clinicians will never be able to master all the various AI platforms. However, if we could provide a single technology entry point, such as an LLM, that linked to various other tools in a seamless fashion, we would be able to accelerate adoption. Technology partners will need to engage with frontline workers to truly understand and streamline clinician workflow.

Policymakers and regulatory bodies have a critical role in accelerating adoption of AI. If we are to entrust aspects of care to machines, robust oversight is non-negotiable.

System transformation

Building a culture that embraces AI requires ongoing advocacy and a focus on achieving results while transitioning people effectively through change. Developing coalitions with other organizations using AI can help share insights and establish best practices. Staying up to date with regulations and considering the broad impacts of AI on the workforce and the environment are also crucial to sustainable leadership.

At its core, health care is a human endeavour. Even as AI changes the game, the rules must still be rooted in compassion, ethics, and service.

Leaders must think strategically, act innovatively, and anticipate regulatory shifts and climate implications related to AI infrastructure.

As we push the boundaries of AI, we face ethical challenges. AI systems learn from data, and the quality of those data determines the quality of the outcomes. So clearly naming where training data came from is important. If the data are biased, the AI's decisions will be biased. If the data are incomplete, the AI's recommendations may be flawed. Garbage in, garbage out.

AI is increasingly in everything, including our supply chains and drug development, our classrooms, training programs, and clinical care. As such, knowledge of AI is no longer optional; it is a professional obligation. So too is our commitment to patient privacy, to ongoing education, and to careful evaluation of the tools we bring into care environments.

At the moment, we do not have one specific law or set of laws establishing the guardrails for AI. We rely on multiple layers of established regulation and frameworks and essentially cross-pollinate them into AI's use. Canada is lagging behind.

Legislation, such as Bill C-27, introduced the Artificial Intelligence and Data Act, recognizing that AI systems require stringent oversight, risk assessments, and compliance with specific regulatory requirements to mitigate potential harm.[4]

A big part of the concern arises out of understanding the data set used for training and validation of AI processes, which we know has serious implications for the outputs. Often this is not made clear to end users, or at least the information is not publicly available.

Many patients and providers may not have the level of digital literacy needed to fully use new tools as they arise. This will drive inequity, and we should be prepared to address this head on.

At its core, **health care is a human endeavour.** Even as AI changes the game, the rules must still be rooted in compassion, ethics, and service.

Patients, health care providers, and the public at large must trust that AI is being used responsibly, and several of the regulatory colleges have released positions on this, including British Columbia,[5] Alberta,[6] Saskatchewan,[7] and Manitoba.[8]

Key to these recommendations is assurance that AI systems are accountable, transparent, and free from bias to prevent inequitable treatment. There are increasing attempts to provide explainable decision trees for AI tools to help us evaluate how the algorithm intends to reach its conclusions, helping to clarify what data were used and in what setting. This is critical as many of the tools to date are trained on small data sets and in particular settings that may not be transferable to other settings.

We should also acknowledge that we cannot expect AI to be flawless. There is plenty of bias in human decision-making.

Key areas of vigilance for leaders to consider in system transformation include:

- data privacy, particularly for sensitive patient information
- cybersecurity for models and training processes selected
- fairness and equity
- transparency
- safety and performance, especially for accreditation, legal, and regulatory issues

Explainability is difficult, however. If we can't explain how AI reaches its conclusions, we can't maintain transparency beyond noting that we employed AI.

The integration of AI into health care is a **defining challenge** for physician leaders in 2025 and beyond. AI in health care is the future.

Conclusion

The integration of AI into health care is a defining challenge for physician leaders in 2025 and beyond. AI in health care is the future. On offer are tangible solutions to the challenges plaguing our current workflow, lack of interoperability, complexity of patients, lack of standardization of protocols, inefficiencies in communication, lack of time and training support for clinicians to learn new technologies, and of course limited funding to implement new strategies.

AI has the potential to ensure that the right care is delivered by the right person, in the right place, at the right time, leading to better patient

outcomes and reducing health care provider turnover, alongside cost reduction through better resource management and reduced waste.

