A TD-MD: Transdisciplinary Double-Doctor, a journey to post-traumatic growth

Gibson, C.

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Christine Gibson MD CCFP MMedEd

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Disclaimer: The views expressed in this document are mine and not necessarily the views of my supervisory team, examiners, or Middlesex university.

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My external mentor was Professor Bob Woollard at the University of British Colombia in Canada. He has been a distinguished contributor to my career over this past decade, a true transdisciplinarian practitioner who has influenced many systems of care.

I would also like to thank my family—mother Lois, sister Cathy, and her children Kate and Ty. My chosen family, the ‘daughters’ Aishwarya and Maryna (both of whom were immeasurable helpers in these works, through wisdom and direct support). And my dog Fife.

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Being located in proximity to the Rocky Mountains, on land stewarded for millennia by Indigenous people, is the greatest blessing. One I do not take for granted. I wrote this body of work on Treaty 7 territory, land in relationship with First Nations of which I am a treaty benefactor. These are the traditional territories of the Blackfoot Confederacy (Siksika, Kainai, Piikani), the Tsuut’ina and Stoney Nakoda nations. It is also the historical home to Métis Nations of Alberta Region 3. As a descendent of settlers to Canada, I have benefited from the genocide committed against these peoples, and the ongoing social harms from policy and bias. I wish to demonstrate my concrete commitment to reconciliation throughout my career and make these acknowledgements more than performative.

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Glossary

ACEs: The Adverse Childhood Experiences study was conducted through a Kaiser-Permanente cohort of over ten thousand patients in California. It was the first measurement of the epidemiology and impact of negative events in childhood. He studied physical, sexual and emotional abuse, as well as household dysfunction. High scores correlated with physical, mental, and social ill outcomes later in life at exponential rates.

AGM: Annual general meeting of a non-profit board.

Anti-oppressive: These practices acknowledge the structural violence and systemic trauma imposed on many communities that experience inequity and discrimination, so aims to create practices and systems that deliberately prevent such harm. For example, anti-racism or anti-colonialism would be ensuring the safety (physical, psychological, and relational) of Black, Indigenous, and People of Color (BIPOC) people. Inclusivity, belonging, and equity are core values of such practices.

CanMEDS roles: These are the guiding markers of assessment for medical students and resident trainees in Canadian programmes.

Canadian College of Family Physicians (CCFP): The accrediting body for self-regulating professional family physicians in Canada, equivalent to GP training and credentials from UK.

East Africa Family Medicine Initiative (EAFMI): A regional collaboration between family medicine programmes in East Africa, including Tanzania (one programme), Kenya (two or three, depending on the year), and Uganda (two programmes). Rwanda participated, but its programme became nascent during the EAFMI. Burundi is a member of East Africa but is yet to have any programme in development.

EFT or Emotional Freedom Techniques: A therapeutic technique that uses the ancient art of acupuncture from Traditional Chinese Medicine to shift emotional experiences in the body.

Global Familymed Foundation: A non-profit entity founded by Dr. Christine Gibson in 2012 that works in Nepal and Uganda but has conducted projects in Ethiopia and Myanmar, as well as throughout East Africa. More at www.GlobalFamilyMed.org

Global Health: This is a discipline related to medicine and health care that takes place in communities placed at risk for vulnerability. When the term “global” is invoked, this is more often tied to international efforts but for many, global health can be local when inequity is evident (inner city, Indigenous, or immigrant health care in high-income nations).

Global North / Global South: The current means of expressing countries with higher income versus low or middle income (LMIC). In the past, terms used included *developed* and *developing*, or *high-resource* and *low-resource,* but both of these are misleading as they do not consider ongoing colonial extraction.

Havening: A therapeutic technique that uses gentle brushing of one’s hands across the body to shift the brain waves into a state of calm.

IMF: International Monetary Fund. In this context, it relates to loans provided to the Global South that have distinct rules attached.

Indigenous: In the North American lexicon, this refers to the people who lived on the lands now called Canada and the United States of America, as well as most nations of Central and South America, prior to colonization and genocide. In some countries, the Indigenous population was murdered and barely

survives. In others, there is strong presence, but they face ongoing structural harm from residential school torture, children being apprehended, and racism.

Knowledge Translation: Moving knowledge from academia into the common domain.

