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SCLM Société canadienne des leaders médicaux

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Contents

Moving into the **second quarter of the 21st century**

Abraham (Rami) Rudnick, MD, PhD

This winter 2026 issue of the Canadian Journal of Physician Leadership (CJPL) starts with a research article on vicarious trauma of hospital leaders, an important and under-addressed matter. Another article in our Health Economics series shows us how to organize data to improve decision-making. Rural leaders will learn how collaborative care can include specialists under conditions of enduring scarcity when reading the current article in the Rural Leadership section. An article on Leadership Education and Training "conceptualizes health-promoting leadership as a core, teachable competency that can guide physician leadership education." In this issue, we are (re)starting the Coaching Corner series with an article that compares coaching with other forms of learning and support. This issue also includes viewpoint articles, some of which at least indirectly oppose each other, such as in relation to aspects of teamwork. We encourage further discussion about these and other matters and welcome letters to the editor addressing them in a critical yet balanced manner. This issue ends with a workbook review on how to achieve happiness.

As we enter this next quarter of the 21st century, it seems that focused sustained attention is needed to address both emerging and longstanding issues related to physician leadership. As part of that, we are starting a new tradition of theme issues. The intent is to try to publish one theme issue each year. The first will address physicians' co-leadership of health-related services with other health care professionals, such as administrators, service users (such as patients and their family members), and/or others. I plan to co-edit this issue with non-physician leaders. Research, viewpoint, and (organizational) case study articles are welcome for submission to this theme issue by co-authors (at least one physician and at least one non-physician for each article). The submission deadline for this theme issue is the 1st of November 2026.

Input on *CJPL*'s content, process, style, and format is always welcome. Thank you for your involvement.

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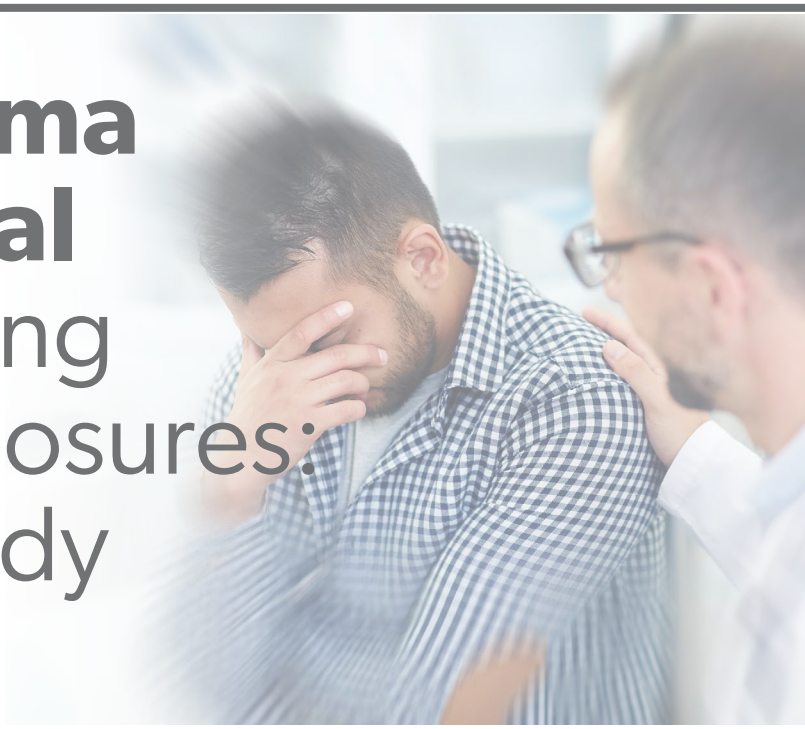
Vicarious trauma among hospital leaders following secondary disclosures: a qualitative study



Astha Patel, BHSc, **Simrat Soni,** MSc, and **Michael Miletin,** MD

Background: The findings of root-cause analyses of critical patient safety incidents are revealed to patients and families via "secondary disclosure" (SD). This process is often emotionally challenging. Although studies have demonstrated the psychological toll of patient safety incidents on frontline health care workers, the impact on physician and non-physician administrators who participate in SD meetings remains unexplored.

Objective: This study aimed to describe the experience of senior health care leaders who participate in SD meetings and explore the organizational support structures available to them.

Methods: We conducted a qualitative study at the William Osler Health System in Ontario. Eighteen senior hospital leaders (nine physicians and nine non-physician administrators) participated in semi-structured interviews using a validated interview tool. Thematic analysis was performed until data saturation was achieved.

Results: Five overarching themes emerged: (1) impacts on self-identity and leadership role, (2) spillover into personal life and coping mechanisms, (3) modulation of professional relationships, (4) emotionally challenging interactions with patients and families, and (5) recommendations for systemic improvements to mitigate burnout. Leaders commonly recalled

experiencing sadness (67%), extreme fatigue (44%), and self-doubt (44%) after participating in an SD. They perceived an absence of structured organizational support. Leaders requested additional training, structured debriefs, and peer support.

Conclusion: Hospital leaders who engage in SD meetings commonly experience significant psychological distress similar to that associated with second victim syndrome. Our findings highlight the urgent need for structured institutional interventions to support the well-being of leaders exposed to vicarious trauma in the aftermath of patient safety incidents.

KEY WORDS: disclosure, critical incident, second victim syndrome, hospital, management

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Critical patient safety incidents are those causing significant harm to patients receiving health care services and are not related to expected clinical outcomes or known treatment risks. Like many other hospitals in Ontario, William Osler Health System, a multisite community teaching hospital, engages in a protocolized institutional response to critical incidents that begins with disclosure of the harm to the patient and family.[1] After the initial disclosure, root-cause analysis is undertaken and recommendations are developed to prevent a recurrence of the incident. This information is shared with the patient and family by the medical and administrative director of the department at a secondary disclosure (SD) meeting, which is mandated by *Ontario's Excellent Care for All Act*.[2]

Critical patient safety incidents have a significant emotional and psychological impact on patients and families.[3] The recognition that critical incidents also have negative effects on health care workers has led to the concept of the "second victim." A second victim may be "a healthcare provider involved in an unanticipated adverse patient event, medical error and/or a patient related injury who becomes victimized in the sense that the provider is traumatized by the event."[4] Second victims may experience symptoms of burnout and some have described reactions akin to post-traumatic stress disorder.[5] Yet, in a study of 3171 physicians from Canada and the United States, only 10% felt that they were adequately supported by their organizations after being involved in an incident.[6] Similar findings have been reported for nurses, medical trainees, and midwives.[7]

"A second victim may be "a healthcare provider involved in an unanticipated adverse patient event, medical error and/or a patient related injury **who becomes victimized in the sense that the provider is traumatized by the event**."[4]

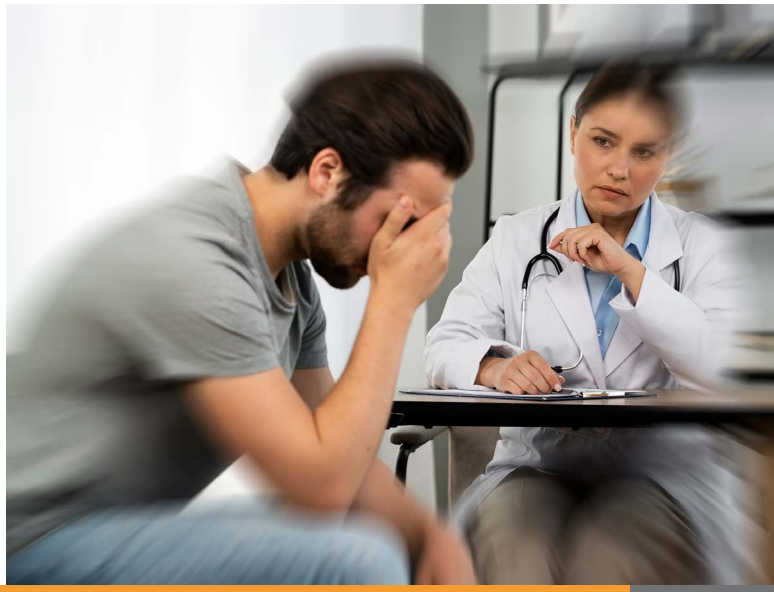
SD meetings may feature anger and hostility on the part of patients and families, as well as blame, accusations of malpractice, and threats of litigation.

Although senior hospital leaders are separated in time and space from the critical incident, they bear ultimate accountability for the quality and safety of the care provided by their clinical teams. To date, no research has examined the emotional and psychological impacts on physician and non-physician administrators who attend SD meetings. We conducted a qualitative study to determine whether senior hospital leaders vicariously experience second victim syndrome after participating in SDs of critical patient safety incidents and what organizational resources are available to support these leaders.

Methods

Departmental senior administrators and department physician chiefs serving between 2018 and 2023 were identified for recruitment through purposive sampling. This group was eligible for the study given their responsibility for providing SDs to patients and families. Each administrator and physician chief received an email invitation, which included a study description, the consent form, and the option to participate virtually or in-person. Respondents were interviewed by a trained member of the study team. During the interview, they were asked to reflect on an impactful SD meeting in which they participated as a senior leader. We used Scott and colleagues'[4] validated second victim Interview guide. To ensure confidentiality, each respondent was assigned a unique study ID, and anonymity was reinforced throughout the consent and interview process.

Audio recordings of the interviews were transcribed verbatim, and transcripts were thematically analyzed using NVivo (version 14; Lumivero, Denver, Colorado). Each transcript underwent multiple reviews to establish initial codes, which were subsequently organized into subthemes and overarching themes. An iterative approach was used and coding stopped once saturation was achieved. The respondents were analyzed as a whole, given their shared experience during SD. No subgroup analyses were planned or performed.



Ethics approval for this study was obtained from the William Osler Health System Research Ethics Board.

Results

We invited 30 senior administrative and physician leaders to participate; 20 agreed and 18 completed the interview for a response rate of 60%. Study respondents included nine physicians and nine senior administrative leaders. Their duration of leadership experience in the William Osler Health System ranged from 1 to 18 years (mean 5.3 years). Time since the impactful SD meeting ranged from 1 month to 5.5 years (mean 15.6 months). Five key themes emerged and are summarized below.

Theme 1: Participating in SD meetings has an impact on leaders' self-identity

Subtheme 1.1: Senior leaders feel an inherent responsibility to accept blame — Despite not being involved in the critical patient safety incident, 12 respondents acknowledged feeling a sense of indirect accountability for or ownership of the incident. Many felt a sense of helplessness, especially when incidents stemmed from issues outside their control.

S06: "But that got shoved on to me and it's always a weird position when you really haven't been involved, you get pulled in because you're the current manager and we need representation at the meeting. And so, you're part of this pretty emotional meeting and then you're given a follow-up item that is hard to implement, sometimes, some of those changes… But in these situations, it's so easy to think you are at fault because you are the manager. You're the head, right? And people pick up the phone, phone all the time and they call us and complain and say, '*well, it's your fault, it's your team*,' but it's not."

S05: "In some cases, later, they're ready just to jump on you because you're the representative of all that was wrong with what they think happened, right?"

Subtheme 1.2: Senior leaders experience emotional dilemmas when balancing conflicting responsibilities to their team — Nine respondents reported being tasked with multiple leadership responsibilities, including providing support, holding their teams accountable for errors, and being an exemplary role model. Balancing the need to provide support with the need to take remedial action was a struggle for seven of the nine respondents. Five respondents reported suppressing their own emotions and/or physical reactions to provide a positive example for their team.

S10: "I'd offer to talk at any point. Of course, this becomes more challenging when it's a recurrent performance issue, in which case you have to temper your supportiveness with holding people accountable to their issues and escalating further, but you try very hard to be supportive at the same time… doing what's necessary in order to put people in remediation, or even escalating beyond that to the Chief of Staff or to the College."

S12: "I think it does impact a bit, my relationship with colleagues who seem to have managed these with not enough vigilance and not enough sympathy."

Subtheme 1.3: The impacts of SD meetings have led to senior leaders reconsidering their career path — Four respondents considered leaving their position or changing departments or had declined promotions as a result of their experience with SD.

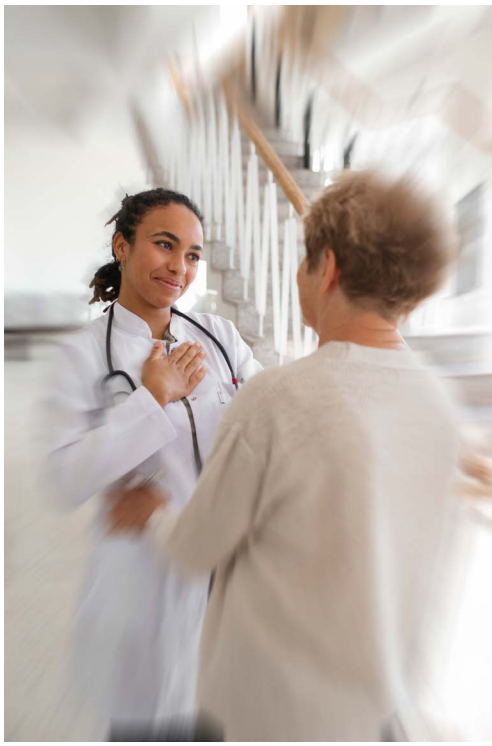
S05: "I needed to change something, but I was considering leaving the job. I was even considering leaving the job without another job to go to."

S12: "Occasionally I've thought, why am I doing this. I don't know if that comes under remorse, but, occasionally I think, why am I doing this? It's time to give it up."

Subtheme 1.4: Senior leaders experience a sense of loneliness in their leadership role — Two respondents reported that supervisors and colleagues did not understand the impact of participating in SD. Because they showed no visible indicators of trauma, respondents felt that their colleagues assumed that they were not affected. Accordingly, respondents struggled to identify resources for support and experienced loneliness in their leadership positions.

Balancing the need to provide support with the need to take remedial action was a struggle for seven of the nine respondents.Five respondents reported suppressing their own emotions and/or physical reactions to provide a positive example for their team.

S12: "Like the senior position I'm in… it's very difficult to seek help, like I think you are in the middle of the management. It's difficult for your seniors… so a senior lead because they don't know how much we are going through and at the same time, your colleagues or people who are under your leadership are already worried for you, so they are not supported from down below. So, you are a bit out. You find yourself a bit lonely in that space between senior leadership and junior followers. So, it's a tough position for people to be in."