We echo the World Economic Forum's 2025 Future of Jobs Report, which states that human skills will remain irreplaceable.[9] In the face of rising automation, it is our empathy, emotional intelligence, and interpersonal agility that differentiate us as leaders. These skills build the psychological safety needed for innovation and system change to flourish and for trust in AI to take root.

By addressing ethical considerations, building trust, managing change, and fostering cultural shifts, health care leaders can ensure that AI serves as a transformative tool that enhances both the efficiency and humanity of medicine. Leadership in this age demands not only technical understanding but also a commitment to advocacy, inclusivity, and ethical stewardship. Together, we can navigate this new frontier and shape a future that honours the core values of health care.

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Choosing one from many: **efficiency in a multi-option world**

Jeffrey S. Hoch, MA, PhD, and **Carolyn S. Dewa,** MPH, PhD

In this fifth article in a series on health economics, we focus on choosing the best option among multiple choices. Leaders must understand how to rule out poor choices and then decide which of the remaining options is best. Building on previous articles, we focus on a concept called the efficiency frontier and show how cost-effectiveness analysis is used to inform choices among options on the frontier. Knowledge of how to choose among multiple options can help leaders in complicated scenarios where optimal courses of action may not be immediately evident.

KEY WORDS: leadership, optimization, cost-effectiveness, health economics

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Many decisions are of the *e pluribus unum* variety. Out of many options, one must be chosen. Each option has its own expected cost and outcome (or effect). Among various cost and effect profiles, how is one to choose? Suppose all options are bad and differ by degree. When comparing these options, some will look better than the others. How can leaders avoid choosing poorly while reducing the information overload from considering many options simultaneously?

In this article, we show how to use an efficiency frontier to organize information when considering multiple options. The frontier separates efficient from inefficient choices (when the objective is to achieve efficiency that produces a well-defined outcome). An efficiency frontier is a collection of line segments that can help leaders to visualize the value of each option.

It is created by calculating slopes along the efficiency frontier, providing cost-effectiveness information to inform leaders about options representing efficient spending. Below, we introduce an example and apply the concepts using results from a published article.

The theory of choosing among multiple options

Efficiency frontier

Assume you must fund one of four options. The expected cost and outcome (effect) for each option are plotted in Figure 1.

