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Building A Co-Curricular Wellness Program for Medical Students at a Canadian Medical School

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Abstract

The increasing number of medical students who present with mental illness and burnout is becoming a very real challenge among medical schools nationally and globally, prompting a need for medical schools to address this very real problem. This Organizational Improvement Plan (OIP) seeks to help solve this problem by means of a co-curricular wellness program aimed at preventing mental illness and burnout from happening. Rather than being reactive as students self-identify as having a mental illness, this OIP argues for preventative measures that help to prevent mental illness and burnout from occurring at all.

Using a three-pronged leadership approach of authentic, distributed and servant, improvement in the area of mental illness and burnout is an institution-wide problem to solve, one that requires the input of everyone: senior leadership, administration, faculty, staff and students. In particular, faculty will be key in the design and implementation of a co-curricular wellness program, as it has been shown that the learning environment directly affects the mental health of students (Daskivish et al., 2014). It is hoped that the change plan which employs a collaborative approach, along with a shared vision and purpose, will help to decrease the number of medical students who present with mental illnesses.

Keywords: medical student wellness, mental illness in medical students, burnout among medical students, wellness program for medical students, medical education, higher education

Executive Summary

Time and time again, research has shown that the prevalence of mental illness and burnout among medical students continues to be higher than those of their peers in other programs (Heiman, Davis, & Rothberg, 2019; Kothari, George, & Hamid, 2018; Wimsatt, Schwenk, & Sen, 2015; Slavin, Schindler, & Chibnall, 2014). Whether this is from the strenuous nature of the program, introduction to different patient illnesses and even death, or the high stakes involved in getting into a residency program, this is a very real problem and is one that needs to be addressed

At Eastern School of Medicine (ESM), the issue is no different and therein lies the problem of practice to be addressed in this Organizational Improvement Plan (OIP): *the lack of comprehensive mental health and well-being supports available to students at the Eastern School of Medicine, potentially leading to an increased prevalence of mental illness and burnout among the medical student population.* In our current situation, we are seeing more and more mental health issues and burnout situations as our students move through their program. However, we continue to be reactive in our approach to this problem, rather that proactive.

Given the increase in those seeking support, I believe it is time that we at ESM approach the problem from a proactive standpoint, rather than that of a reactive one. That is, we need to put programming in place to help prevent mental illness and burnout from occurring within our student population, rather than simply being reactive, as students self-identify as struggling with mental illness and/or burnout.

In Chapter Two of this OIP, I argue for the need to implement a four-year co-curricular wellness program aimed at promoting the personal health and well-being of our

students. The goal of the program is to not only decrease the prevalence of mental illness and burnout among our med students, but to prevent it from happening at all by providing students with the tools necessary to fight mental illness and burnout.

To do this, I propose we implement a wellness program that begins in the med one year and continues on to the med four year where, hopefully, students will, by then, have in their toolkits the resources to be strong, mentally fit and resilient physicians. In doing research for this OIP, I read about different programs, similar to what I am suggesting, that have appeared to be effective in their delivery, resulting in decreases in the number of medical students presenting with mental illness and increases in those who employ help-seeking behaviours aimed at improving their mental health (Velez, Gupta & Gendreau, 2019; Slavin, Schindler, & Chibnall, 2014; Drolet & Rogers, 2010).

Through leadership approaches of authentic, distributed and servant (introduced in Chapter One) and using Schein's (2017) framework for leading change (as discussed in Chapter Two), I propose implementing a four year wellness program that includes, but is not limited to: personal development, resiliency, financial literacy, career counselling, mindfulness, leadership skill development and a guide to establishing a professional identity. In Chapter Two, I discuss how to do this, arguing firstly that in order to implement such a plan, changes to the learning environment will have to be made so that we can include this as a co-curricular program that is in addition to the academic curriculum. We will have to ensure that the program helps, rather than hinders, learning and does not cause any undue stress on our students.

Therefore, great care will need to be taken to ensure the organization is ready for change, as outlined in Chapter Two; that the need for change and the change process is

clearly communicated and that an effective plan for monitoring and evaluating change is in place (as discussed in Chapter Three). Within this OIP, I have addressed all of the above and have, as well, discussed and framed the problem of practice – the lack of mental health and wellness supports available to students within ESM potentially leading to a prevalence of mental illness and burnout among medical students at ESM – within the context of my organization (Chapter One) and included an expanded discussion of my leadership approaches to change (Chapter Two). Lastly, in Chapter Three, I have outlined next steps and future considerations to be addressed.

Acknowledgments

Writing this Organizational Improvement Plan did not only *feel* like a huge and daunting job, it *was* a huge and daunting job. I could not have finished, however, without the help, support and mentorship of my supervisor, Dr. Cheryl Bauman-Buffone, who probably did not realize what a great help she was to me. I am sure I did not say thank you enough. I know it could not always have been easy with my constant barrage of emails, questions, and feelings of doubt. To my Director, Dr. Lisa Sutherland, whose support and encouragement did not go unnoticed. Thank you for allowing me to do readings when I should have been working; to write when I should have been planning; and to pick your brain when I was having a block. And to my mentor and colleague of nearly 20 years, Kevin Bonner, who taught me so much over the years. Part of who I am today is because of you. To each of you, I extend a virtual high five – we did it!

My husband, my rock, my everything. When I first applied to the EdD program at Western, I did so on a bit of a whim and when I found out that I was waitlisted, I told myself it was not meant to me. Then, on one of the best days of my life, my wedding day, I received the news that I had been admitted and I told myself, wait! It is meant to be! However, with a start date of just two weeks away, I did not know what to do. After much discussion with my then new husband, we decided that deferring for a year was the smart and responsible thing to do. My choice to defer was the right choice, despite the many times I lamented to my husband, David, that perhaps I should have taken the plunge at that time.

To him, the love of my life, I say thank you for always being so encouraging, being my voice of reason when I was struggling and tempted to quit. It has been a short

three years, although long in responsibilities, both work and school. Thank you, my love, for your patience throughout this journey. You never complained, even when I did, and for that I am forever grateful.

To my step-children, I apologize for the many times you had to endure Dad's cooking when I had to study; the many practices and games I missed when I had to write; and the missed bedtimes stories because I had class. I promise to make it up to you.

And, lastly, I would like to thank my mother for the brains in my head, the stubbornness to see things through and the courage to do that which I did not know I could. You taught me perseverance and what it means to work hard; you taught me to have strength when facing adversity; and, most important, you taught me how to love. You are my hero.

Table of Contents

List of Tables

List of Figures

Acronyms

CMA (Canadian Medical Association)

ESM (Eastern School of Medicine)

OCC (Organizational Capacity for Change)

OIP (Organizational Improvement Plan)

PoP (Problem of Practice)

Chapter One: Introduction and Problem

A continuing challenge among Canadian medical schools is the high number of medical students who present with mental illness such as anxiety and depression, as well as those who exhibit signs of burnout. In fact, these numbers are "significantly higher than those in the same age cohort in the general population" (Slavin, Schindler, & Chibnall, 2014, p. 573). Med students are "high-functioning and highly resilient, but the accumulation of many stressors" (Glauser, 2017, p. E1569) leads to a variety of mental health issues that affect their overall health and well-being.

Poor mental health symptoms and conditions are most noticeably seen in the classroom and are often a direct result of the rigorous medical education curriculum. Research has shown that the learning environment directly affects the mental health of students (Daskivish et al., 2014) indicating that mental illness and burnout in physicians begins in the early years of their medical education (Mousa, Dhamoon, Lander & Dhamoon, 2016). There has been further evidence in the literature that medical students are reluctant to seek help, perceiving it as a sign of weakness, thus avoiding their own self-care (Chew-Graham, Rogers & Yassin, 2003; Mousa et al., 2016).

Senior leadership, deans and faculty understand this to be a problem, yet we continue to be reactive to the issue rather than proactive. In Chapter One of this Organizational Improvement Plan (OIP), I will set context around this issue within my institution, (for purposes of anonymization it will be referred to as Eastern School of Medicine or ESM), addressing the current situation and highlighting areas of struggle for students. These two things will come together to form the Problem of Practice (POP), while also supporting the need for an OIP to provide a vision for change.

Organizational Contexts

The following section will review the organizational context in which the ever-concerning problem of increasing mental health issues are occurring. Included is the history, organizational structure, vision, mission, values, and goals of ESM.

History

ESM was founded in the late 1800s and is one of Canada's oldest medical schools. Since its inception, ESM has led advances in healthcare locally, throughout Canada and around the world. Nearly 7,000 physicians have graduated from ESM and gone on to practice nationally and internationally at leading health institutions.

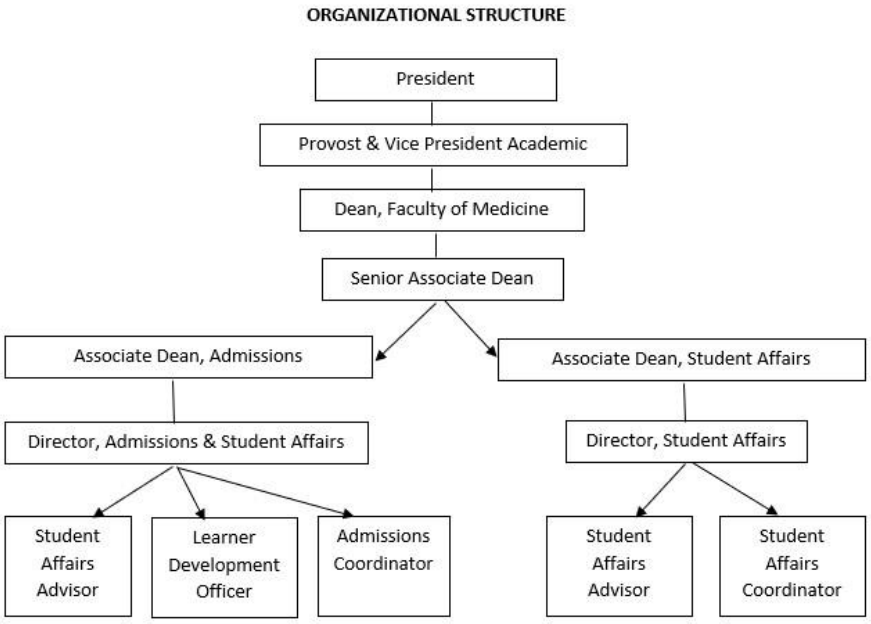

Figure 1. ESM's Organizational Structure.

Growing exponentially over the last 100 years, ESM is now one of the largest health research facilities in Atlantic Canada, with two campuses and seven distributed sites split among two provinces.

Organizational Structure

At the Eastern School of Medicine, faculty, staff and, most importantly, students are supported at all levels of the organizational structure (see Figure 1 above), starting with the President who, in the most recent strategic plan, made a commitment to bringing more awareness to the mental well-being of students (Eastern School of Medicine, 2015). Working under the direction of the Associate Dean, the Student Affairs Office, from within I work, is dedicated to serving the needs of all ESM medical students in many different areas including, but not limited to, financial advising, career planning, and personal health and wellness.

Vision, Mission & Values

Dedicated to teaching excellence in medicine, ESM's mission is to improve the health and well-being of the communities in which they are a part of through education, research, and the delivery of clinical care. With a vision of innovation that is socially accountable, ethical, civic minded and collaborative, ESM values integrity, accountability, social responsibility, and professionalism (Eastern School of Medicine, 2019).

ESM's nearly 200 faculty are award winning educators, researchers, and physicians. Many are experts in their field, having received local, national, and international recognition. ESM is especially proud of the contribution faculty has made to research in the areas of geriatric medicine, cardiology, and infectious disease. Advances and discoveries in these areas have garnered success and improvement in patient care, meeting or exceeding ESM's vision and mission.

National Context

Nationally, a spotlight is being focused on improving mental health among medical students and physicians. In 2018, the Canadian Federation of Medical Students (CFMS) launched its first ever National Wellness Program aimed at promoting mental wellness among students in the four main areas of advocacy, programming, awareness and resiliency and personal development (Canadian Federation of Medical Students, 2018). So, too, has the Canadian Medical Association (CMA) committed to increasing awareness around mental illness among physicians by pledging to foster a culture of wellness, develop system supports, and promote the importance of self-care and peer support (Canadian Medical Association, 2018).

Provincial Context

The provinces in which ESM has campuses have recognized that mental illness is on the rise and, as such, have created action plans to address this ever-increasing problem. Specifically, the province in which I live and work, has created an action plan with a vision of achieving "the best possible mental health and well-being within communities that promote empowerment, belonging and shared responsibilities" (Province of XX, 2018, p. 1), with the goal of bringing awareness to mental health issues and lessening the stigma associated with it. Additionally, the province has pledged to provide a comprehensive, curriculum-based mental health education component to students studying in health related programs so as to better prepare them for their careers; ones that, undoubtedly, will see a high level of clients or patients experiencing mental health issues.

Institutional Context

With approximately 450 students studying at ESM each year, the student body is made up of a nearly equal split between male and female. Although the majority are Canadian, ESM also accepts a limited number of international students each year. Throughout the four-year program, ESM students have the benefit of a vast array of elective experiences in any area of internal medicine they choose, as well as 15 subspecialties, allowing them to expand their knowledge in many different areas.

Along with the many curriculum demands, there is also a service-learning requirement in which students are expected to make contributions to their community. Most recently, ESM has expanded the curriculum to include a mandatory research component in which students are required to complete a two-year research project. Given the rigor of medical school, it is not a wonder that, as per the literature, students are at high risk of burnout (Bridgeman, Bridgeman & Barone, 2018; Mazurkiewicz, Korenstein, Fallar, & Ripp, 2012), depression (Daskivich et al., 2014; Hope & Henderson, 2014) and anxiety (Hope & Henderson, 2014; Shapiro & Burchell, 2012).

As evidenced, medical school is a very trying time for students. As such, addressing the issues associated with medical school, as well as the complex nature of the curriculum, it will be important that I use leadership approaches that fit well within the context of the problem. It is my believe that the leadership approaches of authentic, distributed and servant will best suit the needs of the students at ESM and, in particular, will serve me well when implementing change.

Established Leadership Approaches

Keeping in mind the above, it must also be noted that medical students are not just

students - they are husbands, wives, sons, daughters, mothers, and fathers. Medical students have a great deal of responsibility related to their education and this only adds to their already robust personal lives. As mentioned by Glauser (2017), the many responsibilities put on medical students leads to a great deal of stress for them, resulting in increases of depression, anxiety, and burnout among the medical student body.

ESM has seen a significant increase in the number of students presenting with signs and symptoms of the above mental illnesses and burnout. To combat this, ESM has begun to put supports in place to help students and equip them with the tools necessary to manage their distress. One such support was the creation of a Wellness Advisor whose role it is to build a wellness portfolio/program for medical students at ESM. In fact, this is the position that I was hired for one year ago. Specifically, I am responsible for developing programming to promote learner health and wellness; provide one-on-one support and groups sessions on resiliency; advise and support learners on learning environment related matters focused on preventing burnout; and providing individual crisis management related to a student's personal health and well-being.

In addition to my role, staff at each of the distributed sites have been hired to ensure students completing their clerkship are receiving individual support; training, such has Mental Health First Aid, has been provided to front-line staff; and workshops on mindfulness, resiliency and personal wellness have been offered. Yet, despite its efforts, ESM accreditation reports indicate student satisfaction regarding the personal counselling and well-being supports provided by the school is low, prompting the accreditation body to recommend continuous monitoring of personal counselling and wellness programming at ESM (Eastern School of Medicine, 2017).

With every indication that mental distress among medical students will only continue to rise, it is incumbent on ESM to step up to this challenge. With a mission to improve the health and well-being of its communities, it is my argument that ESM must also make it their goal to improve the health and well-being of the very students who will eventually practice in the communities in which they serve. To do so, would not only help ESM to achieve their mission but also their vision of social accountability to which they subscribe.

With the above in mind, creating change related to such a sensitive and important topic will require that I use leadership approaches that are not only ones that are personal to me, but also those that fit well within the context of the problem. I believe by leading authentically, an approach I use on a daily basis, while also incorporating the traits of both distributed and servant leaders, will help me to both prepare for and implement change. In the following section, I will discuss each of these and how they pertain to my problem of practice.

Leadership Position and Lens Statement

As the problem of practice is investigated and addressed, a variety of leadership styles/approaches will be required. There will be resistance to change, which is, of course, a natural occurrence within organizations, lack of awareness and knowledge of the problem being discussed and a great need for support. As such, different methods of leading people through the Organizational Improvement Plan will be important.

Authentic Leadership

Given the nature and sensitivity of the topic at hand, I believe it will be important that I hold true to my own personal leadership style: authentic leadership. Authentic

leaders, so says Bill George (2003) a leading scholar on authentic leadership, are those who are interested in empowering others while leading with "purpose, meaning and values. They build enduring relationships with people. Others follow them because they know where they stand" (George, 2003, p. 12). I am a leader who is open and communicative, and I am able to bond with others in a way that creates trust. This is key, as relationship building is going to be imperative when implementing this OIP. By leading authentically, I believe I will be able to create respectful relationships built on trust that will go a long way in creating such important change within ESM.

It will be essential that everyone involved, from those at the top of the organizational structure to those below, understand the nature of the problem of practice and the need for it to be addressed. Transparency will be a must and involving faculty, staff and students in the decision-making process will be paramount. As an authentic leader, I will make "decisions with utmost transparency and openness," and include "followers in the decision-making process by encouraging their viewpoint" (Bakari, Hunjra & Niazi, 2017, p. 156) as I believe transparency and involvement of others is key to enacting change.

It is my hope that by leading authentically, I will be able to influence those who are resistant or ambivalent, creating a collaborative environment open to new ways of doing things. In their study on employee engagement, Popli and Rizvi (2016) found that leadership style has a direct, and positive, impact on employee engagement. As per Muceldili, Turan and Erdil (2013), "organizations need authentic leaders for trying to cope with new, turbulent and dynamically changing work environment…by helping employees find meaningfulness and connection at work" (p. 674). In leading

authentically, I will be better able to actively engage everyone involved, while at the same time encouraging those who are already highly engaged to use their own autonomy and decision-making skills to enhance the process.

Distributed Leadership

Aligned with authentic leadership approaches, is the practice of distributed leadership, first introduced by Gibb (1954) and popularized by Gronn (2000) in which the authors describe distributed leadership as a group quality that is holistic in its approach. Since then, more and more researchers have expanded on distributed leadership, including Jones, Harvey, Lefoe and Ryland (2011). Like authentic leadership in which the leader makes a concerted effort to include people at all levels of change, so does distributed leadership. "Distributed leadership is a form of shared leadership that is underpinned by a more collective and inclusive philosophy than traditional leadership theory" (Jones, Harvey, Lefoe, Ryland & Schneider, 2011, p. 4) and is one that "encourages the active participation and partnering of experts and enthusiasts and the networks and communities of practices that are built to achieve organisational change" (Jones, Lefoe, Harvey & Ryland, 2012, p. 69). Each of us within ESM comes with the unique education, skills and expertise required to address the problem of practice. By incorporating distributed leadership approaches, I believe we will be able to make great strides in addressing the problem of mental illness and burnout among our students.

Servant Leadership

For nearly two decades, I have worked as an advocate for students. Prior to that, I worked in the non-profit sector. It is in my nature to want to help people. And it is also in my nature to want to lead. Greenleaf (1970), who coined the term servant leadership,

defined it as "the natural feeling that one wants to serve, and serve first" (p. 15) and then, by conscious choice, they choose to lead. To add to that, servant leaders are those that have strong moral compasses (Graham, 1991), putting the needs of others first. I believe, by definition, I hold many of the traits of a servant leader and, therefore, plan to employ servant leadership approaches, as well.

