COVID Corner IX:
Turning the Corner on COVID?

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On May 7, 2020, CHLNet held its inaugural virtual Network Partner (NP) Roundtable. Thirty-five individuals *zoomed in*, representing over 25 of our partners. In the first of our *COVID Corner* series, we captured some of the key takeaways from the session.[1]

Few would have believed back then that we would not have turned the corner on COVID by now. Clearly, we have not. Indeed, many experts are now suggesting that COVID is endemic, meaning it is here to stay and that we are all going to have to continue to do our part to mitigate its ongoing spread. The WHO has just formally identified yet another 'variant of concern' (*Omnicron*). Some air travel restrictions are now being put back in place. COVID patients are being transferred from one province to another as ICU capacity limits are reached and exceeded. We are being advised by epidemiologists that a third booster shot may required. And, we now have federal legislation being introduced (Bill C-3) that would amend the Criminal Code making it a criminal offence to intimidate healthcare workers or to block access to healthcare sites.

This complex, ever-evolving policy context framed the most recent CHLNet Network Partners Roundtable held on November 3rd and 4th. Still unable to meet face-to-face due to COVID, over 50 participants (representing over 35 NPs) gathered virtually to consider two questions on day one:[2]

1. Reflecting on the leadership lessons learned from the first three waves of COVID 19, how have your experiences entering the fourth wave either reinforced those lessons or illuminated new ones?
2. As we explore implications for future action, what would you want healthcare leaders to learn going forward?

This, the ninth in the COVID Corner series, articulates leadership insights from the November 2021 session by comparing the experiences or observations of healthcare leaders reported back in May 2020.[3] Some of the key takeaways from May 2020, still apply. These have helped guide CHLNet over the past 20 months and include, at a high level, for example: "less is more"; "add value not noise"; "we need to deal better with ambiguity" and "we all need to be communicating clearly".

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[1] First in COVID Corner series link can be found here:https://chlnet.ca/wp-content/uploads/COVID-Corner-May-20.pdf.

[2] The second day focused on the lessons learned over the past two years around wellness and what more CHLNet can do to help address the long-haul effects of burnout and stress due to COVID.

[3] These insights will also form an integral part of the third phase of a CHLNet Action Research Project that is chronicling leadership lessons learned "Leading Through COVID". Phase 1 is synthesized in a two-page Executive Summary. Our first of two peer reviewed articles is now published on The relevance of the LEADS framework during the COVID-19 pandemic.

Here then are the *Key Insights* from the November 2021 NP Roundtable.

1. *Fallout of 'dehumanizing' health leaders:* Public health leaders globally, nationally, provincially and locally have gone from being behind the scenes to being in front of the cameras. Health Ministers, CEOs of Regional Health Authorities, Chief Medical Officers (CMOs) provincially and locally have been in the nightly spotlight. In fact, through waves 1-3 of COVID, health leaders became, in the opinion of one NP 'super humanized'. CHLNet Network Partners discussed concerns that "in the process of 'super humanizing' healthcare leaders, we may have inadvertently 'dehumanized' them, leaving them open to attacks and deterring them from seeking the help or support they now need to recover". "Repeated assaults on individual leaders are taking a serious toll on them and on the system as a whole" (NP). Threats, especially on-line, are commonplace. We now have CMOs with security details. "This (consequence of dehumanization) needs to be acknowledged and addressed in a concerted, ethical way". Indeed, recent federal legislation referred to above is one effort to respond to this need.
2. *Build resilience organizationally as well as individually:* Resilience--the ability to bounce back in the face of adversity--has always been critical to the success of any leader. "I was so impressed, during the first three waves with the resiliency of health leaders" (NP). What the November NPs session underscored, however was that the fourth wave is a "different story". "People are tired and it's bone deep" (NP). "We need to pay much more attention going forward to resilience and avoiding slipping back into a 'pull-yourself- up -by-the-bootstraps' culture or attitude". We need to recognize as a community of practice in health leadership that "Burnout is an organizational or systems issue, not just an individual responsibility". Many NPs report growing as a leader as we enter the next COVID wave (i.e., "post traumatic growth"[4]). "But only if the organization does its part. It can't be just an individual responsibility". As one of the articles referenced in this e-blast notes: "to lead means to guide. To resile means to respond or be guided by circumstances through a process of adaptation and growth within a risky environment". The resilience of health leaders will continue to be tested and grow through this wave and well into the future[5].
3. *Premium on clear, concise, consistent communication:* This was flagged back in May 2020 as an overarching leadership challenge given the "pervasiveness" of social media and the difficulties of controlling or regulating online content. But little did healthcare leaders know then just how right Marshall McLuhan was when he famously suggested (1964) that the *Medium is the Message*. Social media is the ultimate two-edged sword, permitting CMOs and healthcare leaders to convey essential public health messaging to all concerned in real time, servicing the 24-hour news cycle. But it has also enabled the rapid spread of misinformation and, increasingly 'malinformation' or that information intentionally designed to fuel, for example, vaccine hesitancy; and in keeping with the earlier theme of dehumanizing, demonizing establishment health care leaders. NPs feel a heavy burden of responsibility