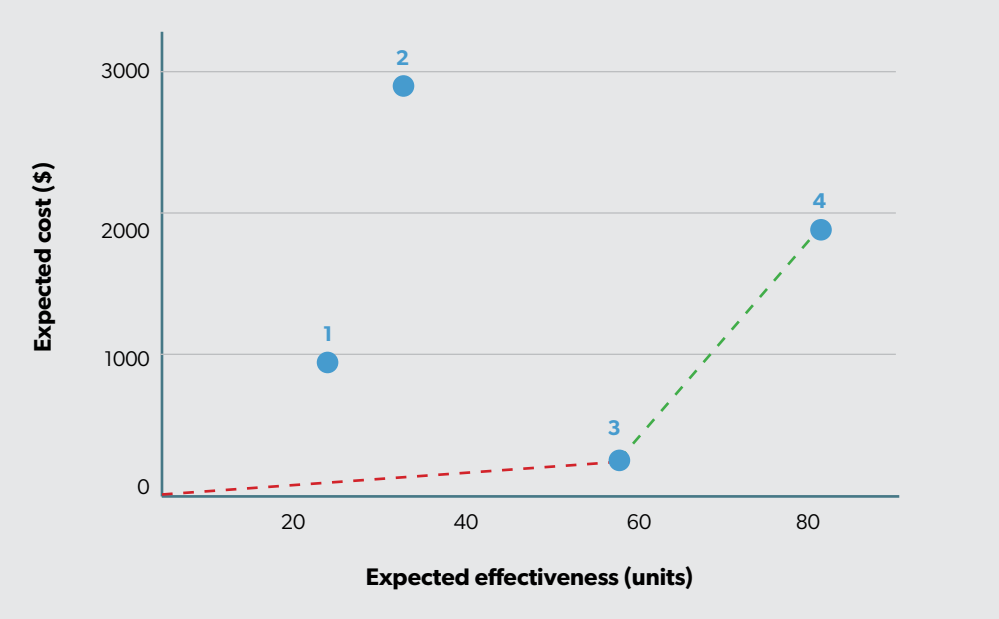

Figure 1. The efficiency frontier

It is helpful to start with the question, What are we currently spending and what are we currently getting for that expenditure? If we assume that status quo is no expenditure and no effectiveness, then the efficiency frontier will begin at the point 0, 0 (i.e., the origin in Figure 1). The efficiency frontier is drawn by starting at "usual care" and drawing a line to each of the options under consideration, creating, in this case, four lines extending from the origin (not shown in the graph). Next, we identify the line with the smallest slope (shown in Figure 1 as a dashed red line). Slope is calculated as the ratio of rise to run, the increase in cost divided by the increase in effectiveness. In this example, the smallest slope is associated with going from usual care to option 3. Now, we examine the slopes of lines from point 3 to the other three options (i.e., the remaining blue dots). Following this process, the next option to consider, if funding is available, is option 4; the

line connecting option 3 to option 4 has the lowest slope in absolute terms (shown in Figure 1 as a dashed green line).

The two options inside the efficiency frontier (options 1 and 2) are considered inferior to options 3 and 4. As Figure 1 shows, they are relatively more costly and less effective than options 3 or 4 or any combination of options 3 and 4. Based on this, analysts often drop options like 1 and 2 from further consideration.

Cost-effectiveness analysis with multiple options

The next step explores the extra cost and extra effect of each option on the efficiency frontier. Compared with option 3, the extra cost of option 4 ($1588) and extra effect (25 units) are summarized in a ratio computed as the extra cost per extra unit of effect (i.e., $1588/25 ≈ $64). In cost-effectiveness analysis, this trade-off is called the incremental cost-effectiveness ratio (ICER); in this example, the ICER estimate is $64. The ICER for option 3 compared with the status quo is $5. This is clearly a better "unit price" at which to buy extra outcome compared to $64; however, if one wants more outcome than option 3 can provide, one must consider option 4. Option 4 provides additional outcome but at a higher additional cost. Leaders decide if the additional gain is worth the additional cost; research creates evidence that can inform these decisions.

Application

Efficiency frontier

A study by Coyle et al.[1] estimated the cost-effectiveness of a new drug to augment elective orthopedic surgery. Table 1 shows the four options they considered. We use their results to demonstrate how to apply the concepts discussed above.

Option label (description)	Effect (expected life years)	Cost ($)
A (usual care)	13.037758	269
B (new drug)	13.037782	1857
C (blood donation)	13.037725	968
D (new drug + blood donation)	13.037731	2903

Table 1: Expected effect and cost of four mutually exclusive options.

Before charting the efficiency frontier, it is a good idea to sort the options by size of effect (Table 2).

Option label (description)	Effect (expected life years)	Cost ($)
C (blood donation)	13.037725	968
D (new drug + blood donation)	13.037731	2903
A (usual care)	13.037758	269
B (new drug)	13.037782	1857

Table 2: Expected Effect and Cost for four mutually exclusive options, after sorting from least to most effective.

The estimates in Table 2 should make us suspicious of options C and D; they provide less outcome but cost more than usual care. In other words, usual care "dominates" options C and D. Intuition suggests the real decision may be between A and B.

Next, we plot the data (Figure 2). The graph looks similar to Figure 1 with its constellation of points. However, the main message from the data is distorted by the x axis; although this version allows even spacing of the data points, it is much distorted by the fact that it does not start at 0.

