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IN THIS ISSUE

2026 Canadian Conference on Physician Leadership proceedings

Same but different: new options that are not significantly different can be cost-effective

What coaching sounds like in practice

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

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Contents

79 GUEST EDITORIAL

Courage and kindness: leadership for the times we are in
Colleen Galasso

82 CCPL2026: CONFERENCE PROCEEDINGS

- ***Keynote address by Dr. Stephen Swensen -*** People-centred leadership: four acts of kindness that create better work
- ***Keynote address by Drew Dudley -*** The leadership test: six questions that transform people and organizations
- ***Keynote address by Dr. Chika Stacy Oriuwa -*** The innovation blueprint
- ***Keynote address by Dr. Husein Moloo -*** Leadership in a warming world: the courage to act on planetary health
- ***Panel session -*** Averting disaster: before "disruptive" becomes the destination
- ***Concurrent workshops***
- ***2026 Chris Carruthers Excellence in Medical Leadership Award***
- ***2025-26 CCPE recipients***
- ***Conference images***

114 HEALTH ECONOMICS

Same but different: new options that are not significantly different can be cost-effective
Jeffrey S. Hoch, PhD, Carolyn S. Dewa, MPH, PhD

122 COACHING CORNER

What coaching sounds like in practice
Jane Graydon, MBA, MCC, Ellen Tsai, MD, MHSc (Bioethics)

128 VISUAL REFLECTIONS

Jaswant Guzder, MD, FRCP

129 BOOK REVIEW

The Outrage Cure: How overcoming anger and betrayal can transform the way we live, connect and heal
Alika Lafontaine, MD, HarperCollins, 2026
Reviewed by Johny Van Aerde, MD, PhD

Courage and kindness: leadership for the times we are in

Colleen Galasso

As a member of the team that helped plan and deliver the 2026 Canadian Conference on Physician Leadership, I am delighted to have the opportunity to reflect on the insights, conversations, and learning that emerged throughout the event in this issue's editorial.

What does leadership require when uncertainty has become routine, health care systems remain under pressure, and expectations of physician leaders continue to grow?

This question shaped this year's gathering in Montréal, where physician leaders from across Canada and beyond came together to explore the theme Redefining Leadership Through Courage and Kindness.

Throughout the conference, a central message emerged: courage and kindness are not opposing leadership qualities, but complementary strengths that are essential in today's health care environment. Courage allows leaders to navigate uncertainty, advocate change and make difficult decisions, while kindness helps build trust, foster psychological safety, support well-being, and create conditions in which individuals and teams can thrive. Ultimately, leadership is not defined by title or position, but by the everyday choices we make — how we respond to challenges, support one another, and inspire others to move forward. Together, courage and kindness are attitudes that strengthen teams, organizations, and health care systems.

The conference featured four inspiring keynote presentations, a dynamic panel discussion, and 24 interactive workshops focused on translating leadership principles into practice. Participants highlighted the relevance of

the content, the quality of the sessions, and the valuable opportunities for connection and learning with peers.

This issue of the *Canadian Journal of Physician Leadership* brings together the insights and ideas shared throughout the conference, featuring articles from the keynote presentations and panel discussion, as well as workshop abstracts highlighting topics such as physician wellness, mentorship, innovation, quality improvement, organizational change, and health system transformation.

We are also pleased to recognize this year's recipient of the Chris Carruthers Excellence in Medical Leadership Award, Dr. Nicole Boutilier from Halifax, Nova Scotia, as well as our newest cohort of Canadian Certified Physician Executives (CCPEs).

We look forward to welcoming you to Calgary for the 2027 Canadian Conference on Physician Leadership, taking place May 21–22, with pre-conference courses on May 20.

In addition to the conference proceedings, this issue also features another article in our Health Economics series, which explores how considering costs and benefits together can support more informed health care decision-making; the latest instalment of Coaching Corner, which uses a fictional dialogue to illustrate how coaching can help physician leaders move from overwhelmed toward clarity, prioritization, and intentional action; and a review of *The Outrage Cure: How Overcoming Anger and Betrayal Can Transform the Way We Live, Connect and Heal,* in which Dr. Alika Lafontaine explores the origins of anger and outrage and the role of empathy, authentic connection, and constructive problem-solving in helping individuals and organizations navigate conflict and create meaningful change. We are also pleased to introduce Visual Reflections, a new section of the journal that invites physicians to share original artwork.

As we continue to grow the journal's reach and impact, we are expanding efforts to connect its content with broader physician audiences. In addition to sharing each issue through our social media channels, we are strengthening connections through academic institutions, professional networks, and physician leadership communities across the country. We are encouraged by initiatives, such as the recent inclusion of the journal on McGill University's Faculty Life website, and look forward to building additional partnerships that will help bring the ideas, research, and experiences featured in these pages to an even wider audience.

Looking ahead, we are pleased to announce plans for a special themed issue focused on co-leadership that will be published in December.

Input on *CJPL*'s content, process, style, and format is always welcome and can be sent to Editor-in-Chief Abraham (Rami) Rudnick or to any of the *CJPL* team members.

We hope the ideas and insights shared in these pages will inspire you in your own leadership journey.

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SPECIAL-THEMED ISSUE - CO-LEADERSHIP - DECEMBER 2026

We invite our readership to share their experiences, lessons learned, and innovative practices through co-authored submissions that explore the opportunities and impact of co-leadership in health care.

Physician leaders and their administrative leadership partners are invited to submit articles for this special issue to Deirdre McKennirey at **deirdre@physicianleaders.ca** by **November 1, 2026.**

People-centred leadership: four acts of kindness that create better work

Giuseppe Guaiana, MD, PhD

In his keynote talk focused on physician leadership and organizational culture, Dr. Stephen Swensen presented a compelling argument for "people-centred kind leadership" as a foundational strategy for improving health care systems, staff well-being, and patient outcomes. Drawing from research, international examples, and personal anecdotes, the talk emphasized that kindness, agency, belonging, and positive organizational culture are not superficial ideals, but evidence-based determinants of organizational effectiveness and human flourishing.

Swensen began with a story about a health care executive whose son underwent a kidney transplant in one of her own hospitals. Although the procedure was clinically successful, she concluded that "there was no love in the system." This observation became the basis for a broader critique of contemporary health care culture. Swensen argued that health care has drifted away from compassion, camaraderie, and meaningful human connection, contributing to rising rates of burnout, loneliness, anxiety, and disengagement among both clinicians and patients. He stressed that healing environments require not only technical competence, but also kindness, respect, and emotionally healthy teams.

Drawing on organizational research, epidemiology, psychology, and health care experience, Swensen structured his presentation around five interconnected dimensions of well-being and leadership: agency ("I choose"), mattering ("I matter"), belonging ("I belong"), compassion ("I care about people"), and optimism ("I choose positive"). He presented these dimensions not as abstract ideals, but as evidence-based determinants of organizational performance, staff well-being, and patient outcomes.

The first dimension, agency, focused on autonomy and control over work. Swensen reviewed evidence showing that individuals with greater workplace agency experience lower burnout, better health outcomes, and greater professional fulfillment. He highlighted examples, such as the Dutch home-care model Buurtzorg, in which self-managed nursing teams operate with minimal hierarchy, and Mayo Clinic leadership structures emphasizing shared governance and physician leadership. He also described the "listen-sort-empower" approach, in which leaders identify operational frustrations or "pebbles in the shoe" by listening directly to frontline staff and empowering them to solve local problems.

The second dimension, mattering, explored meaning and purpose in professional life. Swensen emphasized that individuals perform better and remain healthier when they understand why their work matters. He described a Mayo Clinic sterilization team whose work area displayed the statement, "This is why people are alive," reflecting their understanding that patient outcomes depended on their unseen contributions. He also reviewed research showing that physicians who spend at least 20% of their professional time engaged in personally meaningful work experience substantially lower burnout rates.

Belonging, the third dimension, focused on social connection and community. Swensen reviewed evidence from social epidemiology, including studies of the Italian–American community of Roseto, Pennsylvania, where strong communal bonds were associated with lower cardiovascular disease and increased longevity. He emphasized the importance of mentorship, collegiality, shared meals, and intentional workplace communities in health care organizations. He described Mayo Clinic initiatives involving interdisciplinary "houses" and shared meal programs that improved morale, social connectedness, and professional satisfaction.

The fourth dimension, compassion, addressed kindness toward both others and oneself. Swensen argued that kindness improves not only

He emphasized the importance of **mentorship, collegiality, shared meals, and intentional workplace communities** in health care organizations.

psychological well-being but also physiological health. He discussed leadership behaviours associated with effective organizational cultures, including listening, appreciation, mentorship, inclusion, and transparent communication. He also emphasized physician self-compassion, noting that health care professionals frequently demonstrate harsher self-judgement and poorer self-care than workers in many other professions.

Finally, under optimism, Swensen examined the role of positive affect, resilience, and hopeful leadership. He reviewed evidence linking optimism to increased longevity, improved well-being, and stronger organizational cultures. Referencing Viktor Frankl and Nelson Mandela, he argued that individuals retain the ability to choose constructive attitudes even under difficult circumstances.

Swensen concluded that health care leaders must intentionally cultivate cultures grounded in trust, kindness, agency, and human connection if health care systems are to remain sustainable for both patients and professionals.

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The leadership test: six questions that transform people and organizations

Giuseppe Guaiana, MD, PhD

In his keynote address on leadership and organizational culture, leadership educator Drew Dudley challenged conventional assumptions about leadership and argued that it should be understood less as formal authority or status and more as consistent everyday behaviour rooted in values, courage, and interpersonal impact. Dudley suggested that many highly accomplished professionals fail to recognize themselves as leaders because society traditionally presents leadership through examples of extraordinary public figures rather than ordinary individuals whose actions positively influence others.

According to Dudley, this misunderstanding causes people to overlook meaningful opportunities for leadership within workplaces, organizations, and communities. In an era characterized by declining institutional trust, he argued that leadership is increasingly demonstrated not through titles or rhetoric, but through observable behaviours that reduce fear, increase safety, and improve the experiences of others. Leadership, in his view, is fundamentally relational and expressed through consistent daily actions.

Central to the presentation was the concept of a "personal leadership philosophy," defined as the principle individuals use when making difficult

decisions between competing options. Dudley cited research showing that leaders who can clearly articulate such a philosophy are perceived by those they lead as substantially more effective and trustworthy. Dudley's own philosophy, "What would the person I want to be do?" became the foundation for a broader discussion about aligning behaviour with personal values.