For example, despite having individual expertise, it will still be important to build up the confidence of those involved and to support them in every way possible. As such, it will be necessary to employ the traits and characteristics of servant leaders: understanding, empathetic, accepting, aware and able to actively listen (Greenhouse, 1977). Working through the problem will require a great deal of listening, empathy, awareness and persuasion, traits I believe I have. Like Greenleaf before him, Northouse (2016) also lists these among many of the different skills that servant leaders possess. In particular, he states that a "commitment to the growth of people" (p. 228) is a key skill of servant leaders and I believe this skill, along with the others, will be a necessary, and effective, component when implementing the OIP.

I have chosen these three approaches because I believe these styles work very cohesively together, while at the same time effectively address the unique and varied needs of everyone involved. The recommendations put forth in the following chapters of this organizational improvement plan are going to require copious amounts of buy-in and cooperation from those within the organization. As well, it will also require that I, as the one putting forth the recommendations, have a clear plan in place to put them into action. By having a defined understanding of what leadership traits and characteristics I have, I believe that I will be able to effectively adapt to what is sure to be an ever-changing

environment filled with not only those who embrace change, but also those who are resistant to it and perhaps even ambivalent.

Interpretivist Lens

When viewing the problem of practice through a leadership lens, I believe it is best viewed from the interpretivist lens, as it allows one "to gain a deeper understanding of a phenomenon and its complexity in its unique context" (Pham, 2018, p. 3) which, in this case, is ESM. The prevalence of mental illness and burnout among medical students is a very real problem, requiring an approach aimed at understanding the issues associated with being a medical student: course load, family life, high expectations, financial debt, etc. The interpretivist approach seeks to "understand the problem rather than explain it" (Mack, 2010, p. 8). Research has proven that the problem exists, leaving no need to explain it. More important, is the need to understand the problem and how best we can address it. As such, I believe the interpretivist would work well when trying to find an equal balance between the challenges associated with medical school and those of maintaining good mental well-being.

My problem of practice and resulting OIP, seeks to find answers to why medical students appear to have such high levels of mental health distress and how we can provide them with the tools necessary to prevent mental illness and burnout from occurring. First, however, must understand how we got to this point in order to get to where we want to be. Interpretivism will us to do just that as it "emphasises that action is oriented as much to making sense of the past as to the future" (Morgan, 2018, p. 619). Again, this serves to reinforce the use of interpretivism within my problem of practice and organizational improvement plan, as well as supports the leadership approaches mentioned earlier.

As per Bakari (2017), authentic leaders are focused on transparency, involve followers when making decisions and look to facts for information. Distributed leadership, says Jones et al., (2011), consists of shared leadership that encourages participation of the group in order to achieve change within the intuition. Lastly, servant leadership is concerned about followers and the need to nurture their growth as people (Northouse, 2016).

All three of these leadership approaches fit very nicely with the interpretivist approach as it has many things in common with these leadership styles. For example, through the work of Morgan (2018) and Mack (2010), we know interpretivists, like authentic leaders, are concerned with people, viewing the situation from the "inside through the direct experiences of the people" (Mack, 2010, p. 8). For purposes of this OIP, the "people" include everyone involved – faculty, staff, leadership and, most importantly, students. Interpretivism, like distributed leadership, is concerned with inclusion and building networked communities, taking multiple perspectives into consideration (Mack, 2010) when creating change. And finally, interpretivism, concerned for all involved, is like servant leadership in its concern for people and their growth; it considers the opinions of all, allowing for interpretation and negotiation of others' ideas, thoughts, and recommendations (Morgan, 2018). Therefore, as evidenced, leading change via the interpretivist approach, while also employing the leadership approaches of authentic, distributed and servant, will serve the institution, and the people within, well.

By integrating the above-mentioned leadership approaches into the interpretivism paradigm, I believe I can create a plan that for change that will foster relationships,

allowing for excellent communication, transparency and openness among the group, as well as provide cohesion and consensus among everyone involved.

Leadership Problem of Practice

As evidenced, there is a high degree of need for medical schools to prepare students for the rigors of medical school and the challenges associated with it. With more and more students presenting with mental illness and burnout, we can no longer sit idly by as our students continue to struggle mentally and emotionally. Medical schools must address the mental well-being of their students to help prevent distress and ESM is no different. As such, *the problem of practice to be addressed is the lack of comprehensive mental health and well-being supports available to students at the Eastern School of Medicine, potentially leading to an increased prevalence of mental illness and burnout among the medical student population.*

Current Practices

As noted, ESM is creating inroads to helping students manage the pressures of medical school. However, as evidenced in the most recent accreditation report, more needs to be done. Currently, different departments, along with students themselves, are creating programming that is reactive, as opposed to proactive – and herein lies the problem. I believe that rather than trying to fight mental illness and burnout only after students self-identify as needing help, we should be trying to ***prevent*** it by helping to ingrain "good habits as part of regular daily activity" (Drolet & Rogers, 2010, p. 103), while at the same time developing "a culture of concern for student well-being" (Slavin et al., 2014, p. 576). In their research, Dyrbye et al. (2009), found that the "learning environment appears to be a critical influence" (p. 280) on student well-being and, most

promising, the factors of the learning environment that have the greatest affect "are likely to be modifiable" (p. 280).

Gap Analysis

As previously mentioned, despite concerted efforts on behalf of ESM to improve in the area of personal health and wellness, student satisfaction continues to decline. I believe this is indicative of a gap in wellness programming and supports provided to medical students. Part of ESM's vision is to be socially accountable and ethical in its program delivery. As such, they have a responsibility, both socially and ethically, to ensure our future doctors are mentally healthy as they move into residency and practice. Therefore, it is imperative that we not only provide reactive approaches to mental health and wellness, such as treatment strategies, counselling, and medication, but also proactive approaches that focus on prevention, including wellness initiatives and programs that start in year one.

Additionally, studies show that rates of those who reach out for help continue to be low (Mousa et al., 2016), and that there is an increase in the rate of "alcohol use as a method to relieve stress" (p. 8). I believe this is indicative of a gap in students' understanding and knowledge around the importance of personal mental health, one that can be addressed through a wellness plan that is cemented within the curriculum.

Future Desired State

As we look at the goal of ESM–to graduate physicians dedicated to improving health through education, research, innovation and collaboration (ESM, 2015)–we must also consider the desired state from within which we hope to educate said physicians. That is one of inclusion, that promotes the health and well-being of its students allowing

them to thrive, rather than simply survive. To reach this desired state, ESM must look at the current gaps and fill those gaps by altering current practices in order to destigmatize mental illness, create an environment of care and concern, and address the lack of education and awareness around mental distress and burnout within our own student body. Before this can be done, however, applying context around the problem of practice is important. In the next section, I will frame the problem of practice, outlining the different areas of mental illness that must be addressed.

Framing the Problem of Practice

Mental distress negatively affects students' learning, personal and family life, as well as their future as physicians. Therefore, addressing mental health and burnout in the pre-clinical years is key to the individual success of medical students.

Depression

As evidenced by Slavin et al. (2014), medical students demonstrate significantly higher rates of depression than those of the same age. A later study conducted by Mousa et al. (2016), yielded this same result, reinforcing this as an issue that needs to be at the forefront of discussions surrounding our students and their well-being. It is extremely alarming that our future doctors are presenting with depression during their pre-clinical years. More recent research suggests that medical students may come to medical school with internalized or pre-existing feelings of depression that are more fully manifested once in medical school due "high demands and expectations, intellectually or otherwise; while little attention can be provided to their emotional needs" (Heiman, Davis, & Rothberg, 2019, p. 712). These students are being trained to heal others and save lives. How can they do this if they, themselves, need healing?

Anxiety

Similarly, like depression, anxiety is also prevalent within the medical student Population: "anxiety disorders among medical students constitute a global problem" (Chinawa, Chinawa, Aniwada, Ndukuba & Uwaezuoke, 2018, p. 132). Such anxiety disorders can include generalized anxiety, social anxiety, obsessive-compulsive disorder, and phobias (Chinawa et. al., 2018). There are a multitude of reasons why students may suffer from an anxiety disorder, some of which they bring with them and some of which they develop during their medical education. Either way, it is important that we, those of us working in medical schools, do what we can to help these anxieties from worsening or presenting at all.

Burnout

Burnout is another very real problem among physicians in training. In a study by Mazurkiewicz et al., (2012), it was determined that just over 70% of students who participated met the criteria for burnout. This is an incredibly high number of students, clearly indicating a need to address burnout before it follows them into residency and practice. A study by the Canadian Federation of Medical Students corroborated this. Their research indicated that approximately "37% of Canadian medical students meet the criteria for burnout" (Glauser, 2017, p. E1569). This is another alarming statistic - one that cannot go unaddressed nor the answers as to why this is happening, go unanswered.

Factors Affecting the Problem of Practice

The literature tells us not only that our students are at risk but also that "despite concerted efforts to promote and protect the health and wellness of physicians, the collective state of physician health remains a significant threat to the viability of Canada's

health system (Canadian Medical Association, 2018, p. 3). As well, we know from previous research that the learning environment, inside and outside of the classroom, negatively affects the mental health of students. This, the learning environment, is just one factor that affects the problem of practice and will need to be addressed. Other factors that affect the PoP include both stigma and medical students' shared idea that they need to be perfect…at everything.

Stigma surrounding mental illness is an issue outside and inside medical school. As noted by Wallace (2012), students with mental illness are often perceived as weak, not only by faculty but also by students themselves. Added to this is the misconceived notion of perfectionism that leaves students feeling inadequate (Yanes, 2017) if they are not meeting the expectations, perceived or otherwise, they have set for themselves.

Stigma associated with mental illness and "maladaptive perfectionism (i.e., excessive evaluative concerns" (Velez & Gupta, 2019, p. 9) lead students to place low priority over their own mental health, ignoring their own self-care (Drolet & Rogers, 2010; Minford & Manning, 2017). Early research has shown that students' overall distress is directly linked to the "perception that others expect a great deal of you and will criticize any signs of failure" (Henning, Ey & Shaw, 1998, p. 460). This perception feeds further into students' insecurities related to their idea of perfectionism and the notion that complaints of poor mental health or burnout is a sign of weakness, thus leading to feelings of "shame, guilt and worthlessness" (Heiman, Davis & Rotherberg, 2019, p. 711). This is important to note as these are assumptions they will carry with them into residency and practice; assumptions that will have a negative impact on both themselves and their patients.

"The stigmatization of mental health disorders continues to persist among health care providers" (Mousa et al., 2016, p. 8) and this must change. People must readjust their mindset to one that promotes student health and wellness, while destigmatizing mental illness and the need for perfection. Thompson, McBride, Osford and Halaas (2016) would agree, arguing that a cultural shift within medical schools aimed at decreasing stigma associated with mental illness will empower students to employ coping strategies that will lead to improved mental health.

Along with the above social factors that affect the PoP, there are also financial and economical, governance and political factors. For example, putting through an organizational improvement plan geared toward wellness (further discussed in Chapters Two and Three) will have budget implications related to planning, designing and implementation. As such, a cost-analysis will need to be completed in order to determine the benefits of initiating such a program. An analysis of the impact to stakeholders, including students, the institution and the public will need to be taken into consideration, as well. Lastly, because many people will be involved, a plan for governance will also be required.

Pollanen (2016) discussed several different models of governance in his research, including corporate and stakeholder (p. 100). The corporate model "emphasizes business-like practices and often entails performance measures for operational efficiency and meeting financial targets" (Pollanen, 2016, p. 100) and the stakeholder model involves "a wide range of stakeholders" (Pollanen, 2016, p. 100). Combining these two, which Pollanen (2016) refers to as the "amalgam (hybrid) model" (p. 100) is the model I believe would be the most cost effective to ESM. Using the corporate model of

governance, the university will be able to critically examine the program, measuring its efficiency, while at the same time being fiscally responsible. Likewise, the stakeholder model will bring everyone involved together – faculty, staff, students, and senior leadership. As well, this leadership model works well with my leadership approaches of authentic, distributed and servant.

With the evidenced shortage of doctors in the Atlantic Provinces, governments are becoming increasingly more involved in medical education, offering funding in support of additional seats within medical schools. Because of this, the onus is on the institution to ensure they are meeting government guidelines related to funding. Politically, this has consequences because, as per Botas and Huisman (2012), when the government exercises "their influence over their universities' decision-making processes" (p. 376), universities could start to feel coerced into following government regulations for fear of losing funding. This could lead to a negative relationship between the university and the government, something that would be detrimental to all involved. Therefore, governmental factors will also need to be considered to ensure that both the government and institution work together to achieve common goals.

Within the factors affecting the PoP, questions emerge related to whether or not ESM is doing a well enough job responding to the issue if medical students lack help-seeking behaviours, to name a couple. These and additional questions will be addressed in the next section.

Guiding Questions

As mentioned above, within the problem of practice and the very real need to respond to the increased number of medical students presenting with various mental illnesses and high degrees of burnout, questions emerge that must be addressed.

Is ESM responding adequately and appropriately to help decrease the prevalence of mental illness and burnout among our medical student population? In order to better help medical students through their education, it is important that we seek to determine what tools, resources and supports are necessary to help students through.

Is the climate within ESM contributing to the problem? Climate, more completely defined in Chapter Two, is associated with individual pre-conceived notions, attitudes, and beliefs (Shanafelt et al., 2019) related to a variety of things, not the least of which is thoughts and ideas associated with mental illness. In particular, faculty perceptions of mental illness among medical students influences the climate. Research has shown that learning environment directly affects the mental health of students, yet there is evidence within ESM that faculty do not consider this when teaching. Rather, the thinking is that medical school is hard, and students need to accept this and adapt. As such, it will be necessary to explore this to ensure this is not further contributing to the declining mental wellness of medical students.

Do medical students refrain from seeking help? Specifically, do medical students at ESM refrain from seeking help and support when suffering from mental illness and burnout. This is something that we will need to delve into to determine whether or not there are students in distress who have not sought help, advice, and support.

What measures can be further explored to address the growing concern of mental illness and burnout among medical students? Are there existing programs or frameworks out there that aid in both prevention and treatment of mental distress among medical students, for example, or will a new and unique program need to be created? If yes, do these programs work or will other measures, such as government programs and resources from external agencies need to be incorporated?

Whatever the answer to these questions may be, it will be important that we look at each individually to determine in what areas ESM needs to improve in order that we may move from our present state, into our future desired state, as discussed in the next section.

Leadership Focused Vision for Change

As evidenced in the accreditation review, ESM is performing unsatisfactorily in the area of student health and wellness. However, as pledged in the ESM strategic plan, there is support for, and a commitment to, improving the health and wellness of our students.

Present vs. Future State

As discussed earlier in this chapter, a gap continues to exist between the current state of student health and wellness among our student body and our future desired state. Currently, our students are presenting with high levels of mental illness and burnout and are very dissatisfied with how ESM is responding to their distress levels (Eastern School of Medicine, 2017). Students want more supports in place to address their needs and, given that mental distress is on the rise, this is not an unreasonable request by students. Their lives as mentally healthy and stable physicians are at risk if they do not receive the

help, support and tools necessary to cope with the high demands of both their medical school career and their careers as practicing physicians (Vogel, 2018; Daskivich et al., 2014).

At ESM, we are committed to helping students, as are the provincial bodies and national associations. The desired future state is one of care and concern for students, free of stigma and, it is hoped, one with low numbers of mental illness and virtually no signs of burnout. A state such as this will be beneficial to all involved, both inside and outside the institution.

ESM has a social responsibility to the public. As a health organization educating people to be doctors who will be serving the needs of their communities, we have a responsibility to put out physicians who are mentally fit and have the tools necessary to combat the high level of stress associated with being a doctor. Research has shown that physicians carry with them into practice poor mental health; in fact, "doctors suffer alarming rates of burnout, depression and suicide, and these problems often take root during training" (Vogel, 2018, p. E1426). Therefore, it is of my opinion that ESM has a responsibility to the community in which our trainees will be living and working to help change this for the better.

ESM must also be cognizant of the students themselves, owing a responsibility to them, as well, to provide them with the care and support necessary to get through medical school mentally stable and for those who bring with them pre-existing conditions, perhaps in an even better mental state than when they started medical school. As per Vogel (2018), "teaching and supporting wellness as a core competency of medicine may help reduce burnout in the profession (p. E1426). Given this, at the very least, ESM must be

committed to the prevention of burnout, allowing room in the curriculum for students to focus on their individual health and well-being, while also providing them with the education, tools and resources necessary to prevent burnout.

Priorities for Change

Currently, ESM scores low on personal counselling and student support for mental well-being (Eastern School of Medicine, 2017). We must make it a priority to change this. To that end, improvements are being made, particularly with the creation my position which is dedicated to improving wellness initiatives and supports within ESM. As well, we have signed a service agreement with a local institution to provide counselling services for ESM students. But more needs to be done. We need think about being proactive in our approach to student wellness, rather than being reactive. That is, programs, tools, initiatives need to be in place to prevent mental illness and burnout, rather than waiting for such illness to present themselves.

Another priority is the need for a shift in the climate within medical school; that is, we need to change the way mental illness and burnout is perceived within the academic realm.. I believe it is fair to say that most understand that mental distress and burnout happens; however, the climate around it seems to one of acceptance – medical school is hard and mental distress and burnout is bound to happen. In my role as Wellness Advisor, I have tried to open up the discussion but am often met with reluctance to discuss it, particularly with faculty, with the consensus being that this is med school and students need to step up, accept that it is hard and, well, deal with it. Also, as noted by Wallace (2012), students with mental illness are often perceived as weak and, therefore, it is no wonder students are reluctant to admit they are struggling with

depression, anxiety or burnout when they are met with this type of attitude from faculty. "The stigmatization of mental health disorders continues to persist" (Mousa et al., 2016, p. 8) within medical school and this must change. Faculty, staff and even students have to readjust their mindset, ensuring a climate change within medical schools to one that promotes personal health and wellness, while destigmatizing mental illness and the need for perfection.

Destigmatizing mental illness within ESM must go to the top of the priority list, along with educating students on the importance of self-care. "During medical school students have a higher prevalence of psychological distress" (Thompson et al., 2016, p. 174) and, as such, it will be imperative that stigma associated with mental illness is reduced so that students will feel comfortable seeking help to address any issues they may have. It is evidenced in the literature that medical students lack self-care behaviours and it is hypothesized that part of the reason for this is the perceived stigma associated with mental illness (Thompson et al., 2016) within medical schools. In their study, Thompson and her colleagues (2016) found supporting data that corroborates that of existing literature: "stigma regarding mental health issues is present in the medical community" (p. 174). As such, it will be imperative that ESM address this very serious issue.

Addressing these priorities will be indicative of ESM's commitment to students, stakeholders, and the community as a whole. Doing so will increase students' resiliency to the stressors of medical school and also give them the confidence to seek help when they need it, thus bringing a balance between students and faculty, with whom they normally do not admit feelings of distress out of fear that it will negatively affect them. Research shows that those who use "avoidance strategies" have higher levels of

depression and anxiety (Chew-Graham et al., 2003); therefore, ESM must create a safe space for students to express their feelings so as to avoid increasing levels of mental illness among the student Population.

Change Drivers

As per the above, the OIP will require people to change their mindset, realizing that mental illness and burnout is not a indicative of weakness; rather, it is a result of a rigorous medical education that is creating a very real problem that needs fixing. To help solve this problem, I will need to identify change drivers such as events, activities, programs, and behaviours, that will help to make the change process easier (Whelan-Berry & Somerville, 2010, p. 176).

According to Whelan-Berry and Somerville (2010), a key driver is a **shared vision and acceptance** from each individual that the "change vision is positive for them and the organization" (p. 210). This will require a very articulate improvement plan that clearly outlines the vision and need for it. Another driver that will be required is **support from senior leadership** that expresses to others "the importance of the change vision and its outcomes" (Whelan-Berry & Somerville, p. 181). I believe, at the outset, these will be the two most important change drivers. However, as the OIP progresses, other change drivers such as **communication, training, and organizational structure**, as outlined by Whelan-Barry and Somerville (2010), will also need to be considered.