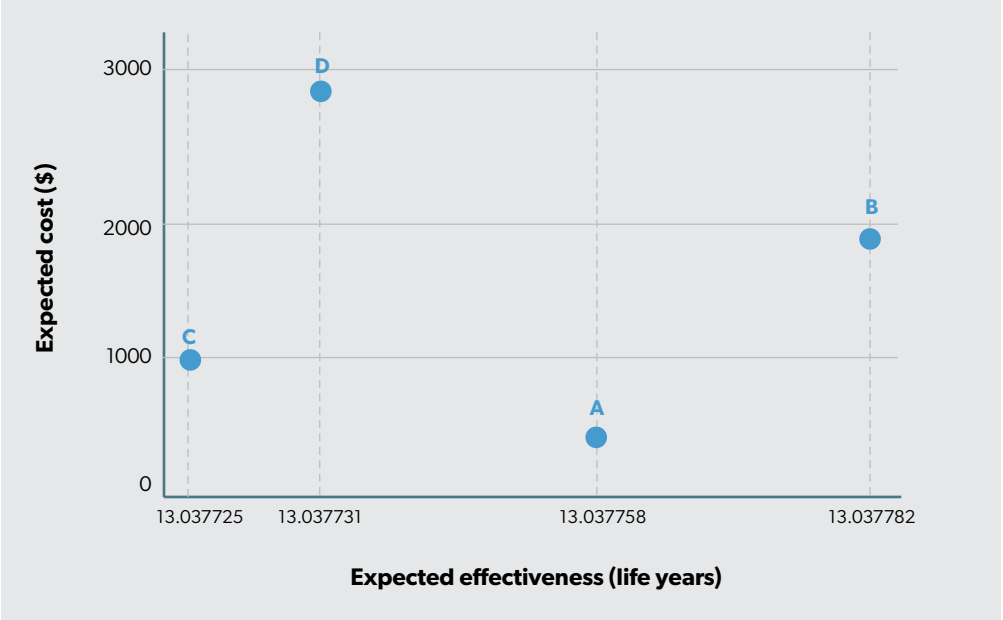

Figure 2: The efficiency frontier using data from Table 2.

Figure 3 shows the same data but with the horizontal range starting at 0 (instead of 13.037725 as in Figure 2).

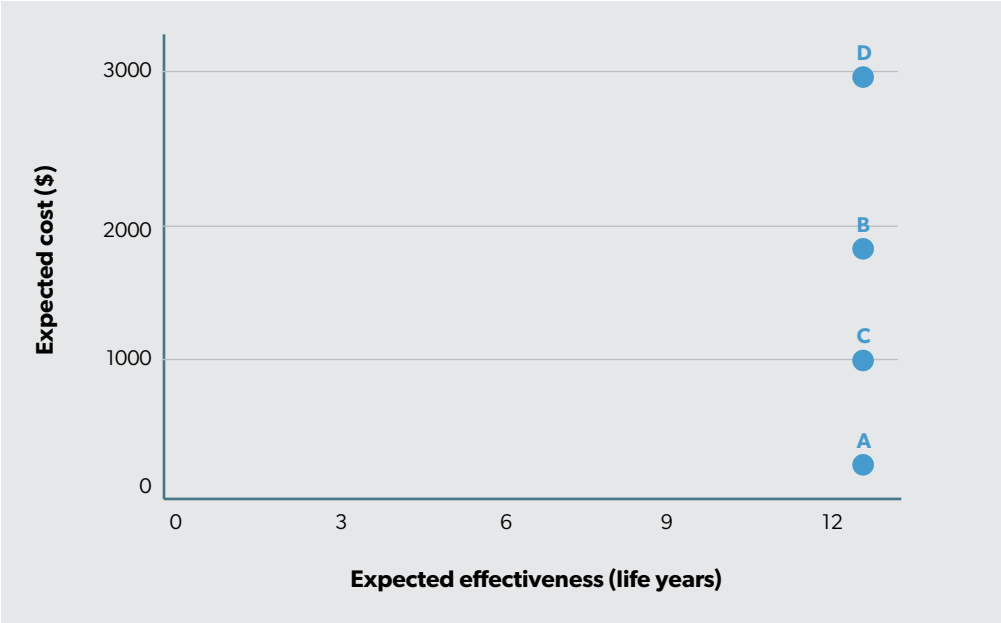

Figure 3: The efficiency frontier using data from Table 2 and a normal horizontal axis.