Dudley then introduced his "leadership test," a behavioural framework originally developed through a university-based social experiment. Students were first asked to identify a core value they wanted reflected consistently in their daily behaviour. Rather than selecting values such as honesty or integrity, the students chose "impact," defining it as "creating moments that cause people to feel better off for having had an interaction with you."

Rather than selecting values such as honesty or integrity, the students chose "impact," defining it as "**creating moments that cause people to feel better off for having had an interaction with you**."

Drawing on behavioural psychology concepts, including the Zeigarnik effect and the question-behaviour effect, Dudley argued that values become more actionable when translated into recurring daily questions. Unanswered questions, he explained, remain cognitively active and, therefore, shape attention and behaviour more effectively than abstract intentions alone.

The leadership test evolved into six daily questions designed to operationalize leadership behaviour:

1. **Impact:** "What have I done today to recognize someone else's leadership?"
2. **Empathy:** "What thread did I pull on today?"
3. **Courage and innovation:** "What did I try today that might not work, but I tried it anyway?"
4. **Growth and service:** "When did I move someone else closer to a goal today?"
5. **Fairness and equity:** "How did I ensure I wasn't cruel today?"
6. **Self-respect and self-care:** "What have I done today to be good to myself?"

Dudley argued that these questions transform leadership from an abstract concept into a repeatable daily practice. Rather than reflecting on values retrospectively, the framework encourages individuals to make intentional values-based decisions throughout the day.

One of the address's most memorable moments involved Dudley recounting what has become known as the "lollipop moment." He described how a former student approached him years after university to explain that a brief interaction during orientation had profoundly altered the course of her life. Overwhelmed and preparing to leave university on her first day, she encountered Dudley handing out lollipops and encouraging another student to introduce himself to her. The interaction interrupted her decision to leave, helped her remain at university, and contributed to a long-term relationship with the student involved. Dudley emphasized that he had no memory of the interaction, illustrating his central argument that leadership often occurs through ordinary interpersonal moments whose significance may remain invisible to the person creating them.

Throughout the presentation, Dudley distinguished between courage and confidence, arguing that courage involves acting despite fear rather than in the absence of it. He also addressed burnout, imposter syndrome, and self-compassion, emphasizing that leadership requires recognizing personal limits and practising self-respect rather than self-sacrifice alone.

Dudley concluded by encouraging physicians to recognize leadership within their daily interactions and routines. Leadership, he argued, is "not in the big stuff, but in the consistent stuff"; repeated ordinary acts grounded in empathy, courage, fairness, and compassion ultimately shape organizational culture more powerfully than isolated heroic actions.

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The innovation blueprint

Giuseppe Guaiana, MD, PhD

In her keynote address, Dr. Chika Stacy Oriuwa explored the relations among innovation, leadership, neuroscience, and human connection, arguing that meaningful innovation begins not with technology itself, but with the ability to recognize "invisible strings" connecting ideas, people, and possibilities. Blending personal storytelling, neuroscience, poetry, psychiatry, and leadership theory, Oriuwa presented what she described as an "innovation blueprint" for cultivating curiosity, creativity, critical thinking, compassion, and psychological safety within health care organizations.

Oriuwa began with reflections on her mother, a personal support worker whose acts of care shaped her understanding of unseen human connections. She linked these early experiences to both her lifelong love of poetry and her current work as a psychiatry resident, in which identifying patterns and hidden relations forms part of clinical diagnosis. She argued that innovation similarly depends on the ability to recognize unseen connections across disciplines, experiences, and perspectives.

Central to the talk was the "innovation blueprint," a three-part framework. First, individuals must prime their own minds for innovation by strengthening neural networks associated with curiosity, creativity, and critical thinking. Second, leaders must ignite innovation in others through authenticity and compassion. Third, organizations must harmonize

collective innovation by creating psychologically safe environments where individuals feel comfortable collaborating and taking intelligent risks.

Drawing on neuroscience, Oriuwa described the interaction between the brain's "discovery domain" (the default mode network associated with curiosity, imagination, and reflection) and the "decision domain" (the executive control network associated with focus, analysis, and critical thinking). Highly creative individuals, she explained, demonstrate strong functional connectivity between these systems, enabling them to both generate broad ideas and execute them effectively. Curiosity, novelty, and daydreaming were presented as mechanisms that strengthen innovative thinking.

At the same time, Oriuwa emphasized that fear suppresses innovation. Using the example of a physician presenting before a highly critical panel of executives, she described how stress and fear activate the amygdala and increase cortisol level, impairing critical thinking, creativity, and cognitive flexibility. In contrast, psychologically safe environments characterized by trust and encouragement increase oxytocin and allow individuals to remain cognitively agile under pressure. She argued that physician leaders must, therefore, create cultures where trust triumphs over fear and where learners feel safe asking questions, making mistakes, and thinking creatively.

Oriuwa illustrated these principles through both organizational and personal examples. She described how Fujifilm survived the collapse of the film photography industry by becoming "boldly curious" and identifying new applications for its proprietary technologies in cosmetics, pharmaceuticals, and medical imaging. This transformation, she argued, depended on interdisciplinary collaboration, risk-taking, intellectual humility, and the willingness to connect seemingly unrelated ideas.

She then paralleled this organizational story with a personal anecdote involving her young son's broken toy train set. Rather than responding to the child's distress with criticism or immediate problem-solving, Oriuwa first approached him with empathy, emotional validation, and physical reassurance. Only once emotional safety was restored could curiosity, creativity, and collaborative problem-solving emerge. For Oriuwa, the lesson extended directly to leadership: innovation and learning flourish only when individuals feel psychologically safe and emotionally supported.

"This transformation, she argued, depended on **interdisciplinary collaboration**, risk-taking, intellectual humility, and the willingness to connect seemingly unrelated ideas."

Throughout the keynote address, Oriuwa repeatedly emphasized the importance of authenticity and vulnerability in leadership. She recounted a pivotal medical school interview during which she was unexpectedly asked to perform her own poetry exploring her experiences as a Black woman. Choosing authenticity despite uncertainty, she performed the poem and was subsequently admitted to medical school. She later reflected that this willingness to bring her "full humanity" into professional spaces became foundational to her identity as both physician and leader.

Question-and-answer discussions following the address expanded on themes of racial trauma in psychiatry, physician motherhood, identity, and inclusion within medical training. Oriuwa argued that medicine must better support trainees with intersecting identities and recognize that personal experiences, including parenting and lived experience of marginalization, can strengthen rather than weaken leadership capacity.

Oriuwa concluded by encouraging physicians to embrace curiosity, compassion, intellectual humility, and authentic human connection. Innovation, she argued, is ultimately not only about systems or technology, but about creating environments where people feel safe enough to imagine, collaborate, and "do hard things" together.

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Leadership in a warming world: the courage to act on planetary health

Giuseppe Guaiana, MD, PhD

In his keynote address on planetary health and physician leadership, colorectal surgeon Dr. Husein Moloo argued that health care leaders can no longer separate human health from environmental sustainability. Moloo framed planetary health as both an ethical responsibility and a practical leadership challenge, emphasizing that health care organizations must recognize the ecological determinants of health alongside the social determinants traditionally emphasized in medicine.

Moloo defined planetary health as the understanding that human well-being depends fundamentally on clean air, clean water, healthy soil, safe food systems, and ecological stability. He also stressed the importance of intergenerational responsibility, drawing on Indigenous teachings encouraging societies to think "seven generations ahead" and consider what kind of ancestors current leaders will become. Throughout the presentation, he repeatedly emphasized that climate change, biodiversity loss, and pollution together represent a "triple crisis" directly affecting both public health and health care delivery.

Using examples ranging from Canadian wildfires and severe storms to droughts in Europe and catastrophic flooding in Pakistan, Moloo illustrated how environmental instability is increasingly shaping lived experience globally. He then engaged the audience directly through an interactive word-cloud exercise asking participants how climate change made them feel. Responses such as "anxious," "worried," "hopeless," and "terrified"

mirrored similar exercises he had conducted with health care workers, students, and community groups. Moloo interpreted these reactions as manifestations of "eco-anxiety," particularly among younger generations increasingly fearful about the future.

A central theme of this keynote address was that health care itself contributes substantially to environmental degradation. Moloo noted that if health care systems were considered a country, they would rank among the world's largest carbon emitters, with Canada ranking fifth globally for health care-related emissions both overall and per capita. He emphasized that climate change affects nearly every organ system and intersects with respiratory disease, cardiovascular disease, infectious disease, mental health, and health inequities disproportionately affecting vulnerable populations.

Moloo argued that health care organizations whose missions focus on improving health can no longer ignore planetary health. In one of the presentation's strongest statements, he asserted that if planetary health is absent from a health care organization's mission and strategic planning, then "your vision and mission [are] irrelevant." He stressed that planetary health need not replace traditional health care priorities but must become integrated into leadership, governance, and organizational decision-making.

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Much of the presentation focused on practical examples of sustainability initiatives developed within health care settings. Moloo described how small quality improvement projects at The Ottawa Hospital evolved into broader organizational change. One initiative involved transitioning surgical services from paper faxing to electronic faxing, substantially reducing paper consumption across the institution. Another project, initiated by a medical student, examined replacing disposable surgical gowns with reusable cloth gowns. The initiative demonstrated no increase in infection rates while reducing costs by approximately $150 000 annually, ultimately leading to hospital-wide implementation. Moloo also described his team's work challenging the routine use of sterile water during colonoscopy procedures despite the inherently non-sterile environment of the colon. After reviewing evidence and consulting infection control leadership, the team safely transitioned to non-sterile water without increased complications, reducing unnecessary resource use and costs. He emphasized that sustainable health care practices frequently align with financial stewardship and operational efficiency.

Beyond operational change, Moloo repeatedly returned to themes of reciprocity, courage, and kindness. Referencing Indigenous teachings, he encouraged health care leaders to reconsider humanity's relationship with the natural world. He argued that viewing nature merely as a resource for exploitation contributes to environmental degradation, whereas recognizing interconnectedness fosters more responsible decision-making.

The address also highlighted the importance of leadership structures in driving change. Moloo described the creation of planetary health leadership positions within faculties of medicine, incorporation of planetary health into strategic plans at The Ottawa Hospital, and the integration of planetary health competencies into the CanMEDS framework. He emphasized that institutional governance signals legitimacy and creates permission for innovation and engagement among staff and learners.