Further to the above, there is hope that I, myself, will be able to drive change in my capacity as Advisor on student wellness. Currently, I sit on both the Student Wellness Committee and Resident Wellness Committee – one committed to helping students while they are here and the other preparing students for residency, providing them with the tools

to withstand the pressures and demands of transitioning from student to resident. As well, I liaise with our Student Affairs Wellness Liaisons (current students) who are front line within their class and who keep me abreast of any issues that arise within the student body. It is hoped that my presence on these committees and my relationships with students will help to build trust, a primary indicator of engagement (Popli & Rizvi, 2016), within ESM and aid in my ability to drive change as it relates to my POP and OIP. That said, before change can happen, it is important to address whether or not ESM is ready for change. In the next section, I will review our readiness for change using Judge and Douglas' (2009) eight dimensions of organizational readiness and capacity for change.

Organizational Change Readiness

Organizational readiness will be a key factor when implementing my OIP. As per Weiner (2009), when an organization has effectively made themselves ready for change, implementation becomes easier, with members exhibiting higher levels of effort, persistence, and cooperation. In order to create a change readiness plan, one must first determine an organization's capacity for change. To do this, I have looked to the work of Judge and Douglas (2009) who assert that change is a "multi-dimensional phenomenon" (p. 638) and who have created an 8-dimension framework to assess organizational capacity for change (OCC). I have also included the research of Cawsey, Deszca and Ingols (2016) who argue that change readiness is determined by several factors including past change experiences, organizational culture, transparency and confidence in leadership, which are very relevant to ESM and fall within the 8-dimensional framework of Judge and Douglas.

Organizational Capacity for Change (OCC)

Based on their research, Judge and Douglas (2009) have arrived at eight dimensions of change associated with an organization's capacity and readiness for change. These include:

1. trustworthy leadership
2. trusting followers
3. capable champions
4. involved mid-management
5. innovative culture
6. accountable culture
7. effective communication
8. systems thinking (p. 638).

As we know from the literature, trust is absolutely key when initiating and readying an organization for change. *Trustworthy leadership* (leaders that have the ability to garner trust from members of the organization) and *trusting followers* (members' ability to trust leadership) are two very important factors when creating an environment open and ready for change. I believe that ESM is working (mostly) within this dimension and by incorporating the leadership approaches of authentic, distributed and servant, I, too, am doing part in helping to create trust. Together with leadership, we increased communication within the organization and are becoming more transparent about other changes that have taken place, mostly as they relate to the education curriculum. Given this, I have confidence in their ability to foster trust from the non-academic side of things, having already shown their commitment to increasing mental

health awareness within ESM.

Capable champions, who are given the autonomy by senior management to step up and lead, is another important aspect of change readiness. At ESM, management has a show a commitment by creating my position within which I work closely with *involved mid-management*, namely, my director, who is directly linked to senior leaders such as the Associate Dean. In my capacity as Wellness Advisor, I have a direct line to decision makers, and this will help a great deal when in comes to implementing my OIP.

ESM is *innovative culture* as one of the top five medical schools in Canada with an exceptional research record. We are a culture that uses innovation to create new and impactful medical research and discoveries that add value to the medical community not only locally, but nationally and globally, as well. Given this, it is important that ESM also work toward being a more *accountable culture*, one that is committed to ensuring its student thrive. In this area, ESM still has work to do. ESM must be more accountable to students and their mental well-being. It is important that a culture of accountability is created in which ESM is proactive it its approach to student wellness, rather than simply reactive.

During my short time here at ESM, I have noticed that departments appear to be very siloed and communication is sparse. I am often surprised that after so many years, miscommunication regarding the same issues continue to happen. I have seen some improvement, particularly within my department; however, there is definitely room for more *effective communication* between our office and that of others within the institution. Expertise lies within the other departments and for change to occur, I will need to seek advice and support from these other *systems thinking* areas, recognizing the

"interdependencies" (Judge & Douglas, 2009, p.638) among each. We need to rely on each other to get to the cause of the problem and provide solutions to it. Using an interpretivist approach, focused on building relationships, creating networked communities and the growth of people (Morgan, 2018; Phan, 2018; Mack, 2010), will help in the area of communication, ensuring that we garner all of the necessary information from all the necessary people.

Past Experience

Intertwined within the Judge and Douglas' framework of organizational capacity for change, is the four key aspects of change readiness as introduced by Cawsey et al. (2016). To start, there is past member experience. Being relatively new to ESM, I am unaware of what past experiences individuals within the organization have had regarding change. Therefore, it will be up to me to research the history of change within ESM to determine what the mindset is regarding change and, to take from the work of Lewin (1951), *unfreeze* any preconceived notions there are related to change. This will require that I garner the trust of not only followers, but upper management, as well, because argues Smits and Bowden (2015), fewer setbacks occur when there is trust among leaders.

Flexibility of the Culture Within

Like the above, culture within ESM will also need unfreezing in order to make way for change. Change will only work if the collective group, as well as the individual, is open to it. "Organizations can create cultures that encourage the conditions best suited to dealing with change" (Dumas & Beinecke, 2018, p. 868) and, in so doing, create a flexibility from within that allows for effective change management leading to a more

innovative and, most importantly, accountable culture.

Transparency of Leadership

By leading authentically with effective and transparent communication, employees will feel empowered to be part of the change process. In order for ESM to effect change related to improving the health and well-being of its students, many people will be involved, including those from the bottom up. As such, ensuring an open and honest dialogue prior to the change implementation, will better able myself and others to "influence employees' ability to adapt to change" (Dumas & Beinecke, 2018, p. 869) as well as ready them for it.

Employee Confidence in Leadership

As pointed out by Dumas & Beinecke (2018), we are moving away from the traditional top-down hierarchy to one that is more inclusive, open, and participative. Leadership is asking more and more of the people within to be part of the strategic planning process and, as such, it is important that employees have confidence in leadership, their vision, and the proposed need for change. Working in a "continuous feedback loop, providing evaluation and feedback" (Dumas & Beinecke, 2018, p. 873) is an important part of assessing organizational change readiness and will certainly go a long way in maintaining confidence in leadership and the organization as a whole. Interpretivism, which is concerned with taking multiple perspectives and individual experiences into consideration, (Mack, 2010), will be particularly useful during this step.

Competing Forces

To assess for change readiness, both internal and external forces will also have to be taken into consideration. Internally, the value associated with the change will have to

measured. Weiner (2009), referring to the value organizational members place on change, argues that "change valence" (p. 3) can help leaders identify "drivers of readiness" (p. 3) in order to better prepare for change. Like that of Cawsey and colleagues (2016), Weiner lists organizational culture and past experiences as key internal factors that affect change readiness, as well.

Externally, I will take into consideration political, environment, social, technological, and economical factors such as those that were discussed earlier in this chapter. In addition, it will be important to share both internal and external data related to the state of mental illness and burnout with everyone at ESM, so they are aware of high degree of need for the problem of practice to be addressed.

Conclusion

In this chapter, I have introduced the reader to the problem of practice, outlining the need for increased awareness around mental illness and burnout among medical students. As evidenced, there is a high degree of "need for mental health resources for medical trainees so that our future physicians can lead productive, successful lives" (Mousa et al., 2016, p. 6) and this is no different at ESM. Therefore, we must create a change within ECMS that reduces stigma, promotes personal well-being, and stresses the importance of self-care. To create this change, I will discuss the planning and development of change, while also expanding further on my leadership styles of authentic, distributed and servant in Chapter Two of this OIP. I will also outline my framework for leading change, that of Schein (2017), while also using Deszca, Ingols and Cawsey's (2019) Change Path Model for diagnosing and analyzing needed changes.

Lastly, I will discuss possible solutions to the problem of practice and the ethical implications associated with the change process.

Chapter Two: Planning and Development

In Chapter One, I introduced the reader to the problem of practice, contextualizing it within ESM, while also articulating a vision for change to address the problem. In this next chapter, made up of five parts, I will further delve into the problem of practice, first by expanding on the three leadership approaches of authentic, distributed and servant in which I intend to use to move change forward. Second, I will introduce a framework by which to lead change. A critical analysis of ESM will follow and include frameworks for diagnosing and analyzing the problem. The fourth section will provide possible solutions to address the problem of practice, while the fifth and final section will discuss leadership ethics.

Leadership Approaches to Change

It is no surprise that in today's world, one filled with skepticism, lack of trust and what appears to be unscrupulous behaviour of our leaders, we are seeing an increased desire for leaders who are ethical and moral, open and transparent, and honest and trustworthy (Kiersch & Peters, 2017; Lyubovnikova, Legood, Turner & Mamakouka, 2017). I believe that this is no different within the walls of ESM. In order to effect change and provide solutions to the problem of increasing mental illness and burnout among med students at ESM, it will be important that I lead authentically to ensure a shared vision in which everyone involved is invested in the success of our students. Given that there will be many different people involved, students, staff and faculty, it will be important that I encourage others to look inward to their own strengths and abilities in order to help develop their individual skills to become leaders themselves. To that end, I

will lead as authentically as possible, in a distributive manner that takes into consideration the greater good.

Authentic Leadership

I work at an institution dedicated to teaching students to be the best physicians they can be—physicians who, they themselves, are happy, healthy and stable. As evidenced in the literature, however, the opposite seems to be true. Medical students are presenting with high levels of stress, mental illness, and burnout and those within ESM are no different. As such, it is my assertion that ESM is obligated to provide a system of supports for students that positively affects their overall mental health and well-being. To do so, will require a change within ESM that is evident at many different levels and involves many different people. I am able to help implement this change and I believe that by leading authentically, I can do just that.

Bill George, a leading researcher of authentic leadership, along with his colleagues, describe authentic leaders as ones who bring with them passion, honesty, integrity and the ability to build relationships and garner trust (George, Sims McLean & Mayer, 2007). Authentic leadership value openness, transparency and ethical behavior., Indeed, argues George, et al., (2007), authentic leaders "know who they are" (p. 129) and I believe I am just that – an authentic leader, one who, states Wong and Cummings (2009), allows for the development of positive "leader-follower relationships" (p. 7) that will help to create a shared vision for change. Additionally, the traits self-awareness, balanced processing, authentic behavior, and relational transparency lead to trust (Wong & Cummings, 2009), something that is key when initiating change. Furthermore, authentic leaders can instill in others confidence in their own abilities, while at the same

time making them more self-aware of their own authentic behaviours, which then leads to feelings of empowerment. Given the high stakes nature of the problem – the increased prevalence of mental illness and burnout among medical students - and the amount of people who will be involved, all of whom bring with them their own unique skills, experience and expertise, this will be key as I will not be able to do this alone. As the Wellness Advisor, my role is to advise those within the institution of not only the problem, but ways in which we can help to solve the problem. Those in roles closely associated with students, such as faculty and tutors, will be important to the change process. As such, change must involve a collaborative system working together in a distributive, group effort, to help solve problem.

Distributed Leadership

As mentioned above, to positively impact the issue of mental illness and burnout at ESM, an authentic leadership approach, that includes many different people, at all levels of the organization will be necessary. To this end, distributed leadership practices, those that are collaborative and participative, will also have to be employed.

Like authentic leadership, distributed leadership values others and what they bring to the table. This approach sees everyone within the institution as important and acknowledges the need for collaboration among groups, encouraging "active participation and partnering of experts and enthusiasts and the networks of communities of practices that are built to achieve organizational change" (Jones, Lefoe, Harvey & Ryland, 2012, p. 69). As stated, I cannot implement change alone; buy-in from all levels of ESM will be required and I will need to develop a process by which individuals come forward to help lead the change process.

Distributed leadership, as per Lumby (2019), "diminishes the power of the solo leader, enabling others also to take a leadership role" (p. 11). This is key for two reasons: first, as an authentic leader, one who promotes the personal growth of others, to try and do this on my own would go against my personal values and beliefs. Second, the expertise of many will be required to implement the change effectively. Distributed leadership allows for information sharing, much like that of a networked learning community or community of practice. It allows for individuals to share their ideas and expertise, thus engaging multiple people in leadership activities that, argues Harris (2006), "is at the core of distributed leadership in action" (p. 41). As someone new to the field of medical education, it is important that I seek the advice of those with more experience and expertise than I. Allowing others to provide advice and support throughout the change process, is important both in this respect and how I am as a leader. An authentic leader, like myself, seeks the leadership of others to help implement change, therefore distributing the leadership of others throughout the process.

Servant Leadership

As discussed above, leading change will require a group effort and be distributed across the many levels within ESM. Therefore, I will need to foster sense of empowerment in everyone involved, encouraging them to step up as leaders themselves, showing my trust in their abilities. Empowerment, belief in others and people development are three of the key characteristics held by servant leaders (Kiersch & Peters, 2017) and are traits I see in myself, as well. In this sense, servant leadership aligns very well with authentic leadership in that it, too, fosters a "positive, ethical and trust-based" (Kiersch & Peters, 2017, p. 149) environment. As such, I will seek to

incorporate servant leadership approaches within the change process at ESM.

Recognizing that expertise lies within other areas and departments at ESM, I must look to others for their advice and support through the process. Greenleaf (1977) suggests that in order to effect change, leaders must become servants to their followers or team, allowing for the personal and professional development of others, while at the same time emphasizing "strong ethical and moral behavior" that puts "the 'greater good' above their own self-interest" (Keirsch & Peters, 2017, p. 154). Putting my confidence in others, empathizing with them throughout the change process, extending my gratitude in their help and support and creating unity with a shared vision will, it is hoped, create a bond of trust among us all, a key component in any change process.

Propelling Change

To propel change forward, I will need to harness the trust, respect, and support others as we seek to find suitable solutions to the problem of increased mental illness and burnout among med students at ESM. I believe that by leading authentically, with distributed and servant leadership approaches entwined, I can do just that. Employing these approaches will help create a climate of care and concern, conditions that, in addition to a framework for leading change, further discussed in the next section, are essential.

Framework for Leading the Change Process

As the Advisor responsible for the student wellness portfolio, I believe I am well positioned to be a change leader when it comes to improving the overall health and well-being of our medical students. To be a change leader, I will not only need to adopt leadership approaches that fit within both ESM and my personal leadership style, such as

those discussed in the previous section (authentic, distributed and servant), but I will also need to adopt a change management framework by which to initiate change within my institution. Given my leadership approaches – authentic, distributed and servant – I believe the change management framework that best fits with these is Schein's (2017) model for change. In his model, adapted from Lewin's three stage change model of unfreeze, change, and refreeze, Lewin provides a framework that allows for a greater analysis into change and how best to implement change. Before expanding on Schein's (2017) model, I think it important to first outline Lewin's (1951) model for change in order to add context around Schein's.

Lewin's Change Theory

Enacting change is a very complex process that involves many working parts. Before doing so, one must ensure that not only is an organization ready for change, but that there is a change plan in place, one that includes embedding change as a permanent of the organization. A scholar in change management, Kurt Lewin, created a three-stage change theory model (see Figure 2) that that does just that - assesses change readiness, includes a change implementation plan and accounts for permanent change within the organization. Lewin (1951) refers to these stages as unfreeze, change, and refreeze. During the *unfreeze* stage, the change leader is preparing the organization for change, identifying areas that need improvement and creating the need for change. The *change* stage is when implementation of changes occurs. Here, there is a need for constant communication, open dialogue, and empowerment of people within the organization to help lead the change. In phase three, *refreeze*, change, it is hoped, becomes anchored

within the organization and the new desired state is embedded within the culture of the organization.

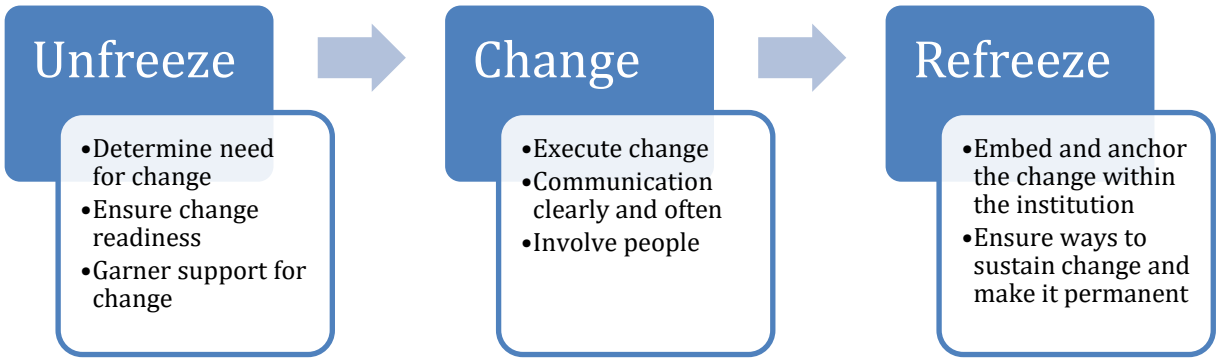

Figure 2. Lewin's Model for Change. Adapted from Schein, H. E. (2017). *Organizational culture and leadership*. Hoboken, NJ: John Wiley & Sons, Inc.

Given the leadership approaches I intend to use, I believe Lewin's 3 stage change process would be an effective way to prepare, implement and sustain change. Lewin's model encourages authentic, distributed and servant leadership. That said, however, since Lewin first introduced his model, several researches have adapted his model to one of their own, taking Lewin's model even further, expanding beyond the three stages to include more in-depth change processes.

As show in Figure 3, Schein (2017) has done just that by adapting Lewin's model to one of his own, adding additional means by which to create motivation (*unfreeze*), learn new concepts and standards (*change*) and internalize said concepts and standards within the organization (*refreeze*). With the sensitive nature of the problem, I believe incorporating Schein's adaptation of Lewin's change theory will further help me to develop and implement the change process and my organizational implementation plan.

Schein's Stages and Cycle of Learning/Change

Schein (2017), although respectful of Lewin's change theory model, feels that it really is just the "starting point for analyzing the whole change process through its various stages" (p. 321). According to Schein, the change management process requires a more in-depth analysis that includes: further understanding of what prompts change and, more importantly, why someone would want to disrupt the status quo; the conditions necessary for change to be successful and how they differ from the current organizational culture; greater analysis into how the change process begins and what stages are involved. To do this, Schein created an expanded version Lewin's three stage model (see Figure 3), referring to his three stages as: (1) Creating the Motivation to Change (Unfreezing); (2) Learning New Concepts, New Meanings for Old Concepts, and New Standards for Judgement (Change); and (3) Internalizing New Concepts, Meanings, and Standards (Refreezing).

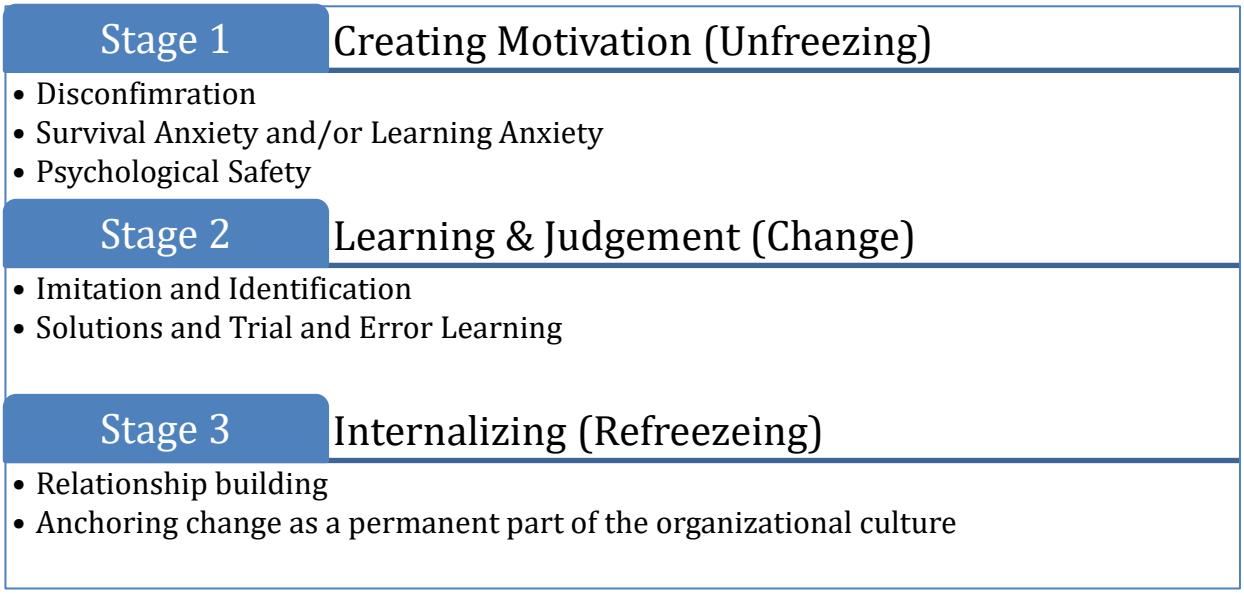

Figure 3. Schein's Stages and Cycles of Learning/Change. Adapted from Schein, H. E. (2017). *Organizational culture and leadership*. Hoboken, NJ: John Wiley & Sons, Inc.

