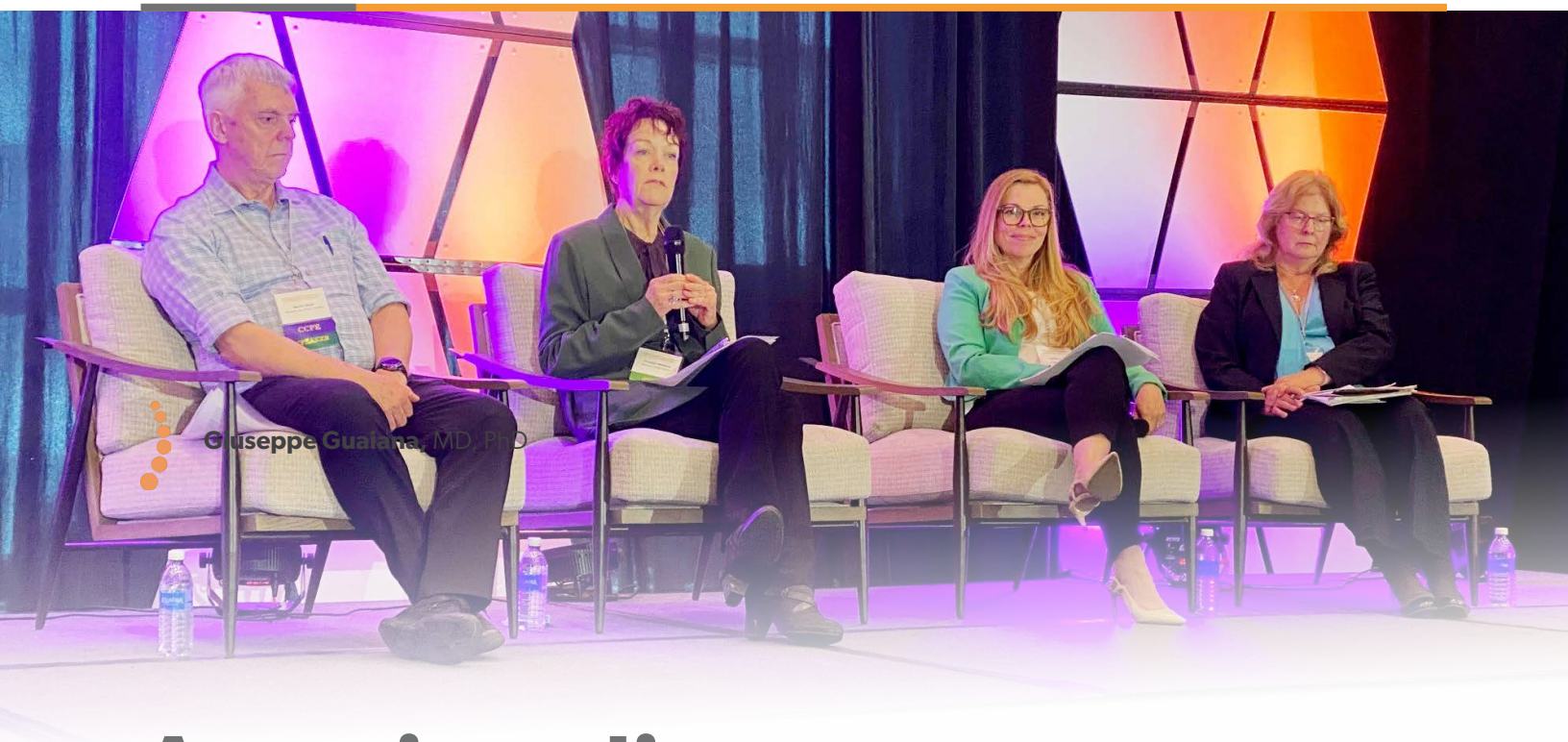

Averting disaster: before "disruptive' becomes the destination

A panel discussion at the 2026 Canadian Conference on Physician Leadership examined the growing problem of physicians being labeled "disruptive" within Canadian health care organizations and explored how leadership cultures, organizational structures, and physician wellness intersect in these situations. The discussion brought together physician leaders, wellness experts, and a former medical regulator to consider how health care systems can better support physicians who advocate change while avoiding punitive or stigmatizing responses.

The session was introduced and moderated by Dr. Martin Wale, a physician coach and consultant who has spent several years conducting external reviews and supporting physicians in conflict situations. Drawing from his work, Wale described a recurring pattern among mid-career physicians

who are clinically competent, deeply committed to patient care, and yet increasingly unable to continue practising in their current environments. Many, he argued, work in small or under-resourced services with limited mentorship, inadequate institutional support, and significant professional isolation. When they attempt to advocate increased resources or organizational improvements, they often become labeled as "disruptive," a designation that can rapidly marginalize them within their institutions.

Wale emphasized that these physicians frequently experience profound loss of agency, belonging, and professional identity. Once the disruptive label becomes attached, physicians may find themselves excluded from collegial relationships, subjected to formal processes, or pushed toward leaving practice entirely. He argued that this represents both a human and systemic failure, particularly given the value and expertise these physicians still possess.

Dr. Dorothy (Sam) Williams, a physician leader in internal and geriatric medicine, argued that the term disruptive itself is often problematic because it oversimplifies complex situations and prevents meaningful inquiry into underlying causes. She emphasized that many organizations engage in insufficient fact-finding before applying such labels, thereby undermining opportunities for learning and improvement. Williams advocated respectful workplace cultures grounded in kindness, transparency, and servant leadership, where physician voices and clinical expertise are genuinely valued in decision-making processes.

Dr. Jodi Ploquin, director of physician wellness and professionalism for the Medical Society of Prince Edward Island, highlighted the distinction between destructive behaviour and constructive advocacy. She noted that physician organizations increasingly recognize that some physicians labeled as disruptive are, in fact, appropriately advocating patient care improvements in strained systems. Ploquin referenced recent position statements acknowledging that physicians who raise concerns may experience silencing, gaslighting, or retaliatory labeling. She stressed the importance of equipping physicians with advocacy, negotiation, and conflict-resolution skills while also supporting physician wellness and nervous system regulation to prevent advocacy from becoming driven by exhaustion and burnout.

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Dr. Karen Shaw, a former physician regulator from Saskatchewan, suggested replacing the term "disruptive physician" with "distressed physician." She argued that many problematic behaviours arise from the interaction among personal vulnerabilities, organizational stressors, and systemic pressures. Shaw emphasized that regulatory systems have gradually shifted from punitive disciplinary approaches toward remediation and support, particularly when behaviours are linked to distress rather than malicious intent. She also highlighted the importance of robust physician health programs and clearer professional conduct guidance.

Audience participation expanded the discussion to include medical trainees and senior physician leaders. Several participants defended "positive disruption" as essential for health care improvement, while others described the emotional toll of advocating within hierarchical and often bureaucratic systems. Panelists repeatedly emphasized the importance of mentorship, relationship-building, governance literacy, and psychological safety for physicians seeking to drive change.

A recurring theme throughout the discussion was that health care systems often fail to distinguish between physicians who create disorder and those who challenge dysfunctional systems constructively. The panel ultimately argued that compassionate leadership, early intervention, restorative approaches, and supportive organizational cultures are critical to preserving physician well-being and ensuring that advocacy for patients and system improvement is not mistaken for unprofessionalism.

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