Moloo concluded by encouraging health care leaders to embrace courageous conversations about sustainability within their organizations. Leadership, he argued, involves empowering learners, listening to innovative ideas, and recognizing that meaningful change often begins through small practical actions. He framed planetary health, not as a peripheral issue, but as a central leadership responsibility for modern health care systems.

Question-and-answer discussions further explored practical leadership challenges associated with sustainability initiatives. Responding to questions about institutional resistance, Moloo emphasized the importance of relationship-building, evidence-based dialogue, and identifying decision-makers capable of enabling organizational change. He also addressed strategies for engaging colleagues resistant to climate action, arguing that most health care professionals wish to contribute positively once concrete opportunities are available. A final discussion concerning the environmental impact of artificial intelligence highlighted the complexity of balancing technological innovation with sustainability goals, with Moloo acknowledging both the importance of the issue and the uncertainty surrounding future solutions.

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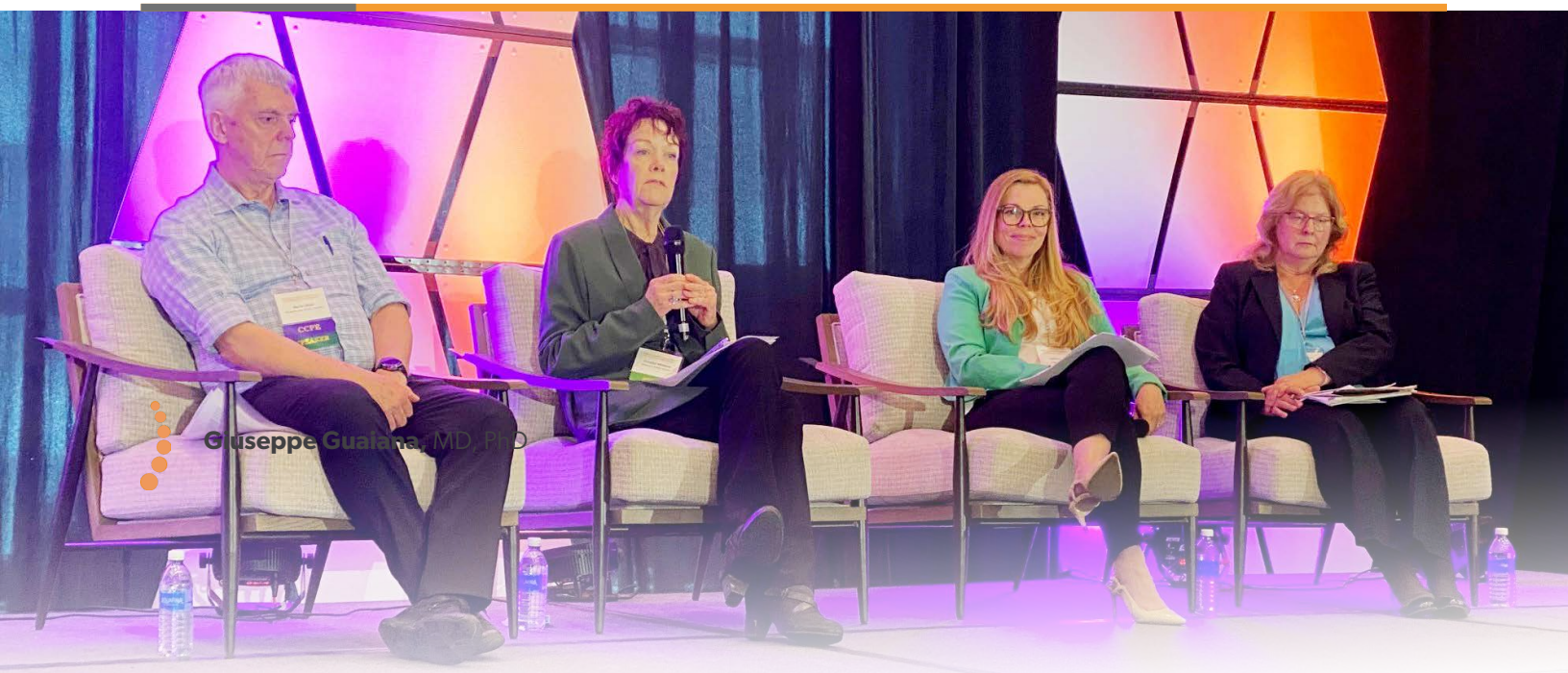

Averting disaster: before "disruptive' becomes the destination

Giuseppe Guaiana, MD, PhD

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.

"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."

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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Concurrent workshops

Colleen Galasso

The 2026 Canadian Conference on Physician Leadership featured 24 interactive 90-minute workshops offered at various levels: introductory, intermediate, and suitable for all participants. Please note that the descriptions have been condensed for the purposes of the journal. To view full, detailed descriptions, see the conference website:
Program – Day 1, Program – Day 2

Rooted in trust: values, character, and belonging

Lyn K. Sonnenberg, MSc, MD, MEd, FRCPC, EMBA; Victor Do, MD, FRCPC, MSc; Jerry Maniate, MD, MEd, EMBA, FRCPC, FACP, CCPE, CPC(HC)

Trust is a foundational element of effective and equitable health systems leadership; yet, it is often assumed rather than intentionally cultivated. This interactive workshop explored how trust, mistrust, and distrust shape learning environments, team dynamics, and systemic equity by examining their relation to organizational culture and identifying pathways to accountability through character-aligned leadership. Using practical frameworks such as the Trust Triangle, mutually accountable spaces, psychological safety, and Brené Brown's "rumble" concept, participants analyzed real-world cases involving admissions, assessment, and belonging, and explored strategies for co-creating and evaluating trust and belonging initiatives focused on equity and well-being.

Turning tension into triumph: leveraging conflict as opportunity

Kevin Wasko, MA, MD, CCFP(EM), CCPE; Constance LeBlanc, MD, CCFP(EM), MAEd, MBA, CCIP

Conflict in the workplace is often viewed negatively; yet, it can be an opportunity for growth when addressed through collaboration and kindness. This workshop explored the importance of addressing conflict

early and its impact on both health care worker well-being and patient care. Using evidence-based approaches, such as the Thomas-Kilmann model and the LeBlanc-Wasko approach, participants examined strategies to manage conflict constructively. Through case examples and "improv prototyping," they practised responding to real-life conflict situations and identified approaches to strengthening teams and improving quality of care.

Beyond blame: cultivating compassion in the face of medico-legal challenges

Keleigh James, MMEd, MD, CCFP, FCFP; Catherine Pound, MSc, MPH, MD, FRCPC; Katherine Baldwin, MD, FRCPC, ACC

Medico-legal complaints, adverse events, and legal proceedings can trigger shame, fear, and isolation for physicians — feelings that impair judgement, strain relationships, and contribute to burnout. This workshop, led by physicians from the Canadian Medical Protective Association, explored how compassion and self-compassion can support physicians in understanding and navigating these experiences. Through evidence-informed teaching, reflection, and discussion, participants examined compassion as a core competency that strengthens psychological safety and supports sound clinical and leadership decision-making, while building skills to respond to medico-legal distress with greater awareness, resilience, and supportive leadership.

Improvising change: building courage and kindness in the unscripted world

Roetka Gradstein, MD, MA; Laura MacLellan, BA, CPHR, CPCC

This highly interactive workshop used theatre-based improvisation to help physician leaders strengthen presence, adaptability, and empathy in fast-paced clinical environments. In guided improv exercises, participants practised responding to verbal and emotional cues, embracing uncertainty, and valuing others' contributions in unscripted scenarios — skills essential for leadership in complex health care systems. A debrief explored how improv principles, such as authentic response, shared problem-solving, and comfort with imperfection, can enhance psychological safety, team connection, and leadership effectiveness. Participants developed practical strategies to apply improv-informed approaches in their leadership practice.

Indoor air quality and health: an urgent call for action

Diane de Camps Meschino, BSc(Hon), MD, FRCPC; Ming-Ka Chan, MD, MHPE, FRCPC; Tasleem Nimjee, MD, MBA, CCFP (EM), CFPC, MSc

Indoor air quality (IAQ) is a critical yet often overlooked determinant of health, as people spend up to 90% of their time indoors. This workshop built leadership capacity to address IAQ challenges in health care by integrating planetary health and equity into decision-making, strengthening collaboration and communication skills, and enhancing preparedness for changes in climate and air quality. Participants explored how poor indoor air quality impacts health — particularly for vulnerable populations — and examined evidence-informed, equity-focused strategies to improve communication, empower patients and families, and co-create solutions that strengthen system resilience.

Elevating women in medicine: advancing equity and leadership for women physicians

Jasmine Gandhi, MD, FRCPC; Krista Hind; Kailey Richards; Camille Munro, MD, CCFP (PC); Susan Peddle, MD, FRCPC

This interactive workshop supported health care leaders in advancing women physicians by addressing systemic barriers and promoting inclusive leadership practices. Drawing on The Ottawa Hospital's Women Physician Leadership Committee guide, participants explored strategies to strengthen leadership identity, implement equitable policies, and build supportive organizational cultures. They examined approaches, such as flexible work arrangements, mentorship and sponsorship, allyship training, inclusive recruitment, and compensation practices. Participants identified barriers to advancement, considered the role of supportive policies in career sustainability and developed strategies to foster mentorship, sponsorship, and inclusive leadership.

Reclaiming the narrative: using social media to rebuild trust

Shazma Mithani, MD, FRCPC

In an era where misinformation spreads rapidly, health care leaders have a responsibility to serve as trusted voices online. This interactive workshop provided practical guidance on building a credible social media presence,

creating evidence-based content, and navigating digital spaces with confidence and professionalism. Participants explored how health care messaging influences public trust, identified characteristics of credible online content, and applied strategies to engage online communities while maintaining professionalism and resilience in the face of misinformation.

Healing conversations in health care: a CMPA workshop on disclosure and apology

Heather Murray, MD, MSc, FRCPC; Evelyn Constantin, MD

Recent estimates indicate that 1 in 17 patient admissions to Canadian hospitals involves at least one adverse event, with significant impacts on patients, families, and care teams. This workshop provided practical medico-legal guidance grounded in Canadian apology legislation, along with case examples and opportunities for practice. Participants explored how to conduct disclosure conversations with confidence and compassion, explained the protections offered through apology legislation, applied a structured framework to patient safety and medical error scenarios, and practised effective disclosure skills with patients and families.