(1) Creating Motivation for Change

*Disconfirmation***.** According to Schein (2017), the want or need to change or learn something new "always begins with some kind of pain or dissatisfaction" (p. 322). Taking on many forms, the *pain or dissatisfaction* is ultimately a result of something negative that has happened within the organization. It could be anything from lost sales to low morale. In the case of ESM, I believe it is the low accreditation scores and *dissatisfaction* students have with our wellness programs, along with the knowledge that medical students suffer from higher rates of mental illness and burnout than their peers in other programs, that cause us *pain*. Acknowledging such *pain* or *dissatisfaction*, is referred to as "disconfirmation" (Schein, 2017, p. 322) and, so argues Schein, is the first step in creating the motivation for change.

*Survival Anxiety & Learning Anxiety***.** *Disconfirmation*, however, is not the only thing needed in order to create motivation; there also must be some form of individual survival anxiety or learning anxiety (Schein, 2017). That is, people are increasingly motivated to change if the *disconfirmation* is sufficient enough that the *pain* causes some form of internal stress that cannot be ignored. For example, accreditation reports for ESM show that we continue score low on student satisfaction with health and well-being programs and supports. This *disconfirmation* threatens our medical school accreditation and, therefore, the med school as a whole. Survival anxiety is thus felt as there could be the potential of lost jobs if accreditation is taken away. To deal with this, new ways of learning how to address the problem of increased mental illness among med students will have to occur and this, in turn, could lead to learning anxiety. Survival anxiety and

learning anxiety, argues Schein (2017), are two key factors in motivating people toward change.

Further to the above, learning anxiety, although often having a positive impact on motivation, can also have a negative one, creating more resistance to change than motivation to change. It is important to note that learning does not have to be in the traditional sense such as learning to a new task, computer program or process; it can be something like learning how to collaborate, change your mindset on an issue or work within a lateral network, free of hierarchy (Schein, 2017). For example, at ESM I have observed a very siloed system, in which different departments work within their scope of practice, with very little collaboration between groups. Also, it is evident that there is a very traditional hierarchical system of reporting, although I do see some movement by our leaders to look to others (such as myself) for advice and support. My OIP is going to require people to get out of their comfort zone and work together for the betterment of our student body. I do understand that I will be met with some resistance and recognize that it is not personal but, rather, "a rational response to many situations that require people to change." (Schein, 2017, p. 327). To turn resistance into motivation, I will, as per Schein, have to decrease *learning anxiety* by clearly communicating the vision, providing education and training on the problem, ensuring resources, supports and structures are in place, and keeping everyone abreast of the change at each step of the way. People will have to come out of their comfort zone; however, I believe that by espousing honesty, transparency, and open communication, I can turn decrease *learning anxiety*, turning resistance into motivation.

(2) Learning & Judgment: Change Implementation

In stage 2, the change implementation stage, Schein (2017) suggest that new behavior is learned by imitation and identification or through trial and error as one works toward a solution that solves the problem. As I mentioned previously, I have been met with some resistance regarding student wellness. Many have suggested to me that it is medical school, it is hard, and students simply need to accept that. However, in discussions with my Director and the Associate Dean, it is clear that they wish for a switch in this mindset and it is hoped that through the creation of my position, that will happen. Given this, and with the support of my leaders, I will have to ensure that I am being as transparent as possible, clearly identifying how I expect the new way to be and how certain beliefs and values should be accepted. Schein argues that by so doing, imitation and identification will be successful, leading to less resistance to change, thus helping to reach the change goals.

(3) Internalizing

In the last stage of Schein's framework, we look at Lewin's (1951) concept of *refreezing*. In this stage, I will have to provide positive results, showing a happier and mentally healthier student body. Essentially, it is hoped that I will be able to prove that the change yielded positive results for everyone involved, most importantly, the students, and that it is worth cementing, or *refreezing*, within the organization. In this stage, old habits will die, a new identity will be created, and interpersonal relationships will be developed.

My leadership approaches of authentic, distributed and servant, as well as the use of Schein's framework for leading change, will be moot if those within ESM are not

aware of the problem and why there is a need for change. In next section, I will critically anyalyze ESM, diagnosing and analyzing why change must occur. Indeed, through the following critical organizational analysis, I hope to clearly show the reader where the gap exists between the present state and the future desired state and how we can help solve the problem of mental illness and burnout among the medical student body at ESM.

Critical Organizational Analysis

In Chapter One, I briefly outlined gaps between current practices and what the desired state within ESM would look like. In this next section of the OIP, I will do a more in-depth gap analyis, indentifying where the gaps lie, what change is needed and why stakeholders within ESM should be concerned. Working withing Schein's (2017) cognitive framework for change, I will, additionally, look to Deszca, Ingols and Cawsey's (2019) Change Path Model to further diagnose and analyze needed changes within ESM.

What Needs to Change

Earlier in this OIP, I introduced Judge and Douglas' (2009) eight dimensions of change used to asess an organization's capacity and readiness for change. When looking at ESM through this model, I believe that the organization and those within ESM are ready for change. That is, they are ready to change the problem of mental illness and burnout among our med students to one of proactive prevention than reactive reponding**,** albeit with hesitance, as trust, which makes up the first and second dimensions, continues to be an issue. For example, our leaders have begun educating staff in the area of mental health and wellnes, having mose recently provided a workshop related to how best to handle difficult conversations. This was very worthwhile, as having a conversation with an indivudual about their mental health is very difficult for both parties invovled.

However, the leaders themselves are not around the table which leads to skepticm and distrust that our leaders are fully committed to addressing the problem if they, themselves, are not also participating. To me, this is indicative that a gap in trust continues to exist and this is something that needs to change particulary because trust leads to both commitment (Ouedraogo & Ouakouak, 2017; Smollan, 2018) and cooperation (Komodromos, Halkias & Harkiolakis, 2019), two very important aspects of successful change.

When it comes to championing others to come forward and help lead change, our leadership seems to be apprehensive about allowing others to provide their opinion and expertise which, like the above, leads to some trust issues. Leadership has shown some commitment to change, in that my position was created to address mental health and wellness for our students, yet there seems to be an attempt to silo me, with explanations that wellness falls outside of the pervue of others' job descriptions. However, in talking with others, it is evident that their advice and experience would be extremely beneficial and, frankly, they are excited to help as they, too, want our students to be healthy. It is important that leadership encourage and facilitate knowledge sharing, otherwise be seen as hypocritical and untrustworthy (Svieby, 2007).

As evidenced in Chapter One, the learning environment direct correlation to the mental health of our students, affecting "a wide variety of factors important to learners and providers alike: burnout, depersonalization and emotional exhaustion; satisfaction and well-being; identity formation; performance and collaboration" (Gruppen, Irby, Durning & Maggio, 2018, p. 2). As such, faculty will need to be involved in helping to solve the problem. At ESM, we have a Faculty Development Coordinator who, in my

opinion, would be a key player in helping to educate faculty on the problem of practice. It will be encumbant upon me to outline the benefits of having *capable champions* (dimension #3) use their individual expertise and relationships with key stakeholders to help propel change within ESM. I will need to establish a climate of learning and development to leverage knowledge and build support toward solving the problem of practice and I believe I am well positioned within my role to do this.

When looking at Judge and Douglas' (2009) sixth dimension of change readiness, *accountable culture*, I continue to see a gap indicating some work related to the culture within ESM surrounding mental illness needs to change. As previously mentioned, although improving, stigma around mental illness continues to exist within the walls of ESM. As such, students are very reluctant to reach out for help, as they fear they will be negatively impacted academically. In my discussions with students, they appear to be particularly reluctant to speak to faculty as they worry faculty will see them as weak and that they, the students, should understand this is medical school—it is hard and they should just deal with it. Now, this is not to say every faculty member feels this way. However, I have heard this first hand from different faculty members and know it is the feeling of some. This tells me that there is a gap in awareness among faculty regarding the prevalence of mental illness among medical students. As per Schein (2017), organizational culture includes shared assumptions among groups. In order to change the culture to one of more accountablility, with faculty helping to take ownership of the problem, I will need to work to create a shared vision for change that will help create an *accountable culture* that is empathetic and sympathic toward our students, rather than one that appears apathetic to problem.

Further to this, are changes needed with regards to gaps noted in Chapter One. We continue to have gaps in wellness programming; we remain reactive in our appraoch to mental illness, rather than proactive, creating a gap in prevention of mental illness and burnout; and students continue to show low rates of help-seeking behaviours, which I believe points to a gap in understanding and education within the med student population with regards to the importance of self-care. This last point is critical. Many studies, including one by Ayala, Omorodion, Nmecha, Winseman and Mason (2017), have determined that medical students who practice a variety of self-care behaviours have lower levels of stress, mental illness and burnout than their peers who do not. Therefore, it is essential that we educate our med students on the importance of incorpating self-care behaviours into both their personal and professional lives.

To summarize, in order for ESM to address the problem of increased mental illness and burnout amoung our student body, the above mentioned gaps must be closed and much needed change surrounding these gaps happen. In addition, change related to awareness of mental illness, the associated stigmas and education also requires change. To address these much needed changes and propel movement away from the problem and toward the solution, I will look to Schein's change model, based on that of Lewin's, as well as Deszca et al.'s (2019) Change Path Model.

Diagnosing and Analyzing Needed Changes

In the previous section, Framework for Leading the Change Process, I introduced the reader to Schein's change framework. Based on Lewin's three stage process of *unfreeze, change* and *refreeze*, Schein expanded on this model by incorporating a more detailed process for analyzing change. In his model, Schein encourages leaders to rethink

the way they approach change by emphasizing motivation to change (*unfreezing*), redefining old and new concepts (*change*) and internalizing change (*refreeze*). In order to fully diagnose and analyze the need for change, I will use Schein's framework for analyzing the organization's readiness for change. In addition, I will also incorporate Deszca et al. (2019) Change Path Model (see Figure 4) as it, too, is loosely based on Lewin's model and fits quite nicely both within Schein's model and my leadership approaches of authentic, distributed and servant. This model is made up of four stages that include *awakening*, *mobilization*, *acceleration* and *institutionalization*.

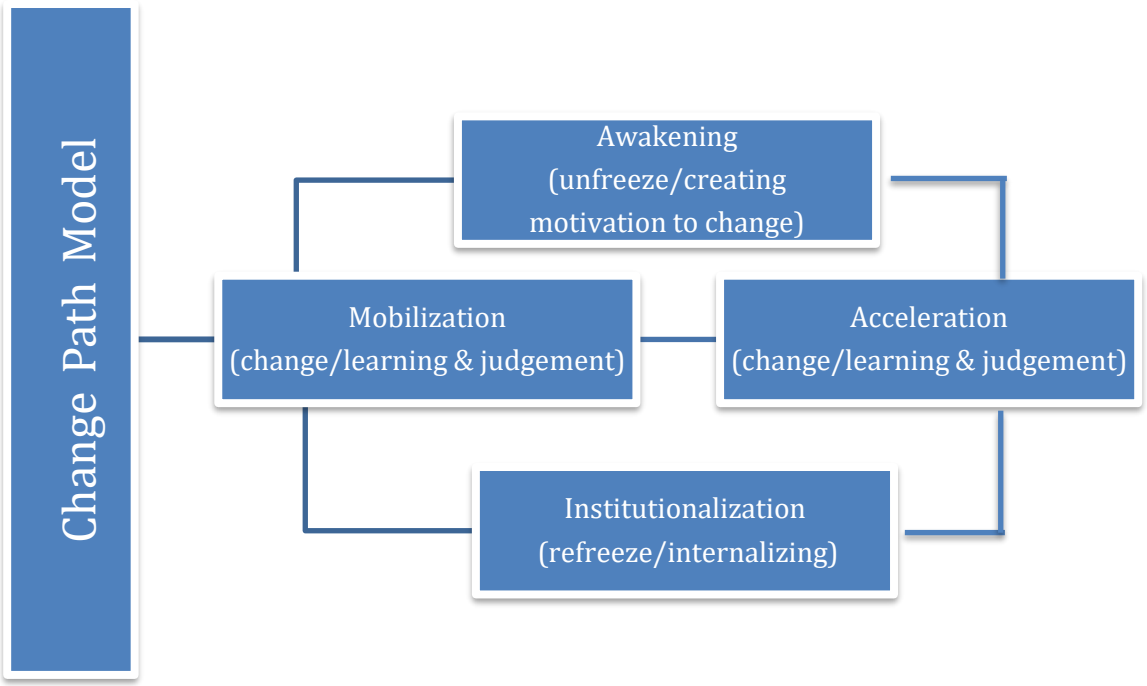

Figure 4. Deszca, Ingols and Cawsey's Change Path Model. Adapted from Deszca, G., Ingols, C. & Cawsey, T. (2019). *Organizational change: An action-oriented toolkit*. (4th ed). Thousand Oaks, CA: Sage Publications, Inc.

As previously stated, there remains many gaps between the current state at ESM and the deisred future state. As such, there are several changes that are needed in order for ESM to close these gaps and embed within the climate, a desired state that includes a

happy, healthy and mentally sound student body. In order to advance the process of change, I will seek to create motivation for change within ESM by *awakening* everyone within ESM to the problem of practice. To do that will require a more in-depth analysis of the problem and what internal and external forces are at play (Deszca et al., 2019). This will require that I spread awareness of the problem through open dialogue with all stakeholders, both formally and informally, underscoring the need to disrupt the current situation; that is, no longer can we stand idly by as our students succumb to the pressures of medical school. No longer can we turn to the excuse of why we do things as we do – because that is how we have always done it. "Past experiences may cause people to become not only complacent but also cynical" (Deszca et al., 2019, p. 101). I have seen evidence of this within ESM and this must change; we have to become more proactive in our approach, such as creating "initiatives for students that prioritize exploration of individual self-care practices" (Ayala et al., 2017, p. 244) that benefit the mental well-being of our students. We must *awaken* ourselves to this very real issue and let go, or *unfreeze*, any of our preconceived notions related to mental illness in the hope of lessening any stigma around it and encouraging students to seek help.

The *awakening* stage will also require that I not only bring awareness to the problem but that I clearly articulate both why change is required and what exactly needs changing (Deszca et al., 2019). To ignore this step would detrimental to the change process, causing confusion all around. As such, it will be imperative that I outline precisely what the problem is, why we need to change it and what needs changing. At ESM, the problem, as identified throughout this OIP is the increasing prevalence of mental illness and burnout among med students. Why we need to address this problem

and change is, in my opinion, quite obvious – ECMS has an ethical and moral obligation graduate physicians who are mentally healthy. In fact, researchers in the field of med student health and well-being would agree: "medical schools have a responsibility to respond to concerns about medical student well-being" (Kemp et al., 2019, p. 2) as it can, and does, affect the student and their future as a physician. If we do not take this responsibility seriously, we are doing a disservice to the student, their future patients and their community. In terms of what needs changing, an articulated gap analysis will be shared with key stakeholders so as to better educate them on the current situation within ESM.

Lastly, I will look to others for their input, advice and expertise. When examining change, Deszca et al. (2019), argues that it is important to seek many perspectives, since change involves them too. This leads to awareness about the problem while also increasing their knowledge of why change is needed. Although people may understand there to be a problem and that there may be, according to Schein (2017), *disconfirmation*, people "will not mobilize their energies until the need is framed, understood, and believed" (Deszca et al., 2019, p. 104).

During the awakening stage, it is hoped that while bringing knowledge and awareness to the increased prevalence of mental illness and burnout among students at ESM, I will also be able to address the gap in trust that I previously noted. As mentioned, the lack of trust followers appear to have with leaderhsip is something that must change. I believe awareness will help others understand the nature of the problem, including everyone from the top down. As well, by requesting the input of others, garnering their

expertise, I will be able to to show those at the top of the heirarchy that everyone has something to contribute and that those invoved can help champion the change process.

From the awakening stage, we move on to the *mobilization* and *acceleration* stages. These two stages make up what Lewin refers to as *change* and Schein as the stage where individuals are encouraged to rethink their previous thoughts and ideas through imitation, identificaion and trial and error problem solving. During *mobilization*, additional development of the gap analysis occurs, resulting in a deeper understanding of what needs to change. Information garnered from this will then be used to "further develop and frame the vision for change" (Deszca, et al., 2019, p. 56). This shared vision will help to foster and nurture relationships within ESM; relationships that will be integral to OIP. In fact, research by Men and Yue (2019), has shown that when employees "feel the care, respect and mutual reliance from engaging in open and equal communication with their organization" (p. 8) they feel more emotionally connected to the organization and are more apt to share the vision associated with organizational change.

It is also within the mobilization stage that institutional culture is addressed. As already discussed, there remains a very real stigma associated with mental illness within medical schools (Mehta & Edwards, 2018; Vankar, Prabhakaran, & Sharma, 2014) and this stigma is seen within ESM. If we are to move forward and become an instituion dedicated to caring for our students, we must change the negative culture that is preventing us from solving the problem. According to Mehta and Edwards (2018), stigma around mental illness among physicians begins in medical school. As such, it is absolutely imperative that we address this issue within ESM and work toward changing the culture and stigma surrounding mental illness among our students.

A common theme throughout my leadership approaches, is the want and desire to include others in the change process and it is through mobiliazation that I will continue to build and grow relationships. In the awakening stage, I hope to make upper management see the importance of including those that are lateral to me on the heirarchy, as well as those who may be below. As per Deszca et al. (2019), leaveraging the assets of others, including their experiences, skills and abilities, will help to reinforce the change vision and will benefit the implementation. The problem of practice is a very serious issue and although I know I can be an effective change leader, I also know that I cannot do it alone; I will need to "mobilize" the troops, as it were, in order to effect change.

Once the mobilizaton stage is complete, it will be time to move into action and begin the *acceleration* stage where "specific actions are undertaken to advance the implementation of desired changes" (Deszca et al., 2019, p. 56). Building on the above, relationships created in the awakening and mobilization stages will continue to be developed and nurtured because, as Deszca et al. (2019) argue, effective change requires information sharing and active participation of others. Here, I will look to others to help create wellness programing for students that will help address the gap in what ESM currently lacks in terms programs and supports. As stated in Chapter One, ESM accrediation reports continously note that our students are unhappy with the lack of health and wellness supports within ESM. This is indicative of a gap and and a need for change.

I believe that not only will it be important to look to others for their input, it will also be important to help develop their skills and abilities in areas where they may be lacking. Not only do we have employees with a great deal of expertise to bring to the table, but in asking for employee input, we help to foster positive "organizational citizen

behaviour" (Men & Yue, 2019, p. 1) which, in turn, leads to increased employee advocacy for change. This, too, is a key component of the acceleration stage and is one that I feel cannot be overlooked. As per Kezar (2018), bringng staff together through professional development opportunities will not only increase knowledge around the change but will also help build and foster relationships. In so doing, we help create a sense of employee empowerment, leading to a shared vision for change.