[4] COVID Corner IV featured resilience and what it takes to move from just surviving but thriving. In short it involves both supporting individual and organizational resilience. See link here: *https://chlnet.ca/wp-content/uploads/Resiliency-Covid-Corner-Oct-21-2020_.pdf*.

[5] Giustiniano,L., Pina e Cunha, M. Simpson, A. Rego, A. and Clegg, S (2021) *Resilient Leadership as Paradox Work: Notes from COVID-19*. Link here: Resilient Leadership as Paradox Work.pdf

amid this *infodemic*, to help set the record straight and as 'trusted sources' address misinformation immediately with the sometimes 'brutal facts'. "Communications going forward will have to be even more deliberate, more carefully constructed and more timely" (NP). Leaders will also have to challenge, directly, those who purvey malinformation.

4. *Model effective leader behaviour:* Back in May 2020, NPs already flagged compassionate, empathic leadership as key to effectively leading through COVID. This remains a key expectation and attribute of effective leaders as we confront the next wave. As one NP noted "self-effacement and humility, not over confidence" is key going forward. Leaders must be "honest with themselves" when it comes to knowing how best to deal with the virus and the seemingly endless 'variants of concern'. "Leaders will have to be even more empathetic and more 'present' in the workplace: not just seen and heard but listening even more carefully to what is not necessarily being said explicitly." (NP). "Fatigue is the story of the 4th Wave". "We can't continue to rely on adrenaline to get us through the next wave". Modelling effective leadership means stressing the importance of leading self "the ability of leaders to get through this and not drop the ball for all those they are leading". (NP). It also means "respecting boundaries and limits of when work begins and ends. These will have to be more clearly established and respected going forward". This concern is giving way to increased attention, for example, around so-called "dusk to dawn" digital workplace practices and policies.[6]
5. *Need for systems thinking and national strategy:* Canada came into the pandemic with significant overall capacity issues: with occupancy rates at or near capacity and widespread physician and nursing shortages[7]. COVID has only exacerbated these capacity issues as the fourth wave now "washes over us". ICU patients are being transferred from one province to another. "Family medicine is imploding across the country" (NP) "We're being forced to provide care in a system that doesn't care about you" (NP). In addition to this capacity of the "system" being tested to the limits, the fragmentation of our loosely connected healthcare systems has been exposed. While early on there was great coordination across jurisdictions over COVID, it has become more politized in the early days of the fourth wave. "Better data and better workforce planning are required...with multipronged strategies to deal with the current crisis (i.e., expected 'exodus' from the health workforce in the wake of wave 4) and the longer term (e.g., need for a national workforce body). And looking ahead, "Nothing is linear going forward" (NP) "A certain bravery" will be needed going forward to address these systemic issues.
6. *Consider the silver-lining of COVID:* While COVID waves 1-3 have posed numerous challenges, many unprecedented, the pandemic has also had a silver lining. It has, for example, brought the research and policy community closer together. There is a "strong bond" now that wasn't recognized before. "Nuggets of innovation" have been introduced that now need to be extended into the future (e.g., value of virtual care as an extension of traditional care

[6] See proposal in Ontario and Federally for 'right to disconnect' or 'log off' legislation link here: https://worldrepublicnews.com/ontario-has-proposed-legislation-to-prevent-your-boss-from-bothering-you-after-hours-but-will-it-help/.