When helping hurts: reframing supportive leadership

Curtis Johnston, MD, FRCPC, CCPE; Nadia Salvaterra, MD, CCFP, CCPE

In the pursuit of compassionate leadership, physician leaders may unintentionally "help" in ways that hinder growth, autonomy, and resilience in their teams. This workshop explored how well-intentioned behaviours — such as rescuing others, avoiding difficult conversations, or over-functioning — can erode trust, limit learning, and undermine psychological safety. Drawing on the LEADS in a Caring Environment framework, participants examined leadership habits that may disempower teams and developed strategies to strengthen coaching, delegation, and boundary-setting with clarity, kindness, and courage. They identified behaviours that limit team autonomy, reflected on personal leadership assumptions, and integrated inclusive practices that support equity, diversity, inclusion, accessibility, and psychological safety across teams.

Leading digital wellness with compassion: empower teams, ease the tech burden

Chandi Chandrasena, MD, CCFP, FCFP; Emily Wu, BSc

We talk a lot about digital transformation, but less about how it feels to work in systems that can be more demanding than supportive. Digital overload is a growing contributor to clinician burnout and compassion fatigue. This workshop introduced the five Bs of digital wellness — bucket filling, building capacity, breaks, boundaries, and balance — as a practical framework to help leaders identify pain points, reduce administrative burden, and foster healthier digital environments. Participants explored challenges in their own settings and developed practical strategies to improve both efficiency and well-being, while identifying how digital environments contribute to burnout and proposing compassionate leadership approaches to strengthen connection in digital practice.

Patient flow: tackling the challenging issues

Warren Ma, MD, MBA, FRCPC; Kirstie McLelland, MD, FRCPC

This interactive workshop explored how the Edmonton Zone Integrated Operations Centre applied Michael Porter's Value-Based Healthcare framework to achieve measurable system improvements, including reduced EMS offload times, fewer red alert events, and significant cost avoidance without compromising patient safety. Participants examined how courageous and kind leadership enables real-time system redesign while fostering trust, collaboration, and psychological safety across teams. They explored practical tools, such as the STEP framework and shared dashboards, and considered how these approaches could be adapted to improve flow, value, and system-wide coordination in their own health care systems.

Courageous and kind mentorship: building leadership capacity across the career continuum

Henry Annan, MD, MPP, FRCPC; Victor Do, MD, FRCPC, MSc

Redefining leadership through courage and kindness begins with how we show up for one another, and mentorship is a key expression of physician leadership. This workshop explored mentorship as a practice of courageous and kind leadership, focusing on how mentoring relationships

can empower, challenge, and support individuals across career stages. Participants examined strategies for navigating challenges, such as power dynamics and emotional labour, and developed practical tools to build and sustain meaningful mentorship relationships. They identified key attributes of effective mentorship, developed strategies for selecting mentors or mentees aligned with their goals, and demonstrated behaviours that foster inclusive, psychologically safe, and values-driven mentorship cultures.

Listening to the next generation: learners leading planetary health QI in health care

Emma McDermott, MD, BSc, MGA, MD, PGY3; Casey Cohen, BSc, PhD, MDCM candidate

Environmental sustainability is increasingly recognized as a core component of physician leadership, with direct links to population health, health care delivery, and professional ethics. This learner-led workshop explored strategies to reduce health care's environmental footprint and strengthen intergenerational collaboration to support sustainable system change. Participants reviewed examples of planetary health quality improvement (QI) projects and discussed practical approaches to embedding sustainability into clinical and operational settings. They examined opportunities to design learner-led QI initiatives, engage trainees in sustainability efforts, and apply evaluation methods to support ongoing improvement and lasting institutional change.

Civility and kindness: foundations of a healthy medical culture

Mamta Gautam, MD, MBA, FRCPC, CCPE, CPE

Civility and kindness are increasingly recognized as essential dimensions of effective medical leadership, reflecting respectful conduct under pressure and leadership grounded in empathy, inclusion, and integrity. This workshop explored how kindness-based leadership can strengthen psychological safety, workforce retention, equity-oriented care, and organizational resilience by embedding respect and compassion as core competencies. Through case discussion and reflection, participants examined how civility and kindness support courageous leadership and team effectiveness. They defined these constructs, considered their relation to psychological safety and system priorities, and applied evidence-informed strategies to foster cultures of respect, inclusion, and compassion in health care settings.

From quality improvement to strategic leadership: embedding physician quality leaders

Marshall Cheng, MD; Dave Williams, MD; Erica Phelps, MD, FRCSC; Rebecca Adams, MD; Angela Tecson, BScN

Health-system transformation requires leadership grounded in clinical insight, data, and collaboration. The Fraser Health Authority's Physician Quality Leader (PQL) program develops physicians from QI trainees into embedded system leaders who drive quality, innovation, and redesign across the organization. Integrated within governance structures, PQLs co-lead initiatives in patient safety, accreditation, and system improvement, strengthening engagement and continuous learning. This workshop examined the structure, impact, and adaptability of the PQL model. Participants explored how physicians transition into system leaders, identified enabling governance and funding structures, and considered how the model can strengthen leadership, collaboration, and safety culture.

LEADing for well-being: applying the LEADS framework and the Okanagan Charter to support high-performing teams

Constance LeBlanc, MD, CCFP(EM), MAEd, MBA, CCIP; Victor Do, MD, FRCPC, MSc

Physician well-being is a leadership imperative, with direct links to patient outcomes, safety, and system performance; yet, it requires intentional, values-based leadership to be sustained. This interactive workshop framed well-being as a core leadership competency grounded in the LEADS in a Caring Environment framework and the Okanagan Charter, emphasizing the interconnected well-being of individuals, teams, and organizations. Participants explored how leadership behaviours influence well-being, identified actions that support or undermine it, and applied the TRIZ method to surface unhelpful patterns. They developed practical strategies to strengthen physician and team well-being and committed to implementing well-being-promoting leadership actions in their own settings.

Beyond process: the human side of system change

Scott McLeod, MD, MPH, MPA, CCFP, FCFP, CCPE; Dawn Hartfield, MD, MPH

Organizational change is one of the most complex challenges facing senior health system leaders. This workshop explored a three-year transformation addressing a substantial backlog of complaints, highlighting how coordinated leadership, workflow redesign, and transparency support sustained improvement in public trust and patient safety. It emphasized that systems change is fundamentally human change, requiring psychological safety, relational leadership, and shared accountability. Participants examined interpersonal dynamics and courageous conversations that enable transformation, explored strategies to foster continuous improvement alongside civility and wellness, and identified tools and approaches to address barriers and co-design solutions to complex organizational challenges.

Transforming health care through proximity-based leadership

Marc Bilodeau, MD; Nicole Boucher-Larrivière, MSc

This workshop examined the impact of courageous and kind leadership through the Proximity-Based Health Management Model implemented by the Centre intégré de santé et des services sociaux de l'Outaouais. In response to workforce shortages, fragmented partnerships, and access challenges, leaders adopted shared governance, community engagement, and decision-making closer to the point of care. The model demonstrates how proximity-based leadership can strengthen trust, improve care pathways, and foster belonging among health professionals and community partners. Participants explored how courageous and kind leadership addresses system challenges, designed strategies to support psychological safety and inclusion, applied shared governance principles to strengthen workforce sustainability and patient-centred care, and considered the impact of collaboration on outcomes and organizational culture.

Exercising moral courage: physician leaders as stewards of values

Anurag Saxena, MD, MEd, MBA, FRCP, FCAP, CHE, CCPE; Linda Snell, MD, MHPE, FRCPC, MACP

Physician leaders play a pivotal role in shaping health care and medical education, with far-reaching impacts. This interactive workshop explored moral courage — the willingness to act on moral convictions despite fear of consequences — and how leaders can bridge the gap between knowing and doing. Participants examined how to voice their values, strengthen ethical decision-making, and lead responsibly in both calm and crisis situations. They defined moral courage, considered its challenges and impact in decision-making, and identified strategies to strengthen their capacity to act with moral courage in leadership practice.

Code Physician HR: harvesting the real-world outcomes of mentorship for physician leaders

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

Mentorship is a critical yet underdeveloped component of physician leadership. This workshop introduced Code Physician HR, a mentorship model designed to provide "just-in-time" support for leaders navigating complex human resource challenges. Participants explored how structured mentorship strengthens leadership capability, supports professional growth, and contributes to healthier organizational cultures through real-world case discussions and practical coaching. They described the core components of a physician-specific mentorship program, examined key mentor competencies, and applied evidence-informed mentorship models to enhance leadership development in clinical and academic settings.

Brain-based psychological safety leadership

Callie Bland, BSc, BSN, CPCC

Psychological safety is a key predictor of high-performing, innovative teams. This workshop introduced a brain-based approach that extends beyond behavioural definitions to include non-conscious drivers of trust and team dynamics. Participants explored how leaders' own psychological safety affects performance and learned strategies to prevent and recover from psychological harm. They described key drivers of psychological

safety, identified strategies to support their own well-being and recognized how the S.A.F.E.T.Y.™ model can enhance team culture and collaboration.

Seeing clearly in a BANI world: cultivating courage and kindness through awareness

Roetka Gradstein, MD, MA; Laura MacLellan, BA, CPHR, CPCC

In a health care environment defined by brittleness, anxiety, nonlinearity, and incomprehensibility (BANI), leaders are called upon to lead with clarity, courage, and kindness. This workshop introduced Presence-Based Leadership and the Three Panes of Awareness (context, soma, and identity) as tools for shifting from reactive patterns to intentional leadership. Participants explored how awareness supports steadiness in uncertainty and strengthens connection in complex systems. They identified how BANI influences leadership behaviours, applied the Three Panes of Awareness to manage reactive responses and practised using tools to build clarity, purpose, and psychological safety within their teams.

Leading with courage and compassion: a dialogue on physician suicide in the context of the Canadian health care environment

Catherine Pound, MSc, MPH, MD, FRCPC; Gino Somers, BMedSci, MBBS, PhD, FRCPA

This interactive session explored physician suicide through the lens of courageous and compassionate leadership, drawing on evidence from Canada and the United States, including the 2025 National Physician Health Survey and the CMPA Physician Well-Being Index. It highlighted key risk and protective factors, the impact of medico-legal stressors, and available prevention, intervention, and postvention resources such as 9-8-8 and the AMA STEPS Forward Toolkit. Participants reflected on how leadership can foster psychologically safe, resilient medical cultures and examined strategies to mitigate distress while supporting physician well-being.