In this stage we will also recognize and celebrate small victories (Deszca et al., 2019), while also recognizing the contributions of others. In so doing, it is hoped that we can keep motivation high. According to Amabile and Kramer (2011) celebrating small wins is as important as celebrating the big ones. In doing their research, the authors discovered that communicating little victories is essential to workplace motivation and progress, finding that "when managers recognize people for the work they do, it signals that they are important to the organization" (Amabile & Kramer, 2011, p. 17). Furthermore, by celebrating milestones and the people who help meet them, I am in keeping with both my authentic and servant leadership styles.

In the final stage of Deszca et al's. Change Path Model, we seek to *institutionalize* (refreeze/internalize) change, making it a permanent part of the ESM climate. Here, we are transitioning to the new, desired state, where, it is hoped, the new state becomes a permanent part of the institution. It is here that I will monitor, evaluate and measure change, key aspects of institutionalization (Deszca et al., 2019). This stage will require constant monitoring and evaluation of what is working and what is not. Both monitoring and evaluation will be further expanded upon in Chapter Three of this OIP.

Now that I have completed a gap analysis and diagnosed and analzyed needed

changes through Schein's framework for leading change and Deszca et al.'s (2019) Change Path Model, it is time discuss ways in which to solve the problem. In the following section of Chapter Two, I will propose possible solutions to help solve the problem.

Possible Solutions to Address the Problem of Practice

This next section of the OIP lists possible solutions to the problem of increased mental illness and burnout among medical students at ESM. Throughout, I will discuss the pros and cons of each proposed solution, along with associated resource needs. Although multiple solutions will be discussed, only one solution will be recommended; one that I believe bridges all gaps and adresses the areas requiring change. This solution will be discussed throughout the remainder of this OIP, encompassing the development and implentation of the organizational improvement plan for change within ESM.

Stay as we are and maintain the status quo.

In Chapter One, I discussed the many ways ESM has shown a commitment to improving the well-being of our students. Staff has been provided training in the area of mental health, peer support activities have been encouraged, increased counselling options have been made available and, perhaps most importantly, my poistion was created specifically to work on the wellness portfolio. These initiatives have been met with positive results and both students and our senior leadership appear to be pleased with the work I have been doing. But, is this enough?

Maintaining the status quo has its advantages. For example, it is comfortable. Many people are adverse to change and keeping things as they are is comforting to them. They remain happy or, at the very least, content within their work environment and to

disrupt this, may result in negative behaviour. However, it is important to note that many support maintaining the status quo because they do not understand the importance of change, therefore making it necessary for leadership to accurately describe the change and why it is necessary (Gigliotti, Vardaman, Marshall & Gonzalez, 2019; Kezar, 2018).

Another advantage to keeping the status quo is that additional resources, people, financial, or otherwise, will not be needed. If we keep on as we are, those students brave enough to seek help and support will reap the benefits as we continue to be reactive when students present to us with mental illness and burnout. This works well in the short term, but what about the long term? I have been arguing throughout this OIP that ESM needs to be proactive in its approach to mental health and wellness. However, by maintaining the status quo, we are not being proactive in our approach to the problem; we would remain reactive and this simply is not solution enough. As per Kezar (2018), "changes are less likely to be sustained unless systems are also changed" (p. 214). As we know from the literature, medical students are presenting with higher levels of mental illness and distress than their peers in other programs (Slavin, Schindler & Chibnall, 2014; Mousa, Dhamoon, Lander & Dhamoon, 2016) and medical students at ESM are no different. As such, we cannot sit idly by; we must upset the status quo, change the system and work to alter these statistics for the better.

Increase the number of wellness related events at orientation and the start of each a new med year (1 through 4).

As we know from the accreditation report and student surveys previously discussed, students are disatisifed with what they perceive to be limited supports available to those experiencing mental distress. Adding additional sessions and workshops on such

topics as resiliency, mindfulness based practices, and how to prevent burnout during orientation and at the start of the med 2 through 4 years, could help to increase student satisfaction. Increasing education and awareness is certainly something that needs to take place at ESM and, therefore, would add value. In fact, researchers in the field argue that it on only adds value, but is critial if students are to reach peak performance (Velez, Gupta & Gendreau, 2019; Agarwal & Lake, 2016; Drolet & Rogers, 2010). These sessions and events could be in addition to what is already being done. For example, like other institutions across the country, we host a full week that is dedicated to wellness. This is in keeping with other universities, including medical schools. As well, they would help to supplement what provincial medical societies are offering, as well as organizations such as Jack.org, which is dedicated to bringing awareness to mental illness. Likewise, increasing programming at this time would show a dedication on behalf of ESM to improving the mental health of our students. It would also educate new students on the pressures of medical school, while at the same time equipping them with the tools necessary to succeed.

The pressure of medical school increases as the years progress (Agarwal & Lake, 2016; Ishak et al., 2013). In the med one year, students are getting acclimated and learning about curriculum. The first year is a foundation year, of sorts, where they are being introduced to medicine and all it entails. That is not to say it is not hard, because it is; however, their work load is not yet at its maximum. Once the speed of things increases, so does the stress level and as students progress through their second year, into their third where stressors associated with clerkship can lead to burnout if students are not adequately prepared. It is here, where we see an increase in avoidance associated

with personal well-being (Velez, Gupta & Gendreau, 2019). Given all of the above, it is clear that additional programming and support is necessary. Presenting information at the start of each year is good, but it cannot end there. And here is where the con lies. One cannot simply provide the information at the start of each year and then walk away. If we are to graduate mentally healthy physicians, education and awarenss is required throughout the four year program and on a regular basis.

Another con to increasing programming at the start of the school year is that students at ESM already complain that the orientation curriculum is very dense and overwhelming. My concern is that we would scare them with numbers and statistics, setting them up with stress from the onset, leaving them without any time to follow-up with us with questions or concerns. The information is necessary; however, information related to mental illness can be easily misunderstood and cannot be rushed. It is important that ESM take the time to develop events, activities and programs that will have a postive affect on students, not a negative one. We need to be holistic in our approach, so as to avoid undue stress for our students.

Change the climate (not the culture).

The culture of medicine is one of long standing traditions, values and beliefs that are implicit to the profession. It starts and ends with the Hyppocratic Oath and this age-old culture is not one to be changed. However, the climate, as defnited by Shanafelt et al. (2019) below, within the culture of medicine certainly can be changed and that within ESM, in particular.

According to Shanafelt et al. (2019), such things as workplace regulations and policies, tolerance to harassment or mistreatment and professionalism are regularly

thought to be part of workplace culture when, in fact, these are better described as workplace climate. At ESM, these behaviours can be translated to academic policies and regulations, tolerance to, or perhaps acceptance of, mental illness and burnout, and stigma around mental illness. This type of climate at ESM has a negative affect on students. Therefore, it is a climate that must change and evolve, recognizing that to stay the same will continue to negatively impact medical students' learning and ability to cope with the stressors of medical school.

Previously, I introduced research indicating that the classroom has a significant effect on students' mental health (Mousa et al., 2016; Slavin et al., 2014). Policies and reglations regarding medical school and, in particular, medical school curriculum, are strictly enforced, not leaving a great deal of room for students to focus on their mental well-being. As well, although improvements have been made, acceptance that some med students will struggle with mental illness seems to be apparent, especially when one looks at how reactive we are to it, rather than proactive.

Lastly, literature related mental health and well-being among med students supports the claim that stigma related to mental illness continues to have a presence within the field of medicine (Thompson et al., 2016; Dyrbye et al., 2015; Chew-Graham, Rogers, & Yassin, 2003). I have evidenced this myself within the walls of ESM and it is important that this not be ignored. To change the climate around mental illness would have a profound effect on our students. For example, setting aside time in the curriculum for wellness activities would allow both the student and we, the staff, to commit time to activites and programming that promotes good mental fitness. It would also permit education on the topic, bringing further awarenss to the problem, so as to, hopefully,

decrease the stigma around mental illness. We need to move to a climate of care and concern; in so doing we can, as per Agarwal and Lake (2016), create a space in which "students are increasingly comfortable discussing their professional vulnerabilities and strengthening help-seeking behaviours, which are necessary elements for successful wellness interventions" (p. 105). Moving to a climate such as this would show those who still struggle with admitting to mental illness and burnout, that leadership will not tolerate negative behaviour from others when discussing mental illness and that they are committed to addressing the problem. Changing the climate in these ways, would certainly benefit the students of ESM.

However, there are also cons to changing the climate. Within the current climate exists a reactive approach to handling cases of mental illness. This is a good thing. We have to be ensure that we do not diminish our efforts to be reactive, while trying a more proactive approach. For those students who bring with them mental illness, the only way to be is reactive; we have to be there for them with the supports in place to help them through medical school. However, we can add to our reactive approaches with proactive programming that helps prevent mental illness and burnout from ocurring at all.

Implement a four year co-curricular wellness program.

At ESM, I see strides in helping students manage the pressures of med school; however, more needs to be done. Currently, different departments, along with students themselves, are creating programming that is reactive, as opposed to proactive. In my capacity as Wellness Advisor, I believe I can help change this environment to be one of prevention through a co-curricular wellness program aimed at ingraining "good habits as part of regular daily activity" (Drolet & Rogers, 2010, p. 103), while at the same time

developing "a culture of concern for student well-being" (Slavin et al., 2014, p. 576). It is one thing to have resources in place when students need it; it is another thing entirely to have resources in place so that students ***do not*** need it. It has been shown that the learning environment directly affects the mental health of students (Daskivich et al., 2014) and it is my hope that through curriculum changes and/or creation, we can help prevent, rather than simply manage, mental illness and burnout among our students.

I believe curriculum-based programs like that of the Vanderbilt School of Medicine and Saint Louis University School of Medicine would be beneficial. These programs are "directly preventative," attacking "the source of distress within context through the curriculum itself" (Slavin et al., 2014, p. 574). Developing a four-year wellness strategy that begins in the med one year is key as "psychological distress among physicians was found to originate in the early years of medical school" (Mousa et al., 2016, p. 2).

Wellness programs are necessary to both educate and prevent depression, anxiety, and burnout among the medical student population. In fact, not only are they necessary, they are imperative to the overall health and well-being of our students. We not only have to provide reactive approaches to mental health and wellness such as treatment strategies, counselling and medication, but also proactive approaches that focus on prevention like wellness initiatives and programs that start in year one. Without these, we risk students ignoring the problem exists or seeking other methods of coping such as self-medicating with drugs and alcohol. Studies show that rates of those who reach out for help continues to be low (Mousa et al., 2016), and that there is increase in the rate of "alcohol use as a method to relieve stress" (p. 8). I believe this is indicative of a much

broader problem, one that can be addressed through a co-curricular program aimed at decreasing mental illness and burnout.

Research has shown us that when it comes to their own personal health and well-being, medical students consistently ignore their own self-care (Drolet & Rodgers, 2010). This is concerning as it leads to "a decline in quality care and increased substance abuse, divorce, and even suicide" (Drolet & Rodgers, 2010, p. 103). This, once again, reinforces the need for a comprehensive wellness curriculum that starts in the first year and continues through to the end of year four and is why *I have chosen this as the solution to the problem of practice.* I believe by implementing a co-curricular wellness program we can help decrease the prevalence of mental illness and burnout among medical students at ESM.

Like that of the Vanderbilt School of Medicine who is experiencing much success within their wellness program (Drolet & Rodgers, 2010), the ESM Wellness Program will be an integrated, co-curricular program. To start, I will establish committees that will include staff, faculty, and students, who will work collaboratively to create programming that promotes the importance of wellness while at the same time, destigmatizes mental illness.

At Vanderbilt, they include elements of environmental, intellectual, physical, and emotional wellness (Drolet & Rodgers, 2010). I intend to incorporate these into my programming, as well, but also include financial wellness as a big piece of the curriculum. Students at ESM are graduating with an average debt load of $125,000 (Eastern School of Medicine, 2017) and this amount is likely to increase as they progress into residency. Research by Price, Choi and Vinokur (2002) found that financial strain is

directly linked to depression. A decade later, Shapiro and Burchill (2012), conducted research that led to the same conclusion, finding that students experiencing financial difficulty "were more likely to report poorer mental health and social functioning" (Shapiro & Burchell, 2012, p. 92). As such, it will be very important to incorporate financial wellness into the curriculum.

Once committees are established and areas of programming solidified, the curriculum will be broken down into specific goals and outcomes for each of the med one through four years. The structure of the program will include academic and career advising, social and community involvement and physical health, to name a few (see Table 1). The goal of the med one year will be to ensure students understand what mental illness and burnout is and how to recognize the signs within themselves and others. The med two year will involve mindfulness techniques and how to provide self-care. In the med three year, students will be introduced to resiliency and how to handle conflicts, while also building on the goals of the med one and two years. By med four, it is hoped that our students will be "putting into practice" (Drolet & Rodgers, 2010, p. 107) what they learned in the previous three years.

Table 1

Four Year Co-curricular Wellness Program

Year	Focus
Med One	Personal development Understanding mental illness & burnout Financial literacy Career advising
Med Two	Preventing distress; coping strategies Leadership skill development Mindfulness and self-care techniques Career advising

Med Three	Communication Resiliency Handling conflict Self-advocacy
Med Four	Establishing professional identity Putting into practice skills, techniques, tools What to expect in residency

Putting this OIP into place is going to require additional research, time, structural changes, and resources. Establishing working groups and garnering support from stakeholders and students will require work and much effort on my part. As well, changes to the structure of the current curriculum will be necessary in order to accommodate a co-curricular wellness program. And all of these are going to require resources, both people and monetary. We have a great deal of expertise within ESM and I do not foresee any additional HR requirements. With the recent creation of my position, I am uniquely positioned to be able to lead this change and will look to current faculty and staff to help implement the program.

Currently, as a distributed program with multiple campuses, I do not foresee any additional technological needs as we are already very technologically advanced. Time is a resource we will have to tap into, both that of people, since we will be asking them to do things outside of their job description, and curriculum, as we will be seeking time inside and outside of the academic curriculum to put on wellness programming. Lastly, financial resources (discussed more in Chapter Three) will be the largest resource required when implementing this OIP.

Although, time and money resources may be perceived as the negative side of change, I believe the positive affects will far outweigh any negative ones. In fact, I

strongly believe that a program such as this is not only necessary but is the ethically responsible thing to do. The learning environment influences rates of depression, anxiety, and burnout. Therefore, making improvements to the learning environment is arguably one of the most important things we can do to help support our students. In doing so, we "will protect trainees and will honor the lives and accomplishments of those whose deaths prompted this nationwide dialogue" (Daskivich et al., 2010, p. 147) on mental illness among medical students. To that end, ESM has a moral and ethical responsibility to deliver physicians who are mentally healthy and by ignoring the problem and not attempting a solution, we are not meeting our ethical responsibility – of which I will speak more to in the next section.

Leadership Ethics and Organizational Change

When we talk to our students about their individual well-being, we speak of the importance of taking time for self-care, yet me make great demands of their time, filling their schedules with school related work. We tell them that the competition is over, they are now in medical school and they should no longer feel the pressure to get accepted, yet we seem to instill a need for perfection. We tell our students that it is ok to make mistakes, yet we have created a climate that lacks self-compassion and good help-seeking behaviours (Agarwal & Lake, 2016; Chan, Batterham, Christensen, & Galletly, 2014). To be a just, ethical, and moral institution, we must change and put an end to what is a clearly a contradiction between what espouse and what we actually do.

What is ethical leadership?

When one thinks of ethical leadership, they envision specific individual leader traits often associated with those of authentic leaders, ones that emphasize good, ethical,

and moral behaviour. Although these are true and should not be ignored, Wilson and McCalman (2017), suggest that perhaps we should reimagine ethical leadership "as leadership for the purpose of ethicality more so than leadership in the context of ethicality" (p. 152). What they mean by this, is rather than seeing ethical leadership in the context of traits of an individual, we should look at ethical leadership "as leadership for the greater good" (p. 152) whereby the traditional adjective-noun definition should be reimagined as a direction pointing leadership away from the individual and toward the whole.

Traditionally, authentic leadership, of which I prescribe, falls under what is historically considered ethical leadership; that is, leadership traits and behaviours typically associated with an individual leader. However, by looking at ethical leadership through the lens of Wilson and McCalman, we can now also group servant leadership under that of ethical leadership. Servant leadership, like Wilson and McCalman's (2017) notion of leadership, seeks to help and support the greater good, while at the same time taking a broader look at societal and worldviews while serving the needs of others first (Greenleaf, 1977).

When we look at the broader society, we can also include distributed under this umbrella because, as per Harris (2006), distributed leadership takes a collaborative and shared practice approach, moving beyond the individual and focusing a more collective effort on societal or organizational improvement, pushing boundaries and distributing leadership across programs, networks and, in the case of ESM, multiple locations. Distributed leadership allows others within the organization to take on a leadership role and at ESM with its distributed campuses, this is key. By allowing others to lead at their

particular site, we are helping students, the public and society as a whole; we are working for the improvement of the greater good. As such, authentic leadership, servant leadership and distributed leadership all fall under the umbrella of ethical leadership, particularly as defined by Wilson and McCalman (2017). Now that I have defined ethical leadership within the context of my leadership approaches, I will discuss the ethical responsibilities of my organization, the different actors involved and how these ethical responsibilities will be addressed.

Ethical Responsibilities

As a medical school dedicated to educating future physicians, ESM has made a commitment to provide an optimal learning, teaching, research, and clinical environment in which our students can thrive. With this, comes many ethical responsibilities for which I believe ESM must uphold. These include the following:

#1. ESM has an ethical responsibility to ensure continuous improvement in the area of mental health and wellness that includes both short- and long-term goals, ones that "produce physicians who can deliver an individualized plan of care that reflects the physician's mastery of basic physiology, awareness of the best current evidence, skillful patient communication, and shared decision-making" (Buju, 2019, p. 2). As evidenced in the literature, med students are reluctant to seek help for themselves. If our goal is to produce doctors who are skilled in providing the best possible care for their patients, we must first provide our medical students with the tools to provide their own self-care first.

When it comes to our programs, services, and supports related to the above, we have work to do. As mentioned, student surveys indicate we fall short in this area. If we are to implement a four-year wellness curriculum, this is going to take time and involve

both short term and long-term goal setting. It will require not only the buy-in from upper management, but also those below. I believe that the collective "we" have a responsibility to make this happen and ESM's leadership has an ethical responsibility to make sure improvements are made in this area. As physicians themselves, they have a responsibility to students to ensure they reap the benefits of improvements to programs, much like their patients would when improvements in medicine occur. After all, we are teaching future physicians who will one day themselves, have to offer the same ethical responsibility to their own patients.

#2. ESM has an ethical responsibility to promote a diverse learning experience free of discrimination based on race, culture, gender, age and, as is the topic of this OIP, mental illness. Despite much work in this area, research shows that stigma surrounding mental illness within the medical profession is alive and well and, in fact, often carries an equal or greater degree of stigma toward mental illness than do those in the general population" (Papish et al., 2013, p. 1). Our students should not have to worry about stigma associated with mental illness nor be discriminated against because of it. ESM must place high importance on this, and leadership must promote a climate of care and concern, one that can be mirrored by their followers. In this sense, ESM's leadership has an ethical responsibility to uphold; our students are the future of medicine, after all, and we must instill in them the importance of destigmatizing mental illness. I believe that I, too, must be ethically responsible in this area, as well, making sure that I *practice what I preach*, as it were. As an authentic leader, I must hold steady my values and beliefs, including those that are ethical in nature. Like the above, I believe that this is an ethical

responsibility of everyone within ESM. It is time we destigmatized mental illness within ESM as it is the ethical thing to do.

#3. "Career planning, decision making about specialty choice, and preparation for residency matching are significant sources of stress for medical students" (Howse, Harris, & Dalgarno, 2017, p. 1543). As such, it is my argument that ESM has an ethical responsibility to provide in-depth career counselling to help eliminate any additional stress where we can. As the one responsible for student wellness, I believe I am ethically responsible for ensuring that there is programming in place to help and support students through their academic careers and into their medical careers. As are faculty members, those who are teaching and testing our students. They must ensure that students are receiving information in such a way that promotes learning. Career advising and counselling is incredibly important as students are in jeopardy of not matching to a residency program if they are not properly counselled. We have an ethical responsibility to make sure they are receiving the most up-to-date information on career options, competitiveness of programs and how best to help students become an ideal candidate. Students are spending four years of their time, energy, and money to become a doctor. If we do not help them through this process, we would not be acting ethically responsible.