Figure 3 clearly shows that all four options produce almost the same amount of outcome. With each option having approximately the same expected effect, it makes sense to choose the cheapest way to purchase this amount of outcome. For leaders who want to drill down into the exact efficiency of each option, cost-effectiveness analysis is next.

Cost-effectiveness analysis

Cost-effectiveness analysis compares options on the efficiency frontier. From Figure 3, it is nearly impossible to visualize the efficiency frontier (the dots are so close to each other!). Fortunately, Figure 2 magnifies the differences in effect, so we can create an efficiency frontier using that graph. The first step is to identify which option is the "usual care" or "current situation." Table 2 lists option A as usual care. This becomes our starting point.

From that starting point, we draw lines to the other options and choose the line with smallest slope, making option B our next point on the efficiency frontier; it is the next cheapest way to provide more effect (for more cost) after option A. This is similar to the line segment from option 3 to 4 in Figure 1.

Cost-effectiveness analysis suggests that going from option A to option B is not very efficient. The extra cost is $1588 (i.e., $1857 minus $269) and the extra effect is 0.000024 years of life (i.e., 13.037782 minus 13.037758). That is about 13 minutes. If you spend $1588 to buy 13 more minutes, you are spending at a rate of nearly $66 million per additional year of life.

Mathematically, the line segment connecting option A to option B in Figure 3 has a slope of $66 166 667 per additional year of life. As is visually apparent, going from point A to point B involves spending a lot more to gain very little.

Discussion

There may be good reasons to switch from standard care (option A) to the new option B, but economic efficiency is not one of them. The authors of the article concluded, "Thus, any decision to adopt the [new drug] prior to… surgery will involve the use of scarce health care resources which could be used for other health care interventions, and must be justified by factors other than cost-effectiveness."

The idea that leaders should be good stewards of scarce resources (like money) stems from the belief that resources spent one way are no longer available for other opportunities. This concept of "opportunity cost" is the basis of why leaders should care about efficiency and research that provides economic evidence. Previous articles in this health economics series have argued that opportunity cost is both essential:

> As a leader, you are a steward of your organization's most precious resources. When you invest them, whether time or money, your choices are important. You purposefully choose to direct resources toward higher value alternatives. Understanding costs allows you to do more with your organization's scarce resources to achieve its goals and fulfill its mission.[2]

and potentially multi-dimensional:

> One leader's "wasting resources" may be another leader's "investing resources." It is acceptable for leaders to emphasize inefficiency on a single metric as long as their organization's mission is advanced in other areas of strategic importance. Spending resources inefficiently (for no conceivable gain in value) is a dereliction in a leader's duty of stewardship of scarce resources (punishable by a course or two in economics).[3]

In addition to the truth that leaders may have more than one objective they are trying to optimize, there is also the issue of uncertainty. The points on the figures we examined are simply estimates. It is possible that the true values of these estimates may lie elsewhere in 95% confidence intervals that are not shown in this type of analysis. Typically, the remedy for this type of statistical uncertainty is to (1) characterize the uncertainty (e.g., use a 95% confidence interval) and (2) collect more information. However, when evidence gathering must move at the speed of decision-making, both 1 and 2 may not be

as necessary as academics think they should be. The other type of uncertainty attending these types of analyses has to do with not knowing a number. This is not fixed by collecting more data. For example, when we compared option 4 to option 3 the trade-off was about $64 in extra cost for an additional unit of outcome. Is that worth it? The short answer is, "It depends."

In this article, we demonstrated how to make recommendations based on constructing the efficiency frontier and using cost-effectiveness analysis. These recommendations must be considered in light of uncertainties that may affect the placement of the options on the efficiency frontier or the existence of priorities that may make "inefficient" options seem like worthwhile investments. To see an example of this in your hospital setting, peruse the overview of the Canadian Coordinating Office for Health Technology Assessment from 1998[4] and compare it with what happens in your hospital regarding elective orthopedic surgery. Economic evidence can inform decision-making, but it is not sufficient to make the decision for you. Leaders must make value judgements. Considering the efficiency of health care spending using the results of cost-effectiveness can help inform the decision.