Schwartz Rounds for medical leaders: courageous conversations that cultivate kindness and connection

Tracey Receveur, BScN

Medical leadership requires composure and decisiveness, while also calling for authenticity, empathy, and connection. This interactive workshop adapted the Schwartz Rounds framework for medical leaders, providing a structured space to share stories of vulnerability, ethical tension, and courage. Participants explored how compassionate storytelling and reflective dialogue can strengthen trust, psychological safety, and connection within leadership teams. They described the purpose and evidence base of Schwartz Rounds, experienced how reflective dialogue fosters connection, recognized trauma-informed facilitation approaches, and explored practical steps to implement Schwartz Rounds in their own organizations.

Author

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Dr. Nicole Boutilier

**Executive Vice President, Medicine and Clinical Operations, Nova Scotia Health*

"She has been a highly respected champion of physician voice, ensuring physicians are true partners in service delivery, policy development, and system transformation."

– Dr. Minoli Amit

"She fosters a culture of collaboration, inclusion and shared purpose, where individuals and teams are empowered to achieve their best."

– Dr. Cheryl Pugh

Dr. Nicole Boutilier is a highly respected physician leader whose career has been defined by her commitment to advancing physician leadership while strengthening health systems across Nova Scotia. As Executive Vice President of Medicine and Clinical Operations at Nova Scotia Health, she played a pivotal role in shaping a more integrated, accountable and high-performing provincial system.

Throughout her career, Dr. Boutilier has held progressive leadership roles at the departmental, regional and provincial levels, contributing significantly to Nova Scotia's transition to a unified health system and helping to guide change across diverse communities and care settings.

Her leadership has led to significant improvements in healthcare delivery, including enhanced physician recruitment and retention, expanded access to care in rural communities and more coordinated, data-informed clinical operations.

In addition to her system-level contributions, Dr. Boutilier is widely recognized for her authentic, inclusive and values-driven leadership style. A dedicated mentor and certified physician coach, she actively supports the growth of physician leaders and fosters environments where physicians feel valued, supported and equipped to lead and contribute.

Respected nationally for her contributions to physician leadership and system transformation, Dr. Boutilier exemplifies integrity, service and excellence. Her lasting impact is reflected both in the strength of the health systems she has helped shape and in the many physician leaders she has inspired and developed.

**At the time of the conference, Dr. Boutilier served as the Executive Vice President of Medicine and Clinical Operations. She has subsequently been appointed President and CEO of Nova Scotia Health.*

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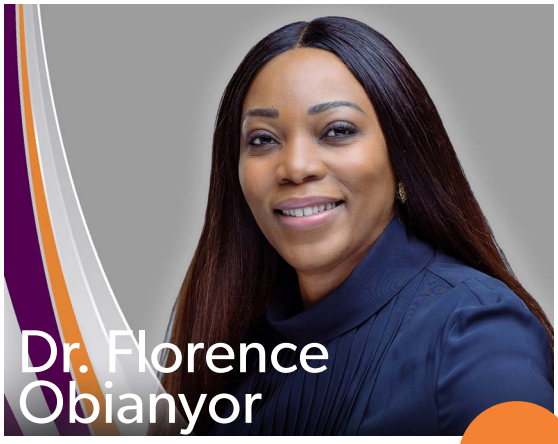

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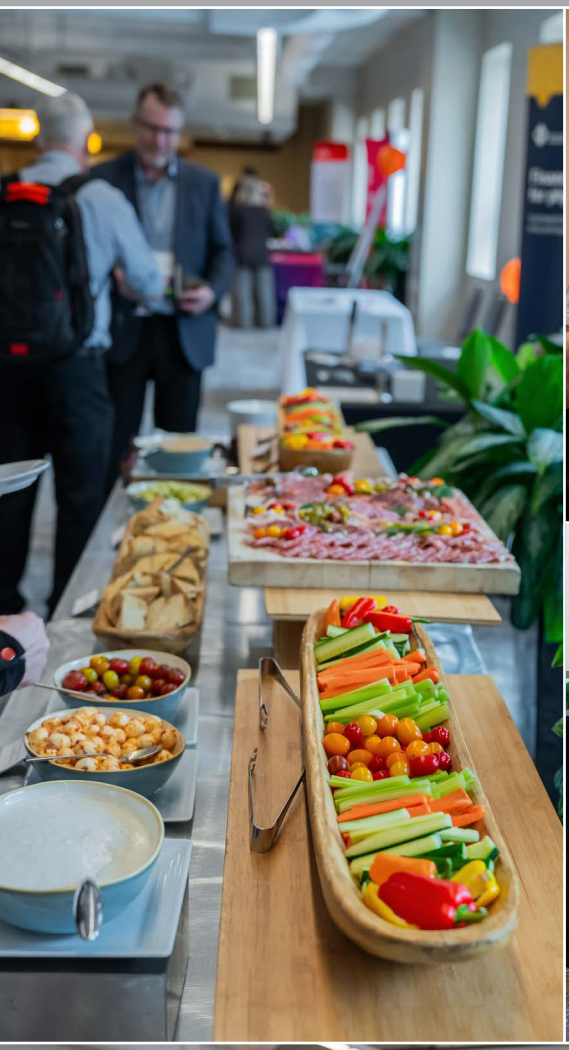

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Same but different: new options that are not significantly different can be cost-effective

Jeffrey S. Hoch, PhD,
Carolyn S. Dewa, MPH, PhD

In this eighth article in the health economics series, we explore the idea that a new treatment can be cost-effective but not significantly different from usual care in terms of costs or outcomes. This situation occurs because a cost-effectiveness analysis considers costs and outcomes simultaneously. In addition, researchers often employ a different statistical approach, using a Bayesian instead of frequentist framework. We provide an example illustrating a new option with non-statistically significant differences in both cost and health outcome with a high probability of cost-effectiveness.

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

Hoch JS, Dewa CS. Same but different: new treatments that are not significantly different can be cost-effective. *Can J Physician Leadersh* 12(2): 114-121. https://doi.org/10.37964/cr24810

It is easy to think of cost-effectiveness analysis (CEA) as a study that tests both cost and effectiveness for statistical significance. Often researchers design clinical trials to detect a statistical difference in the main outcome (e.g., treatment effectiveness), potentially leaving the test of cost differences underpowered. Raftery and colleagues[1] studied the prevalence of "paradoxical conclusions" in "doubly null" trials with non-statistically significant differences in both cost and health outcome. They found that

almost 40% of trials they reviewed had doubly null results and about a third drew economic conclusions in favour of a new option. That is, the new treatment was neither cheaper nor more effective. Yet, researchers concluded it was cost-effective. How could this be?

In this article, we explore conditions under which such a seemingly paradoxical conclusion can arise. Different interpretations of uncertainty (e.g., Bayesian vs. frequentist) explain the important distinction that can help readers appreciate "probability of cost-effectiveness" as opposed to "statistical significance."

Reviewing cost-effectiveness analysis

We briefly review CEA in this section, as previous articles in the health economics series have discussed it in greater detail.[2-7] CEA produces estimates of extra cost (ΔC) and extra health outcome, viewed as extra effect (ΔE). To illustrate the main concepts, we create hypothetical data with descriptive results.

	Average (mean or expected value)	
Type of care	Cost, $	Effect (outcome)
New (n = 10)	1617	81
Usual (n = 12)	2017	76
Difference (95% CI)	−400 (−923, 123)	5 (−2, 11)

Note: CI = confidence interval, n = sample size.

Table 1: Results from a hypothetical study.

Table 1 shows that a new type of care is both cheaper (ΔC = −$400) and more effective (ΔE = 5). However, as the confidence intervals for both ΔC (−923, 123) and ΔE (−2, 11) include 0, neither the cost-saving estimate nor the effectiveness estimate is precise enough to rule out a hypothesis of no difference. The new option may be more costly or less costly; it may be more effective or less effective. This might be expected given that the hypothetical data are based on only 22 people. So, what are we to conclude about a small study showing a promising value proposition? The signal is there but the noise is loud. What tools can be used to make CEA meaningful for decision-makers?

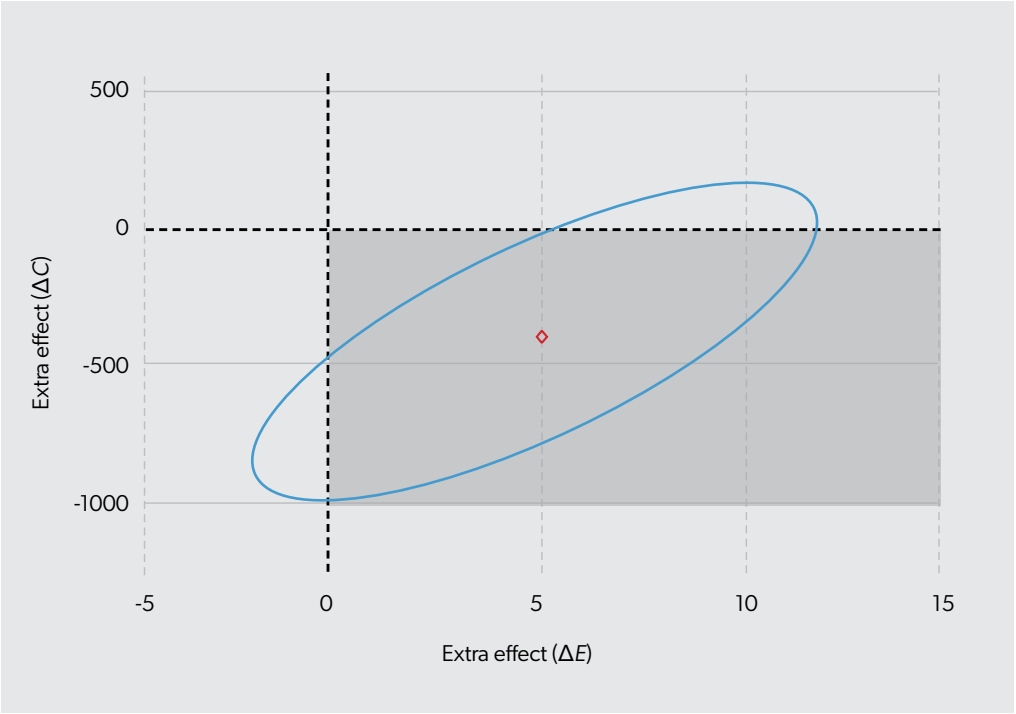

Figure 1: Cost-effectiveness plane showing both an estimate and uncertainty.

Conveying CEA information

Researchers often use two related figures to convey cost-effectiveness conclusions. The first is a cost-effectiveness plane showing both an estimate and uncertainty.

Note: The estimate is shown as ◊, with 95% confidence interval for ΔC and ΔE illustrated by the ellipse. The shaded area shows where there is more effectiveness and less cost.