Metaplasia: Early cell changes that can result in cancer. If caught by the immune system, this change can be reversed.

MCAT: The Medical College Admission Test is a standardized test that is considered for most admissions into medical school in North America.

The Modern Trauma Toolkit: A book released by Christine in 2023, which is a primer on trauma and stress, explaining the neurobiology and sharing personalised solutions.

NARM: The NeuroAffective Relational Model is a novel psychotherapeutic intervention designed by Joseph Heller and taught by Brad Kammer. It is based on the texts *Healing Developmental Trauma* and *A Practical Guide to Healing Developmental Trauma*, both of which are in the reference section. It focuses on the unhealed desire (and fear of) connection, authenticity, trust, intimacy, and autonomy in us all and bases its interventions on agency and adult consciousness.

Plandemic: A term used by conspiracy theorists who decided that the COVID-19 pandemic was not a real entity, part of the 'fake news' warped reality.

SAAS: Subscription as a Service, a model of digital entrepreneurship based on an ongoing financial relationship.

Self-psychoanalysis: This is not a formal term but a way that I describe looking deeply at my conscious and subconscious beliefs from the psychotherapeutic perspectives that I have studied.

Social Innovation: An endeavor that is aiming to create beneficial social change. It may be educational, entrepreneurial, regulatory, or another process or practice.

South-South Partnerships: While it is not an accurate geographic description, it is a more neutral reflection of ongoing extraction when the partnership is less equal Thus, a South-South partnership would be one within and between nations that are low-and-middle income, where they collaborate on their own issues. This differentiates from traditional partnerships in international development where the Global North comes with more power and often an agenda that is imposed on their Southern partner.

Systems Constellations: This is a consultation where representative markers of factors and incentives within systems are labelled, then the participants determine where they move and how they might influence future directions.

Teal organisation: An organisation that achieves harmony and balanced power amongst its leadership and employees.

TED: Technology Education and Design Talks, or TEDx talks, are a global phenomenon where experts are invited to share 8-18 minute memorized speeches.

Transdisciplinary: Concerns itself with the interconnectedness of disciplines, domains of experience and thought, using a lens of complexity and agential knowing.

TRE or Trauma Releasing Exercise: A therapeutic technique that allows the body to tremor in order to release sympathetic tone.

Navigation Page

I am Dr. Christine Gibson—a family physician, trauma therapist, social entrepreneur, global health funder, speaker, and author. After practising clinical medicine in hospital and community, creating a residency program in health equity, and attaining a Masters in medical education which allowed me to do academic consulting throughout the world—it is time for me to self-reflect. For the second half of my career, I have the ability to make an impact on some of the most critical issues of our time—systems-thinking and resiliency. My desire is to do this with clarity of intention, to avoid recreating the systemic oppression that has benefited my own career.

You can find my resume for the Doctoral of Professional Studies by Public Works in Appendix C—I had one that is 3 pages long and the other was 27 pages long, so it took some effort to create one that reflected both breadth and depth in a succinct enough manner.

The Public Works selected are:

1. **Global health and international KT:**
   - Global Familymed Foundation: East Africa Family Medicine Project (newsletters)
   - WONCA Standards journal article
   - Brazil Storybooth project article
   - Emergence podcast episodes
   - Global definitions in Family Medicine article
   - Narratives in Family Medicine globally article
2. **Social innovation and community engagement:**
   - The Solutions Studio article
   - Digital Storytelling Project video links: Charlene, Trish, Rob, Mary's accessibility
   - The Healing Centred Cooperative (including 'Music and Breathwork for Newcomer Communities' project) media
   - First TEDx talk
3. **Trauma and post-traumatic growth:**
   - The Modern Trauma Toolkit book
   - Social Media @TikTokTraumaDoc videos about climate trauma, about developmental trauma, about post-traumatic growth, about refugee resettlement, about medical assistance in dying, and about one of my favourite tools for shifting
   - Keynote about trauma for International Society of Addiction Medicine
   - Safer Spaces Training curriculum available online)

I have selected these to develop further insights into the myriad pathways my career has journeyed thus far. Each of these areas are atypical activities for an average family physician / GP. When I consider the ways that I have contributed to the larger body of knowledge, acting in a transdisciplinary fashion, or innovated beyond what was expected—these public works are undeniable examples. I selected these also because of my desire to further contribute to each of these realms, potentially at their intersection. In a deep self-reflection of my current endeavours, it will aid as a signpost of the estimated half-way mark in what I hope to be a long career. The more that I study, it is evident that people with great privilege can also leave scars as well as marks. My intention is to examine both shadow and light.