4. Lastly, we have an ethical responsibility to ensure a safe, supportive environment in which students have access to health services, wellness programs and personal counselling. Unfortunately, our graduate surveys indicate ESM is falling short in this area. And we are not alone. According to Billingsley (2015), a study by the British Medical Journal (2015) showed that 80% of medical students who participated in the survey felt under supported by their medical school. This must change. As I have

presented throughout this OIP, medical students are increasingly suffering from mental illness and distress. Those students within ESM are no different. As such, everyone within our institution is ethically responsibility to provide a safe, supportive environment for our students. We must ensure they have timely access to health care and personal counselling, allowing them the time off to seek the care they may need. This ethical responsibility falls under the purview undergraduate medical education and those responsible for the academic curriculum, including faculty and administrators. Moreover, we must create a more robust wellness program that helps our students adjust and adapt to the rigors of medical school, both physical and emotional. This will fall to me, as the Wellness Advisor, along with faculty, staff, and leadership, as I will need their support and guidance when initiating such programming. Our students are struggling with mental illness and burnout; it is our ethical responsibility to help prevent this from occurring.

Much like physicians have a code of ethics they must follow so, too, should medical schools. At ESM, we have policies and regulations but there does not appear to be anything that shows our commitment to being ethically responsible. I believe it is time we made such commitments, working within an ethically responsible environment that has the interests of our students as the top priority. I hope that by bringing forward my problem of practice and this organizational improvement plan, that I will be able to address all the ethical responsibilities discussed above. I believe the introduction and implementation of a four-year co-curricular wellness program will go a long way in solving the problem of practice, while at the same time, ensuring we remain ethically responsible.

Conclusion

In Chapter One of this OIP, I introduced the reader to the problem of practice – the prevalence of mental illness and burnout among medical students at ESM. I discussed the context within which the problem exists, my leadership position and vision for change, along with ESM's readiness for change.

In this second chapter, I expanded further on my vision for change, providing a more comprehensive discussion of my leadership approaches to change (authentic, distributed and servant). With my approaches in mind, I then discussed a framework for leading change, that of Schein's (2017) which he adapted from Lewin's (1951) three stage mode of unfreeze, change, and refreeze. Schein's model allows for a more in-depth analysis of organizational change, providing a framework by which to further analyze motivation for change, change implementation and internalizing change. A critical organizational analysis followed, whereby I introduced Deszca et al.'s (2019) Change Path Model. Using their model, I expanded on the gap analysis introduced in Chapter One, outlining the need for change. I chose these two models as I feel they best fit with my leadership approaches. From here, I discussed possible solutions to address the POP, in the end recommending that a co-curricular four-year longitudinal wellness program be implemented to solve the problem of practice. Lastly, I discussed the ethical responsibilities held by ESM and the people within, arguing that implementing a wellness program embedded alongside the academic curriculum is the ethically responsible thing to do.

In Chapter Three, I will further expand on the change process, outlining ways in which to implement the change plan, while connecting it with the organizational analysis

completed in Chapter Two and the recommended solution. Within the change implementation plan, I will discuss stakeholder involvement, individual engagement and empowerment, resources and supports, issues associated with implementation, as well as any limitations and challenges. The additional sections of Chapter Three will include change monitoring and evaluation, communication strategies and future considerations.

Chapter Three: Implementation, Evaluation and Communication

In Chapter Two, I further expanded on my leadership styles – authentic, distributed and servant – while also introducing the reader to my framework for leading change, that of Schein's three stage process for change: (1) creating motivation for change, (2) learning and judgement and (3) internalizing. I also provided a critical analysis of ESM, including Deszca et al.'s (2019) Change Path Model for diagnosing and analyzing the problem of practice: the high prevalence of burnout and mental illness among medical students at ESM. Lastly, I outlined four possible solutions to the problem of practice, arguing that the fourth solution, implementation of a four-year co-curricular wellness program, is the best solution to the problem.

In this next and final chapter, I will further expand on the organizational improvement plan by discussing the implementation plan in greater detail; how I best intend to both monitor and evaluate the change process; and how I plan to communicate the need for change and the change process. I will end Chapter Three by discussing next steps and future considerations.

Change Implementation Plan

The problem of practice to be addressed in my organizational improvement plan is the lack of comprehensive mental health and well-being supports available to medical students at ESM. To help solve this problem, I am recommending that ESM implement a four-year co-curricular wellness program that is co-curricular to the academic curriculum (see Table 1 in Chapter Two). Elements of environmental, intellectual, social, physical, and emotional wellness (Drolet & Rodgers, 2010) must be included, along with what I believe to be a huge cause of concern for students – their financial well-being. Medical

students amass an extremely high level of debt that does not end at med school; they continue to incur further debt as they progress into residency. Research by Price et al. (2002), found that financial strain is directly linked to depression. A decade later, Shapiro and Burchill (2012) conducted research that led to the same conclusion, finding that students experiencing financial difficulty "were more likely to report poorer mental health and social functioning." (Shapiro & Burchill, 2012, p. 5). As such, it will be very important to incorporate financial wellness into the curriculum.

As a co-curricular program, all related activities and events would be in addition to the regular academic curriculum and although some aspects will be mandatory, others will not. The academic curriculum is very heavy, and we do not want to add more to our students' already overflowing plates. The aim of the program will be to provide tools and resources that allow students to become more resilient, reduce stress, effectively use their time and manage their workload, while helping fight mental illness and burnout.

Through my leadership approaches of authentic, distributed and servant, I believe that implementing this program will be best done using Deszca et al.'s (2019) Change Path Model that includes four stages: Awakening, Mobilization, Acceleration and Institutionalization. Drawing from the work of Lewin (1951), Deszca et al.'s model employs aspects of the unfreezing, change and freezing stages of Lewin's work, along with reflecting that of Schein (2017) whose work I introduced in Chapter Two of this OIP. Schein (2017) analyzes the change process through a series of steps that involve creating motivation for change, learning new information and internalizing the information. In Chapter Two, I outlined Deszca et al.'s (2019) Change Path Model from

the perspective of diagnosing and analyzing needed changes. Similarly, this model will be effective in helping to implement my OIP, as well.

Change Path Model

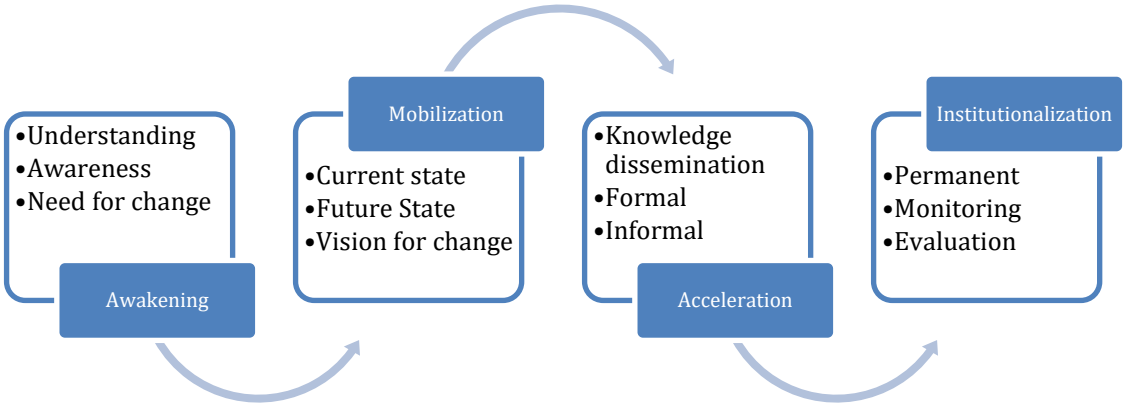

Figure 5. Deszca, Ingols and Cawsey's Change Path Model (for implementation purposes). Adapted from Deszca, G., Ingols, C., & Cawsey, T. (2019). *Organizational change: An Action-oriented toolkit.* (4th ed). Thousand Oaks, CA: Sage Publications, Inc.

I believe that the Change Path Model (see Figure 5 above) for implementation works congruently with Schein's model for change and will help the implementation process move along with relative ease. With its emphasis on open communication, knowledge dissemination and empowerment of people, this model works congruently with the interpretivist approach outlined in Chapter One.

Schein (2017) argues that before change can be implemented, people must be motivated to change. I believe the first two stages of Deszca et al's (2019) Change Path Model, awakening and mobilization, will help to do just that – motivate people to change. By bringing awareness to the PoP through the awakening stage, I will be able to help others understand the problem. Through mobilization, I can properly outline the current state, expressing the importance of the problem, one that cannot be ignored.

Using what Kezar (2018) refers to as "sensemaking," I will be better able to help everyone involved understand the problem and why it must be addressed. "Sensemaking is about changing mindsets, which in turn alters behaviours, priorities, values and commitments" (Kezar, 2018, p. 87). I will need have to do just that – alter behaviours, priorities, values and commitments – if I am to effectively implement change.

An additional strength of using the Change Path Model as a means of change implementation is that it allows for knowledge dissemination through formal and informal communication, development and empowerment of people and promotion of the future desired state. Deszca et al. (2019) refers to this stage as the acceleration stage. Lastly, using this model allows one to measure progress throughout the implementation. Although there will be times of uncertainly and shifting of priorities, the institutionalization phase of the Change Path Model will allow me to continuously monitor the change and ensure processes are working. It is in this stage, as well, that progress toward goals and priorities is gauged and assessed (Deszca et al., 2019). In fact, key to any implementation plan, is the creation of said goals and priorities. As such, the next section will outline what I believe are the goals and priorities important to the implementation of a wellness program at ESM.

Goals and Priorities

My OIP and, more specifically, the implementation plan, includes six key goals and priorities that I aim to achieve via the Change Path Model discussed in the previous section. The first priority or goal is, of course: (1) bringing awareness to the problem of practice by (2) clearly articulating what needs to change and why. Key to this will be (3) seeking input from stakeholders (leadership, faculty, staff, students) in an effort to (4)

create a shared vision for change. Throughout, I hope to (5) develop, empower, and recognize everyone involved, while also celebrating our victories, both big and small. Lastly (6), it is hoped that the change – the implementation of a co-curricular wellness program – will be successful and continue to be included as part of ESM's programming for many years to come. Essential to achieving these goals and managing the change, is garnering buy-in at many different levels and from many different stakeholders, internally and externally. Deszca et al. (2019), argue that identifying stakeholders early, in the awakening phase, is a must and maintaining constant communication throughout the remaining stages is key to successful implementation. As such, in the next section, I outline the stakeholders both internal and external to ESM that I believe I important to the change implementation process.

Stakeholders

In my role as Wellness Advisor, I will oversee the implementation process and act as lead change agent and implementer. I will work very closely with all stakeholders to help develop a strong wellness program that aids in preventing mental illness and burnout from occurring within our student body. Stakeholders involved in the change process will include a wide range of professionals and individuals.

Senior leadership. First, senior leadership will critical to the change process. As leaders within ESM, it will be important that they set an example for everyone else within ESM. That is, leading my example and showing support for the change while making it a priority.

Administration. Administration, too, will be responsible for leading by example and supporting the program by providing the necessary budget required, people resources

and professional development opportunities.

Faculty. More than anyone, faculty are with our students the most and it will be important that they have a role in helping to improve the mental wellbeing of our students. Indeed, I cannot implement such a program without the help of faculty whose advice and expertise will be essential.

Staff. Within ESM we have staff members who are exceptional and who bring with them a wealth of experience that will help with the implementation process. These staff members have key roles within a student's academic life, and it is important that they be given the tools and empowerment required to help with the success of our students. I hope to empower staff to get involved by offering professional development opportunities that will not only educate them to the problem but also enhance their skills in such a way that they feel excited to be part of the change.

Students. Without students as a key stakeholder, the implementation of a wellness plan is sure to fail. After all, it is the students who we are trying to help. Seeking their input regarding their needs cannot be overlooked. It is hoped that class leaders will encourage their peers to actively participate in their individual well-being, making it a priority.

External stakeholders. Lastly, external stakeholders such as government and community resources will be included in the implementation process. We will look to them for additional resources students can access outside of ESM, as well as hone in on their expertise as it relates to activities and programs that aid in decreasing poor mental health and burnout.

In Chapter One, Figure 1, I introduced the reader to the ESM's organizational

structure. However, I believe it is necessary to now introduce a new organizational chart, one that is strategic to the implementation of this OIP and supports my PoP. Given that there will be many people involved, both at the top and bottom of the hierarchy, a new strategic organizational chart, one that is free flowing, with information passing among all stakeholders, at every level, must be created.

Strategic Organizational Chart

Along with the stakeholders identified above, as lead change agent, I will establish a Student Wellness Committee that will be made up of representatives from the stakeholders identified, including senior leadership and administration, as well as from smaller committees that will also be created. This will result in a new strategic organizational chart (see Figure 6) that is decentralized.

There is much expertise that lies within ESM and it is not limited to faculty alone. Staff, too, have a great deal of knowledge and experience that I believe will be integral to implementing a wellness program. I want to develop staff and help them promote themselves as advocates for change.

A decentralized organizational structure allows for "flexibility in strategic change and encourages communication and participation of employees in decision making" (Gupta, 2015, p. 373) and, as such, will help staff to be more comfortable with getting involved. According to Gupta (2015), decentralized structures increase employee moral, motivation, and satisfaction because of the free-flowing nature of communication in all directions, as per Figure 6.

Figure 6. ESM's New Strategic Organizational Chart based on the principles of a decentralized structure. Adapted from Gupta, M. (2015). Organizational structure affected by strategic change. *International Journal of Advanced Research and Innovative Ideas in Education, 1*(3), 372-376.

Research has shown that programs related to student mental health become more impactful when they involve a variety of individuals (Habib, 2012; Splett, Weist & Fowler, 2013). Similarly, "interactions among stakholders and implementers may influence, and be influenced by, stakholders' assessments of each other and stakeholders' concern about the change" (Lewis, 2019, p. 117). Therefore, it will be imperative that I, as the change agent and implementer, be cognizant of stakeholder reactions to to change, any concerns they may have and what "ripple effects" (Lewis, 2019, p. 9) the change may have among the stakeholders and within the organization.

To ensure that all stakeholder concerns are taken into consideration and that there is no confusion surrounding the change, it will be critical that I am constantly

communicating, both formally and informally, with everyone involved, keeping them abreast of everything that is happening. Using the interpretivist approach will help me to establish positive relationships that foster open and collaborative communication. Deszca et al. (2019) likens change to that of trying to change a car tire while it is moving: "conditions change in unanticipated ways and change leaders need to be able to learn and adapt their understanding of the situation and what is needed as they go" (p. 53). By constantly disseminating information and soliciting input from stakeholders, I believe that I will able to keep up with the change and any issues that may be encountered along the way, while at the same time making adjustments to the process in order to decrease any concerns there may be.

Like the identification of stakeholders and a new strategic organizational structure so, too, is identifying supports and resources that will be necessary when implementating change. These are discussed in the following section.

Supports and Resources

As mentioned above, several different supports will be necessary when initiating change. Following is a discussion on the different resources, both people and financial, that will be required.

People. The most obvious support and resource required is that of people; in particular, the stakeholders listed above. With a need for people, also comes a need for their time. This may be one of the biggest constraints as everyone is already very busy. There will need to be incentives for them to get involved, along with approval from leadership and administration for staff to step outside their job description to help. As an authentic leader employing both distributed and servant leadership traits, I believe it is

important to empower others. It will be important that I stress to senior leadership that the experience, traits, skills and expertise of others will not only be necessary, but also beneficial to the change implementation process. Research has shown that involving staff in the change process increases their commitment to change and, perhaps more importantly, has "showed higher levels of work-related well-being" on the part of employees (Guglielmi et al., 2017, p. 101). As such, there are many benefits to including them in the change process.

External agencies. The support of community organizations with expertise in the area of student mental health will be important, as well. Community supports will help us to create a program that is inclusive of everything related to improving the mental health of our students. For example, experts in recognizing students in distress will be brought in to educate us on signs to look for when assessing for mental illness and burnout among our students. There are also such programs as Mental Health First Aid (Mental Health Commission of Canada), for example, that will be key education and professional development pieces we will want to include.

Along with community resources, governmental agencies need to be invovled. As a program dependent on provincial funding, it will be necessary that we keep government officials abreast of changes made to our programming. We will need their support in order for the change implementation to be successful.

Financial support. Implementing a wellness program for our students will require some financial support, however I do not expect it to be a huge burden. Administration and senior leadership have expressed student wellness as being a priority and, therefore, I do not anticipate any roadblocks financially. As the Wellness Advisor, I

am uniquely positioned to provide advice and influence is this regard and am prepared to argue the need for a comprehensive wellness program.

Internally, we have the people expertise and experience to create such a program and I do not believe we will need to hire externally to help us with the creation. However, in order to educate faculty, staff and students on mental illness and burnout, experts in the area will have to be brought in and this will, of course, be an expense. As well, material resources will have to be created and, therefore, costs associated with printing will have to be factored in. Currently, ESM has a Communications Coordinator who creates all of our print resources, allowing us to do this in-house rather than out. Lastly, there will be a cost associated with incentives to get students to attend wellness programs and events such as food, guest speakers and fun activites to help alleviate the stress of medical school. I anticipate an initial total cost of approximately $20,000 - $25,000 and an annual cost thereafter of $5,000 - $8,000. Given that our accreditation is partially dependent on improving our wellness supports for students, I do not foresee budget approval from senior administration to be an issue.

In the above sections, I have discussed my plan for implementation, using Deszca et al's (2019) Change Path Model. In addition, I have introduced the reader to the different stakeholders involved, outlined a new strategic organizational chart and outlined supports and resources required for implementation. However, no implementation plan is complete without the identification of strengths and weaknesses associated with the plan. These are discussed in the next, and final, section of my change implementation plan.

Strengths, Weakenss & Limitations to the Implementation Process

No change management plan is perfect. With it comes not only strengths, but both

weakness and limitations, as well. The next few paragraphs will outline each of they relate to the implmentaiton process.

Strengths. Within the previous section on the Change Path Model, I outlined specific strengths related to its use for implementation of my organizational improvement plan. Such strengths included is the cohesiveness with Schein's (2017) model for change, in that the different steps of the Change Path Model fit very well within Schein's four stage change plan. As well, the Change Path Model allows for knowledge dissemination, development of people and promotion of the future desired state. A final strength of the model is its process for monitoring and evaluating change; a continuous one that allows for institutionalization within the organization. However, like as with strengths, there are also weaknesses.

Weaknesses. Unlike some other change implementation models, Deszca et al.'s model may feel too simplistic. Dissimilar to others, such as Kotter's (1996) eight step process, the Change Path Model is just three stages. There is concern that perhaps some important pieces of the implementation process may be missed. I will keep this in mind, however, when formalizing the change implementation process. Another weakness could be that, due to its simplicity, the Change Path Model ignores such important things as ethical responsibility associated with change. Recognizing this, I intend to ensure that this piece is not missed with the change implementation process.

Assumptions and Limitations. It is assumed that everyone will get on board with the change and although this may seem naïve of me to assume such a thing, my hope is that providing a clear understanding how very important the issue of mental illness and burnout is will help to garner the support of others. That said, I recognize that not

everyone will be as engaged and invested in the change process as I will be. Knowing this, I hope to educate everyone to the problem of practice through a series of discussions and presentations outlining the seriousness of this issue.

It is also assumed that given ESM's low ratings within the accreditation report related to wellness supports and programming, that both senior leadership and administration will be supportive of such a program and that they will allow for the resources necessary to implement a wellness program. This is one that I will have to turn into one of assurance, rather than assumption. Although I feel strongly leadership and administration will agree to the importance of such a program, it will be important that I not assume this and seek their input, advice and support for the OIP.