S20: "I think that comes from the idea that even your supports… in that circumstance, I think even your supports don't get it because they've not had to do that."

Theme 2: The impacts of SD meetings on senior leaders are intertwined with their personal lives

Subtheme 2.1: Some senior leaders struggled to maintain separation between their work life and personal life — Ten out of 18 respondents said that SD meeting-related emotions and stressors impacted their personal lives. Because of their busy schedules, many senior leaders attended and/or prepared for SD meetings outside of working hours. Some respondents felt they neglected their personal needs and did not have space to self-reflect during or after SD meetings. Several reported that they related personally to the case (e.g., having a family member with a similar condition), which added to the emotional impact of SD meetings.

S07: "I guess I have not really had that addressed. Because I've moved on and done other things and had many other secondary disclosures and many other difficult situations, many other debriefings since. But I didn't address my need to unpack that from a psychological perspective for myself."

S04: "You know, I would think about it at home. I would think about the family. I would think about how did they… and even when that disclosure is happening, I wonder how they've managed for the past three months or six months or other time frame."

Subtheme 2.2: Some senior leaders rely on personal strategies to compartmentalize, thus limiting the impact of SD meetings on their well-being — Fourteen respondents used personal strategies to manage stress or process their emotions following an SD meeting. Examples included exercise, friendships outside the workplace, support from spouses, and professional support. Two respondents used

compartmentalization to avoid bringing emotions from SD meetings into their personal lives.

S10: "This idea about transference, or the patient's emotions; you don't have to take them on and, actually, there should be a degree of distance… you're going to see stuff that's horrible and terrible. And you do the secondary disclosures, and now you're talking to the family about the cases that you see, which is obviously even more difficult than just seeing them and participating. So, there is some sort of… you have to recognize, this is part of the job. And you have to be able to have some degree of distance to it, otherwise it's just not possible to do it for a long period of time."

S04: "I have a 30–45 minute car ride, I do the decompression on the way. I might talk to one of the other managers in the car on the way home, so that by the time I get home, I can do home stuff."

Theme 3: Participation in SDs modulates a senior leader's professional relationships with colleagues and the organization

Subtheme 3.1: Participating in SD meetings strengthened senior leaders' bonds with their colleagues — Fifteen respondents felt that participating in SD meetings improved relationships with their colleagues through the provision of emotional support and mentorship. Many respondents highlighted that this support was essential because of the of lack of system-level support.

S16: "And so there's this bond that forms because we've been through an emotional experience that we never want to have happen again, for us or for anybody else… for the family, more importantly."

S06: "In the workplace, I certainly have colleagues that I will call and they are people who I have either trained with, worked with closely for a long time, or have gone through challenges together."

Subtheme 3.2: Participating in SD meetings fostered a negative work environment for some senior leaders — Seven senior leaders reported a negative impact on professional relationships with their colleagues after attending SD meetings. Some respondents felt that their department was unjustly left to accept responsibility for critical incidents. Six respondents highlighted a feeling of poor communication with other senior leaders present at the SD meeting.

S05: "I also felt like I didn't have a safe place to talk about it, to be honest, like I just didn't have… I did have some spaces and places to talk about it, there were some staff colleagues to talk to, there were also times where it was not welcome, or that it was misunderstood, right?"

S10: "There have been situations where I felt that the department that I represent was unfairly left holding the hot potato. And really, I felt that the other departments didn't take their shared responsibility."

Subtheme 3.3: Participating in SD meetings shapes senior leaders' perceptions of the organization — Four respondents felt negatively about the organization's role in SD meetings, six felt that the organization played a neutral role, and five felt supported by the organization. Senior leaders felt that the organization took a compliance-centred approach to SD meetings. Most leaders who reported a "neutral" feeling indicated that the supports provided were inconsistent. All five respondents who felt supported by the organization attributed this perception to support received from work colleagues involved in SD meetings, rather than system-level supports.

S03: "I think its more, OK, we gotta get this done, its check, check, check, check mark, check mark. You know, government and compliance. But they don't really think about the men and women who are involved, for example… I don't think anybody really sat back and said, '*Oh my God, how are those doctors?*'"

S07: "Well my experience has been, it's been supportive, because we've come together as a group and supported each other to say, '*wow, how are you doing with this?*' I think, at least in my experience, the people that I have been in a secondary disclosure with have been very open to talking about it post-disclosure to have a check-in with each other. So, I find it very supportive."

Theme 4: Senior leaders face unique dynamics with patients and/or their families during SD meetings

Subtheme 4.1: Senior leaders facing violence, anger, legal threats and/or litigation from the patients and/or their families during SD meetings experienced profound emotional impacts and trauma — Three senior leaders reported experiencing an SD meeting that was physically and/or emotionally assaultive in nature. When recounting these experiences, respondents seemed deeply affected (e.g., tearing up, appearing demoralized, recounting vivid details).

S12: "So, there was some physical, you know, interaction by the husband towards me. He didn't hit me or anything, but, you know, approached me and stood up and shouted."

S07: "The extent to which this particular family expressed their anger was particularly difficult… it was assaultive, really, in nature."

Subtheme 4.2: Senior leaders strive to express their empathy and honesty while balancing the expectations and needs of the patient's families — Four respondents noted that emphasizing empathy and honesty was well received by patients and their families. Ultimately, most leaders who recalled empathetic SD meetings viewed SD meetings in a positive light and felt that the experience was meaningful and worthwhile for the family.

S19: "[You want] not only to take responsibility for what's happened, but you want to be transparent. So, you don't want to be hiding things. You want to let families know what has happened, and you want to try and be there for them and support them. I think no matter what the outcome is… and there's bad outcomes, like all the time… I think [the family is] always supportive in those cases.

S10: "I do remember that there was a heartfelt apology. Recognition of what we could have done better and making specific recommendations, and what we're doing differently and being transparent and forthright with the family. And in this case, I think it was well received."

Theme 5: Senior leaders suggest specific changes to the process and dynamics of SD meetings to promote well-being and combat systemic factors contributing to SD-related burnout

Subtheme 5.1: Senior leaders mostly support the use of simulation-based learning to prepare for SD meetings, if changes are made to the process — Six respondents reflected on the use of simulation-based training (i.e., scenarios played by actors to allow respondents to engage in a mock SD) to better prepare senior leaders for SD meetings. Although two respondents felt completely satisfied with simulation-based training, four expressed a sense of anxiety and unpreparedness. It was suggested that the organization consider providing more context on the purpose of simulation-based training and offer one-on-one or self-guided training for senior leaders.

Although two respondents felt **completely satisfied with simulation-based training**, four expressed a sense of anxiety and unpreparedness.

S16: "It [simulation-based training] was an active experience, like it wasn't an easy sort of experience and so, that was helpful. And then there was some feedback at the end. So, what we think went well, what we didn't think… you know, what you could have improved upon."

S11: "It just stresses me out, like, even having to play a role. I just don't know if I would benefit… for me, I don't know. I'd be more worried about the role-playing concept or just, like acting, and it seems so artificial."

Subtheme 5.2: Receiving external validation and team debriefs following SD meetings may help reduce the emotional impact on senior leaders — Eleven respondents valued recognition of their emotions following a difficult SD meeting. Six felt that, although debriefs are necessary to discuss the technical strengths and weaknesses of an SD meeting, they would appreciate a separate check-in that was strictly person-oriented (e.g., a call to ensure they are feeling supported and are connected to the resources they require to process their emotions). Three respondents recommended a peer-support program through which senior leaders would be connected to colleagues to confidentially and safely discuss their emotions and reactions to SD meetings.

S03: "There [should be a] check-in later, and I wouldn't call it a debrief, it's more of a check-in. Just to allow time to pass. But it's like an expectation, and that people understand that like it's not just an activity and it's not just tasks that we check off our list, it's something that we're integrating into ourselves into how we work and live here at the hospital, how we work with others and so… it would be further out but also more about the person. Like, '*are you doing okay? Do you need any support?*'"

S05: "I think there needs to be some acknowledgement of that as well, that this takes an emotional toll on people."

Subtheme 5.3: Structuring SD meetings with a protocolized process can reduce ambiguity, anxiety, and stress — Fourteen respondents said that formalizing the SD process would be beneficial. Seven also recommended including relevant subject-matter experts (e.g., ethics, legal, spiritual, and religious representatives) in SD meetings. Four suggested that an allocated self-reflection period should be included after the SD meeting to allow senior leaders to process their emotions before engaging in other work.

S04: "So, having a clear idea of what the process is meant to look like and what tangible product is meant to come out of it thereafter and having [something] standardized, even if it's a survey or a checklist."

S16: "I would say that there shouldn't be any meetings after that… And I would say that there should be like a mandatory hour, even half an hour would be helpful, so that there's no opportunity for another… Because then you gotta go from one meeting to the next and… They're exhausting, you do feel exhausted after a meeting like that. It's tense."

Subtheme 5.4: Key changes to the training process for SD meetings can help senior leaders feel better prepared — Training was identified as a key area of improvement. Four respondents felt that they would benefit from self-assessing their training needs and engaging in training that they would find helpful. Five respondents expressed an interest in observation-based training (e.g., viewing recordings of SD meetings, listening to an audio recording).

S07: "So, don't assume that because someone is an experienced leader, that they're good at this. Because this is a very different type of leadership. So, I would approach it from a novice-to-expert perspective in that you build competencies."

S06: "If there was a way to… record, with permission, and be able to listen to the conversations in a training room where everyone could watch or listen to it… I think that's the type of training that would go a long way."

At the end of the interview, respondents were asked whether they experienced certain symptoms of vicarious trauma. Respondents responded yes or no. Those responding yes were asked to elaborate on their experience.

Training was identified as a key area of improvement. Four respondents felt that they would benefit from self-assessing their training needs and engaging in training that they would find helpful. Five respondents expressed an interest in observation-based training

Discussion

This study explored the experience of senior physician and non-physician hospital administrators at William Osler Health System who participate in SD meetings. Our findings demonstrate that such participation has a significant psychological and emotional impact on hospital leaders.

We found vicarious trauma in physician and non-physician leaders who are not clinically involved in patient safety incidents but bear accountability for the provision of safe care in their work units. Initially described in health care workers providing care to the affected patient, the second victim syndrome was evident in our population. Scott et al.[4] described

"haunted re-enactments, often with feelings of internal inadequacy" as a common experience among health care providers directly involved in safety incidents. We saw a similar impact on personal identity in our study, with 44.4% of respondents feeling a sense of self-doubt and inadequacy. Unique to our population is the feeling of loneliness and an inherent responsibility to accept blame, which have not been linked to the impact of vicarious trauma in other populations.

The presence of compassion fatigue may help explain our findings. Compassion fatigue is related to "the stress resulting from helping or wanting to help a traumatized or suffering person."[8] In our analysis of subthemes 2.1, 2.2, and 4.2, we found that leaders often suffered a degree of compassion fatigue when they related closely to the safety incident discussed at an SD. A reflective self-care stance is a key strategy for decreasing the risk of compassion fatigue and facilitating the development of compassion satisfaction.[9] Our analysis suggests that senior administrators seek similar opportunities to reduce the emotional burden of vicarious trauma, as seen in subtheme 5.3. Although the current literature has highlighted compassion fatigue in health care providers who are directly involved in patient care (e.g., palliative care physicians, psychologists, urgent care nurses), our study suggests that it may be a key driver of the vicarious second victim syndrome faced by senior leaders participating in SD meetings.[8-10]

There is a paucity of data on interventions to mitigate risk factors that contribute to vicarious second victim syndrome.[11] Our study provides suggestions for strategies to combat this syndrome in affected senior leaders. First, debriefs are important in facilitating positive emotional experiences and well-being among health care professionals following a traumatic event.[12] Senior administrators derived a similar benefit from group debriefs following SD meetings, as seen in subtheme 5.2. Unique areas for improvement include the implementation of a "person-centred debrief," where emotional experiences are the focus of the conversation. Providing structure to the SD meeting process (preparatory work, meeting, and post-meeting debriefs) was also identified as a key area of improvement. Further research is needed to explore the feasibility and benefit of implementing these interventions.

Strengths and limitations

To our knowledge, this study is the first to explore the concept of a vicarious second victim syndrome among physician and non-physician hospital

administrators who participate in SDs of critical patient safety incidents. Our study population consisted of a variety of leaders with diversity in their degree of experience participating in SDs. Although our participant response rate was reasonable at 60%, our study size remains small, and our results are exploratory and hypothesis-generating in nature. Although the respondent group consisted of an equal number of physicians and administrators, we did not intend, a priori, to compare the two categories of respondents. As a result, our ability to compare these groups to one another is limited by a lack of data saturation within each subgroup.

This was a semi-structured, interview-based study and, as some respondents reflected on experiences that had occurred several years in the past, their recollections may have been affected by recall bias. As a single-centre study, our findings may not be transferable to other centres with differing processes for SD.

Conclusion

Hospital leaders participating in mandated SD of critical patient safety incidents experience a vicarious form of second victim syndrome. This finding warrants replication in other health care administrative contexts as well as an exploration of system-level initiatives to mitigate this threat to personal and professional well-being.

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Author attestation
All three authors contributed to the research proposal, the ethics application, and formulation of the interview guide. SS led respondent recruitment. AP conducted and transcribed all interviews. AP conducted thematic analysis with SS and MM to resolve queries. MM and AP wrote the manuscript. All authors approved the final article.

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Removing a negative does not always add a positive: how decision analysis can probably help you

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In this seventh article in the health economics series, we introduce decision analysis to provide leaders with insights when making strategic decisions amidst uncertainty. The additional clarity offered by decision analysis can improve decision-making by organizing evidence to allow better interpretation of the data. A hallmark of decision analysis is a model structure that illustrates what is known (e.g., strategies and types of outcomes) and what is unknown (e.g., a certain future). Results from this type of research help leaders understand what their options are and how to think optimally when making decisions under uncertainty.

KEY WORDS: leadership, decision analysis, health economics

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Decision analysis can help leaders organize their thinking about a problem's structure and uncertainty. Many challenges lend themselves to this manner of organizing. Let's take a day-to-day example in which you probably have used decision analysis. Remember the last time you were faced with the decision of whether to pay for parking? Your answer probably depended on beliefs about the likelihood of a ticket as well as the facts about parking cost and fines (ethics of not paying aside). If you think the likelihood of getting a parking ticket is low, you might decide to forgo paying. On the other hand, if the likelihood is high, you might decide to pay. Decision

analysis can guide other decisions as well, from modeling mitigation strategies for a pandemic[1] to optimizing diagnostic procedures for the diagnosis of Whipple's disease.[2]

In this article, we explore the use of a decision tree to help resolve a paradoxical example involving a funding announcement. The structure of the decision combined with the use of probabilities for uncertain events can help to guide leaders toward more accurate evidence-informed insights.