Why these? These works were selected because they are the three spheres where I have been able to innovate and experiment the most. At least half of these transpired within the last five years, if not the past three, but I did add a few historical artefacts that seemed to complement or provide context that were older (e.g., the 2015 TEDx talk). I did not want to focus on medical education, the Masters I completed, yet education is a theme–in terms of both my keen learning and my knowledge translation. I think that there is a web of threads to be found that will link the themes as well as the epistemologies from which they can be examined. My motivations for exploring these themes pollinated where my broader influence as well as personal growth could evolve.

Why now? Having graduated from residency in 2001, I'm just over the 20-year mark of my employment as a physician. I will be fifty years old while submitting this work, so anticipate this marks the second half of my career. During this landmark stage, I have developed the privilege and power to leverage multiple platforms, and want to be conscientious in focusing my efforts in service of collective humanity. *Who am I and how can I serve what's needed in these times?* The opportunity for self-reflection, critical appraisal, and a honing in on purpose is the pause within this liminal space.

Why me? When I finished high school, I told my mother I wanted to be a writer. She immediately sent me to an occupational assessment. I was told that my career possibilities were pluripotential. I am pleased overall that I chose medicine but have always wanted to break from the mould that we are stifled and constricted within. As I gained education, standing, and power within medical communities—I have also managed to express my innate transdisciplinary nature. I have had multiple careers within and adjacent to medicine. I want to examine how this features in my career path as well as how it expresses the context of these times—of interconnectedness, of innovation, and of collective trauma.

Chapter 1 introduces the multi-layered context in which the public works took place. It presents an overview of my upbringing and influences. It focuses on the layers of impact from the individual body to

the community to the larger geopolitical timeframe. Addressing the intrinsic influence of growing up in 1970s Western Canada, in an intact family… and the frames from where I derive ongoing benefit (racism, capitalism, and colonialism). In it, there is a sense of how my drive to fight inequity was birthed. In examining the ontology of my personal growth, it gives context to my achievements—and my dreams.

Chapter 2 presents my choice of the critical lens. The frame with which I examine these artefacts is that of autoethnography. I chose both evocative and analytic autoethnography as I feel this dichotomy was a written representation of the struggle to choose a science or arts-related career. Imagine a canvas representing a physician where one is psychedelic splatters and the other is an almost hyper-realistic, precise rendition… welcome to my mind. It was important to involve both of these frames, as this could be the academic bridge across the lobes of my brain that have resulted in this career of contrived chaos. The epistemology behind combining these lenses is that the critical analysis would not be possible without a holistic and comprehensive discourse that does not narrow into a limiting frame. Due to the expanded nature of my different works, a creative yet rigorous analysis is best suited. Other lenses that will be employed will be chapter-specific, but the autoethnographic frame provides the overall insight.

Chapter 3 is the examining of my artefacts related to Global Health. In this section, I have chosen to fully deploy my contrasting nature to examine parts of my own ontology—those elements of my psyche that are embedded in colonialism and those that are deeply anti-oppressive. The question that I attempt to answer is whether my work in international development and overseas medical education was constructed in a colonial paradigm. I use aspects of my work, describe mentorship and influences, while firmly sitting in both positions. This chapter is critical in understanding my intention to decolonize my mind and works as much as is possible for someone of my social position.

Chapter 4 is about Social Innovation and so I chose to look at my artefacts and their impact (personal and professional) through a lens of the adaptive cycle. In selecting this infinity loop and its labels, it helped me reframe my comfort and skills within stability and anarchy. It examines my intrinsic and extrinsic motivations, the thought process behind my social innovations, and a deep self-reflection on emergence.

Chapter 5 focuses on Trauma by journeying through traumatic events that shaped key transitions within my professional career through the lens of psychoanalysis. While I am a family physician, I have studied multiple forms of psychotherapy. Using the frames of developmental, parts, narrative, somatic, cognitive, and (a gentle surprise) therapeutic epistemology; I dive into my own psyche and the reasons

behind the decisions I made. This helps present not just the sheer amount of study I have achieved in becoming an integrated traumatologist but also gives me an opportunity to look at my motivations in a more profound way. This led to the insights necessary to close the analysis from a micro perspective to move to a more macro final chapter.