Along with assumptions, there will be limitations that include resistance to change, power struggles (such as who is responsible for what), concern over people, financial and time resources and ensuring everyone understands the nature of the problem and what exactly we are trying to change. By using the Change Path Model for implementation, I hope to overcome these limitations by ensuring a clear understanding of the PoP and the importance of a shared vision in solving the problem. As evidenced, having a clear plan for implementation is important. So, too, is having a process for assessing, monitoring, and evaluating change, discussed in the following section.

Change Process Monitoring and Evaluation

Along with having an effective change implementation plan, one for assessing, monitoring, and evaluating change is as equally important, particularly for determining whether or not the OIP is, or will be, successful. In fact, research has shown that organizations who do not include monitoring and evaluation as part of their ongoing

change efforts, tend not to be successful (Neuman, Robson & Sloan, 2017; Gustafson, Sainfort, Eichler, Adams, Bisognano & Steudel, 2003). For my monitoring and evaluation plan, I look to Kusek and Rist's (2004) ten step process for monitoring and evaluating change which helps to support the solution to my PoP, while also working congruently with the interpretivist approach.

Monitoring & Evaluation Plan

Like the researchers noted above, Kusek and Rist (2004) also stress the importance of having a monitoring and evaluation plan, underlining the need to move "beyond an emphasis on inputs and outputs to a greater focus on outcomes and impacts" (p. 1). To do this, the authors developed a ten-step process for change that includes several key steps such as readiness assessments, data collection, monitoring and evaluation. I have chosen this model because, despite being nearly 20 years old, it is still a very useful and relevant process for monitoring and evaluating change. Likewise, it works well within Deszca et al's. (2019) Change Path Model which I have chosen to use as a guide for the implementation process. I believe the 10 steps associated with Kusek and Rist's model aligns very well within the Change Path Model and is, therefore, an excellent resource to use (see Figure 7). For purposes of this OIP, however, I will adapt their process to that of nine steps, omitting their first step, Conducting a Readiness Assessment, as this was done in Chapter Two.

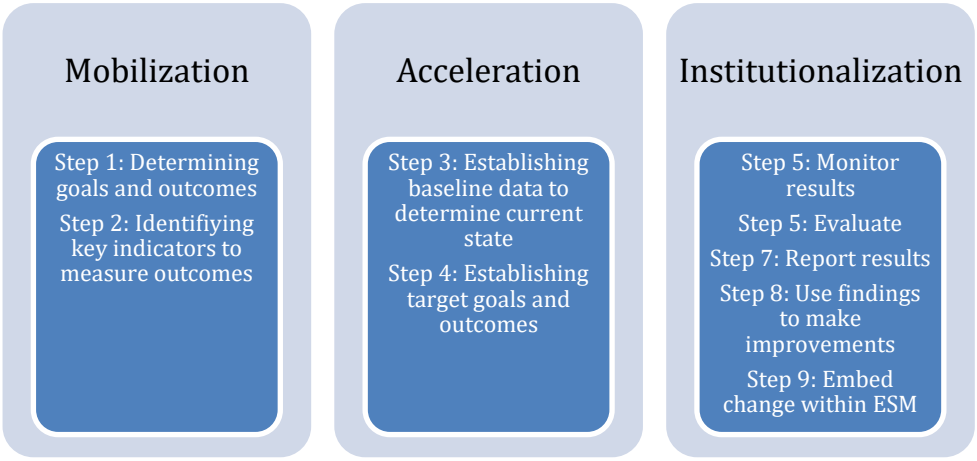

Figure 7. Change Process Monitoring and Evaluation Plan. Adapted from Deszca, G., Ingols, C., & Cawsey, T. (2019*). Organizational change: An action-oriented toolkit.* (4th ed). Thousand Oaks, CA: Sage Publications, Inc. and Kusek, J. & Rist, R. (2004). *Ten steps to a results-based monitoring and evaluation system*. Washington, DC: World Bank.

Mobilization - Steps 1 and 2. These first two steps of the monitoring and evaluation process, as shown above, will start within the mobilization stage of implementation. Here, we will (1) establish goals and outcomes associated with the organizational improvement plan, while also (2) setting indicators to monitor outcomes. As per Kusek and Rist (2004), step one should be a group effort that involves key stakeholders; it is a participatory process that starts with establishing goals and continues with setting outcomes (Kusek & Rist, 2004). Although I have yet to go through the goal setting process, I anticipate one such goal, for example, will include bringing awareness to the Problem of Practice – the high prevalence of mental illness and burnout among medical students at ESM – and the importance of improving our wellness programming for students. An outcome would be the creation of a shared vision in which everyone involved is invested in. Another goal would the development of faculty and staff through professional development opportunities that will empower people to become part of the change process. Outcomes of professional development include increased participation in

the change process, supported by senior leadership and administration. The ultimate goal, of course, is the creation of a co-curricular wellness plan that provides medical students with the tools and resources to combat mental illness and burnout, while also preparing them for a career in medicine. Outcomes associated with this goal include decreased levels of stress, anxiety and burnout, along with a student body that is well-informed and well-educated on the need to take care and concern with their own mental and physical well-being.

Although it may seem counterintuitive, creating goals and outcomes must come before setting indicators because, the authors argue, "it is the outcomes – not the indicators – that will ultimately produce the results" (Kusek & Rist, 2004, p. 57). Indicators measure the progress of stated goals while also helping to determine whether the outcomes associated with each goal are achievable. Looking to the first example above, bringing awareness to the problem of practice and its importance, an example of an indicator that we are reaching our outcome is the number of people or stakeholders that become involved in the process and are keen to help solve the problem. If there is a great deal of resistance and lack of buy-in, that will be an indication that we are not going to reach our goal and the intended outcome.

Acceleration - Steps 3 and 4. Outlined in Figure 7, in what would be Deszca et al's (2019) acceleration phase, is where we will (3) establish baseline data to determine our current state, while also (4) planning for improvements through targeted results. Baseline data is what is used to determine the future desired state and targets to be met (Kusek & Rist, 2004). The problem at hand is the high levels of mental illness and burnout within the medical student Population at ESM. We know this to be true based on

the current number of students who self-identify. However, we are certain there are others that do not self-disclose. It will be important that we survey our student body to determine what percentage of students are actually experiencing symptoms so that we have a baseline with which to work. From there, we would establish a target at which we hope our future state to be. For example, if in 2020 40% of our student body is experiencing signs of mental illness and burnout, then in 2021 our target result may be to decrease that number to 35%. Once we establish baseline data and our target result for year one, we can also establish future target results for subsequent years.

Institutionalization - Steps 5 through 9. Throughout these next steps, depicted in Figure 7, institutionalization (Deszca et al.'s step 4) of the plan as a regular part of the curriculum within ESM will occur. Here, we will (5) monitor for results, (6) evaluate the plan (7) report and (8) use our findings to make improvements and, lastly, (9) create a system for sustaining an ongoing monitoring and evaluation plan within ESM.

In **step 5**, the monitoring phase, I will begin to determine whether or not we are on track to reach our goals and outcomes using two types of monitoring: implementation monitoring and results monitoring. According to Kusek and Rist (2004), implementation monitoring is important because it helps to ensure you stay on budget, that people are still supportive of the change and programming is being created. Results monitoring, on the other hand, helps to determine whether or not programming, for example, is resulting in us meeting a particular target. Looking at a survey example again, we will need to do a survey at the beginning of the year to determine our baseline data. In order to monitor for results, it would be a good idea to do another survey midway through year one to determine if the number of those presenting with mental illness and burnout is decreasing.

In so doing, we can determine whether or not the wellness program is working.

Step 6 will seek to address the strengths and weaknesses of the implementation plan, as well as "other important questions regarding the generation of appropriate results" (Kusek & Rist, 2004, p. 113) through both formative and summative evaluations to assess the change process.

Formative evaluations. As per Neuman et al., (2017), formative evaluations take place during the development phase, aiding in the implementation process. More of a monitoring activity, suggest the authors, a formative evaluation is a "live" (p. 122) proactive practice that provides "continuous feedback where associated information supports an improvement-focused process" (Neuman et al., 2017, p. 121). In their research, Uzarski and Broome (2017), too, note the importance of formative evaluations, suggesting the need for a "living document" (p. 14) that can be continuously updated and edited as the change process moves along.

Summative evaluations. Targeted toward stakeholders, summative evaluations are "undertaken post-programme implementation" (Neuman et al., 2017, p. 123) and are necessary in order to determine the overall success of the change process, ensuring that deliverables have been met and goals achieved. Included in the summative evaluation are two other types of evaluations: outcome evaluations and impact evaluations (Neuman et al., 2017).

Outcome evaluations, according to the authors, offer short-term results and measurement of proposed outcomes. Outcome evaluations seek to explain to stakeholders the reasons behind either success or failure of the program by identifying "critical lessons learned…from which it offers recommendations relating to performance

improvement" (Neuman et al., 2017, p. 123). On the other hand, impact evaluations or impact assessments, as they are sometimes referred (Neuman et al., 2017; Kusek & Rist, 2004)), focus on long-term results and the impact "to which the outcomes experienced by the changing organization can be attributed in full or part to the change programme" (Neuman et al., 2017, p. 123).

According to the literature, **steps 7 and 8**, are often thought of as the least important (Kusek & Rist, 2004) and yet it is within these two steps that a project can reap the most benefit. For example, reporting the findings (step 7) to not only key stakeholders but the institution as a whole, provides justification for the project; helps to educate others on what is and isn't working; and often garners additional support for the project from those who were previously sceptical (Kusek & Rist, 2004). I anticipate there to be some resistance to change and I believe that reporting findings will have a positive effect on those naysayers who have yet to buy-in to the importance of a wellness plan for med students. For purposes of transparency, it will be important that we also report on those parts of the program that are not working. I am not so naïve as to think that we will get this right on the first try. We will have to continuously monitor for results, reporting on them along the way.

Equally important, argues the authors, is the need to use these findings (step 8) in such a way that it increases the chances for success (Kusek & Rist, 2004). In addition to the obvious ways to use the findings such as making adjustments to those pieces that are not working or using the findings to justify budget increases, there are other means by which the findings should be used, including using them to evaluate external resources, provide more efficient services and motivate those involved to continue helping to make

improvements (Kusek & Rist, 2004). This is an important step and an obvious one – why monitor if you are not going to use the findings for the betterment of the program?

Finally, in **step 9** it is hoped that I will be able institutionalize the change within ESM, allowing for sustainability within the institution. To do this, Kusek and Rist (2004) outline six critical components to sustaining the results: demand for programming, clear roles and responsibilities, trust, accountability, capacity, and incentives (p. 152). I agree that all six of these are incredibly important and without taking these into consideration, I will not be able to successfully institutionalize a wellness curriculum as part of the overall medical school experience at ESM.

Now that I have outlined how I plan to implement, monitor and evaluate change, it is time to move on to another very important part of the implementation process – that of communicating the need for change and the change process.

Communicating the Need for Change and the Change Process

I recognize that not everyone will be as engaged and invested in the problem of practice as I will be and, therefore, it will be important that I have communication plan in place that effectively outlines the problem and the need for change. As the literature purports, open, honest, and transparent communication leads toward increased participant satisfaction and support, while reducing resistance to change (Lewis, 2019; Schulz-Knappe, Koch & Beckert, 2019). In order to do just that, I look to the work of Lewis (2019), a scholar in the field of communicating change. In her book, Lewis defines both formal and informal methods of communication, while outlining three key processes required when communicating planned change: dissemination of information, soliciting input and socialization (Lewis, 2019, p. 54).

Formal Communication

Formal communication takes on many forms and, if done right, can set a positive tone for the change process. As per Lewis (2019), formal communication includes official announcements on the change; policy and sanctions related to the change and, in particular, the project; approvals for programs and activities related to the project; implementer's instructions related to the change; and invitations for feedback and advice related to the change. As mentioned at the beginning of this section, when communication is done correctly, it sets a positive tone for the change. However, if done incorrectly, it can have the opposite affect. Therefore, it will be important that I, as the implementer and change maker, have all of the relevant pieces in order so that I may communicate the change and the need for it, effectively and efficiently, so as to create a positive atmosphere surrounding it.

Informal Communication

Like formal communication, informal communication is equally as important and perhaps even more so because it is spontaneous and unplanned. Informal communication often happens on the fly and includes expressions of hopes and fears related to the project; ridiculing of change; opinions and views, both positive and negative, related to the change; and sharing of feedback among peers (Lewis, 2019). Informal communication is undocumented and can have major effects on the change process. In fact, says Lewis (2019), these informal "interactions have the potential to shape attitudes, willing participation, efforts to oppose change, and ultimately, the outcomes of change" (p. 56). I participate in informal modes of communication on a daily basis. In fact, I would say that, as a form of communication, informal is by far more popular than formal

communication. As such, it will be essential that I take informal communication into consideration when communicating the change process**.**

Key Processes for Communication During Planned Change

As briefly mentioned at the start of this section, Lewis (2019) outlines three key communication processes that should be included when planning for change: dissemination of information, soliciting input and socialization. In order to build awareness of, and support for, my organizational improvement plan, I intent to implement these three processes as part of my communication strategy.

Dissemination of information. Schulz-Knappe et al., (2019) state that in order to successfully implement change, it is "crucial to generate a positive perception of the change to garner support and reduce resistance" (p. 672). To achieve this, dissemination of information, formally and informally, officially and unofficially, will be necessary. Lewis (2019) argues this step is key as it allows the implementer to explain the purpose of change, provide understanding of the change effort and help alleviate concerns and dispel rumors.

As part of my communication plan, I intend to start with a written communication piece from senior leadership on the problem of practice and the importance of addressing it. This initial communication will also include a piece from administration, offering their support, as well, and their commitment to providing the financial resources necessary to implement a wellness plan aimed at solving the problem of increased mental illness and burnout among the student body at ESM. Information pieces and literature related to this topic will be included so that students, faculty, and staff are better able to understand this to be a problem that cannot be ignored.

Once the initial communication piece is disseminated, I will then invite everyone within ESM to attend a series of oral presentations that speak to the problem of practice. This will allow people to ask questions, garner additional information and express any concerns they may have. Although not mandatory, it is hoped that those who are not directly involved will attend these open presentations. For those directly involved in the planning, regular meetings of each group will take place and it will be expected that everyone attend. At both the open sessions and group meetings, I will be able to provide clarification around the change and, it is hoped, reduce resistance associated with the proposed improvement plan. "Employees are welcoming change process, when they perceive the motives as beneficial" (Schulz-Knappe et al., 2019, p. 672) and, because of this, I will ensure that I communicate the reasons why the change must occur and all benefits associate with it. Accordingly, the more information employees have, along with the transparency and quality of the information, the less chance of resistance there will be (Schulz-Knappe et al., 2019).

Soliciting input. Lewis (2019) argues the importance of soliciting input from those within the institution that are outside of the stakeholder group and I agree – this is incredibly important. As mentioned previously, I hope to utilize the experience and expertise of those staff within ESM who I believe would be an asset to the implementation of a wellness program within ESM. Given this, it will be important that I include them in the planning process, seeking their advice, input and opinions related to programming.

To do this, I will create "deliberative discussion focus groups" as introduced by Rothwell, Anderson and Botkin (2015). According to the authors, deliberative

discussions ensure that participants are informed; the information presented is comprehensive and includes both pros and cons; and that discussions include voluntary participants whose ideas are based on merit and not on who the person is. To help solve the problem of practice, my OIP is going to involve many people and using a deliberative discussion approach will help ensure that everyone involved is informed and part of the discussion. Using this approach will also validate the ideas of others, while at the same time, making certain that everyone is aware of both the advantages and disadvantages of the planned change. All of these will be necessary if I am to successfully implement my OIP.

Socialization. Socialization, according to Lewis (2019) is how an employee adapts to an organization's values, mission, culture, and priorities. The change I am proposing is a big one. It will be necessary that employees adapt to a new set of values, ones that will affect ESM's mission, culture, and priorities. Luckily change, says Lewis (2019), provides an excellent opportunity for resocialization, allowing employees to adapt to new and different ways of doing things within the organization, and although I do not believe it will be an easy transition through the change process, I do believe it is possible.

As mentioned throughout this OIP, employees are going to be a key component to the change process and the implementation of a wellness program for medical students. Therefore, it will be important that they understand how their role within the organization may change, while at the same time, providing a climate in which employees feel as sense of comfort and trust as this "reduces their resistance to the change processes" (Schulz-Knappe et al., 2019, p. 681). Obviously, they have a job to do and, as such, their role will not change entirely. It is my hope that employees will see their work as being enhanced

by the change process, as they adapt to a new mission and values associated with the change. In order for employees to "resocialize" within ESM, I will need to ensure we, the stakeholders, show our appreciation for their help and support of the change by providing professional development opportunities, celebrating the wins, both big and small, and acknowledging employee contributions to the change process.

Throughout this chapter, I have outlined the change implementation plan, my plan to monitor and evaluate change, along with how best to communicate the need for change and the change process. In this last section of Chapter Three, I will discuss next steps and future considerations that must be addressed.

Next Steps and Future Considerations

In this organizational improvement plan, I have outlined the need for a co-curricular wellnes program for medical students at ESM. However, things do not stop at implementing a wellness program; there are other steps and future considerations that will need to be taken into consideration.

Culture of Concern

Given the critical nature of the problem of practice, it is important that ESM create a culture of concern for medical students. As evidenced in the research presented in Chapter One, there is a high prevalence of mental illness and burnout among medical students across the globe. It is no different at ESM where our students struggle regularly. As per Slavin et al. (2014), "overall mental health declinces soon after they begin their medical studies" (p. 576) making it absolutely imperative that we show care and concern for the well-being of our students. As per Agarwal and Lake (2016), in order improve the mental well-being of our students, we must "promote a culture within medicine where

students are increasingly comfortable discussing their professional vulnerabilties" (p. 105) so that they are more apt to seek help and support when they are struggling.

Additional research

Although I believe the wellness program submitted in this OIP is substantive and based on relevant research, it is still hard to present a full picture of what the program will look like and how it will be implemented. Futher research will be needed to determine what has been done in the past, what works and does not work and what aspects of a wellness program should be ongoing. That said, results of similar programs are promising, with students exhibiting positive behaviours and support for such wellness curriculums (Agarwal & Lake, 2016; Slavin et al., 2014; Drolet & Rodgers, 2010).

Resiliency

When looking at next steps, it is going to be important that I consider not only mental illness in medical students, but also their resiliency and ability to bounce back from events that might cause them stress, pressure, and anxiety. Dr. Peter Gray (2015), an expert in the field of resiliency among college students, feels that resiliency has been on the decline for many years now, causing a serious problem for post-secondary schools. In his research, Dr. Gray (2015) argues that children today are not given the skills or abilities to solve their own problems and be resilient because parents have not given them the opportunity to do so. Although I am not entirely convinced this to be true, at least not of every parent, I do agree that we risk a continued decline in resiliency and other mental health conditions if we do not educate students on how to be resilient, providing them with the tools and resources to withstand the pressures of medical school and their careers as physicians.

Expanding the Wellness Plan

ESM has two main campuses, with the parent campus in another province. As we go through the program, monitoring and evaluating along the way, we will have to consider how we can best expand the program across both campuses so that all students are benefiting from the program, not just those on my campus. Equally important will be considering how we will include the six smaller distributed sites, as we have learners there, as well. We will have to consider developing a strategic framework by which the main campus and the distributed sites can implement the wellness program within their locations. This will involve a great deal of collaboration, which may not have taken place during the initial program creation. Therefore, it will be essential that we consider including key people, most likely senior leadership, at each site to keep them informed of the progress we make, including any changes to the program we make along the way.

With next steps and future considerations noted, I have come to the end of my Organizational Improvement Plan. It is hoped that through change and the implementation of a co-curricular wellness program, we will help improve the well-being of our students. And, with that said, I leave you with some concluding thoughts.