Introducing the decision tree

Analyzing the decision about whether to pay for parking illustrates a key concept of decision analysis. Table 1 summarizes the main information: paying for parking costs $10; the parking fine is $30; and the probability of a meter visit from parking enforcement is one in three.

	Cost to you	
Decision	**Meter visit (i.e., parking ticket)**	**No meter visit**
Pay	$10	$10
Do not pay	$30	$0
Probability	1/3	2/3

Table 1: Available data for a hypothetical parking decision.

Figure 1 illustrates a decision tree with the branches showing the events that could occur and their probability. The two options "Pay for parking" and "Don't pay for parking" have different costs (with these "payoffs" shown on the right side of Figure 1).

	Cost by option	
	Pay for parking	**Don't pay for parking**
Meter visit (P1)	$10	$30
No meter visit (1 – P1)	$10	$0

Figure 1: Decision tree for two options: Pay for parking and Don't pay for parking

Note, the probability of a meter visit (P_1) is unaffected by one's decision to pay for parking. Based on the assumptions in Table 1, $P_1 = 0.33$. The feeling that a meter visit is more likely if one has not paid for parking could be incorporated by introducing a different probability $P_2 > P_1$. However, for this example we will assume that a meter is inspected by parking enforcement one out of every three times you park; this visit is not related to whether you pay for parking. The payoffs differ between the pay for parking and the don't pay for parking options in the right side of Figure 1 (as specified in Table 1).

Because of uncertainty (about a meter visit), one must compute "expected" values to inform the decision of whether to pay. Expected does not mean what you expect to happen to you this time. Rather, it means if you faced this choice many, many times, overall, what could we use for the average (needed for overall impact). This is an important distinction. What happens to you as an individual is that you will either get a ticket or not; parking enforcement does not give you 1/3 of a ticket. When considering a large set of occurrences (e.g., you park there every day for 300 days), the average is 100 parking enforcement meter inspection visits. As a leader responsible for a large group or large number of occurrences, an average is crucial for assessing the overall impact or total. The individual perspective concerns itself with what will happen to a person in this one instance. The population or expected value perspective suggests overall parking fines of $3000 this year (i.e., the product of $30 fine per ticket and 300/3 expected tickets).

The difference between individual and population experience highlights the tension clinical leaders face. From their clinical experience, leaders may have familiarity with dealing with the mismatch between patient preferences and population guidelines. For example, theoretically different "optimal" amounts of chemotherapy may exist.[3] For decision analysis, computing expected value is the key calculation to do what is best for the population for which you are responsible.

Expected values are computed by multiplying probability times "payoff" (i.e., outcome). In our parking example, we are concerned about costs. Combining Table 1 and Figure 1 illustrates the process of computing the expected costs for both options: pay for parking vs. do not pay for parking. The top branches representing the pay for parking choice show paying $10 for parking will cost you $10 regardless of whether there is a meter visit from parking enforcement. The lower branches show the cost and

expected cost of not paying for parking. The 1/3 chance of a $30 parking ticket combined with the 2/3 chance of no ticket generates an expected cost of $10 (i.e., 1/3 x $30 + 2/3 x $0 = $10). From a one-time (individual) parking perspective, if you do not pay for parking, you will either get a $30 ticket or have $0 cost. From a multiple time (population) perspective, you should budget about $10 a day for the expected cost of the "do not pay for parking" strategy, under the current conditions (i.e., parking enforcement does not increase its diligence or becomes more merciful).

With the current assumption that the probability is 1/3 that parking enforcement will issue a ticket, both strategies have the same expected costs. While the "do not pay for parking" strategy has more variability in costs (i.e., $0 or $30), the expected cost is $10 for both strategies.

A paradoxical example

Background

You are the lead physician executive for a health care organization in region A. To address the primary care crisis, the ministry of health has decided to fund a massive "Integrated Primary Care Pilot" in one of three rural regions: A, B, and C. The ministry has already selected the region, but the decision is under embargo. However, the minister's chief of staff knows which region was selected.

As the physician lead for region A, you know that the chief of staff cannot tell you whether your region was chosen. Nevertheless, you ask them privately, "I know you cannot tell me if my region got the pilot, but of the other two, can you tell me one region that definitely did not get the funding? If region B was selected for the pilot, tell me region C lost out; if region C was selected, tell me region B lost out; and if my region A was selected, just flip a coin and name either B or C as a loser." This is your initial data.

The chief of staff responds, "Region B will not receive the funding." This is new data to incorporate into your analysis.

How decision analysis improves thinking

Figure 2 illustrates the different possibilities occurring with the probabilities described above.

	State of the world			
	C Chosen	C Chosen	A Chosen	B Chosen
Revealed	B	B	B or C	C
				
Rewritten, so no "or"	B	B	C	C
	B	B	B	C
				
Region B revealed	B	B	C	
	B	B	B	

Figure 2: Illustration of uncertainty and outcomes

The state of the world columns in Figure 2 shows the different potential winners of the ministry of health funding. The column labeled "C chosen" appears twice and the others only once because of your initial beliefs about the minister choosing region C (1/2), region A (1/4) and region B (1/4). The directive, "If my region A was selected, just flip a coin and name either B or C as a loser" can be seen as "B or C" in the first row labeled Revealed. To translate this into something more mathematical with equal probability (1/2 vs. 1/2) for B and C, Figure 2 shows another row labeled *Rewritten, so no "or"*. In this row section, it is clear that if region A is selected, half of the time B will be revealed, and half of the time C will. The last row section of Figure 2 incorporates the new information when the chief of staff says region B will not receive the funding; it is possible to rule out scenarios where region C is the denied region (e.g., the last column of Figure 2). Now, we can redo the analysis using new evidence. Only the scenarios from the first three columns remain.

The cells traced by the heavy line in Figure 2 are the only ones that accurately describe the reality. Four of five times, region B is revealed if region C was selected as the winner; one of five times this occurs if region A is the winner. Figure 2 illustrates this with four region B cells in the C is chosen columns and only one region B cell in the A is chosen column. In our example, there are only five situations where B is revealed. According to Figure 2, with region B ruled out, there is a 20% (1/5) chance region A won; conversely, there is an 80% (4/5) chance that region C won.

Discussion

Initially, you believe region A has a 25% (1/4) chance of receiving funding. After the chief of staff's comment, this shrinks to 20% (1/5) given region B is eliminated. At the same time, region C now has an 80% (8/10) chance of getting the funding (up from the initial 50% (1/2)). Manager 1 who felt that there was a 50/50 chance that the funding would go to either region A or region C missed the importance of the fact that region C had an inside track. Region C's initial probability was 50% (1/2), leading to an unequal distribution of "Bs" on the last row section of Figure 2 (compare the Bs in the "C chosen" columns to those for the "A chosen" column). Manager 2 felt that region A started with a 25% (1/4) chance of winning and still had a 25% (1/4) chance of being the winner. This ignores the opportunity to update beliefs based on new data. When the chief of staff removes from consideration the lower probability region (in this case region B), then region A's chances decrease.[4] This is because, as explained elsewhere,[4] the probability that region A wins given that region B is removed from consideration equals the product of P_A and $1/(1 + \delta_{cd})$ where P_A is region A's initial probability and $\delta_{cd} = P_C - P_B$. In our example, $\delta_{cd} = 1/2 - 1/4 = 1/4$. Therefore, the likelihood that region A wins given that region B is removed from consideration equals the initial probability for region A (i.e., P_A) shrunk by a factor of 4/5. The likelihood of region A winning shrinks to 80% of its original estimate (i.e., 1/4 x 4/5 = 1/5) after the chief of staff shares the additional information (that region B did not receive the funding). It is left as an exercise for the reader with insomnia to show that even with equal initial likelihoods of receiving funding (i.e., $P_A = P_B = P_C = 1/3$), when the chief of staff rules out region B then region C's chances of winning the funding double from 1/3 to 2/3 (hint: remove one of the C chosen columns from Figure 2).

This article contributes to the health economics series[5-10] by illustrating how leaders can approach uncertain decisions using decision analysis. However, there are some challenges associated with the technique: the structure of the model and data inputs. In a perfect world, the model structure is simple but complex enough to capture key elements of the problem. There are examples where more complicated approaches have been used in complex contexts, such as screening for infectious diseases, and they produced different results from those reported in earlier papers.[11]

Lack of data can also be challenging. For example, in 2011, when provincial decision-makers were considering the cost-effectiveness of adjuvant trastuzumab with chemotherapy for the treatment of HER2-positive breast cancer patients with node negative tumours ≤ 1 cm, no direct evidence supporting the effectiveness of trastuzumab in these patients was available. The Pharmacoeconomics Research Unit had completed analysis to inform the decision,[12] but the results were only as strong as the evidence used in the model. Moreover, a trial for such patients was considered unlikely. In the absence of strong evidence supporting the use of trastuzumab in this patient population, conditional funding for these patients was approved with the expectation that real-world data would be collected to evaluate the clinical safety, effectiveness, and cost-effectiveness and inform a final funding decision.[13]

Although health economists often use decision analysis for economic evaluation, the techniques and way of thinking can help leaders examine complicated and unintuitive circumstances. The paradoxical example we explored is based on the "problem of three prisoners."[14,15] Research has studied the many ways people become confused when addressing this type of situation.[4] Decision analysis can help by organizing initial uncertainty (e.g., prior beliefs about funding) showing the need to update probabilities based on new information when it becomes available (e.g., after the chief of staff shares the news about region B). The example illustrates how information that removes a negative (region B did not get funding) does not always add a positive to your position. In fact, the news about region B *decreased* the likelihood of funding for your region. Understanding how to make decisions under uncertainty is crucial for leadership. Decision analysis is a valuable tool for discovering insights that leaders need.

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Collaborative care in rural health: receiving specialist expertise under constraint

Giuseppe Guaiana, MD, PhD

Rural health systems operate under persistent constraints related to geography, workforce scale, and service redundancy. As a response, collaboration between family physicians and specialists is best understood not only as a discrete intervention but also as an organizing principle for rural health system design. Evidence from collaborative care models, continuity-of-care research, and specialist access initiatives, such as provider-to-provider consultation systems, is relevant to rural contexts. The literature suggests that structured collaboration can strengthen primary care capacity, support continuity, and extend specialist expertise beyond episodic referral-based models. Although collaborative care does not eliminate broader workforce or infrastructure challenges, it offers a coherent organizational approach to delivering specialist-informed care under conditions of enduring scarcity.

KEY WORDS: Collaborative care; rural health; continuity of care

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Rural health care systems operate under conditions of persistent constraint. Geographic distance, limited redundancy, and small clinical teams are enduring features rather than transient failures. Leadership in rural health care is, therefore, increasingly concerned not with eliminating scarcity, but with designing care models that function reliably in the face of it. In this context, collaboration between family physicians and specialists, a model called "collaborative care," has been repeatedly proposed as a

means to improve access and quality of care. The literature suggests that collaborative care is best understood not only as a discrete intervention, but also as an organizing principle for rural health care systems.

Conventional specialist care models have evolved largely in urban environments. These models assume physical co-location, high patient volumes, and ready access to alternative services when disruptions occur. In rural settings, referral of responsibility to distant specialists often results in their episodic involvement without sustained integration into local care pathways. Although such arrangements may provide access to specific procedures or assessments, they are less well suited to supporting continuity, shared clinical reasoning, or longitudinal management in low-density settings.

Collaborative care represents a different organizational logic. In collaborative models, family physicians retain longitudinal responsibility for patients, while specialists provide structured, ongoing input through consultation, co-management, or advisory roles. The emphasis is not on transferring care, but on distributing expertise. This distinction has practical implications in rural contexts, where most care is delivered in primary care settings and specialist presence is intermittent.

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Examples and models of collaborative care

Evidence supporting collaborative care is well established in clinical areas that are highly relevant to rural practice. A Cochrane systematic review of collaborative care for depression and anxiety demonstrated improved clinical outcomes compared with usual care across a range of settings and delivery formats.[1] The review showed that structured collaboration can improve management when specialist availability is limited. For rural systems, the importance of this finding lies in the mechanism: sustained specialist input enhances primary care capacity without requiring continuous on-site specialist presence.

Continuity of care provides a complementary lens through which to view the value of collaboration. A systematic review examining continuity of care and mortality found a consistent association between higher continuity with doctors and lower mortality, while acknowledging the observational nature of the evidence.[2] Rural patients are structurally exposed to discontinuity through travel distance, limited provider choice, and fragmented service pathways. Care models that repeatedly shift responsibility away from primary care risk undermining a factor that appears to be protective.

Collaborative care aligns with continuity by reinforcing the central role of the family physician while extending access to specialist expertise.

Provider-to-provider consultation systems offer a practical example of how collaborative care can be operationalized. A systematic review of asynchronous electronic consultation services found that such systems improve access to specialist advice and may reduce unnecessary face-to-face referrals.[3] Canadian experience has shown that primary care clinicians are used to e-consultation for specialist advice,[4] although there are concerns that this will create expectations that they should provide care previously offered by specialists.[4]

These findings support a measured conclusion: structured access to specialist advice can strengthen primary care decision-making. They do not suggest that technology alone constitutes a care model, nor that virtual consultation replaces the need for clear clinical accountability on the specialist's side. Australian research has evaluated structured specialist access initiatives designed to reduce dependence on conventional outpatient pathways. For example in Queensland, a pilot program enabled general practitioners in urban and rural/remote practices to send asynchronous requests for specialist advice to general physicians) with responses typically provided within 72 hours.[5] Notably, only about 13% of cases required a subsequent face-to-face appointment, indicating that specialist guidance can be delivered effectively without conventional referral pathways. This work shows that formalized GP-to-specialist asynchronous consultation, delivered securely and responsively, has the potential to improve access to specialist support for patients managed in primary care and may reduce the need for subsequent in-person specialist visits in underserved areas.

Implications of collaborative care for rural health care systems

Across these bodies of evidence, a consistent pattern emerges. Collaborative care is most effective when it is treated as system design rather than professional goodwill. Informal or personality-dependent collaboration remains fragile. Where expectations, scopes of co-management, and lines of responsibility are explicit, collaboration becomes more durable. This observation reflects an organizational rather than a clinical insight.