Chapter 6 is the culmination of the insights and learnings that emerged from this time of self-reflection and critical analysis. I use the common tryptic of ‘What–So What–Now What’ to uncover the themes of justice, innovation, trauma, and education while keeping focus on what is yet to be explored. For gazing into the future, I describe a session of systems constellation. This chapter makes coherent the disparate journeys through the artefacts. The interconnectivity between my explorations of shadows and light now forms a coherent image, while further possible paths can be seen. My desire to bring social change has a proven impact; these experiences have shaped what is possible in the second half of my career.

Positionality Statement

The author of these works completed an undergraduate degree at an institution in the Global North before undertaking medical school in Eastern Canada, then two further degrees in the UK. These experiences brought enhanced awareness of the inequities of global health and academics. They also provided an awareness of the constructs of race, beauty, normal, gender, and class, among others. She acknowledges the complexity of terms such as Indigenous, Western, low- or middle-income countries, and Global North/South. The perspectives shared are not a solution to thousands of years of systemic violence, but a hopeful catalyst towards dialogue, understanding, and systems-level change.

This statement was constructed with the assistance of Dr. Vanessa Andreotti, Professor Dean of the Faculty of Education at the University of Victoria in Canada, through personal communication.

Abstract

The context in which my public works were created has been and continues to be complex environments that include diversity, conflict, trauma, deprivation, colonialism and, more recently, while writing this thesis—a global pandemic and the war in Ukraine. I have chosen an autoethnographic lens to this critique. I open with a critical reflection of the shaping of my agency in the world through the formative years of childhood in Canada that account for some of the ways that I have, in turn, shaped my environments and how they have shaped me to have the positionality I have today. This leads onto my professional accomplishments and personal growth as I engage myself and the reader in narrative discourse. I chose autoethnography as a lens for its capacity to embrace both the evocative nature of personal and professional practice and analytic autoethnography which guides the evocative and the experiential towards contributions beyond self and one's profession that have something to say about the human condition and how humans have interacted with the world both constructively and destructively. Both these dimensions are intrinsic to understanding the dichotomous skills and understanding that I possess and the diverse works I have both created and conducted, which are manifestations of my agency in and on the world. At this transition point in my life, I felt the need to subject them to a critical gaze. Three themes had arisen in my own works which I wanted to look at more closely through this opportunity to engage more critically in my own outputs. First: Global Health; my work as executive Director and founder of Global Familymed Foundation as well as an article written with colleagues from Nepal and Myanmar and a podcast series I have run with global partners. I question whether the work conducted was through a colonial paradigm. Second: Social Innovation, where I use the Adaptive Cycle metaphor to analyse different facets of my career representing each phase. Artefacts in this chapter include the two non-profits, the Cooperative, and the corporation I founded as well as programming I conducted in other organizations. Third: Trauma, both the intense study I conducted to become an integrated traumatologist as well as the demonstration of my critical questioning through TikTok-style self-psychoanalysis around my motivations to create my social media channel and write my book *The Modern Trauma Toolkit*. The insights which have emerged for me are profound; offering future directions related to social justice, education, innovation, and post-traumatic growth.

Chapter One: Myself in Context

This chapter will journey from the fractals evident in individual to the collective systems, relating the production of my artefacts in the context where they were constructed.

Context influences how humans make sense of things, our values, traditions and beliefs, the choices we make, the way we behave. It also influences the creation of the public works which embody our knowledge at the time and is a manifestation of our agency in the world. In critiquing my public works and being both a practitioner and agent of change, I am also part of the context and therefore it is important to declare to others and indeed to myself who I am, what has shaped me and my agency in the world. It is from such a critique that I can extract learning and increased awareness of who I am and who I can become in this evolutionary voyage towards what is not yet known.

What I know and what others know at a professional level is that I am a physician and trauma specialist who made choices that have exposed me to a range of experiences in different cultures from the traumatic and dissociated to the meaningful and connected. Preparing these analyses helps me observe the progression with the eye of a calm observer, who holds compassion for both the naive learner and the professional. It is clear to see they remain in an interactive dance on this journey.