Concluding Thoughts

As evidenced in the literature, mental illness and burnout is highly prevalent among students in their pre-clinical years. There is a high degree of "need for mental health resources for medical trainees so that our future physicians can lead productive, successful lives" (Mousa et al., 2016, p. 6). Therefore, I propose implementing a wellness program that will be longitudinal in nature and embedded along side the academic curriculum. Such a program will involve both reactive and proactive measures

to help prevent mental illness and burnout among our students from worsening or, it is hoped, happening at all.

Wellness programs are necessary to educate faculty and staff on the importance of good mental health for students, but also to educate students themselves on the importance of taking charge of their own personal health and to prevent depression, anxiety and burnout among the medical student Population. In fact, not only are they necessary, they are vital to the overall health and well-being of our students. We not only have to provide reactive approaches to mental health and wellness (treatment strategies, counselling, medication) but also proactive approaches that focus on prevention (wellness initiatives and programs that start in year one). Without these, we risk students ignoring their own self-care or seeking other methods of coping such as self-medicating with drugs and alcohol (Mousa et al., 2016).

The literature confirms that med students are not adequately prepared for or trained in ways to provide quality self-care. It also tells us that mental distress and burnout in physicians leads to a decline in quality of patient care. Lastly, we know that the "training process and environment contribute to the deteriorating mental health in developing physicians," (Brazeau et al., 2014) therefore confirming that education related to personal health and well-being must take place in medical school. Having a wellness plan that is cemented alongside the curriculum "will enhance the student's well-being and physicianhood," (Lipsitt, 2015, p. 64) equipping students with the knowledge, tools and resources required to lead them through long and successful careers.

Obviously, the health and wellness of our students is integral to their health and well-being as physicians and, therefore, it is imperative that we address this problem

during their pre-clinical years to circumvent any further issues when they are residents and practicing physicians. It is my assertion that rather than trying to fight mental illness and burnout only after students self-identify as needing help, we should be trying to ***prevent*** it through curriculum development aimed at ingraining "good habits as part of regular daily activity," (Drolet & Rodgers, 2010, p. 76) while at the same time developing "a culture of concern for student well-being." (Slavin, Schindler, & Chibnall, 2014, p. 576). It is one thing to have resources in place when students need it; it is another thing entirely to have resources in place so that students ***do not*** need it.

References

Agarwal, G., & Lake, M. (2016). Personal transition to the profession: A novel longitudinal professional development and wellness medical student curriculum. *Academic Psychiatry, 40*(1), 105-108.

Amabile, T. & Kramer, S. (2011). The power of small wins. *Harvard Business Review*. Retrieved from https://hbr.org/2011/05/the-power-of-small-wins

Ayala, E., Omorodon, A., Nmecha, D., Winseman, J., & Mason, H. (2017). What do medical students do for self-care? A student-centred approach to well-being. *Teaching and Learning in Medicine, 29*(3), 237-246.

Bakari, H., Hunjra, A., & Niazi, G. (2017). Organizational change? The role of employees' perceptions: Integration of the theory of planned behaviours and Lewin's three step model. *Journal of Change Management, 17*(2), 155-187.

Billingsley, M. (2015). More than 80% of medical students with mental health issues feel under-supported. *BMJ, 2015*, 351. https://doi.org/10.1136/sbmj.h4521

Botas, P. C., & Huisman, J. (2012). (De)constructing power in higher education governance structures: An analysis of representation and roles in governing bodies. *European Journal of Higher Education, 2*(4), 370-388.

Brazeau, C., Shanafelt, T., Durning, S., Massie, F., Eacker, A., Moutie, C., … Dyrbye, L. (2014). Distress among matriculating medical students relative to the general Population. *Academic Medicine, 89*(11), 1520-1525.

Bridgeman, P. J., Bridgeman, M. B., & Barone, J. (2018). Burnout syndrome among healthcare professionals. *The Bulletin of the American Society of Hospital Pharmacists, 73*(3), 147-152.

Buju, L. M. (2019). Medical education today: All that glitters is not gold. *BMC Medical Education, 19*(110), 1-11.

Canadian Federation of Medical Students. (2018). CFMS National Wellness Program. Retrieved from https://www.cfms.org/news/2018/04/27/cfms-launches-the-national-wellness-initiative

Canadian Medical Association. (2018). *CMA national physician health survey*. Ottawa, ON: CMA.

Canadian Medical Association. (2018). CMA statement on physician health and wellness. [PDF file]. Retrieved from https://www.cma.ca/sites/default/files/2018-11/physician-health-wellness-statement-e.pdf

Cawsey, T., Deszca, G., & Ingols, C. (2016). *Organizational change: An action-oriented tool kit*. Thousand Oaks, CA: SAGE Publications, Inc.

Chan, W., Batterham, P., Christensen, H. & Galletly, C. (2014). Suicide literacy, suicide stigma and help-seeking intentions in Australian medical students. *Australasian Psychiatry, 22*(2), 132-139.

Chew-Graham, C. A., Rogers, A., & Yassin, N. (2003). 'I wouldn't want it on my CV or their records': Medical students' experiences of help-seeking for mental health problems. *Medical Education, 37*(10), 873-880.

Chinawa, A. T., Chinawa, J. M., Aniwada, O. A., Ndukuba, A. C., & Uwaezuoke, S. N. (2018). Spectrum of anxiety disorders among medical students in a Nigerian medical school: A cross-sectional study with standardized screen tools. *Journal of Educational and Developmental Psychology, 8*(2), 132-146.

Daskivich, T. J., Jardine, D. A., Tseng, J., Correa, R., Staff, B. C., Jacob, K. M., & Harwood, J. L. (2014). Promotion of wellness and mental health awareness among physicians in training: Perspective of a national, multispecialty pan of residents and fellows. *Journal of Graduate Medical Education, 7*(1), 143-147.

Deszca, G., Ingols, C., & Cawsey, T. (2019). *Organizational change: An action-oriented toolkit*. (4th ed). Thousand Oaks, CA: Sage Publications, Inc.

Drolet, B. C. & Rodgers, S. (2010). A comprehensive medical student wellness program – Design and implementation at Vanderbilt School of Medicine. *Academic Medicine, 85*(1), 103-110.

Dyrbye, L. N., Eacker, A., Durning, S. J., Brazeau, C., Moutier, C., Massie, F. S., … Shanafelt, T. D. (2015). The impact of stigma and personal experiences on the help-seeking behaviours of medical students with burnout. *Academic Medicine, 90*(7), 961-969.

Dyrbye, L., & Shanafelt, T. (2016). A narrative review on burnout experienced by medical students and residents. *Medical Education, 50*(1), 132-149.

Dyrbye, L.N., Thomas, M. R., Harper, W., Massie, F. S. Jr., Power, D. V., Eacker, A., … Shanafelt, T. D. (2009). The learning environment and medical student burnout: A multicentre study. *Medical Education, 43*(3), 274-282.

Dumas, C., & Beinecke, R. (2018). Change leadership in the 21st century. *Journal of Organizational Change Management, 31*(4), 867-876.

Eastern School of Medicine. (2017). Accreditation report. [citation withheld for anonymization reasons].

Eastern School of Medicine. (2019). ESM website. [citation withheld for anonymization reasons].

Eastern School of Medicine. (2015). Strategic plan. [citation withheld for anonymization reasons].

Glauser, W. (2017). Medical schools addressing student anxiety, burnout and depression. *Canadian Medical Association Journal, 189*(50), E1569-E1570. doi: 10.1503/cmaj.109-5516

Graham, J. W. (1991). Servant leadership in organizations: Inspirational and moral. *Leadership Quarterly, 2*(2), 105-119.

George, B. (2003). *Authentic leadership rediscovering the secrets to creating lasting value*. San Francisco, CA: Jossey-Bass.

George, B., Sims, P., McLean, A., & Mayer, D. (2007). Discovering your authentic leadership. *Harvard Business Review, 85*(2), 129-138.

Gibb, C. A. (1954). *Handbook of social psychology*. Cambridge, MA: Addison Wesley.

Gigliotti, R., Vardaman, J., Marshall, D., & Gonzalez, K. (2019). The role of perceived organizational support in individual change readiness. *Journal of Change Management, 19*(2), 86-100.

Gray, P. (2015). Declining student resilience: A serious problem for colleges. *Psychology Today, 22*, 09-15.

Greenleaf, R. K. (1977). *Servant leadership: A journey into the nature of legitimate power and greatness*. Mahwah, NJ: Paulist Press.

Greenleaf, R. K. (1970). *The servant as leader*. Westfied, IN: Greenleaf Centre for Servant Leadership.

Gronn, P. (2000). Distributed properties: A new architecture for leadership. *Educational Management and Administration, 28*(3), 317-338.

Gruppen, L., Irby, D., Durning, S., & Maggio, L. (2018). Interventions designed to improve the learning environment in the health professions: A scoping review. *MedEdPublish, 7*(3), 1-33. Doi: 10.15694/mep.2018.0000211.1

Guglielmi, D., Florini, M., Mazzetti, G., Depolo, M., Calabro, E., Miglioli, S., … Cioni, G. (2017). Assessment of organizational well-being in an Italian general hospital after an organizational change. *Italian Journal of Medicine, 11*(788), 95-101.

Gupta, M. (2015). Organizational structure affected by strategic change. *International Journal of Advanced Research and Innovative Ideas in Education*, *1*(3), 372-376.

Gustafson, D., Saintfort, F., Eichler, M., Adams, L., Bisognano, M., & Steudel, H. (2003). Developing and testing a model to predict outcomes of organizational change. *Health Services Research, 38*(2), 751-776.

Habib, F-N. (2012). Universal school-based mental health programmes for multicultural contexts: Insights and potential for cultivating safe, socially inclusive schools. *Advances in School Mental Health Promotion, 5*(1), 4-22.

Harris, A. (2006). Opening up the 'black box' of leadership practice: Taking a distributed leadership perspective. *International Studies in Educational Administration (Commonwealth Council For Educational Administration and Management (CCEAM)), 34*(2), 37-45.

Hieman, N., Davis, R., & Rothberg, B. (2019). A deeper understanding of depression and suicidality among medical students. *Medical Teacher, 41*(6), 711-713.

Henning, K., Ey, S., & Shaw, D. (1998). Perfectionism, the imposter phenomenon and psychological adjustment in medical, dental nursing and pharmacy students. *Medical Education, 32*(5), 456-464.

Hope, V., & Henderson, M. (2014). Medical student depression, anxiety and distress outside North America: A systematic review. *Medical Education, 48*(1), 963-979.

Howse, K., Harris, J., & Dalgarno, N. (2017). Canadian national guidelines and recommendations for integrating career advising into medical school curricula. *Academic Medicine, 92*(11), 1543-1548.

Ishak, W., Nikravesh, R., Lederer, S., Perry R., Ogunyemi, D., & Bernstein, C. (2013). Burnout in medical students: A systematic review. *The Clinical Teacher, 10*(4), 242-245.

Jones, S., Harvey, M., Lefoe, G., Ryland, K., & Schneider, A. (2011). *Report to ALTC Leadership Meeting.* LE9-2222, February. Unpublished report.

Jones, S., Lefoe, G., Harvey, M. & Ryland, K. (2012). Distributed leadership: A collaborative framework for academics, executives and professionals in higher education. *Journal of Higher Education Policy and Management, 34*(1), 67-78.

Judge, W., & Douglas, T. (2009). Organizational change capacity: The systematic development of a scale. *Journal of Organizational Change Management, 22*(6), 635-349.

Kemp, S., Hu, W., Bishop, J., Forrest, K., Hudson, J., Wilson, I., … Wearn, A. (2019). Medical student wellbeing – A consensus statement from Australia and New Zealand. *BMC Medical Education, 19*(69), 1-8.

Kezar, A. (2018). *How colleges change: Understanding, leading and enacting change*. (2nd ed). New York, NY: Routeledge.

Kiersch, C., & Peters, J. (2017). Leadership from the inisde out: Student leadership development wihin authentic leadership and servant leadership frameworks. *Journal of Leadership Education, 16*(1), 148-168.

Komodromas, M, Halkias, D., & Harkiolakis, N. (2019). Managers' perceptions of trust in the workplace in times of strategic change: The case of Cyprus, Greece and Romania. *EuroMed Journal of Business, 14*(1), 2-20.

Kothari, V., George, N., & Hamid, O. (2018). Provision of mental health support for medical students. *Advances of Medical Education and Practice, 9*, 925-926. https://doi.org/10.2147/AMEP.S184571

Kotter, J. (1996). *Leading change*. Boston, MA: Harvard Business Review Press.

Kusek, J. & Rist, R. (2004). *Ten steps to a results-based monitoring and evaluation system*. Washington, DC: World Bank.

Lewin, K. (1951). Field theor of social science: Selected theoretical Papers. New York, NY: Harper & Brothers.

Lewis, L. (2019). *Organizational change: Creating change through strategic communication*. (2nd ed). Hoboken, NJ: John Wiley & Sons Ltd.

Lipsitt, D. (2015). Developmental life of the medical student: curriculum considerations. *Academic Psychiatry, 39*(1), 63-69.

Lumby, J. (2019). Distributed leadership and bureaucracy. *Educational Management Administration & Leadership, 47*(1), 5-19.

Lyubovnikova, J., Legood, A., Turner, N., & Mamakouka, A. (2017). How authentic leadership influences team performance: The mediating role of team relfexivity. *Journal of Business Ethics, 141*(1), 59-70.

Mack, L. (2010). The philosophical underpinnings of educational research. *Polyglossia, 19*, 5-11.

Mazurkiewicz, R., Korenstein, D., Fallar, R., & Ripp, J. (2012). The prevalence and correlations of medical student burnout in the pre-clinical years: A cross-sectional study. *Psychology, Health & Medicine, 17*(2), 188-195.

Mehta, S., & Edwards, M. (2018). Suffering in silence: Mental health stigma and physician's licensing fears. *American Journal of Psychiatry, 13*(11), 2-4. https://doi.org/10.1176/appi.ajp-rj.2018.131101

Men, R., & Yue, C. (2019). Creating a positive emotional culture: Effect of internal communication and impact on employee supportive behaviours. *Public Relations Review, 45*(3), 1-12. https://doi.org/10.1016/j.pubrev.2019.03.001

Minford, E., & Manning, C. (2017). Current status and attitudes to self-care training in UK medical schools. *Journal of Compassionate Health Care, 4*(1), 1-6.

Morgan, G. (2018). Paradigms, metaphors, and puzzle solving in organization theory. *Administrative Science Quarterly, 25*(4), 605-622.

Mousa, O. Y., Dhamoon, M. S., Lander, S., & Dhamoon, A. S. (2016). The MD blues: Under-recognized depression and anxiety in medical trainees. *PLoS ONE, 11*(6), 1-10. doi: 10.1371/journal.pone.0156554

Muceldili, B., Turan, H., & Erdil, O. (2013). The influence of authentic leadership on creativity and innovativeness. *Social and Behaviour Sciences, 99*, 673-681.

Neuman, J., Robson, A., & Sloan, D. (2017). Monitoring and evaluation of strategic change programme implementation – Lessons from a case analysis. *Evaluation and Program Planning, 66*, 120-132.

Northouse, P. (2016). *Leadership: Theory and practice* (7th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Ouedraogo, N. & Ouakouak, M. (2018). Impacts of personal trust, communication, and affective commitment on change success. *Journal of Organizational Management, 31*(3), 676-696.

Papish, A., Kassam, A., Modgill, G., Vaz, G., Zanussi, L, & Patten, S. (2013). Reducing the stigma of mental illness in undergraduate medical education: A randomized controlled trial. *BMC Medical Education, 13*(141) 1-10.

Pham, L. (2018). A review of key paradigms: Positivism, interpretivism and critical theory. doi: 10.13140/RG.2.2.13995.54569

Pollanen, R. M. (2016). Financial regulation and governance in Canadian higher education. *International Journal of Business, Accounting, and Finance, 10*(2), 94-109.

Popli, S., & Rizvi, I. (2016). Drivers of employee engagement: The role of leadership style. *Global Business Review, 17*(4), 965-979.

Price, R. H., Choi, J. N., & Vinokur, A. D. (2002). Links in the chain of adversity following job loss: How financial strain and loss of personal control lead to depression, impaired functioning and poor health. *Journal of Occupational Health Psychology, 7*(4), 302-312.

Province of XX. (2018). Action Plan. [citation withheld for anonymization reasons].

Rothwell, E., Anderson, R., & Botkin, J. (2015). Deliberative discussion focus groups. *Qualitative Health Research, 44*(4), 661-681.

Schein, H. E. (2017). *Organizational culture and leadership*. Hoboken, NJ: John Wiley & Sons, Inc.

Schulz-Knappe, C., Koch, T., & Beckert, J. (2019). The importance of communicating change: Identifying predictors for support and resistance toward organizational change process. *Corporate Communications: An International Journal, 24*(4), 670-685.

Shanafelt, T., Schein, E., Minor, L., Trockel, M., Schein, P., & Kirch, D. (2019). Healing the professional culture of medicine. *Mayo Foundation for Medical Education and Research, 94*(8), 1556-1566.

Shapiro, G. K. & Burchell, B. J. (2012). Measuring financial anxiety. *Journal of Neuroscience, Psychology, and Economics, 5*(2), 92-103.

Slavin, S. J., Schindler, D. L., & Chibnall, J. T. (2014). Medical student mental health 3.0: Improving student wellness through curricular changes. *Academic Medicine, 89*(4), 573-577.

Smits, S. & Bowden, D. (2015). A perspective on leading and managing organizational change. *Economics and Business Review, 1*(15), 3-21.

Smollan, R. (2013). Trust in change managers: The role of affect. *Journal of Organizational Change, 26*(4), 725-747.

Splett, J., Weist, M., & Fowler, J. (2013). The critical role of school psychology in the school mental health movement. *Psychology in Schools, 50*(3), 245-258.

Sveiby, K. (2007). Disabling the context for knowledge work: the role of managers' behaviours. *Management Decision, 45*(10), 1636-1655.

Thompson, G., McBride, R., Hosford, C., & Halaas, G. (2016). Resilience among medical students: The role of coping style and social support. *Teaching and Learning in Medicine, 28*(2), 174-182.

Uzarski, D., & Broome, M. (2017). A leadership framework for implementation of an organization's strategic plan. *Journal of Professional Nursing, 35*(1), 12-17.

Vankar, J., Prabhakaran, A., & Sharma, H. (2014). Depression and stigma in medical students at a private medical college. *Indian Journal of Psychological Medicine, 36*(3), 246-254. doi: 10.4103/0253-7176.135372

Velez, C., & Gupta, N. (2019). The development and implementation of a longitudinal wellness curriculum for mcgill university's undergraduate medical program. *International Journal of Whole Person Care, 6*(1), 6-21.

Vogel, Lauren. (2018). Medical education needs reform to improve student well-being and reduce burnout, say experts. *Canadian Medical Association Journal, 190*(48), E1426-E1427.

Wallace, J. (2012). Mental health stigma in the medical profession. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 16*(1), 3-18.

Weiner, B. J. (2009). A theory of organizational readiness for change. *Implementation Science, 4*(67), 1-9.

Whelan-Berry, K. S., & Somerville, K. A. (2010). Linking change drivers and the organizational change process: A review and synthesis. *Journal of Change Management, 10*(2), 175-193.

Wilson, S. & McCalman, J. (2017). Re-imagining ethical leadership as leadership for the greater good. *European Management Journal, 35*(2), 151-154.

Wimsatt, L., Schwenk, T., & Sen, A. (2015). Predictors of depression stigma in medical students: Potential targets for prevention and education. *American Journal of Preventative Medicine, 49*(5), 703-714.

Wong, C. & Cummings, G. (2009). The influence of authentic leadership behaviours on trust and work outcomes of health care staff. *Journal of Leadership Studies, 3*(2), 6-23.

Yanes, A. (2017). The culture of perfection: A barrier to medical student wellness and development. *Academic Medicine, 92*(7), 900-901.