Using data from Table 1, Figure 1 shows that the estimate (i.e., ◊) for the new option is both cheaper ($\Delta C < 0$) and more effective ($\Delta E > 0$). The exact location of the estimate is at (5, −400), corresponding to the mean results in Table 1. Uncertainty is conveyed by the ellipse, which serves as a 95% confidence interval (CI) for the estimate. Assuming the means are jointly normally distributed with cost and effect correlated implies an ellipse-shaped 95% CI.[8]

Treating cost and effect as two separate outcomes would create a 95% CI shaped like a rectangular box.[9]

The 95% CI ellipse shows it is possible for ΔC or ΔE or both to be zero. In fact, the current evidence shows that the new option may be:

a. cheaper and less effective

b. cheaper and more effective

c. more expensive and more effective

However, the bulk of the ellipse's area is in the "saves money and is more effective" region. This means this is the most likely scenario (with the highest probability). Consequently, analysts should more confidently conclude that the new option is a good deal.

What is a good deal?

For some decision-makers a good deal means saving money (i.e., $\Delta C < 0$); for others, good means better health outcome (i.e., $\Delta E > 0$). Often, leaders must be nuanced in their approach to value and consider when the extra effect is worth the extra cost. Health economists use "cost-effectiveness threshold" to refer to the point where the extra effect is exactly worth the extra cost. Some have speculated that the cost-effectiveness threshold could be a single number or a range.[10-12] Suffice it to say, the person doing the analysis for you does not know the number you want to use for the cost-effectiveness threshold in your context. Consequently, rigorous research provides a wide range of values for your consideration.

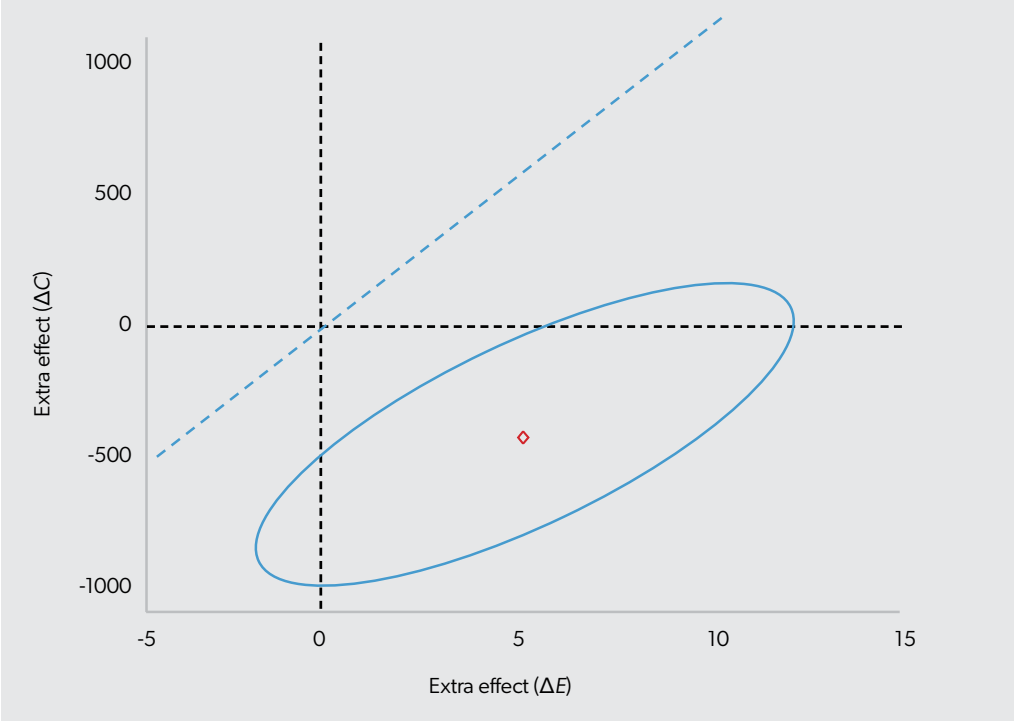

Figure 2: Cost-effectiveness plane with different cost-effectiveness thresholds.

Note: The estimate is shown as ◊, with 95% confidence interval for ΔE and ΔC illustrated by the ellipse. The dashed lines represent three cost effectiveness thresholds.

Figure 2 illustrates the application of three cost-effectiveness thresholds (dashed lines showing $\Delta C/\Delta E$) to the results in Figure 1. The horizontal dashed line illustrates a cost-effectiveness threshold of zero. This is consistent with the thinking that the only good deal is one where the new option saves money (i.e., $\Delta C < 0$). In this setting, anything below the horizontal line represents good value for money (regardless of the effectiveness!). The vertical dashed line illustrates a cost-effectiveness threshold of infinity. Anything to the right of the line represents a good deal (regardless of the cost!). If you are like most decision-makers, you probably have a cost-effectiveness threshold somewhere between 0 and infinity. The grey dashed line in Figure 2 has a slope of 100. On this line, each unit of extra effect is worth $100. Anything below this dashed line is considered cost-effective, including options that are more expensive (and more effective) as well as those that are less effective (and less costly).

In Figure 2, the cost-effectiveness estimate (◊) falls below each of the cost-effectiveness threshold lines. This means that the new option is cost-effective, regardless of the decision-maker's cost-effectiveness threshold. However, the *probability* that the new option is cost-effective varies with the cost-effectiveness threshold. This is evident when examining the relation between each cost-effectiveness threshold and the 95% confidence ellipse. The dark dashed lines cut through the upper and lower parts of the ellipse, while the grey dashed line does not intersect the ellipse. By keeping track of how much of the uncertainty is below the dashed lines, researchers can report the probability of cost-effectiveness. We can use a cost-effectiveness acceptability curve (CEAC) to display the probability of cost-effectiveness for each value of the cost-effectiveness threshold.

The probability of cost-effectiveness

On the CEAC in Figure 3,[8] probability ranges from 94% to 100%. The horizontal axis shows values corresponding to the slopes of the dashed lines (representing cost effectiveness thresholds) in Figure 2. The vertical axis of Figure 3 shows the probability that the new option is cost-effective, which corresponds to the proportion of probability that is below the dashed lines in Figure 2. The horizontal axis shows the cost-effectiveness

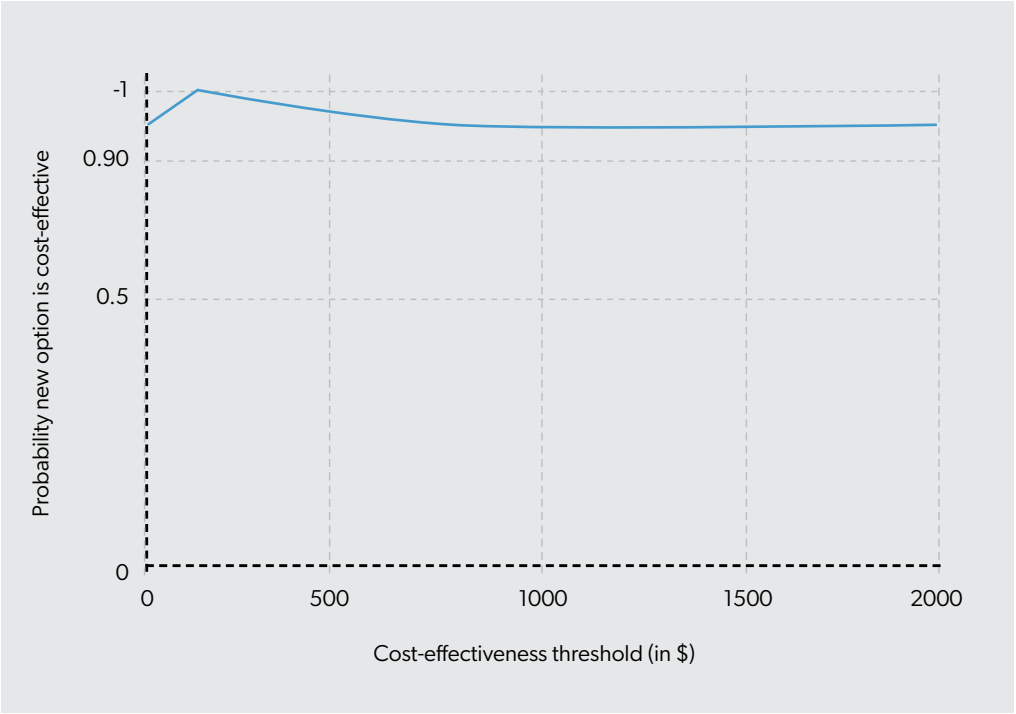

Figure 3: Cost-effectiveness acceptability curve for a range of cost-effectiveness thresholds.

threshold from $0 to $2000. Figure 3 shows that the probability of cost-effectiveness is very high and does not vary much.

The concept of "probability of cost-effectiveness" uses a Bayesian interpretation of uncertainty, instead of a traditional frequentist interpretation of probability (*p*). The value of Figure 3's vertical axis is not changed by this switch in paradigm, but the interpretation is. Because the Bayesian interpretation is more intuitive, it has been widely adopted in the cost-effectiveness literature. One can convert a p-value into "probability of cost-effectiveness" and then use this for the vertical axis of the cost-effectiveness acceptability curve (see Figure 3).[13]

Discussion

The data in Table 1 provide an example of a new option that is less costly (i.e., $\Delta C < 0$) and more effective (i.e., $\Delta E > 0$) than usual care. However, when looked at separately, neither estimate of the difference in cost and effectiveness is statistically significant. Studying the cost and effect outcomes simultaneously produces a 95% confidence interval shown as the ellipse in Figure 1. Because the ellipse stretches into three quadrants in Figure 2, the promising estimate of less cost and more effect could have

occurred by chance alone. Clear from Figure 2 is that most of the time, most of the ellipse is below the cost-effectiveness threshold lines; there is a high probability that the new option is cost-effective, even though it does not have statistically significant cost or effect differences. This is because most of the ellipse is in the southeast quadrant of Figure 2 meaning there is high probability that the new option is both more effective and less costly.

Figure 3 demonstrates that it is possible for the probability of cost-effectiveness to increase and then decrease as the assumed cost-effectiveness threshold value changes. This change in slope is related to the change in probability that is below Figure 2's dashed line. The mostly flat line in Figure 3 vacillating between 94% and 100% means that the new option has a very high probability of cost-effectiveness for all cost-effectiveness threshold values considered in the analysis.