[7] According to the most recent data from the Organization for Economic Cooperation and Development, Canada ranks 26/37 countries in terms of physicians per 1000 population (at 2.46) and 17/37 with 10 nurses per 1000 population. See link here: https://data.oecd.org/healthres/doctors.htm#indicator-chart.

processes). Decision-making processes have been streamlined. Consideration needs to be given to how 'work arounds' that have been exploited due to COVID (e.g., streamlining licensing requirements) can now be embedded longer term. New, trusting relationships have been formed which will ensure beyond when we finally do turn the corner on COVID.

7. *Greatest lesson learned is 'speed over perfection':* Policy makers and healthcare leaders have learned through the first three waves of COVID that 'dithering is dangerous. Nowhere has this been more in evidence than in the long-term care sector, where some have gone as far as to say when it comes to decisions like mandatory masking in healthcare facilities that "delay is deadly"[8]. This increased attention to speed has also created more pressure on healthcare leaders when it comes to explaining why they did or did not act more quickly to address the most recent outbreak.
8. *Embrace the agility quotient:* In the early days of COVID-19 top-down, 'command and control' leadership was seen as both expected and appropriate. But this has changed over time. By May 2021, NPs reported that this top-down approach had to give way to a more distributed or collaborative leadership styles as the pandemic continued. Creating and empowering teams was (and continues to be seen) as key to turning the corner on COVID. Over the past number of months this view has changed yet again. NPs now report that effective leaders must shift from directive leadership to collaborative leadership and vice versa quickly as circumstances dictate and as the needs of the leadership team demand. The so-called 'agility quotient' reflects one's ability or capacity to swiftly adapt to changing circumstances or needs. Agile leaders are effective in optimizing on the right leadership style at the right time for the right people. "A lot of rules have had to be cancelled" (NP). As we continue through the fourth wave of the pandemic, some leaders can embrace ambiguity better than others and agility comes more easily to some leaders. "We need to be flexible and agile in how we support staff" (NP).
9. *Existence of the polarizing effects of the pandemic:* The "narrative" going into the next wave of COVID is increasingly polarizing and this is of concern to healthcare leaders[9]. Mandatory masking and ongoing tensions around mandatory vaccination continue to polarize communities and cause friction in families. The recent policy reversal in some jurisdictions in relation to mandatory vaccination of healthcare workers is perhaps the most recent and disturbing example of the polarity surrounding pandemic, with tough decisions being downloaded onto local decision makers. This adds to the stress and burnout of healthcare leaders. The politicization of the pandemic is some quarters hasn't helped and while NPs believe the media are doing a good job (on balance), "…we have (fact-based) policies reported in the media not holding true any more when someone can tweet or share a view and advocate for whatever they happen to believe in". "Working through polarity is a key leadership skill going forward" (NP). It points to the need, for example, for stepped up efforts to develop media kits for members and the ongoing need for media training for healthcare leaders. The overall message emerging from NPs in addressing the polarizing

[8] Ontario Long Term Care Commission: Final Report (2021). See link here: http://www.ltccommission-commissionsld.ca/report/pdf/20210623_LTCC_AODA_EN.pdf.

[9] See COVID Corner V for more detail here: https://chlnet.ca/wp-content/uploads/Polarity-Management-E-blast-final_.pdf.

effects of the pandemic is that we need to "let science and the scientists lead". (And that is medical science, not political science!)

10. *Heightened importance of networking*: Interest in and support for CHLNet in general and for special purpose networks in particular (e.g., CanCOVID[10]) continues to grow, in part due to the recognition that networking…both personally and organizationally…is one important factor in building system level resilience over time. Leaders value time to reflect, even amid a pandemic, to "celebrate all that we have been able to accomplish and recognize the tremendous accomplishments to date". "Not sure we are compassionate enough with ourselves".

In summary, while many of the lessons learned in the earlier waves of COVID have carried through to the fourth, and potentially a fifth wave, NPs are beginning to look beyond COVID. Not that we have 'turned the corner yet', because we haven't but there is a consensus that as a community of practice, healthcare leaders need to be "intentional and purposeful" in mapping leadership lessons being learned such as those set out above into the new normal that ultimately emerges from leading through COVID.

[10] CanCOVID is a special purpose, multidisciplinary network bringing together research and policy/decision-makers in the fight against COVID. Here's the link to their home page: https://cancovid.ca/.