LEADerShip at a Glance

CHLNet's "Top Three (or Eight!)" Suggested LEADS Readings for COVID-19[1]

In this version of the 'Top Three' I wanted to focus on the issue of leading the creation of healthy workplaces. I do so for three reasons. First, there is a plethora of recent evidence that during the first stages of the pandemic this issue became more and more relevant and crucial to the ongoing sustainability of care delivery, and health care systems themselves. Second, as COVID-19 moves into a 'chronic crisis' state, the problem is growing steadily worse rather than better, regardless of our consciousness of the problem and efforts to address it. And third, the cumulative effect of stress, fear, and physical threat from the virus has the potential of further ravaging our health workforce when—and if—the pandemic comes to an end. We must be prepared, and act now, to deal with the workforce issue; to save the people we are so dependent upon.

Link to LEADS: The Engage Others domain of the LEADS framework articulates the capability of 'Engaging leaders contribute to the creation of healthy organizations'. As leadership must adapt to situation and circumstance, being deliberate in creating engaging conditions is a challenge facing all leaders moving forward.

BEFORE COVID

First, let me start by highlighting three articles by the same research team, out of the UHN in Toronto.

Rubin, B., Goldfarb, R., Satele, D., & Graham, L. (2021). Burnout and distress among physicians in a cardiovascular centre of a quaternary hospital network: a cross-sectional survey. *CMAJ open*, *9*(1), E10.

Rubin, B., Goldfarb, R., Satele, D., & Graham, L. (2021). Burnout and distress among nurses in a cardiovascular centre of a quaternary hospital network: a cross-sectional survey. *CMAJ open*, *9*(1), E19-E28.

Rubin, B., Goldfarb, R., Satele, D., & Graham, L. (2021). Burnout and distress among nurses in a cardiovascular centre of a quaternary hospital network: a cross-sectional survey. *CMAJ open*, *9*(1), E19-E28.

Summary:
The first of the three articles highlights burnout and stress in physicians, the second for nurses, and the third for allied health professionals in the context of a cardiovascular centre of the UHN. The studies were conducted BEFORE COVID-19 hit; and show that the level of burnout and stress—even then—was high. As the authors state re physicians: "Physicians in this study had high levels of burnout and distress, driven by the perception of inadequate staffing levels and being treated unfairly in the workplace. Addressing these institutional factors may improve physicians' work experience and patient outcomes."

[1] As recommended by Dr. Graham Dickson (CHLNet Senior Research Advisor)

With respect to the nurse study, they argue that: "Although levels of burnout and distress were high among nurses, their perceptions of adequate staffing and fair treatment were associated with lower distress". Addressing these issues for nurses will "improve their work experience and patient outcomes". In the context of allied health professionals, they state, "The prevalence of burnout, emotional problems and distress was high among allied health care staff.". Collectively these studies imply that a greater investment in staffing can relief stress and burnout, and that 'fair treatment' would also contribute to alleviating psychological distress and improve patient care.

If these three studies were chronicling the challenges of healthy workplaces before COVID, how much more will have to be done—i.e., in addressing inadequate staffing for example—as we move through the COVID crisis? Where are the solutions? And what 'unfair treatment' needs to be addressed?

LEADS Link: The LEADS framework identifies positive attributes of leadership intended to grow overall organizational capacity to deliver results: especially in a crisis. A review of the negative behaviours identified in this study shows that they are diametrically opposite to the guidance of LEADS; suggesting that selective use of the opposite LEADS capabilities during a crisis will contribute to positive results.

DURING COVID

Ananda-Rajah, M., Veness, B., Berkovic, D., Parker, C., Kelly, G., & Ayton, D. (2020). Hearing the voices of Australian healthcare workers during the COVID-19 pandemic. *medRxiv*.

This study was conducted with health care workers between 3 August and 26 October 2020. 569 free text responses were analyzed. *NOTE: while this study was done in Australia, it is important to note that country had a much lower prevalence of COVID infections than did Canada. Canadian leaders need to review this article with their own workplace lens in mind.*

Dominant themes included concerns about: work health and safety standards; guidelines on respiratory protection including the omission of fit-testing of P2/N95 respirators; deficiencies in the availability, quality, appropriateness and training of personal protective equipment; and a command-and- control culture that enabled bullying in response to concerns about safety that culminated a loss of trust in leadership, self-reported COVID-19 infections in some respondents and moral injury.

Deficiencies in work health and safety, respiratory protection, personal protective equipment and workplace culture have resulted in a loss of psychological and physical safety at work associated with an occupational moral injury. The challenge for healthcare leaders is to repair trust by addressing HCW concerns and fast track solutions in collaboration with them.

Weiner, K. (2021). Clinician Burnout Is Only Getting Worse. Here's How to Tackle the Problem. *NEJM Catalyst Innovations in Care Delivery*, *2*(2).