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Rural leadership isn't a subset — it's the stress test for the whole system

Giuseppe Guaiana, MD, PhD

Rural health care challenges are not isolated — they expose the weakest points in the broader system. Leadership in rural settings requires navigating structural blind spots in staffing, logistics, and governance. In this article, I argue that rural health care is not a marginal concern but a frontline test of national health care resilience. To build robust systems, policymakers must treat rural leadership as central to long-term reform.

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When rural health care falters, it does not reveal a niche problem; it exposes the structural fault lines of our entire health system. The pressures faced by rural communities, such as staffing instability, logistical fragility, governance blind spots, and chronic access gaps, are not isolated issues. They are the leading indicators of where the broader system is beginning to fail. Rural leadership, therefore, is not secondary; it is where real system performance is tested under maximum constraint.

Physician shortages affect the entire country, but in rural and northern regions, they **threaten basic functionality.**

Nowhere is this more apparent than in workforce sustainability. Physician shortages affect the entire country, but in rural and northern regions, they threaten basic functionality. The Canadian Institute for Health Information has shown that rural areas consistently have fewer health care providers per capita, and their systems are more vulnerable to turnover, burnout, and recruitment gaps.[1] A 2021 study by Hansen and colleagues,[2] examining physicians in northern Canada, found high levels of burnout driven by systemic issues, such as lack of local governance, professional isolation, and poor alignment between provider expectations and system structures.

These leadership challenges are compounded by operational realities that would be considered unacceptable in urban environments. Geography magnifies fragility. In regions, such as Nunavut or Northern Ontario, supply chains are disrupted by weather, transportation breakdowns, and telecommunications failures. These are not exceptions: they are daily conditions for rural leaders. A resilient health care system should be designed to operate under such pressures. Instead, we too often patch together short-term workarounds that collapse with the next staffing loss or budget cycle.

Further complicating the landscape is the persistent invisibility of rural needs in policy development. Despite decades of evidence, rural health care remains structurally underrepresented in planning and resource allocation. Metrics used for funding and system performance are often designed with urban throughput in mind, ignoring the higher fixed costs, limited economies of scale, and distinct service models required in rural areas. Leadership in these environments is less about executing strategy and more about enduring a system that does not see you. The 2023 report of the House of Commons Standing Committee on Health, *Addressing Canada's Health Workforce Crisis*,[3] plainly acknowledged that rural and remote areas continue to suffer severe shortages of physicians, nurses, and allied health professionals — gaps that require focused, structural solutions rather than episodic interventions.

The consequences are visible to anyone who has practised in rural Canada. **Wait times are longer, specialty care is sporadic,** and **mental health services are stretched thin** or are altogether absent.

The consequences are visible to anyone who has practised in rural Canada. Wait times are longer, specialty care is sporadic, and mental health services are stretched thin or are altogether absent. Reports from the College of Family Physicians of Canada[4] confirm that rural Canadians have less access to core services. This situation is not the result of negligence; it is the predictable consequence of a system designed around urban density and not recalibrated for rural complexity.

Rural health care should not be viewed as a marginal domain: it is the most sensitive diagnostic tool we have for system failure. Weak access, burnout, and governance failures appear here first. When a model fails in rural practice, it signals that the model lacks resilience. Yet too often, policymakers treat rural health care as an afterthought rather than a proving ground.

A more robust approach would recognize that rural and urban systems must be designed and resourced differently. One-size-fits-all policies undermine both. Rural systems require incentives for continuity, and governance structures that reward adaptability, not only throughput. Urban systems, in contrast, can rely on density and specialization. Expecting identical performance from both environments is a categorical error. As Young and Chatwood have argued,[5] Canada could learn from circumpolar models that are built from the ground up for rural and remote realities rather than adapted from urban frameworks.