Several implications for rural health system design follow from this synthesis. First, collaborative arrangements benefit from clarity regarding which

conditions are managed in primary care with specialist support, which require shared care, and which necessitate transfer. Ambiguity in these areas is associated with defensive referral patterns and inefficient use of specialist capacity.

Second, incentive structures influence the sustainability of collaboration. Models that remunerate only face-to-face encounters implicitly devalue advisory and co-management roles. Where collaboration is expected but unsupported, it is experienced as additional workload rather than as an integral component of care delivery. Appropriately remunerating electronic and indirect consultations will lead to greater uptake.

Third, longitudinal collaborative relationships are more effective than one-off consultations. Ongoing relationships allow for shared understanding of local context, available resources, and acceptable risk, all of which are particularly salient in rural practice. At times, the use of telephone rather than e-consultations may result in better development of the relationship between the primary care provider and the specialist.

Finally, virtual collaboration should be considered enabling infrastructure rather than experimental innovation. The evidence base for provider-to-provider consultation systems is now sufficiently mature to support broader implementation, provided these systems are embedded within clear governance and accountability frameworks.

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Limitations

This article draws on a selective body of literature rather than a systematic review, and much of the empirical evidence for collaborative care originates from specific clinical domains (notably mental health) and from health care systems with particular funding and governance arrangements. Evidence on specialist access models primarily reports process and utilization outcomes rather than long-term patient outcomes, and rural-specific evaluations remain limited. Consequently, although the synthesis supports collaborative care as a coherent organizational approach, its transferability across all rural contexts and specialties should be viewed with appropriate caution.

Conclusion

Collaborative care does not eliminate the need for in-person specialist services, nor does it resolve broader challenges related to workforce distribution or infrastructure investment. It does provide a more coherent

way of organizing care under conditions of permanent constraint. By strengthening primary care, supporting continuity, and extending specialist expertise beyond episodic encounters, collaborative care offers a viable organizational response to the realities of rural health systems. Taken together, the available evidence supports a shift in how specialist–primary care relationships are conceptualized in rural settings. Rather than viewing collaboration as an adjunct to conventional referral models, it may be more productive to view it as a foundational element of rural care design. This framing has implications for leadership, funding, and service organization, and provides a basis for further discussion about how rural health care systems can more deliberately organize expertise to meet population needs.

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Health-promoting leadership as a core competency across the physician leadership education spectrum

Victor Do, MD

Physicians are increasingly expected to lead teams, programs, and health care systems in contexts marked by growing clinical complexity, workforce distress, and persistent inequities. In response, physician leadership education has expanded across the education and career continuum; yet, well-being is often addressed as a parallel concern rather than as a core leadership responsibility. This article advances health-promoting leadership as a framework for understanding how leadership practices shape the conditions for health within medical learning and working environments. Informed by the Okanagan Charter and contemporary leadership scholarship, this article conceptualizes health-promoting leadership as a core, teachable competency that can guide physician leadership education. It describes key competency domains; outlines how health-promoting leadership can be cultivated across stages of training and practice; and identifies institutional responsibilities for aligning leadership education, governance, and accountability with the creation of healthy, equitable, and sustainable health care environments.

KEY WORDS: health promotion, leadership education, Okanagan Charter

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Over the past decade, physician leadership education has gained increasing prominence across undergraduate, postgraduate, and continuing professional development contexts. Leadership programs commonly address domains, such as change management, quality improvement, negotiation, and organizational governance, reflecting the growing recognition that physicians play influential roles within health care systems.[1] At the same time, physician burnout, moral distress, and workforce strain have been widely identified as pressing challenges with implications for health care quality, system sustainability, and patient safety.[2]

These parallel developments have created an important opportunity to examine more closely the relation between leadership and health in medical learning and working environments. Leadership is increasingly understood as shaping not only organizational performance, but also the everyday conditions in which physicians learn, work, and provide care. Decisions related to workload, team functioning, communication, and resource allocation influence psychological safety, trust, and well-being, and they accumulate over time to shape professional identity, team culture, and system sustainability.[3] Leadership practices, therefore, function as an important influence on health at individual, team, and system levels.

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In many leadership curricula, well-being is addressed as a distinct or complementary topic, commonly through self-care strategies, resilience-building approaches, or optional wellness initiatives.[1] Although these efforts are valuable, they may not fully capture the ways in which leadership practices and organizational structures actively shape health. Physician leaders are frequently encouraged to support well-being without explicit attention to how leadership itself functions as a mechanism through which health is promoted or undermined in clinical and educational environments.

The Okanagan Charter[4] offers a useful and underused framework for addressing this gap in physician leadership education. The charter articulates interrelated action areas that emphasize embedding health into institutional culture, fostering health-promoting environments, supporting personal and collective well-being, promoting community engagement, advancing research and scholarship, and aligning leadership

and governance with health promotion. Although developed for academic institutions, the charter's principles align closely with the realities of medical education and health care organizations, where leadership decisions shape learning environments, workplace culture, and the conditions for health.

Health-promoting leadership provides a way to translate the Okanagan Charter's strategic directions into leadership education and practice. By emphasizing how leadership practices influence environments, relationships, and systems of care, health-promoting leadership positions well-being as an outcome of intentional leadership action rather than an individual responsibility alone. In this article, we explore how health-promoting leadership, informed by the Okanagan Charter, can guide physician leadership education across the continuum of training and practice.

By emphasizing how leadership practices influence environments, relationships, and systems of care, health-promoting leadership positions well-being as **an outcome of intentional leadership action** rather than an individual responsibility alone.

Defining health-promoting leadership in medicine

Health-promoting leadership can be defined as leadership practice that intentionally creates, sustains, and repairs the conditions that enable psychological, social, and organizational health.[5] Rather than focusing narrowly on individual well-being interventions, health-promoting leadership attends to how culture, power, relationships, policies, and learning environments shape health outcomes for learners, clinicians, and patients. This framing shifts attention from individual coping to the broader institutional and relational contexts in which health is produced.

In medical contexts, health-promoting leadership is enacted through everyday leadership actions. This includes how leaders structure work and learning environments; respond to error, uncertainty, and vulnerability; and distribute power, voice, and recognition within teams. It also encompasses how leaders address inequities embedded in systems and practices, and how they align stated values with operational decisions. These leadership practices directly shape whether clinical and educational environments foster trust, psychological safety, and belonging or contribute to distress, disengagement, and moral injury.

The Okanagan Charter provides a useful lens for conceptualizing these leadership actions. It has been adapted to the medical context to emphasize creating supportive environments, integrating health into organizational culture, and aligning leadership and governance with health promotion.[6] Health-promoting leadership operationalizes these principles by translating them into leadership competencies that can be taught,

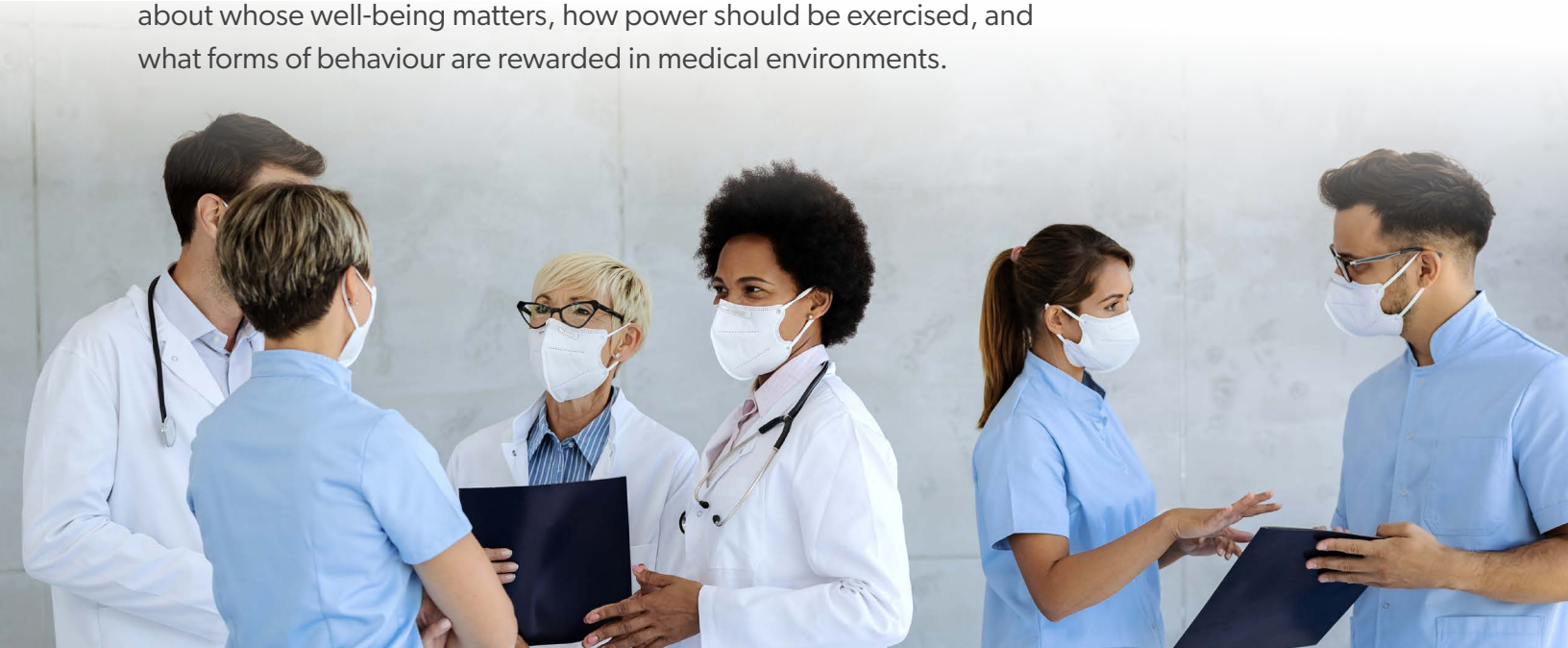
practised, and evaluated in medical education and leadership training programs.

Health-promoting leadership is distinct from traditional leadership competencies. It does not replace skills, such as strategic planning or financial stewardship. Instead, it reframes their purpose by recognizing that decisions related to efficiency, performance, and change carry consequences for health. Within this orientation, leaders are accountable not only for organizational outcomes, but also for the health effects of the environments they create.

Health-promoting leadership is not synonymous with wellness programming. It represents an ethical orientation to leadership practice that recognizes leadership as a mechanism through which health is either produced or eroded within health care systems. By making these dynamics explicit, health-promoting leadership offers a foundation for physician leadership education that aligns closely with the Okanagan Charter's vision of institutions as settings that actively promote health.

Why health-promoting leadership must be developed across the continuum

Leadership identity and leadership practice are often shaped before physicians assume formal leadership titles.[7] From the earliest stages of training, physicians are exposed to implicit and explicit messages about authority, hierarchy, endurance, and professionalism through role modeling and the hidden curriculum.[8] How supervisors respond to mistakes, how clinical workload is justified or normalized, and how learner vulnerability is acknowledged or dismissed all function as powerful lessons about leadership. These experiences contribute to deeply ingrained assumptions about whose well-being matters, how power should be exercised, and what forms of behaviour are rewarded in medical environments.



When health-promoting leadership is introduced only in mid- or late-career leadership programs, physicians may already have internalized leadership norms. In contrast, leadership education that explicitly names leadership as a determinant of health from the outset supports physicians in recognizing their influence across a range of contexts, including situations in which they do not hold formal authority. Embedding health-promoting leadership across the physician education and career continuum supports coherence among what physicians are taught in formal curricula, what they observe in clinical settings, and what they are ultimately expected to enact as leaders.

Without **explicit competencies**, leadership education risks positioning health and well-being as values rather than as skills that can be developed, practised, and evaluated

Core competency domains for health-promoting leadership

To meaningfully integrate health-promoting leadership into physician leadership education, programs must move beyond aspirational language and articulate clear, teachable competency domains. Without explicit competencies, leadership education risks positioning health and well-being as values rather than as skills that can be developed, practised, and evaluated. The Okanagan Charter provides a useful organizing framework for this work. Drawing on these principles, here are five proposed interrelated competency domains that should be intentionally embedded across leadership curricula and revisited at various stages of the physician education and career continuum.

1. Creating healthy learning and working environments

Health-promoting physician leaders require the ability to recognize how organizational structures, policies, and workflows shape health in learning and care environments. This includes understanding how workload design, scheduling practices, supervisory expectations, and evaluation systems influence psychological safety, chronic stress, and sustainability over time. Leadership education should support physicians in developing the capacity to identify environmental contributors to distress and disengagement, rather than attributing challenges solely to individual limitations. This domain closely aligns with the Okanagan Charter's emphasis on creating supportive and health-promoting environments by equipping leaders with systems-thinking skills and the ability to redesign processes in ways that promote learning, recovery, and long-term workforce sustainability rather than endurance alone.

2. Relational leadership and trust stewardship

Trust is foundational to effective leadership and to the functioning of

healthy clinical teams. Health-promoting leadership involves the capacity to build, maintain, and repair trust, particularly in contexts characterized by uncertainty, conflict, or harm. Physician leaders must be prepared to attend to how trust is influenced by transparency, consistency, follow-through, and responsiveness to concerns raised by learners and colleagues. Leadership education in this domain should address how trust is strengthened or eroded through everyday interactions, including how leaders communicate during crises, respond to feedback, and acknowledge mistakes. This competency reflects the Okanagan Charter's focus on fostering supportive institutional cultures and strengthening relationships as a core mechanism through which health is promoted.

3. Power, equity, and inclusion in leadership practice

Leadership decisions inevitably shape how power, burden, and opportunity are distributed in health care environments. Health-promoting leaders must be able to recognize how power operates within teams and institutions and how structural inequities influence experiences of safety, belonging, and voice. Leadership education should move beyond a narrow focus on individual bias to examine how policies, norms, and leadership practices can either perpetuate or disrupt inequity. This includes supporting leaders to reflect on whose perspectives are prioritized, whose labour is rendered invisible, and how decisions may differentially affect learners and staff from structurally marginalized groups. This domain aligns with the Okanagan Charter's commitment to equity, diversity, and social justice as foundational to health-promoting institutions.