Summary:
This article is written in an American health care context. However, many of the questions it poses—as a result of a number of surveys—are pertinent to us in Canada. They state, for example, "In a survey of NEJM Catalyst Insights Council members in October 2020, 70% of respondents say that they anticipate health care provider burnout at their organization will get worse in the next 2–3 years, a period in which Covid-19's impact is likely to be greatly reduced. Given that only 9% say they expect things will get better, the data suggests that burnout will continue unabated unless comprehensive organizational and systemic

changes are made." They go on to say—and this is important for senior leaders—that physicians (according to 90% of respondents), nurses (89%), and advanced practice providers (79%) have more serious or moderate problems with burnout than do clinical leaders (58%) or executives (43%). The trend to giving front-line clinicians more administrative work is the top contributor to burnout.

They go on to state that "If we hope to do anything to improve the caregiver experience and decrease burnout, we need leaders who are committed to developing themselves and their teams in pursuit of the core servant leadership competencies of humility, curiosity, and courage." They also describe a range of techniques to reduce provider burnout, such as peer support programs, and mindfulness huddles.

NOW AND AFTER COVID

Ahern, S., & Loh, E. (2020). Leadership during the COVID-19 pandemic: building and sustaining trust in times of uncertainty. *BMJ Leader*, leader-2020. Accessed @ Leadership during the COVID-19 pandemic: building and sustaining trust in times of uncertainty | BMJ Leader

Summary:
This paper argues that a global pandemic is a 'litmus test of trust in a health system.' They define trust at a system, organizational, or personal level, and state that trust in leadership is needed for transformative, collective action in times of uncertainty, such as during a pandemic.

For leaders to instil trust in their followers, they must take appropriate action via preparation and planning; seeking out information and intelligence; leading adaptation; and ensuring a coordinated response. However, to sustain trust, leadership requires taking ongoing responsibility and accountability, and remaining closely connected to those on whom their decisions impact. Developing and maintaining leader trust in circumstances such as a pandemic is a dynamic process, changing over time from pre-existing trust, to trust based on actions, to trust in the strength of the authentic relationship. As COVID-19 continues to play out over the globe, it is becoming clear that trust ultimately also requires leaders to offer hope, a credible vision of our lives for the future and guidance on how it can be achieved.

Bourgeault, I. (2021 February 17). Levels of stress, overload and burnout among health workers surging. Canadian Healthcare Network. Accessed @ Levels of stress, overload and burnout among health workers surging | Canadian Healthcare Network - Healthcare Managers

Summary:
Dr. Ivy Bourgeault is the Lead of the Canadian Health Workforce Network. In this article she argues that the only way to truly and systematically improve the quality of the clinical workforce's workplace experience is to embrace health workforce science, and the data research infrastructure to support it. She shows that Canada lags behind comparable OECD countries on big data analytics and digital research infrastructure that is vital to health workforce planning. She describes the paucity of data we do have, and argues that the Federal Ministers of Health, Labour and Innovation need to make the health workforce data infrastructure a top priority.

In Conclusion:
One of the primary goals of health care leadership is caring: not just for patients, but also for providers. The LEADS framework is built on that principle, and describes the leadership capabilities of caring leadership. These articles point out that we have not been caring enough about our health care workers prior to the pandemic, and our awareness of that inadequacy has been heightened by it. Going forward,

provider health must become a priority in action. As Dr. Ivy Bourgeault states in her paper, "We need to stop simply clapping our hands in support of health workers—and start planning to create better workforce conditions for them".

In closing, let me share some of the poems of an Emergency Room physician, and that can be found in the following publication (the titles of each of the poems follows the text). Please imagine the psychological stress this young doctor was experiencing—daily—as she coped with the challenges of COVID-19.

Ali, H. (2020). COVID reflections of an emergency physician. *Canadian Journal of Emergency Medicine, 1-1. (Accessed @* Ali, H. (2020). COVID reflections of an emergency... - Google Scholar).**

The Emergency Department is empty, as if everyone died already.
Is this what the future of Emergency Medicine will look like? Quiet and dead?
-April 2020

I intubated you. But before I did, I held your face in my hands and said
"you're going to be okay."
You had COVID. You died, father of four.
I'm sorry I lied, I didn't know any better at the time.
-Death of an immigrant

You died and we are trying to resuscitate you.
You are lying in front of me, naked. CPR in progress.
A room full of strangers rhythmically pump your chest.
Your family is not allowed to be with you as your soul leaves your body.
This is the loneliest way to die.
-COVID deaths

You hold my gloved hand and cry.
You cry and thank me for listening and tell me I am a hero for working the frontlines during this pandemic. You thank me for protecting the people.
I cry with you.
But I cry because I never wanted to be a hero in this pandemic.
-Unwilling hero

Everyone at work is spewing their COVID anxieties.
I feel drenched in their undigested hurt and their inability to cope with their feelings.
Leave my mind alone. I have enough of my own to work through.
-the Limbic Circuit