The Story of Me

I was bullied a lot as a kid. This has come up in my most recent therapy sessions consistently.
I studied the NeuroAffective Relational Model of therapeutic practice (NARM), which describes the childhood strategies that we use in order to cope. These strategies often carry on throughout life.

Together with clinical supervisors, we identified that, because of the critical nature of my parents' discourse as well as the relentless bullying, I decided that I had to be perfect to be liked and respected. This is such a foundational belief for me that it resonates throughout my personal and professional life. Mostly because it works. Perfectionism and people-pleasing as coping skills are highly rewarded in capitalistic societies that value achievement and productivity.

When I was bullied, my mom had the opportunity to transfer me to a full academic program. She knew that my delicate continence was suffering—while I never explicitly mentioned my psychological symptoms (sadness, shame, loneliness), she must have sensed them. We did not speak about emotions in my family. In fact, these were seen as a sign of weakness and it was implied that we were to quickly suppress or work through any feelings.

The decision to move pulled me out of French immersion studies and into the International Baccalaureate stream where my educational needs were met and even exceeded. We studied the stock market to learn maths. We studied the magic realism of Latin American authors. I had 100% grades in both maths and English. Even in my younger years, there was no apparent dominant side to my brain.

Finishing high school, I was the first woman in many generations on both sides who had pluripotential options available to me. So many that I could not decide. My mother sent me to an occupational therapist to analyse my abilities and interests. It did not narrow the field substantially. I told her I wanted to write, and she said, “Do something else and then write about it.” She told me later that she was afraid that I would take on too much and that when I expressed an interest in medicine, she discouraged me because she knew it was a rough occupation. I think she meant existentially.

I asked mom recently why she said to me, “You don’t have to go to med school - that seems really hard.” Was she prescient? Did she realise the trauma and sacrifice it entailed? She responded that it was *reverse psychology*, as I was a stubborn adolescent at the time, and she figured if she recommended that I not choose a career in medicine then it might propel my decision to apply. My sense was that this sentiment did not particularly discourage me; much like my parents, I have always relished a challenge.

Even though I chose to go to Canada’s top medical school at the University of Toronto, I was still able to graduate in the top ten percent of my class. I recall my interests in neurobiology being fostered, but when I did my electives in pediatric neurology, the unbearable sadness of intractable seizure disorders in children and the resentment of their parents when cure was unachievable became evident. I sampled pediatric emergency and cardiology. By the time clerkship electives came, I was even keen on neurosurgery (which is gruelling even by medicine’s standards). The point is—I loved it all. Rural family medicine experiences solidified my enjoyment of comprehensive, holistic care from ‘womb to tomb.’ Despite the Toronto elite mentality telling me that, since I was evidently gifted, I was wasting my potential… I knew otherwise.

Family Medicine (GP specialty in the UK) was the generalist scope that my brain needed. From here, I could practise in the emergency room and the adult inpatient ward and at community clinics. So I did, from 2001 onwards. Generalist practice is inherently transdisciplinary (Lynch et al. 2021) as we see undifferentiated problems and manage multisystemic disease states. But even here, the box was too constricting.

My medical graduating class was one of the first that had predominantly female students. Yet, even 25 years later, it remains men who dominate leadership. Noticing the characteristics that it took to succeed, I became even more determined and driven. My quest for learning and achievements went beyond my parents' dreams. Even beyond what I could have imagined. Complex adaptive systems are naturally adaptive—shifting with experience, anticipating the future (Waldrop 1993).

But the dialogue is changing. We are more self-reflective about misogyny and racism, calling it out when we see it. Speaking truth to power and then taking some for our own. And while I was able to create a residency program in health equity, there are multiple internalised biases that I have subsumed from the culture and context in which I was raised: a relatively affluent, white privileged background in the suburbs, doing all the posh sports like dance and water polo as a teenager. These social constructs will necessarily colour my own work, and my view of this work.

I remember being in a small lecture hall in 2006, listening to the adventures of a Calgary-based team who had gone to Laos in a partnership to create a Family Medicine program. I joined them the next year and went annually for 4-6 weeks from 2007-2013. Recognizing that just having graduated from the residency did not qualify me as a teaching faculty member, I began a Masters in Medical Education through the University of Dundee in 2008. The London School of Tropical Medicine and Hygiene accepted me into their Diploma program in 2009. In rural Laos, the liver and lung flukes were common from the consumption of raw fish. I could not even spell *opisthorchis* when I visited the first time.