4. Modeling vulnerability and psychological safety

Physician leaders play a critical role in shaping whether vulnerability is perceived as a professional risk or as a foundation for learning and growth. Health-promoting leadership includes modeling uncertainty, reflection, and accountability, and responding to error in ways that support improvement rather than fear or blame. Leadership education should explicitly address how leaders' responses to mistakes, questions, and expressions of distress signal what is safe to say and do within teams. By learning to model vulnerability appropriately and to foster psychological safety, physician leaders can create environments that support open communication, learning, and collective responsibility. This competency reflects the Okanagan Charter's emphasis on cultivating cultures that support well-being and enable individuals and communities to thrive.

5. Accountability for health and well-being outcomes

Health-promoting leadership ultimately requires accountability. Physician leaders should be trained to consider health and well-being outcomes as meaningful indicators of leadership effectiveness, alongside traditional metrics related to productivity, efficiency, and performance. This includes the ability to interpret data related to workforce well-being, learning environment quality, and equity, and to integrate these considerations into strategic and operational decision-making. Leadership education in this domain aligns with the Okanagan Charter's call to align leadership, governance, and institutional priorities with health promotion. This shift moves leadership education from supporting well-being as an ancillary concern to accepting responsibility for the conditions that produce health within systems, reinforcing health-promoting leadership as a core leadership function rather than an optional commitment.

Teaching health-promoting leadership across the continuum

The Okanagan Charter emphasizes that health promotion must be embedded across institutional roles, structures, and stages of engagement, rather than addressed through isolated or time-limited interventions. Teaching health-promoting leadership through the lens of the Okanagan Charter encourages educators to align leadership education with the creation of supportive environments, the integration of health into institutional culture, the advancement of equity, and the alignment of leadership and governance with health promotion. Table 1 provides a summary of the health promoting leadership competencies that can be prioritized at different stages of physician training and practice.

Undergraduate medical education: foundations and identity formation

In undergraduate medical education, leadership is often framed as a future responsibility associated with formal roles, rather than as a set of everyday practices enacted through interactions, teamwork, and responses to challenge. Health-promoting leadership education offers an opportunity to reframe leadership as something that is exercised daily, even by those without positional authority, and to situate leadership within the stewardship of learning and care environments. This approach aligns with the Okanagan Charter's call to embed health into institutional culture from the earliest points of engagement.

Health-promoting leadership education **offers an opportunity to reframe leadership as something that is exercised daily,** even by those without positional authority, and to situate leadership within the stewardship of learning and care environments.

Table 1: Health-promoting leadership across the physician education and career continuum

Stage of training or practice	Stage of training or practice	Examples for incorporating into curriculum
Undergraduate medical education	Understanding leadership as relational and environmental	Case-based discussions on power, speaking up, and responses to error
	Shaping healthy learning environments	Explicit teaching on how leadership behaviours influence well-being
	Supporting psychological safety	Reflective exercises on role modeling and the hidden curriculum
Postgraduate medical education	Trust stewardship	Integration of leadership into academic half-days and chief resident programs
	Responding to error and uncertainty	Assessment of supervisory behaviours
	Leading teams under pressure without causing harm	Structured debriefs following high-stress clinical events
Early-career physicians	Informal leadership and cultural influence	Peer mentorship and coaching
	Boundary-setting	Facilitated discussions on navigating institutional culture
	Values-aligned leadership	Training in workload negotiation and role clarity
Mid- and senior-level physician leaders	Systems-level leadership	Integration of well-being and equity indicators into leadership evaluation
	Equity-oriented decision-making	Leadership coaching focused on systems redesign
	Accountability for health and well-being outcomes	Organizational responses to moral distress and workforce strain
Institutional and faculty leaders	Institutional stewardship	Faculty development in health-promoting leadership
	Alignment of governance, culture, and leadership expectations	Promotion criteria that value leadership behaviours supporting health
	Faculty role modeling	Institutional accountability structures for learning and working environments

Educational approaches at this stage should introduce leadership early as a responsibility for shaping healthy learning environments and relationships. Case-based discussions can be used to examine power dynamics, speaking up, and responses to error, supporting learners in recognizing how leadership behaviours influence psychological safety, trust, and belonging. Explicitly naming leadership practices that promote or undermine health helps learners develop a shared language for discussing leadership and well-being, reinforcing the idea that health is produced through everyday interactions and institutional norms. The central shift in undergraduate education is from viewing leadership as positional to understanding it

as relational and environmental, thereby embedding health-promoting leadership within early professional identity formation.

Postgraduate medical education: applied leadership and role modeling

During residency and fellowship, physicians occupy dual roles as learners and supervisors, making this a critical period for applied leadership development. Health-promoting leadership education at this stage should emphasize skill-building through lived experience and role modeling, as residents' leadership behaviours have immediate consequences for team functioning, learning environments, and patient care. The ways in which residents lead rounds, manage uncertainty, and respond to error communicate powerful messages about professionalism, safety, and whose well-being matters within clinical settings.

Leadership education in postgraduate training should integrate health-promoting leadership principles into existing structures, such as academic half-days, leadership curricula, and chief resident programs. Leadership behaviours that support psychological safety, equity, and learning should be recognized and assessed as part of supervisory roles, reinforcing their importance alongside clinical competence. Training should also prepare residents to lead teams during high-stress clinical situations in ways that preserve trust and minimize harm. This approach reflects the Okanagan Charter's emphasis on creating supportive environments and strengthening institutional capacity for health promotion.

Early-career physicians: informal leadership and cultural influence

Early-career physicians can exert substantial influence within teams and organizations despite lacking formal leadership titles. Leadership education at this stage should acknowledge and support this reality by focusing on informal leadership, cultural influence, and boundary-setting. As new staff physicians navigate institutional expectations and entrenched norms, they frequently encounter tensions between personal values and prevailing practices, particularly in relation to workload, availability, and definitions of professionalism.

Health-promoting leadership education for early-career physicians should address navigating institutional cultures, setting boundaries around workload, and negotiating roles and expectations in ways that align with health-promoting values. Supporting physicians in understanding their

influence as culture carriers can help them engage more intentionally in shaping team norms and practices, even in the absence of formal authority. This approach aligns with the Okanagan Charter's emphasis on empowering individuals and communities to take action for health.

Mid- and senior-level physician leaders: systems and accountability

For physicians in formal leadership roles, health-promoting leadership education must address systems-level accountability. At this stage, leaders have significant influence over policies, resource allocation, and institutional priorities, all of which shape the health of learning and working environments. Leadership education should, therefore, equip leaders to recognize the health implications of strategic and operational decisions and to understand how leadership and governance structures can either support or undermine institutional commitments to well-being and equity.

Programs for mid- and senior-level physician leaders should integrate well-being and equity indicators into leadership evaluation, planning, and decision-making processes. Leaders should be supported in aligning operational choices with health-promoting values and in addressing moral injury and distress at a systems level rather than through individual remediation alone. This approach reflects the Okanagan Charter's call to align leadership and governance with health promotion and represents a central shift from managing burnout reactively to designing systems that proactively promote health.

Institutional responsibilities for advancing health-promoting leadership

Embedding health-promoting leadership into physician education cannot rely solely on individual programs or local champions. Institutions play a critical role in shaping the conditions under which leadership education is designed, delivered, and valued. The Okanagan Charter explicitly calls on institutions to align leadership and governance with health promotion, emphasizing that health-promoting environments require structural commitment rather than discretionary effort.

Institutions must recognize health-promoting as a core leadership competency and signal its importance through formal expectations, evaluation processes, and accountability structures. Leadership training should be aligned with promotion and performance frameworks so that leadership behaviours that support health, equity, and psychological safety

Leadership education should, therefore, equip leaders to **recognize the health implications of strategic and operational decisions** and to understand how leadership and governance structures can either support or undermine institutional commitments to well-being and equity.

are valued alongside traditional indicators of success. Investment in faculty development is also essential, as educators and clinical leaders serve as powerful role models whose everyday practices shape the hidden curriculum of leadership. Without institutional alignment, leadership education risks reinforcing the very conditions that contribute to distress, inequity, and disengagement within medical learning and working environments.

Limitations

This viewpoint is conceptual in nature and does not present empirical evaluation of health-promoting leadership education or outcomes. Although the Okanagan Charter offers a robust and transferable framework, its application to physician leadership education may require contextual adaptation across institutions, specialties, and health system settings. In addition, the competency domains and educational approaches described reflect a synthesis of existing scholarship and practice rather than a prescriptive model. Future empirical work is needed to evaluate how health-promoting leadership education influences leadership behaviours, learning and working environments, and health outcomes across the physician education and career continuum.

Conclusion: from leadership training to leadership responsibility

Health-promoting leadership offers an important reframing of physician leadership education. By recognizing leadership as a determinant of health, educators and institutions can move beyond preparing physicians to cope within unhealthy systems toward equipping them to actively shape healthier learning and care environments. Grounded in the principles of the Okanagan Charter, this approach positions leadership education as a form of health promotion that operates through culture, relationships, and governance. Embedding health-promoting leadership as a core competency across the physician education and career continuum positions leadership education as a powerful lever for cultural and systems change.

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What is **coaching?**

Ellen Tsai, MD, MHSc (Bioethics)

Coaching Corner is a collaboration between the Canadian Physician Coaches Network and the Canadian Society of Physician Leaders to highlight the value of coaching for physician leaders, including how they may effectively use coaching skills in their own interactions. In this first article of the series, we begin the journey of a physician leader as they explore how non-directive coaching differs from other resources that can support them in navigating the challenges of their new leadership role.

KEY WORDS: physician leaders, coaching, mentoring, professional development

Tsai E. What is coaching? *Can J Physician Leadersh* 2026;12(1): 43-47. https://doi.org/10.37964/cr24805

> *Dr. Vargas recently became chair of the orthopedics department at a large community hospital. The department has gone through significant upheaval. Two of the surgeons left the hospital last year because of dissatisfaction with changes to operating room allocation and call schedule distribution. They have been replaced by three recent graduates who have been openly critical of the surgical techniques of their more senior colleagues. The operating room has seen significant staff turnover, which began during the COVID pandemic, and vacant positions remain to be filled. Dr. Vargas has been in the department for 15 years and is well respected for their surgical and interpersonal skills. Dr. Vargas is excited about this leadership opportunity and has registered for a few leadership development workshops. However, Dr. Vargas feels very unsure about how to best prioritize and navigate the specific issues at their hospital.*

The CanMEDS role of Leader indicates that all physicians should be engaged in shared decision-making for the operation and ongoing evolution of the health care system, noting that physicians function "as individual care providers, as members of teams, and as participants and leaders in the health care system

locally, regionally, nationally, and globally."[1] Yet despite these expectations, competencies related to the Leader role generally receive less attention during postgraduate training than those related to other CanMEDS roles such as Medical Expert and Collaborator.[2]

A qualitative study by Lüchinger and colleagues[3] explored physicians' perceptions and experiences regarding leadership. They found that participants ascribed their negative reactions toward leadership and management "to the fact that they felt ill-prepared to endorse such roles and had little or no training in this field, regardless of their level of hierarchy or clinical experience." Chairpersons especially expressed "the feeling of being between a rock and a hard place between higher governance and their team."

What resources are available to physicians when they take on formal leadership opportunities?

The maxim "see one, do one, teach one" in clinical medicine, which has largely been set aside with the development of competency-based educational frameworks, seems equally inadequate in the context of physician leadership. However, given that many new physician leaders lack formal training when they first take on leadership responsibilities, they often end up relying on guidance from their own role models or they learn through a process of "trial and error."

> *Dr. Vargas speaks to one of their colleagues, who suggests reaching out to a senior leader to see if they would be willing to act as a mentor. Dr. Vargas had heard about peer coaching for surgeons and is wondering how leadership coaching is different from peer coaching, mentorship, and consulting (Table 1).*

Table 1. How coaching compares with other modalities of support.[4-7]

	Coaching	Relationship	Duration	Focus
Coaching	Non-directive, collaborative communication process that helps to clarify objectives and discover more effective approaches for achieving those objectives	The coach is a process expert who facilitates client self-discovery through questioning and reflection, without necessarily being an expert in the client's specific field (non-hierarchical)	Can be short to long term, often with a defined duration	Personal and professional growth, often transformational by changing how one thinks
Peer coaching	Direct observation and feedback — areas of focus can include teaching methods, clinical skills, practice management, and communication skills	The peer coach is a colleague in the client's specific field who engages in a structured exchange of feedback and reflection to achieve specific goals (non-hierarchical, often reciprocal)	Typically short-term and focused	Professional development
Mentoring	Developmental guidance that includes career navigation and professional growth	The mentor is typically a more experienced colleague who offers advice, guidance, and support based on their own career trajectory (hierarchical)	Often long-term, lasting a year or more	Career development
Consulting	Systems-level leadership	Integration of well-being and equity indicators into leadership evaluation	Typically short-term and focused	Fixing problems, optimizing performance
Training	Formal, direct instruction that leads to developing new or refreshing existing knowledge and skills	The trainer is a content expert who imparts specific knowledge and skills, more often done in a group setting but may be one-on-one (hierarchical)	Typically short-term and focused	Transfer of specific knowledge and skills
Counselling/ therapy	Helping to address mental, emotional, and behavioural health concerns and to promote well-being	The counsellor creates a therapeutic environment to explore emotions and navigate personal challenges (hierarchical)	Can be short to long term, depending on the concerns	Remediation or treatment of challenges in cognitive, behavioural, interpersonal, and emotional functioning

There is accumulating evidence that coaching is an important resource for physicians. Not only does coaching facilitate personal growth through a reflective learning mindset, but gaining clarity and alignment about one's values and purpose also contributes to professional satisfaction, well-being, and reduced burnout.[8,9] The authors of the aforementioned qualitative study suggested adding coaching in the workplace to complement leadership development programs, noting that both should be aligned with clear institutional goals and strategies.[3]

Leadership coaching does not supplant the value of role models, mentors, or formal training. However, coaching can maximize what one can learn from experience (or "trial and error") by offering the opportunity for guided self-reflection that is results-oriented and transformative for the physician leader.