If we want to future-proof health care in Canada, we must start with rural systems, not only because they are politically urgent, but because they are structurally revealing. Rural leadership is not a side branch of physician leadership: it is the front line of system integrity.

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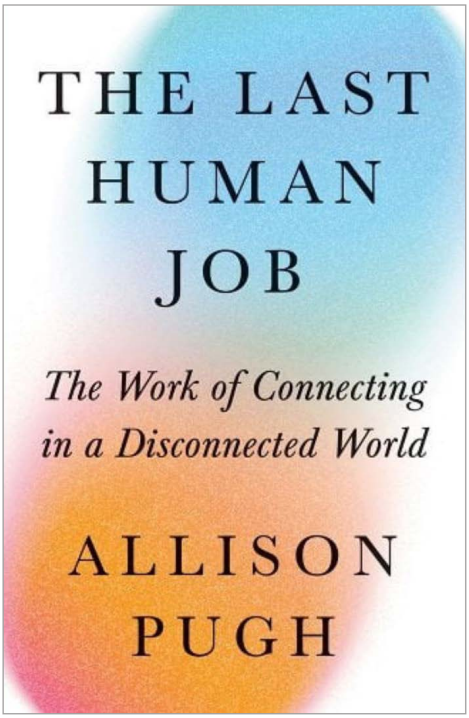
The Last Human Job: The Work of Connecting in a Disconnected World



Allison Pugh
Princeton University Press, 2024
Reviewed by **Johny Van Aerde**, MD, PhD

In The Last Human Job*[1], *sociology professor Allison Pugh researches the profound effects of automation and artificial intelligence (AI) on professions centred around human connections. Through interviews and shadowing of individuals who are involved in what she calls connective labour, she argues that the increasing emphasis on efficiency, data, and automation threatens to erode the essential human-centric roles that rely on empathy, spontaneous human interaction, and mutual recognition of humanity. This connective labour is practised mainly by professionals like physicians, teachers, chaplains, and therapists. Pugh wonders what effect AI systems are having in moments when we express and experience our humanity and what their impact will be on belongingness, which is crucial to human thriving.

Connective labour is a deeply interactive, two-way process between provider and client, involving recognition of the other by the provider, as well as recognition of the provider by the other — seeing and being seen. This requires compassion and emotional attunement. The results of such relationships between physician and patient — dignity, purpose, and understanding — are well known to increase the chances of therapeutic success.

Industrial logic, introduced in factories by Taylorism at the beginning of the 20th century, has now also infiltrated connective labour, whether it be driven by the bottom line in for-profit businesses or in resource-deficient

public institutions, such as health care. In many industries, counting, measuring, and applying all kinds of data is on the rise, infringing on time for people to pursue human connections. The cultural ascendance of data as authority has resulted in counting and measuring to make caring professions more effective and productive like factory work. As the demand for and costs of connective labour increase, many industries try to increase managerial control by introducing systems for data collection and analysis, imposing manuals and checklists, and implementing evaluation and assessment plans.

Occupations are being transformed, as these complex interpersonal jobs are reorganized to increase predictability and accountability. This is happening both in the private sector, with the goal of extracting profit, and in the public sector, with the goal of managing austerity in the context of limited time and resources. Both sectors impose very similar pressures on interpersonal work, emphasizing outcome over process. Scripting of the process of interactive service work threatens creativity and autonomy, transforms clients or patients into standardized objects, and demoralizes workers. For health care workers, this contributes to burnout and job dissatisfaction. For patients, it leads to a depersonalization crisis already visible in increasing social alienation and isolation, fragmentation of social connectedness, a growing societal trust gap, and loneliness. While the intention of increasing efficiency by scripting is to decrease time and resources needed, the depersonalization crisis increases the need for human connection at the point of service.

The power of connective labour lies in its capacity to create belonging. Belonging is an emotional state with real consequences, whose contours are honed by powerful societal forces shaping who is in and who is out. Belonging matters; research evidence shows that physical and mental well-being are influenced by whether someone is excluded. If the explosion of all things data severely removes or erases connective labour, it will result in a redefinition of what it means to be human!