The example reminds us of the difference between statistical uncertainty and decision uncertainty. The large ellipse shows a lot of statistical uncertainty. So much in fact, it is not clear whether the new option compared to usual care is more or less costly or whether it is more or less effective. The high statistical uncertainty is due to the small sample size. However, the decision uncertainty is modest. Most of the probability characterizing the uncertainty can be classified as a good deal (below the cost-effectiveness threshold line, regardless of which one is chosen).

Leaders interested in using the results from economic evaluations, such as CEA, should rely on viewing both the estimate and its uncertainty to help inform their decisions. In this process, it is important to separate uncertainty of interest to the analyst (size of the ellipse) from uncertainty of interest to the decision-maker (location of the ellipse). Whether the ellipse spills over into multiple quadrants is important, but so is its relation to different assumed cost-effectiveness thresholds (the dashed lines). This means that it is important to understand the cost-effectiveness thresholds that analysts assume and whether they fit with your context. Since these thresholds are unknown to the analyst, research should employ a variety of them for decision-makers to consider.

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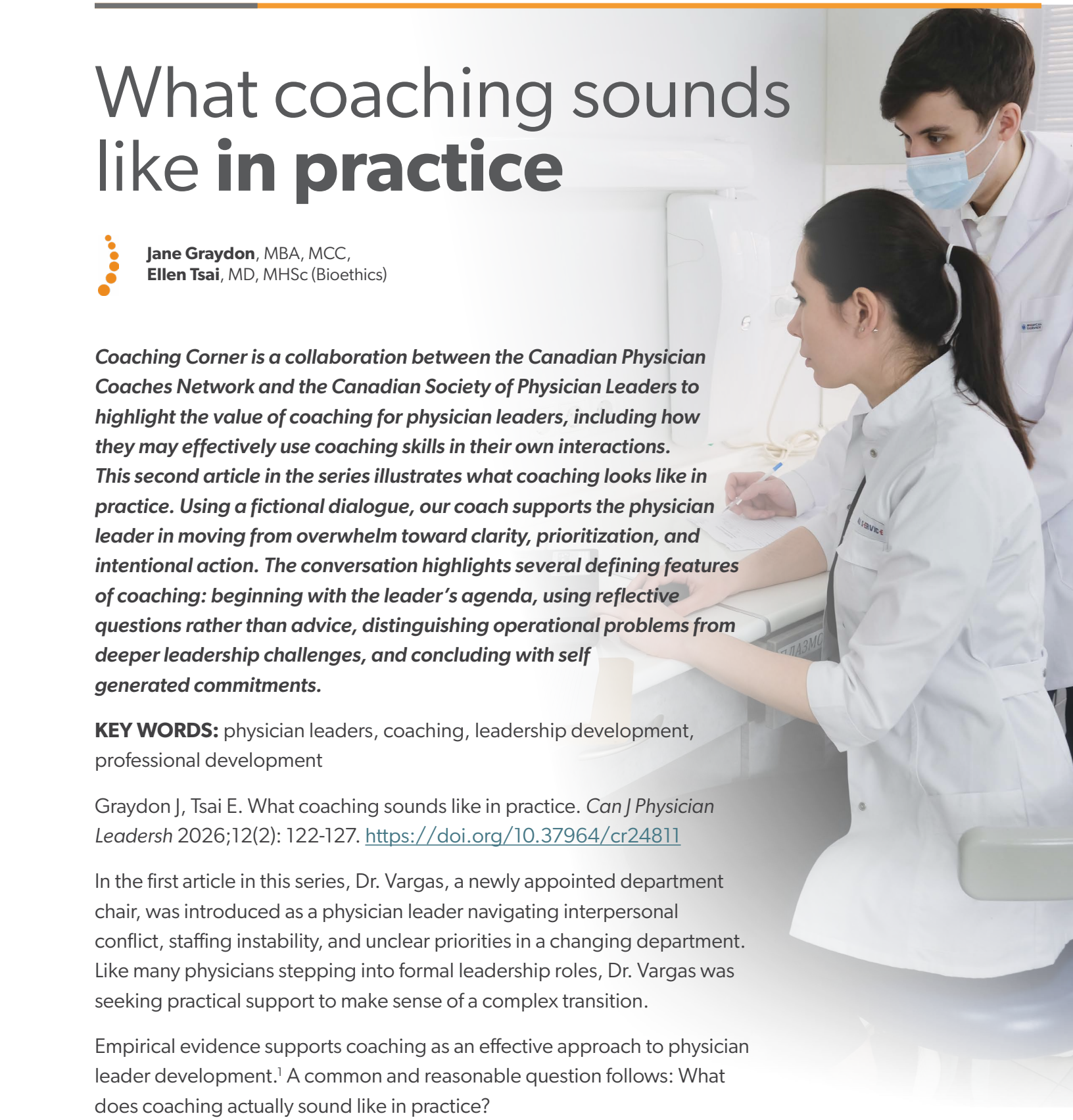
What coaching sounds like **in practice**



Jane Graydon, MBA, MCC,
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. This second article in the series illustrates what coaching looks like in practice. Using a fictional dialogue, our coach supports the physician leader in moving from overwhelm toward clarity, prioritization, and intentional action. The conversation highlights several defining features of coaching: beginning with the leader's agenda, using reflective questions rather than advice, distinguishing operational problems from deeper leadership challenges, and concluding with self generated commitments.

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

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In the first article in this series, Dr. Vargas, a newly appointed department chair, was introduced as a physician leader navigating interpersonal conflict, staffing instability, and unclear priorities in a changing department. Like many physicians stepping into formal leadership roles, Dr. Vargas was seeking practical support to make sense of a complex transition.

Empirical evidence supports coaching as an effective approach to physician leader development.[1] A common and reasonable question follows: What does coaching actually sound like in practice?

At its core, coaching is a reflective conversation that helps leaders think more clearly, examine assumptions, reconnect with values, and identify meaningful, aligned action. Coaching unfolds within a collaborative relationship between coach and client.[2] Many leadership challenges — particularly those involving culture, conflict, or ambiguity — are not resolved by quick answers alone. They require space for reflection and processing complexity before action. In coaching, that space is intentionally created through presence, deep listening, and thoughtful questioning. It is within this relational space that the coach facilitates learning of new perspectives and supports the client's forward movement.[2]

The fictional dialogue below illustrates what an early coaching conversation with a physician leader may involve.

Getting clarity

Coach: What would make this conversation valuable for you today?

Dr. Vargas: I need help sorting out where to focus. Everything feels urgent. I'm dealing with newer surgeons who are openly critical of us senior surgeons. The hospital leadership is putting pressure on me to improve the efficiency of the operating room when the problem is that there aren't enough nurses, and hiring more nurses isn't my responsibility. I feel pulled in too many directions.

Coach: What feels most important to focus on today?

Dr. Vargas: The tension in our department. It's affecting morale, and I worry that another surgeon might leave because of the negative climate, which would eventually affect patient care, recruitment, and the department's reputation.

Coach: What would you like to have by the end of our conversation?

Dr. Vargas: More clarity — and a better sense of what to do first.

Coach: What makes this issue rise above the others?

Dr. Vargas: It touches everything. And people are watching how I respond as the new chair.

Coach: Hmm.

Dr. Vargas: I want to be fair and thoughtful. And I don't want to avoid the issue.

Coach: Hmm.

Dr. Vargas: I think I've been hesitating because I want the perfect approach.

Coach: What effect is that hesitation having?

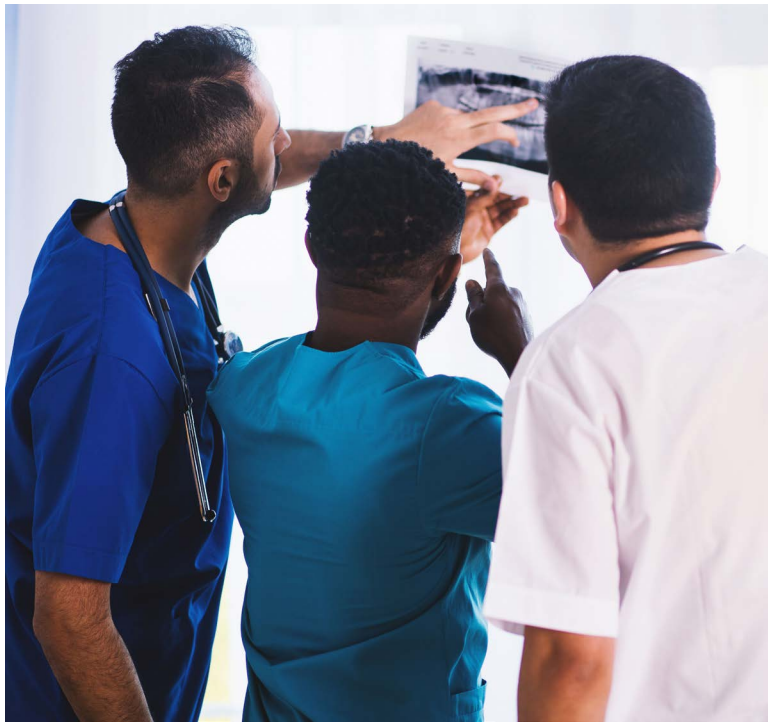
Dr. Vargas: More ambiguity. I'm worried that people think I don't see the issue — or that I'm a weak leader.

Coach: How does that fit with the leader you want to be?

Dr. Vargas: It doesn't. I want to be calm and deliberate, but also willing to address difficult things directly.

This early exchange illustrates a core feature of coaching. Rather than offering solutions, the coach supports Dr. Vargas in clarifying the issue, noticing what is driving hesitation, and reconnecting with their intentions as a leader. The use of reflective pause in coaching is not avoidance. It often creates the conditions for more thoughtful and effective action, which has also been observed in other medical contexts.[3,4]

Expanding awareness



Coach: When you are at your best as a leader, how do people experience you?

Dr. Vargas: Steady. Respectful. Someone who listens carefully.

Coach: Which of those strengths will be most useful here?

Dr. Vargas: Steadiness.

Coach: What could steadiness look like over the next two weeks?

Dr. Vargas: Not rushing to judgement, but also not waiting for things to resolve on their own. Maybe I could meet individually with key people, understand what's underneath the tension, and then decide what further conversations are needed.

Coach: What assumptions might you be making right now?
Dr. Vargas: That the conflict is mostly generational. That may be too simple — it could also be about insecurity, status, workload, or fear of losing influence. I think I'm projecting my own feelings into my interpretation of this situation.