> *Dr. Vargas decides that in addition to attending the workshops that they have already registered for, they are going to approach a senior faculty member from their residency training program to see whether they would be willing to serve as mentor. Dr. Vargas also decides to interview a few coaches. Dr. Vargas observes how the coaches all listen attentively and encourage self-reflection during these initial conversations. Dr. Vargas concludes that working with a coach would help with having more clarity and being able to prioritize which issues to tackle first as chair of the department. Dr. Vargas also notes that working with a coach will allow them to experience coaching skills which they can in turn apply to their own interactions.*

In the next article in this series, we will see how Dr. Vargas and their chosen coach work together to prioritize and explore solutions to the challenges that Dr. Vargas is grappling with.

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Otroversion and physician leadership: clinical reflections on independence, authority, and ethical action in medicine

Rami Kaminski, MD

Physician leadership is commonly understood through models emphasizing collaboration, visibility, and group engagement. Although these qualities are often essential, they do not encompass the full range of leadership orientations observed in clinical practice. In this article, I introduce otroversion as a clinically observed personality orientation characterized by resistance to group rituals, norms, and the pressure to conform, with low intrinsic need for group belonging and reliance on internal reference points. Drawing on my experience as a physician in various leadership roles, alongside emerging organizational discourse, I explore how otroversion may represent an underrecognized but valuable leadership orientation within medicine. I argue that otroverted physicians may be particularly well suited to roles requiring independent judgement, resistance to groupthink, and ethical steadiness, and I suggest implications for leadership development, evaluation, and physician well-being.

Kaminski R. Otroversion and physician leadership: clinical reflections on independence, authority, and ethical action in medicine. *Can J Physician Leadersh* 12(1): 48-53. https://doi.org/10.37964/cr24806

Leadership expectations in contemporary medicine

Leadership in medicine is increasingly emphasized as a professional competency. Physicians are encouraged to assume leadership roles, not only in clinical teams but also in institutions, policy environments, and professional

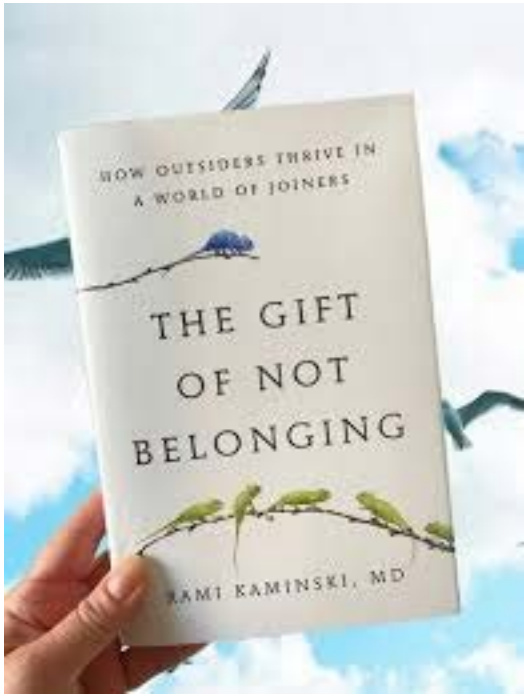
organizations. Dominant leadership models tend to privilege collaboration, consensus-building, emotional attunement, and visibility. These qualities are frequently framed as inherently virtuous and universally desirable.

Yet in my clinical work as a psychiatrist and in my leadership positions, I have repeatedly encountered a subset of physicians who do not comfortably conform to these expectations, but who nevertheless lead effectively, ethically, and with considerable influence. These physicians do not derive motivation from group belonging, social affirmation, or institutional identity. Nor do they retreat from responsibility or avoid engagement. Instead, they operate from a position of principled independence and clarity of role.

Over time, I have come to conceptualize this orientation as otroversion.[1] In this article, I reflect on otroversion in relation to physician leadership. These thoughts are offered, not as a definitive psychological classification, but as a clinically grounded framework that may help expand our understanding of how leadership actually manifests in medical settings.

Defining otroversion: a clinical perspective

Since the release of my recent book, *The Gift of Not Belonging*,[1] in which I describe the concept of otroversion, the term has emerged in discussions of organizations and culture. Otroverts are described as capable, engaged professionals who nonetheless lack a strong communal impulse and do not organize their identity around group belonging.[2,3]



From a clinical perspective, the physicians I describe as otroverted share several recurring features:

- Low intrinsic need for social belonging or group identification
- Comfort with decision-making under pressure
- Preference for clearly defined roles and responsibilities
- Propensity for sustained one-to-one engagement
- Reliance on internal ethical standards

Many otroverted physicians are articulate, socially skilled, and capable of public leadership. Their otroversion traits should not be mistaken for detachment, oppositionality, or social anxiety. Their defining feature is independence from the psychological rewards and pressures of belonging.

Otroversion as distinct from existing personality frameworks

Traditional personality frameworks have been invaluable in helping clinicians and leaders understand differences in temperament and motivation. However, most models assume that social belonging is either energizing (as in extroversion) or draining (as in introversion). In my experience, this assumption does not hold universally.

Otroverted physicians are often neither energized nor depleted by group interaction. Instead, they experience group dynamics as largely incidental to their sense of purpose. Their motivation is closely tied to their sense of duty as physicians and leaders, rather than to relational, political, or social reinforcement.

This distinction matters in medicine, where leadership is frequently assessed through visible participation, committee engagement, and relational presence. Physicians who do not seek these forms of engagement may be perceived as disengaged or insufficiently collaborative, even when their leadership impact is substantial.

Otroverted physicians are often **neither energized nor depleted by group interaction**. Instead, they experience group dynamics as largely incidental to their sense of purpose. Their motivation is closely tied to their **sense of duty as physicians and leaders**, rather than to relational, political, or social reinforcement.

Groupthink, medicine, and the value of psychological distance

Medicine is uniquely susceptible to groupthink. Hierarchical structures, time pressure, fear of error, and institutional loyalty can all discourage dissent. Numerous analyses of medical error have demonstrated how excessive cohesion and deference to authority can impair judgement and compromise patient safety. Many studies have explored the impact of psychological distance in medical decision-making, suggesting that clinicians who maintain a degree of independence from group pressures may mitigate the risks of groupthink and foster more robust ethical standards in health care settings.[4]

Physicians who are less psychologically invested in group belonging may serve as critical counterweights to these dynamics. In my experience, otroverted physicians are often more willing to question assumptions, resist premature consensus, and tolerate the interpersonal discomfort that accompanies dissent.

This does not mean that otroverted physicians are inherently contrarian. Rather, their independence from group identity allows them to evaluate

situations with less concern for social consequences. In leadership contexts, this quality can be particularly valuable during crises, ethical dilemmas, or institutional failures.

Otroverted leadership in clinical practice

Leadership in medicine often occurs quietly and informally. It may take the form of mentoring or moral leadership rather than positional authority. Otroverted physicians frequently excel in these roles.

Examples I have observed include:

- Physicians who intervene decisively when clinical standards are compromised, despite institutional resistance
- Leaders who provide clarity and stability during crises without seeking recognition
- Mentors who profoundly influence trainees through focused, one-to-one engagement
- Medical directors who prioritize role coherence over popularity

These physicians may not conform to dominant leadership narratives, yet they are often those to whom colleagues turn when clarity and judgement are required.

Cultural and organizational discourse supporting the concept

Although the concept of otroversion has emerged primarily from my clinical observations, it has begun to resonate in broader organizational and cultural discourse. Articles exploring otroverts in the workplace describe individuals whose contributions are often overlooked in socially driven organizational cultures, despite their reliability and effectiveness.[2,3]

Cultural essays have likewise explored the experience of individuals for whom belonging is not central to identity or fulfillment, challenging the assumption that social integration is a universal psychological need.[5] Mainstream media publications, including my article in *The Guardian*'s "The Big Idea" column, have further reflected growing public interest in alternative models of identity and participation.[6]

These sources do not constitute empirical validation, but they do suggest that the construct resonates beyond a single clinical lens. They provide a

conceptual backdrop against which the original clinical observations may be better understood.

Implications for physician leadership development

If leadership development in medicine continues to privilege social visibility, consensus-building, and performative collaboration, we risk marginalizing physicians whose leadership is guided by different mechanisms.

Recognizing otroversion has several practical implications:

Leadership identification: Leadership potential should not be assessed solely through committee participation, extroverted communication styles, or group engagement. Independent physicians — mavericks — may possess leadership capacities that are less visible but equally important.

Leadership training: Training programs might benefit from acknowledging multiple leadership orientations and offering pathways that do not require constant social performance.

Physician well-being: For some physicians, leadership expectations that emphasize continuous relational engagement may contribute to burnout. Validating alternative leadership styles may reduce unnecessary psychological strain.

By operating from internal rather than social reference points, otroverted leaders **may help preserve professional integrity within increasingly complex health care systems**.

Ethical leadership and moral courage

Perhaps the most significant contribution of otroverted physicians lies in ethical leadership. Moral courage often requires standing apart from the group, tolerating disapproval, and acting without assurance of support. Physicians who are less dependent on belonging may be better positioned to meet these demands.

In this sense, otroversion may represent a form of ethical resilience. By operating from internal rather than social reference points, otroverted leaders may help preserve professional integrity within increasingly complex health care systems.

Limitations and the need for further inquiry

This article does not propose otroversion as a diagnostic category, nor does it claim empirical validation. The concept remains descriptive and

exploratory. Future research might include qualitative studies among physicians, examination of leadership outcomes, and exploration of correlations with burnout, ethical decision-making, and institutional resilience.

The otrovert's reticence to participate in organized activities, such as conferences and administrative and policy meetings, and their tendency to eschew social events can limit their effectiveness in certain important aspects of physician leadership. An otrovert physician seeking a senior role would be ill advised to pursue roles that require a heavy load of meetings and executive decision-making (e.g., chair of a medical department). Otroverts are more suited to running clinics or other clinical settings where clinical engagement and hands-on teaching are often the most important requirements.

My intention is to articulate a pattern that many physicians recognize intuitively and to invite thoughtful inquiry rather than definitive classification.

Conclusion

Leadership in medicine is not monolithic. By recognizing otroversion as a legitimate and potentially valuable orientation, we may broaden our understanding of how physicians lead — and how they can be supported to do so authentically. In a profession that demands independent judgement, ethical clarity, and resistance to undue influence, otroverted leadership may not only be valid, but also essential.

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What great teams sound like: **reflections on leadership, listening, and performance in health care**

Aaron Smith, MD

Contemporary leadership literature increasingly emphasizes the role of teams in delivering performance under conditions of complexity and uncertainty. However, discussions at the point of health system delivery often continue to focus on individual actors rather than on how they function as teams. Leadership scholars have long used music as a metaphor to describe how groups coordinate, adapt, and perform collectively. Drawing on this tradition, and on lived experience playing in a musical group, this viewpoint explores music as a practical lens for understanding what enables effective teamwork in health care. The concept of the sound of great teams highlights four interrelated conditions: shared purpose and pace, active listening and psychological safety, clear roles with room for professional judgement, and collective learning through practice. Although these conditions are well recognized in musical performance, they are less consistently cultivated in health care settings. This article reflects on how physician executive leaders influence these conditions during periods of large-scale system change and argues that medical leadership effectiveness in health care lies less in individual action than in shaping the environment in which teams can perform together.

KEY WORDS: physician leadership, team performance, health system change, psychological safety, organizational learning

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The song is collective: when individual excellence isn't enough

Health care is delivered by teams, yet much of how leadership is enacted at the point of care continues to emphasize individuals. We value expertise, decisiveness, and personal resilience, often assuming that very capable individuals will naturally produce highly effective teams. As health care systems grow more complex, multidisciplinary, and fast-moving, the limits of this assumption become increasingly evident. What ultimately distinguishes high-functioning teams in health care is not the excellence of any one member, but how effectively the group works together as a whole.[1]

An unexpected source of personal insight into this dynamic has come from playing in a small musical group — a "dad rock band." Like health care teams, bands bring together people with different skills, experiences, and professional identities. They work within real constraints, including limited preparation time and moments of public performance that can make errors readily apparent. When a band functions well, the result can feel effortless. When it does not, the issue is rarely a lack of technical skill; it is almost always something about how the group is working together.

Music provides a useful metaphor because teamwork can be heard. Listeners can immediately sense whether a group is aligned, attentive, and responsive or whether it is fragmented and out of sync. Bands that sound good together share a clear sense of purpose, listen closely to one another, balance structure with individual expression, invest time in practice, and shape the overall mix with care. These same conditions underpin effective clinical and operational teams across diverse professional and lived experiences; yet in health care they are often assumed rather than intentionally cultivated.

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When the music leads: lessons for leading expert teams

Leadership scholars have long drawn on musical ensembles as metaphors for teamwork, most commonly referencing chamber music and jazz. In chamber music, particularly the string quartet, leadership is shared and

fluid rather than fixed. Authority shifts depending on the musical passage, requiring deep listening, mutual accountability, and continuous negotiation among highly skilled peers. Individual virtuosity matters, but only insofar as it serves the collective performance. As such, the string quartet has been widely cited as an illustration of non-hierarchical leadership, psychological safety, and coordination among expert teams.[2]

Jazz ensembles extend this metaphor by emphasizing adaptability and improvisation within agreed-upon structure. Although jazz values individual expression, that freedom is bounded by shared frameworks such as tempo, key, and form, which allow coherence to emerge without rigid control. Leadership in jazz is situational, requiring participants to step forward or step back in response to the moment, while remaining attuned to the ensemble as a whole.[3,4] In the leadership literature, jazz has become a dominant metaphor for navigating uncertainty, balancing standardization with flexibility, and making sense of complexity in real time.

Although these metaphors are typically applied to leadership in general, they are particularly salient in the context of physician executive leadership. Physician executives lead in environments characterized by high expertise density, professional autonomy, and limited tolerance of hierarchical control. Clinical authority and subject-matter expertise reside primarily at the point of care, meaning physician executives often lead peers whose technical expertise may exceed their own in specific contexts. Therefore, influence is earned through credibility, trust, and the ability to shape conditions that allow others to perform well together. In this setting, the lessons drawn from chamber music (shared leadership and disciplined listening) and jazz (adaptive leadership within structure) resonate less as metaphor and more as a reflection of how medical leadership and expertise are shared in practice.

Although chamber music and jazz dominate the leadership literature, they are not the only musical forms familiar to those who work in teams — nor, in my case, the genres I am most drawn to play. My own musical experience sits squarely in rock. Research on group creativity and "group flow" suggests that similar dynamics apply in rock and pop bands, where effective performance depends on clear role differentiation, disciplined rehearsal, mutual trust, and the ability to adapt in real time, particularly in live settings.[5,6] Rock specifically adds further lessons that resonate strongly

with contemporary health care leadership: sustaining performance over time, maintaining cohesion under high visibility and external scrutiny, and coordinating reliably in loud, imperfect, and unpredictable environments. In this respect, whether the setting is a string quartet, a jazz ensemble, or a rock band with the amps cranked, lessons for effective physician leadership are less about genre and more about listening, coordination, and shared accountability for outcomes.