Better than nothing

In light of increasing workloads and an insufficient number of providers, some say that AI is "better than nothing." Pugh argues that not dealing with the root cause of resource shortages will increase the danger of eliminating the human connection in AI services. The resulting depersonalization of care might lead to reduced patient engagement and less adherence to treatment plans. It might also generate communication challenges and

misunderstandings, as AI-generated responses so far lack contextual awareness or cultural competence that a human clinician brings to sensitive conversations. For instance, AI chatbots might address access to mental health support services, but they often lack the depth of understanding or empathy that human professionals provide. Systems are increasingly trained to simulate empathic or connective responses. Your chatbot apologizes for your frustration, your virtual assistant encourages you, your mental health app listens without judgement. But these systems don't feel anything; they just know what to say. "Empathetic" algorithms are starting to outperform our managers at recognizing distress, while lacking a moral compass to decide what to do with that information. Performance is replacing presence, replacing not only connective labour, but also our emotional responsibility to one another.

However, AI continues to develop at light speed. In April 2025, only one year after the publication of this book, a research group in Dartmouth reported how a generative AI chatbot for mental health meaningfully reduced the clinically significant symptoms of adults with major depressive disorder, generalized anxiety disorder, or at high risk for eating disorders.[2] In contrast to Pugh's concerns, users appeared to develop a bond with the chatbot. Therabot received ratings comparable to those of human providers when participants were asked whether they felt their provider cared for them and whether AI and the patient could work toward a common goal. This finding is important because the therapeutic alliance is often one of the best predictors of whether psychotherapy works or whether therapeutic suggestions are accepted.

Better than humans

AI is better than humans for non-connective tasks, such as pattern recognition in diagnostic images or pathology slides, designing new drugs, or managing the overwhelming volume of knowledge databases. Systemically induced biases are still possible and sometimes unnoticeable.

Better together

Pugh acknowledges that, when used thoughtfully, automation can augment human roles. They can be better together when they distinguish between thought or data and feeling or emotion, with the latter reserved for humans. Automatic transcription in medical settings frees up time for professionals to engage more deeply with patients. Another example would be a virtual intake nurse who does the rote work before human interaction, creating

space to enhance rather than replace the human elements of connective work. This "better together" relationship is good as long as the freed-up time creates more contact between the professional and the patient and not heavier workloads resulting in job dissatisfaction and burnout.

The research in this book is meticulous, blending interviews and observations across diverse fields to illustrate how connective labour fosters community and individual well-being. The book's unideological approach, focusing on socioeconomic realities rather than on moralizing, lends credibility to Pugh's warnings. Her writing is clear and easy, but her explanations are sometimes tedious and slow moving because of a repetitive structure in the nine chapters. The core message — that human work must be prioritized in an automated world — resonates powerfully. The book is thought-provoking for professionals and students in health care, education, or any care-giving jobs, and for policymakers grappling with the societal impact of AI.

At a time when AI continues to permeate various aspects of life, Pugh makes a compelling call to recognize and preserve the irreplaceable value of genuine human connection in the workforce. As a society and as caring professionals, we must ensure that technological advancement doesn't come at the cost of our shared humanity. For AI to become a partner rather than a replacement for humans, we will need ethics, design choices, and policies to protect the connective care of the jobs that involve empathy, caring, and compassion. The danger is not AI itself but who uses it, how it is used, and for what purpose.

AI is penetrating our daily lives everywhere, from the annoying virtual assistant during telephone inquiries to the self-help checkout in grocery stores. The loss of a human voice or contact adds to the explosion of loneliness. Connective labour is facing an existential threat, but the blame does not only fall on AI. What countermeasures do we, as individuals, take? Do we take off our headphones to be more present in stores or waiting rooms, or put down our ever-present mobile phone to create opportunities for conversation? As we encounter people in our daily lives, are we present, do we give them our full attention?

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