Coach: How useful is that realization?
Dr. Vargas: Very. It reminds me not to settle too quickly on one story. I also need to be aware that I'm not 100% objective as I address this conflict.

For new leaders, the pressure to act quickly can be strong — particularly when others are watching. Coaching helps distinguish urgency from reactivity. In many leadership situations, the primary task is not immediate problem solving but understanding the system more accurately. Coaching supports leaders in organizing complexity, transforming diffuse overwhelm into clearer priorities.

Exploring new perspectives

Coach: If we zoom out, what are the major buckets of work on your plate?
Dr. Vargas: Well, I still have a pretty heavy clinical workload. And I've discovered that getting settled in this new role as chair of our department is taking more time and energy than I expected, especially with all the meetings I am expected to attend with hospital administration.

Coach: Which requires your attention most right now?
Dr. Vargas: Department culture and surgeon conflict — and establishing myself as chair. They feel connected.

Coach: How so?
Dr. Vargas: How I respond to this conflict will signal what kind of chair I am.

Coach: Beyond resolving the conflict, what is the leadership challenge here?
Dr. Vargas: Setting the tone. Showing that disagreement can be handled professionally, that respect matters, and that I'm willing to address difficult issues directly.

Coach: What part of that is within your control right now?
Dr. Vargas: Having conversations where I listen well and naming expectations more clearly.

Coach: Where is the best place to start?
Dr. Vargas: Listening first. Then naming expectations.

Here, the conversation shifts from the presenting issue to the underlying leadership task. This is often where coaching is most valuable. Physician leaders are typically highly skilled at managing clinical and operational problems. Leadership, however, also involves shaping culture, relationships, and norms. Coaching supports leaders in responding to these responsibilities in ways aligned with their values and leadership identity.

Moving to action

Coach: What will you do between now and our next session?
Dr. Vargas: I'll meet one on one with four people — two senior surgeons and two newer surgeons — to understand their perspectives before deciding what intervention is needed.

Coach: What intention will you bring to those meetings?
Dr. Vargas: Curiosity first. Then clarity.

Coach: What might get in the way?
Dr. Vargas: Wanting to smooth things over too quickly — or being so cautious that I avoid asking hard questions.

Coach: What support do you need from yourself?
Dr. Vargas: Remembering that I don't need to solve everything in one conversation. My first job is to understand the landscape.

Coach: What are you taking away from today?
Dr. Vargas: That I don't need the perfect answer before I begin. I need a clearer understanding of the system — and to lead into this intentionally.

By the end of the conversation, Dr. Vargas leaves with greater clarity, a grounded leadership stance, and self generated next steps. This illustrates why coaching can be so valuable for physician leaders: it strengthens not only action, but the quality of thinking that informs that action.

Coaching may also have a broader ripple effect. As physician leaders experience effective coaching, many begin to integrate coaching practices into their own conversations, becoming more authentic as leaders and increasing their leadership effectiveness.[5] Questions such as "What feels most important here?" or "What assumptions might we be making?" can foster reflection, ownership, and engagement within health care teams.

Conclusion

This fictional dialogue highlights several defining features of coaching: beginning with the leader's agenda, relying on reflective questioning rather than advice, expanding perspectives, and concluding with commitments generated by the physician leader. Coaching is particularly well suited to leadership challenges involving conflict, complexity, competing values, or uncertainty. Coaching can support leaders to behave more authentically in alignment with core values, which, in turn, is positively correlated with leadership effectiveness.

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Jane Graydon and Ellen Tsai discussed the outline, content and format of this article. Jane prepared the initial draft and Ellen contributed to subsequent revisions. Both authors approved the final version of the article.

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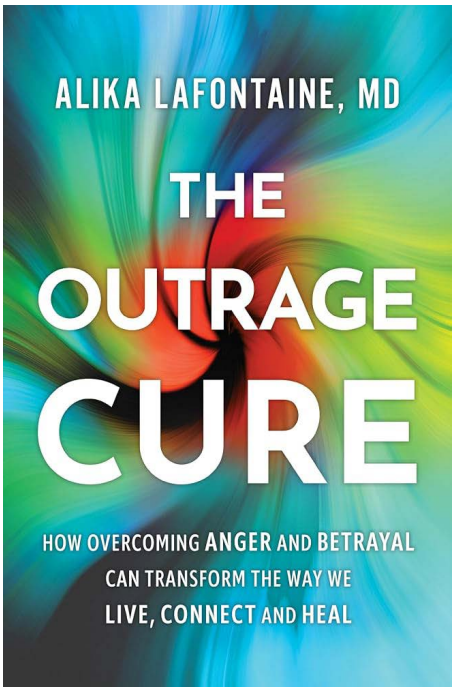
Dr. Guzder is currently working as a trainer for the Vancouver Island Counselling Centre for Immigrants and Refugees. Earlier she was a community psychiatrist with Indigenous Child and Youth Mental Health.

Her training was at McGill, where she was a senior psychiatric consultant at Jewish General Hospital with roles as head of child psychiatry, director of Childhood Disorders Day Hospital, and the founding clinical director of Montréal's first Cultural Consultation Services for refugees and immigrants. She has worked as a consultant for research, teaching, and global health projects in Jamaica, Brazil, Sri Lanka, Nepal, and India. She is a mother and a third-generation South Asian settler on Vancouver Island, where her maternal grandfather arrived from India in 1906.

CJPL is accepting artwork submissions. Submitted photos of original artwork should reflect or explore themes relevant to the journal, such as leadership, healthcare, health systems, innovation, equity, patient and provider experiences. Please provide to Deirdre McKennirey at deirdre@physicianleaders.ca.

The Outrage Cure: How **Overcoming Anger and Betrayal** Can Transform the Way We Live, Connect and Heal



Alika Lafontaine, MD
HarperCollins, 2026
Reviewed by **Johny Van Aerde**, MD, PhD

The world around us is shouting and fighting; our view is distorted by polarizing filters. The realities of patients struggling, providers burning out, and communities left behind are deeply personal and profoundly human problems that cause anger and outrage. Those two emotions are quite different, according to Dr. Alika Lafontaine. In his book, The Outrage Cure, he shares deeply personal examples to help us understand where these emotions come from and how they can be avoided or reversed.

Anger is a cry for help, a signal to others that we have a problem we cannot solve by ourselves. Anger starts with loss, creating an emotional trigger that activates our limbic system and inhibits the executive parts of our brain. During the initial stage, the call for help is constructive in that it seeks interventions and solutions from people in whose competence and credibility we believe.

When our plea is met with dismissal, rejection, or failure, we start to question that competence and credibility. This leads to progressive loss of trust, opportunity, or fairness. As the social contract is progressively violated, as the moral imperative is attacked, anger starts to turn into outrage against "the system" and against those who prefer to keep the status quo rather than bring about change. The angry no longer assume just incompetence, they now assume bad character and systemic failure; they feel betrayed by the decision-makers and "the system." At this stage, the goal is no longer fixing

the problem, it is exposing and punishing those who failed and reinstating or rewriting the social contract.

While outrage spirals, rumination makes it self-sustaining, leading to polarization which can then be amplified further by social media-led echo chambers. Ongoing lack of change can lead to indifference, as people become uninterested in a problem they think cannot be solved. This phase can be dangerous as problems fester and lead to further decline of the issue we tried to solve in the first place.

Although the same process of anger and outrage can evolve on both individual and societal levels, at the higher level, frustration becomes part of a shared identity, part of the culture. Collective anger gains momentum non-linearly and a small tipping point can ignite widespread outrage. Massive outrage can fracture the status quo favoured by the resisting forces that were benefiting from it. Like any complex system, this leads to collapse and reshaping of the existing world.[1]

As a physician-leader, Dr. Lafontaine shares not only very personal, but also quite practical examples from his personal, professional, and systemic life. By taking us deeply into some of those experiences, he demonstrates honesty, courage, and vulnerability, all traits of strong authentic leadership. As a physician, he gives simple explanations of how biology, physiology, and psychology affect the workings and interactions of the emotional limbic system and the executive, rational parts of the brain. As an indigenous physician-leader, he gives good and respectful insights, not only into the anger and outrage caused by indigenous health-related problems and injustice, but also into some of the problem-solving efforts and reconciliation that he and others have led between the indigenous and the medical communities.

Solutions offered in the book apply more to systemic experiences, but some can also be applied to individual life experiences. The important message is that solving problems is the antidote to anger, before it becomes outrage or indifference. The first step is recognizing and validating anger without aggression or punishment and allowing space for constructive dialogue. Institutions and individuals can then redirect emotional energy toward resolution rather than conflict. As emotional release can precede reason and logic, disruption of anger and outrage should occur in a safe place. Emotional security allows constructive engagement, which requires courage and authenticity, and transition from reactive outrage to productive dialogue. In that space, people also need to move from perception to

perspective. Perception is emotional and keeps us stuck in the present. Stepping back or zooming out shows us perspective and connections within the system's complexity, creating opportunities for problem-solving and unlocking what is possible in the future. Transitioning to perspective also helps place the limbic system in a less overactive emotional mode. One example of such a change in perspective or paradigm shift would be to view the health system's purpose as health for all, rather than just curing disease.[2]

Dr. Lafontaine warns about "weaponized outrage," which leads to a state of permanent outrage and emotional absolutism, even indifference. Such weaponization is engineered by consolidating power and creating division and polarization, ensuring that those in power remain unchallenged. It seeks long-term dominance, ongoing division, and control of the narrative. Once society is sufficiently primed for perpetual outrage, the cycle becomes self-sustaining, and after several cycles, people stop resisting and become silent and indifferent. Although outrage is weaponized to divide, exhaust, and burn out people, indifference is weaponized to ensure obedience. It made this reviewer wonder whether today's bigger danger to humanity is indifference, preventing us from dealing with issues like climate change and its consequences, the collapse of our health system, food security, poverty, a peaceful and sustainable world, to name a few.

Given Dr. Lafontaine's vast network and experience clinically, politically, and as a leader, he has unique insights into our health care system, and one might have expected more content on the current shape of that system. But that was not the intent of the book: it was written to give us the foundational tools to recognize, reflect on, and deal with anger, outrage, and indifference in a variety of contexts, including our health care system.

In short, solving problems is the antidote for anger. Outrage can be soothed when we start believing in each other again, opening our hearts to authentic connection, finding others to do the same, and walking toward a place where we can see what else is possible. One of the last sentences in the book deserves to be the last one of this review: "If you put down outrage, your hands will be free to pick up something else…" Let's free up our hands!

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