Taken together, these genres suggest that the dynamics underpinning effective leadership are not confined to a narrow musical canon. Other contemporary forms offer complementary perspectives. Country music emphasizes shared narrative, trust, and collective meaning-making over time. Hip hop highlights collaboration across difference, the importance of voice, and the creative tension between structure and improvisation — particularly in contexts shaped by power and exclusion. Metal underscores discipline, precision, and mutual reliance under intensity, where cohesion matters most when conditions are loud, fast, and unforgiving.

Some musical traditions invite a different posture altogether — one grounded in listening rather than interpretation. Indigenous musical traditions offer teachings about relationality, collective responsibility, and connection to land and community that predate contemporary leadership theory. As a non-Indigenous physician leader, and within the context of colonization and ongoing harms, it is not my place to interpret or extract lessons from these traditions. Rather, their presence here serves as a reminder that leadership wisdom exists beyond dominant frameworks, and that meaningful learning requires humility, attention to whose knowledge is centred, and a sustained commitment to truth and reconciliation.

Getting on the same beat: making the "why" shared

In music, alignment begins well before the first note is played. Bands may agree on key and tempo, but what ultimately shapes the sound is a shared sense of purpose: what the song is meant to convey, who it is for, and how it should feel. Without this shared intent, even technically proficient musicians can sound disjointed, each playing accurately but not together.

Health care teams face a similar challenge. Strategic goals are often articulated clearly at a system level, yet shared purpose at the point where care is delivered is less consistently developed. Teams may understand

what is being asked of them — new workflows, performance targets, or models of care — without a clear sense of why the work matters or how it fits into a broader strategy. In the absence of this shared understanding, teams begin to drift, move at different speeds, or disengage when pressures mount.

Pace matters as much as direction. In music, a rushed tempo creates tension and errors, while a sluggish one drains energy and focus. In health care, the pace of change has become a defining feature of daily work. When teams are pushed faster than their capacity allows, quality, safety, and morale suffer. When momentum is lost, improvement stalls. Finding a sustainable rhythm is not a one-time decision but an ongoing act of calibration.

Turning down the noise: creating conditions to listen

Listening plays an equally central role. In music, it is as important as playing. A musician who focuses only on their own part — regardless of technical ability — quickly destabilizes the group. Good bands listen continuously, adjusting volume, timing, and tone in response to what they hear around them. Crucially, this requires attention not only to sound, but to balance: whose parts are featured, whose are softened, and how the overall mix is shaped. Small signals matter, and when they are noticed early, correction is often quiet and instinctive.

Attentive listening in music is not only about maintaining coherence in the moment, but also about sensing what may come next. Bands that continue to grow listen for emerging patterns — changes in tempo, evolving influences, or shifts in what resonates — and use these cues to explore new directions while staying grounded in a shared sound. This kind of listening also requires discernment. Not every sound warrants adjustment, and experienced musicians learn to distinguish meaningful cues from background noise, allowing groups to adapt deliberately rather than reactively.

These same dynamics are evident in health care teams, where the quality of performance depends on how well people listen to one another and respond to early cues. High-functioning teams are defined less by individual expertise than by their collective ability to listen, ask questions, and adjust in real time. Psychological safety allows team members to voice uncertainty, surface concerns, and share incomplete information without fear of embarrassment or reprisal.[7] For physician executives, this means shaping

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These same dynamics are evident in health care teams, where the **quality of performance depends on how well people listen to one another** and respond to early cues.

a culture where listening is expected and protected — where early signals are noticed, voices are balanced, and teams are supported in separating meaningful change from transient noise. When listening is poor or speaking up feels risky, early indicators of trouble (clinical deterioration, workflow strain, or cultural tension) tend to go unnoticed until they escalate into harm.

Listening is not only an interpersonal skill; it is also shaped by structures and expectations. Teams listen well when systems make it possible to do so: when there are regular forums for sense-making, clear invitations to question assumptions, and routines that support timely course correction. Leadership cultures that prize confidence and decisiveness without equal attention to inquiry often increase volume at the expense of awareness.

The space between the notes: balancing structure and innovation

Another lesson from music lies in the balance between structure and freedom. Strong performances depend on both. Musicians follow a shared score, yet the most compelling performances leave room for interpretation, variation, and occasional solos. When structure is too rigid, the music feels flat; when it is too loose, coherence is lost. Improvisation works because there is enough shared reference to keep the group together while individuals explore within it.

Health care teams require the same balance. Clear roles and accountabilities provide the structure teams need to function safely and efficiently, while clinical and operational work demands judgement, responsiveness, and adaptation to context. Improvisation in this setting is not the absence of standards, but the informed use of professional discretion when situations do not unfold as expected. Leaders must be attentive to how improvisation is received — who is given room to explore and whose variation is questioned. When tolerance for improvisation is uneven, teams become cautious rather than adaptive, and learning gives way to risk avoidance. Physician executives play a critical role in setting boundaries that are clear enough to ensure safety, yet fair and transparent enough to support judgement, innovation, and trust.

The musical metaphor also clarifies the physician executive's responsibility for quality improvement infrastructure. Good bands do not improve simply by performing more often; they improve in rehearsal, supported by a

shared score, agreed cues, and mechanisms for feedback. The score itself is not neutral — it reflects assumptions about what matters, what is measured, and whose contributions are most visible. These structures do not constrain creativity; they make it possible to play together, notice variation, and adjust without losing coherence.

In health care, quality improvement processes serve a similar function. Clear aims act as the score, measures provide feedback on performance and variation, and regular improvement forums create rehearsal space where teams can test changes before implementing them. For physician executive leaders, supporting quality improvement, therefore, means stewarding these structures deliberately, ensuring they are visible, trusted, and examined for how well they serve all teams and patient populations. When improvement infrastructure is weak or fragmented, teams are left to improvise without shared reference points, increasing noise rather than learning.

Innovation, like musical variation, emerges most productively when there is enough structure to keep the group together while still allowing room to explore. Physician executives play a critical role in setting these boundaries — signaling where fidelity matters, where experimentation is encouraged, and how learning will be shared across the system. Without this guidance, innovation risks becoming either stifled or chaotic, neither of which serves patients well.

For physician executive leaders, supporting quality improvement, therefore, means stewarding these structures deliberately, **ensuring they are visible, trusted, and examined** for how well they serve all teams and patient populations.

The band gets better offstage: learning, safety, and collective adaptation

Practice offers a final, often overlooked lesson. No band performs well without rehearsal. Practice is where timing is refined, mistakes are surfaced, and trust is built. Rehearsal is separate from performance; it is a space where errors are expected and even welcomed as part of learning. Rehearsal also creates room to notice patterns that may be harder to surface in the pressure of performance — whether technical missteps, breakdowns in coordination, or dynamics that leave some contributors consistently unheard.

In health care, opportunities for collective rehearsal are often limited. Reflection, debriefing, and improvement work are frequently displaced by operational pressures, leaving little protected space for teams to learn together. Learning tends to be individualized rather than shared, and

opportunities to reflect on how work is actually unfolding are lost; mistakes are more likely to be managed reactively than used as sources of insight.[8] In the context of large-scale system reform — where policy intent, operational realities, and professional practice must align across multiple levels — the capacity of teams to maintain shared purpose, reflect, learn, and adapt together often determines whether change is integrated into daily work or resisted in practice.[9]

Shaping the final mix: leadership as stewardship of conditions

Across all these observations, a consistent leadership role emerges. In music, the leader does not improve the sound by playing every instrument or correcting every note in real time. Instead, the focus is on creating the conditions that allow the group to perform well together. In health care, senior physician executives are similarly positioned as stewards of the conditions in which teams operate. In complex adaptive systems such as health care, effective leadership involves both attentiveness and restraint — recognizing when direction is required and when conditions are better shaped by enabling teams to respond to emerging information rather than prescribing solutions.[10]

Most people recognize the sound of a good band immediately. It is cohesive without being rigid and adaptive without becoming chaotic. The music holds together because purpose is shared, listening is active, roles are clear, and there is space to rehearse, learn, and adjust. That coherence depends not just on what is played, but on how contributions are taken up — whether innovation is received consistently and whether all parts are given room to be heard.

High-functioning health care teams share these same qualities. For physician executives, the work is not to dominate the performance or play every instrument, but to ensure the score is clear, the rehearsal space is protected, and the conditions exist for teams to listen and respond to one another in fair and predictable ways. When these elements are in place, teams can sustain their collective sound — and the care they deliver can continue to improve, day after day.

Limitations

This article uses music as a metaphor to reflect on team functioning and physician executive leadership. As with any metaphor, it simplifies

complex realities and will resonate differently depending on professional background, cultural context, gender, and lived experience. The parallels drawn are intended to support reflection rather than provide a comprehensive account of teamwork in health care.

These reflections are grounded in lived experience and selected leadership literature rather than empirical evaluation. They do not test specific leadership behaviours or interventions, nor do they fully capture the structural forces that shape power, inequity, and inclusion in health care organizations. Although the discussion attends to listening, balance, and whose voices are heard, a fuller and sustained exploration of anti-racist, gender-responsive, and Indigenous-informed approaches to physician leadership remains necessary and critical. Such work — particularly when centred beyond the perspective and privilege of a white cisgender male physician leader — lies beyond the scope of this viewpoint but is essential to advancing more equitable and effective leadership practice.

Epilogue

Now who'd have thought that after all
Something so simple as rock 'n' roll would save us all

— Frank Turner, I Still Believe

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Leading with integrity: the role of values-based leadership in health system transformation

Alexandre Ngoc Nguyen Teichmann, MD

As health systems become increasingly complex, values-based leadership (VBL) can serve as a guiding framework for ethical and effective decision-making. VBL offers a framework in which leaders align decisions, behaviours, and organizational actions with core ethical principles, including integrity, compassion, and authenticity. This article briefly examines the evolution of value-based health care and the emergence of VBL, to then explore its significance for today's physician leaders and outline strategies to cultivate this competency in future leaders.

KEY WORDS: values-based leadership, health systems leadership, physician leadership, ethical leadership, leadership development

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Health care systems are facing mounting pressure these days, involving increasing complexity, public scrutiny, and often burnout. These challenges have highlighted the need for strong and responsive leadership across health systems. How is this achievable and, more specifically, which leadership approach is essential to strive toward this objective? Among existing and emerging leadership paradigms, values-based leadership (VBL) has gained attention as a guiding framework centred on ethical consistency, authenticity, and compassion in decision-making.

First, it is important to distinguish between value-based and values-based leadership, as the two terms, although similar, describe fundamentally different perspectives. Value-based leadership (singular "value") often relates to principles of efficiency and cost-effectiveness in health care delivery, reflecting the focus of value-based health care as articulated by Porter and Teisberg.[1] In contrast, VBL (plural "values") focuses on the moral and ethical principles that guide professional behaviour, which this paper explores in depth.

A brief history of value-based health care and values-based leadership

The notion of "value" in health care arose in response to growing dissatisfaction with systems that emphasized activity and output rather than meaningful outcomes. In the late 20th and early 21st centuries, concerns about rising costs, inefficiencies, and inequities in care prompted a fundamental re-examination of what constitutes "success" in health care delivery. The concept gained prominence following Michael Porter and Elizabeth Teisberg's influential work, *Redefining Health Care: Creating Value-Based Competition on Results*,[1] which proposed that health care systems should focus on achieving the best possible outcomes for patients relative to the resources invested. This framework, referred to as value-based health care, has redefined success, not by volume or activity, but by the creation of measurable value for patients. Over the past two decades, it has shaped global reform initiatives, emphasizing outcomes measurement, care integration, and patient-centred decision-making as mechanisms to improve both quality and efficiency.[2]

In parallel, leadership scholarship began to evolve toward similar principles of alignment and integrity. Earlier leadership paradigms, such as servant leadership,[3] authentic leadership,[4] and ethical leadership,[5] highlighted the importance of moral grounding, humility, and self-awareness in guiding others. These models laid the foundation for the emergence of what has come to be known as VBL, an approach that emphasizes coherence in a leader's personal values, actions, and organizational mission.[6]

Since the early 2000s, value-based health care and VBL, have together reflected a growing recognition that ethical transparency is essential for the performance of a health organization. In complex health systems, where economic, political, and human factors intersect, VBL is an approach that permits value-based health care to be concretely applied.[7] Today, VBL has

evolved from a conceptual ideal into a practical framework guiding health care organizations toward ethical, patient-centred decision-making.

Defining values-based leadership

VBL can be broadly understood as the alignment of a leader's decisions, behaviours, and their stated values or ethical commitments.[6] VBL in health care refers to a leadership approach where decisions, behaviours, and organizational strategies are guided by core ethical principles, such as integrity, compassion, justice, transparency, and respect for persons. It emphasizes alignment of personal values with professional responsibilities to foster trust, improve team cohesion, and advance patient-centred care in health systems.

"Values-based leadership is about leading by deeply held beliefs and ethical principles, creating alignment between values, actions, and impact within an organization."[6] VBL ensures that concrete leadership actions remain aligned with professional ethical principles and patient-centred care, balancing system-level performance with moral and societal responsibility.

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The significance of values-based leadership in health care

Health care systems are under considerable influence from an increasing number of interest-holders in industry, technology, and business. These economic and political influences, combined with systemic constraints, have the power to shift health care from its moral groundings. Evidence shows that increasing systemic constraints, such as financial pressures, efficiency mandates, and market-driven reforms, have shifted the focus from relational and ethical care toward productivity and cost containment.[8,9] This drift threatens to undermine the profession's foundational commitment to compassion, equity, and the broader societal good. In this context, upholding fundamental values in health care systems, such as caring and compassion, is of utmost importance.[2,10] In addition, integrity and authenticity practised through VBL emerge as significant elements that shape health care leadership.[11]

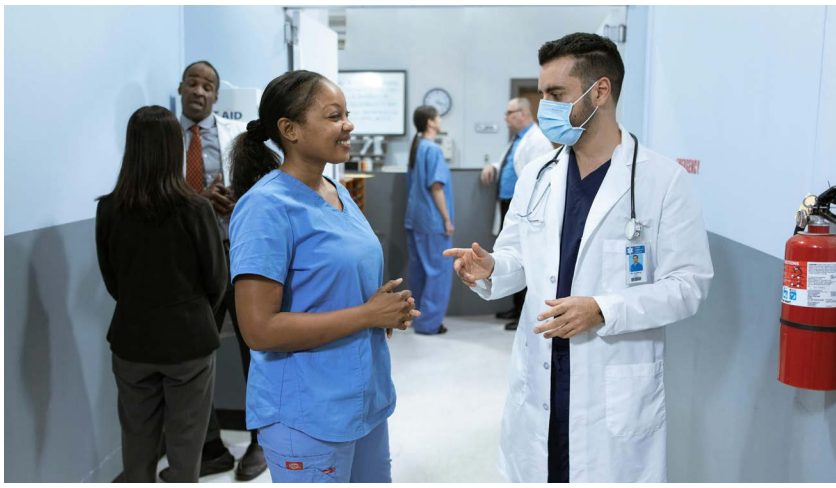
VBL emphasizes the alignment of a leader's decisions and behaviours with deeply held ethical commitments, ensuring that organizational priorities remain consistent with both professional and societal expectations. By fostering authenticity, transparency, and moral accountability, VBL

strengthens relational trust among health care teams, mitigates burnout, and promotes psychological safety, conditions essential for effective collaboration and sustainable system performance.[7,12] For example, a systematic review of authentic leadership in health care settings found associations between authentic leadership and improved staff psychological states, satisfaction with work, favourable work environments, health and well-being, and performance outcomes.[13] Notably, authentic leadership was correlated with lower burnout and higher compassion among nurses.[13] A study in acute care settings showed that nurses' perceptions of authentic leadership by their managers had a positive direct effect on perceived quality of care.[14] Literature more specific to VBL has also demonstrated correlations with enhanced trust among teams, stronger professional collaboration, greater voice for staff, empowerment, and improved patient-centric outcomes.[15]

The importance of VBL becomes especially apparent during periods of crisis or heightened uncertainty. Leaders who consistently act in accordance with their values provide stability, demonstrate reliability, and model ethical decision-making, reinforcing team cohesion and organizational resilience. Leading by example during times of crisis not only shows compassion to colleagues, but also serves to stabilize teams and optimize chances of better outcomes through these moments, a key leadership skill that highlights the importance of VBL (referred to as "being a present and trustworthy leader during sun and storm").[11] In this way, VBL is not only a framework for ethical conduct but also a strategic asset, enabling physician leaders to navigate complex health care environments while upholding the moral and professional principles at the heart of patient-centred care.

Developing values-based leadership

Fostering VBL in tomorrow's health systems leaders is vital in ensuring efficient yet ethical innovation. Literature around this topic suggests several approaches to develop this competency. Leaders must understand their own values before they can lead by them. Structured reflection tools, such as journaling or coaching, can help integrate these internal commitments. Graber and Kilpatrick summarize this as the first two of four elements of VBL: "Recognize your personal and professional values.... Determine what you expect from the larger organization and what you can implement within your sphere of influence."[16]



Emerging leaders benefit from observing role models who lead with integrity. Antoine and colleagues identify this as one of the components of VBL: "Servant leadership including mentorship." Institutions should formalize mentorship opportunities, as they are recognized as a method of skill development.[17]

Developing VBL must also be done through practice in low stakes but real-life environments. Emerging leaders should seek opportunities in advocacy organizations, committees, or research teams where they can test ethical decision-making and interest-holder navigation without the full weight of administrative responsibility. Leadership curriculums must, therefore, be "based in the real-world experience of successful organizations."[18]

Finally, cultivating VBL requires organizational support. Health systems must create cultures in which values are explicit, celebrated, and embedded in policies, performance evaluations, and leadership curricula. Integrating VBL into formal leadership programs, such as physician leadership training or health administration education, ensures that ethical leadership becomes visible, viable, and desirable for future health leaders.[19,20]

Limitations and future directions

Although this article draws on a range of conceptual and empirical sources, current literature on VBL in health care remains limited. Much of the existing evidence is extrapolated from general leadership theory or related constructs, such as authentic and servant leadership. There is a need for more empirical research specifically examining how VBL influences organizational outcomes, patient experiences, and leader well-being in health care contexts. In addition, limitations exist around the difficulty of enacting VBL within complex, resource-constrained health care systems. Even when leaders adopt moral and ethical values, systemic pressures, such as financial constraints, productivity targets, and conflicting interest-holder values, can impede consistent values-based decision-making.[16,21] Therefore, embedding VBL requires not only individual commitment but also structural and cultural support within health care organizations. Future work should also explore methods for effectively integrating VBL into leadership training and evaluating its long-term impact on system performance and culture.

Conclusion

Health care systems inevitably face crisis, pressure from interest-holders, and other complex challenges and dynamics throughout their existence. Thus, it is essential for health systems leaders to learn to navigate those challenges with integrity, authenticity, and accountability, all of which are key elements fostered through VBL. This highlights the need for developing education around implementing VBL and ensuring that the leaders of tomorrow cultivate this competency to build equitable, sustainable, and morally grounded health care systems.

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Leadership lessons: decisiveness, listening, and the future of Canadian health care

Ibraheem Almani, MD

Leadership in health care requires decisiveness, active listening, and the ability to balance oversight with empowerment. Insights from the literature and a conversation in 2025 with Dr. Janet Pope, professor of medicine at the University of Western Ontario and former division head of rheumatology at St. Joseph's Health Care, provide a broad viewpoint on physician leadership in Canada. This article highlights decisiveness as disciplined speed, listening as a foundation of psychological safety, and the ability to zoom in or out as circumstances require. It further considers how physician leaders should tackle systemic challenges, such as inefficiencies, workforce shortages, and pharmacare gaps and also mentor future leaders. The literature supports key leadership principles and illustrates their application in health care contexts. Canadian health care leaders must embrace decisiveness, listening, empowerment, and mentorship to address current system pressures and transform health care for the future.

KEYWORDS: active listening; decisiveness; healthcare; healthcare transformation; leadership; mentorship; physician leadership; psychological safety.

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Leadership is not optional in health care — it is essential. In Canada, where health care systems face the mounting pressures of resource constraints, staffing shortages, and increasing patient complexity, physician leaders should step beyond clinical expertise to influence systems, shape policy, and mentor future colleagues. Such leadership has been identified as a critical driver of quality improvement, system sustainability, and patient safety.[1]

Dr. Janet Pope, a nationally and internationally recognized rheumatologist, researcher, and mentor, embodies many of these qualities. Her reflections on decisiveness, listening, and empowering teams offer important lessons for Canadian physicians. This article combines her perspectives with a selective literature review to provide a narrative that connects leadership theory with practical application in Canadian health care.

Decisiveness as a core leadership skill

Decisiveness is one of the first skills emphasized by Dr. Pope. Effective leaders must be willing to weigh options, consider ethical implications, and make timely decisions, even when consensus is impossible. This aligns with McKinsey & Company's research, which identified decisiveness as one of four critical behaviours that set effective leaders apart.[2]

Effective leaders must be willing to **weigh options, consider ethical implications, and make timely decisions**, even when consensus is impossible.

The importance of decisiveness was underscored during the COVID-19 pandemic. Leaders who acted promptly and transparently, while incorporating frontline input, preserved workforce morale and positive patient outcomes[3] and were able to pivot as new data/policies emerged. In Canadian settings, delays in decision-making can exacerbate overcrowding, prolong wait times, and increase patient harm.[4] Decisiveness, therefore, is not simply about speed but about disciplined speed — acting with the best available evidence while being prepared to adapt as circumstances evolve.

Active listening and psychological safety

Listening is a hallmark of effective leadership. Leaders who dominate conversations may secure compliance but often fail to inspire collaboration. By contrast, leaders who listen actively foster dialogue, harness diverse perspectives, and encourage innovation.

Amy Edmondson's work on psychological safety demonstrates that environments where individuals feel safe to voice concerns without fear of retribution are more adaptive and innovative.[5] In clinical teams, this translates into better error reporting, collaborative problem-solving, and learning. As Dr. Pope has observed, leaders who thank team members for identifying mistakes reinforce a culture of trust. This shift — from blame to learning — is essential in Canadian health care organizations striving for quality improvement.

Balancing oversight and delegation

Another theme Dr. Pope emphasizes is a leader's ability to know when to "zoom in" to details and when to "zoom out" to empower others. This balance is central to effective delegation. Micromanagement can demotivate teams, while unchecked delegation can increase the risk of errors.

Research in high-stakes environments, such as anesthesia teams, shows that shared leadership, where responsibility shifts fluidly between leaders and team members, enhances both performance and safety.[6] Dr. Pope's own leadership practice has reflected this. With experienced staff, she has delegated and requested concise summaries, trusting them to manage details. With junior staff, she has initially provided more oversight until trust is built. This flexible approach ensures both accountability and empowerment.

System transformation and unpopular decisions

Perhaps most relevant to Canada's health care crisis, Dr. Pope underscores the necessity of system-level reforms that may be unpopular but are essential for sustainability. She has called for eliminating wasteful practices, strengthening workforce planning, closing screening gaps, negotiating fair pharmaceutical pricing, and implementing universal pharmacare.

The Institute for Healthcare Improvement's Triple Aim framework similarly emphasizes better care, improved population health, and reduced costs — goals that cannot be achieved without difficult trade-offs.[7] Ontario's lack of a comprehensive health care workforce plan has already led to shortages in family physicians and specialists. Repatriating Canadians trained abroad and integrating non-physician professionals into care delivery are pragmatic solutions requiring leadership advocacy.

Universal pharmacare, long debated in Canada, remains critical for equity. Without it, vulnerable populations face barriers to essential medications, undermining the principles of a publicly funded system. Leadership, as Dr. Pope notes, requires not only envisioning these changes but also having the courage to pursue them despite resistance.

Developing the next generation of leaders

Finally, Dr. Pope's reflections highlight the responsibility of current leaders to mentor and empower future leaders. She emphasizes the importance

of reliability, follow-through, and thoughtful engagement. These traits are often more important than charisma or extroversion.

Leadership development literature reinforces this. West and colleagues[1] argue that leadership potential lies not in personality type but in the capacity to commit, learn, and collaborate. Formal leadership training, coupled with mentorship, can cultivate these qualities in physicians at all stages. Dr. Pope has taken pride in seeing her trainees surpass her — a hallmark of true leadership.

Conclusion

These leadership lessons, informed in part by Dr. Pope's work and experience, resonate strongly with current challenges in Canadian health care. Decisiveness, active listening, balancing oversight and empowerment, and mentoring future leaders are not optional skills but essential competencies.

As Canada grapples with systemic inefficiencies, workforce shortages, and growing demand, physician leaders should embrace these principles. Doing so requires courage to make unpopular decisions, humility to listen, and generosity to nurture others. The future of Canadian health care will depend not only on policies and funding but also on the capacity of physician leaders to model these lessons and enact change.

She emphasizes the importance of **reliability, follow-through, and thoughtful engagement**. These traits are often more important than charisma or extroversion.

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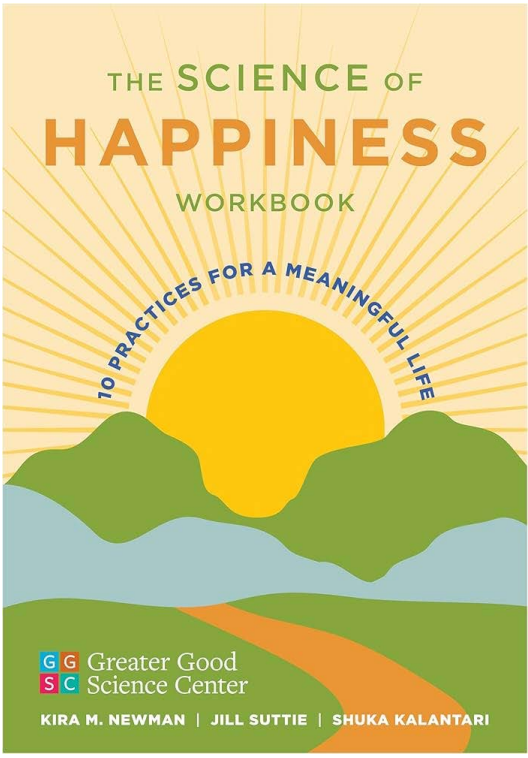
The Science of Happiness Workbook: 10 Practices for a Meaningful Life



Kira M. Newman, Jill Suttie, Shuka Kalantari
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Reviewed by **Johny Van Aerde**, MD, PhD

The Science of Happiness Workbook is a practical, evidence-based guide from the Greater Good Science Center (GGSC) at the University of California, Berkeley. It offers short and actionable daily exercises to develop habits for building happiness and meaning. The 160-page self-help book, based on studies and courses generated at GGSC,[1] doesn't just make promises, it also delivers results by turning research into action in a positive yet realistic way.

The content is based on behavioural science and positive psychology, with a focus on cultivating a resilient life. The values and skills covered are connection, kindness, empathy, compassion, awe, mindfulness, gratitude, and self-compassion, coming together in the final two chapters on emotion regulation and purpose.

The identical structure of each of the ten chapters adds to the practicality of the book. Each starts with a section on the benefits of a value or behaviour, supported by science and a few narratives and followed by a survey to measure the present and future skill level of the learner. Several simple and actionable practices follow, and the chapter ends with a section on how to put that specific topic into practice.

For each value or behaviour, the reader learns not only what to do and how to practise it, but also why it works. The combination of what, how, and why entices the reader to engage in the practices and makes the workbook feel more like a supportive companion rather than a textbook full of prescriptions.

The authors are realistic in acknowledging discomfort, stress, and uncertainty as part of the human experience, but they also maintain a positive undertone in the carefully designed exercises that emphasize small, repeatable habits.

The book is of value not only to those who live and work under stressful conditions, but also to each of us when dealing with difficult transitions in our personal life. The practices can take as little as 15 minutes once or twice a day. As a matter of fact, this book cannot and should not be studied and practised in big chunks. For leaders in the health care system who use the LEADS framework, the book aligns closely with all four capabilities of the Lead Self domain.[2] In short, *The Science of Happiness Workbook* is a comprehensive, actionable, easy, and evidence-based workbook, providing short step-by-step practices that can fit easily into the busy-ness of daily life. It's worth trying!

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