The arrogance of global health was not lost on me. With this achievement, I was recruited to join the Department of Family Medicine as an Associate Program Director. By 2008, I was in charge of creating a novel residency program in Global Health (now named Health Equity)—which became the basis of my Masters studies. I have often wondered why I have such a strong connection to equity issues—was it the fact that my ancestors on both sides faced cultural genocide from neighboring countries? Is it that I identify (more openly nowadays) as pansexual—scholar bell hooks described gay white women as being more passionate in their anti-racist work (hooks 1984)?

The experiences in Laos propelled me to seek out mentorship from Dr. Jennifer Hatfield, who ran the Global Health Office at the University of Calgary. She is a PhD psychologist who had a profound understanding of partnerships and power dynamics. This was the mentorship I needed. By 2011, she invited me on an official visit to East Africa, asking me to assess the status of Family Medicine programs and create a plan for North-South relationships. But as I explored, it was evident that South-South dialogue was what was needed, between the African partners themselves.

In 2012, I created the non-profit Global Familymed Foundation (GFF). We have been working in East Africa since this time. Further consultation opportunities in Ethiopia, Myanmar and Nepal came through my expanding network. To this day, Global Familymed Foundation pays tuition for almost all of the resident doctors studying Family Medicine at both Ugandan universities that offer the program. I ran the health equity residency in Calgary, sometimes bringing students along overseas, until 2014. GFF had a major scare during my divorce, as my unfaithful husband had brought the business acumen and knowledge of corporate processes to the organisation. He also brought his friends to the Board, all of whom deserted during the split. Luckily, I found two volunteer Directors that kept the ship afloat.

By 2017, I was aware that the long hours of hospital-based care were too strenuous on my aging physique. We would work 100+ hour weeks when you factor in overnight shifts—which were often busy. In fact, so stressful that my 24-hour blood pressure monitor suggested I might suffer a stroke on the job myself.

One of the ways that I processed the traumatic events at work was to write poetry. I also took woodworking, glassblowing, and pottery classes through the City Arts programs. I hiked, biked, skied as much as I could in the nearby Rocky Mountains. To fundraise for the non-profit, I hosted bands to play music events in my backyard, an annual fun run (for only 3 years), and even hired a movie theatre to screen the documentary *Circus Kathmandu*.

I travelled extensively. Initially, it was to satisfy my curiosity and sense of adventure. Eventually, the trips became more work-related for GFF and to present my work at international conferences. There was a time where my country-count was keeping pace with my age, but I am now exceeding 65 nation passport stamps without reaching geriatric milestones.

I began writing poetry as a way to process my existential angst—whether it was about ‘boy trouble’ or work-related horrors. By the age of 35, I began a work of fiction that explored the journey of my ancestors from Ukraine to Canada in 1903 (historical fiction) while incorporating the knowledge that our planet was heading towards times of scarcity and ecological transition (what is now called cli-fi or

climate fiction). This book is now being reworked in the context of Russia's ongoing genocide against Ukraine. I learn more of this story by hosting Ukrainian evacuees in my small basement—three so far, one remaining (Marina) who has become like a daughter to me.

The influence of narrative continues through my participation in the College of Family Physicians' Besrour Centre. The aim of this Centre is to promote the academic and clinical work of family doctors worldwide, very aligned with GFF. I met Professor Bob Woollard at their inaugural conference, who quickly became another insightful mentor. We co-founded the narrative working group, where we used appreciative inquiry to gather the stories of family medicine (Gibson 2017). My most recent involvement was to create a story-booth experience at a global family medicine conference in Brazil, where we interviewed 135 participants from over 50 nations—my Rwandan colleague led the systematic qualitative analysis (Cubaka et al. 2019).

I was also yearning to affect more change at a systems-level—something I came to understand through my international work.

In 2017, I approached the Executive Director of a local Community Health Centre (CHC). She agreed to a first meeting, then asked more of the leadership team to meet with me for a second. I pitched a new position—I agreed to practise clinical family medicine if I could also develop holistic wellness programing. Fortunately, they'd just been granted a massive endowment for cancer prevention. I let them know that it would be easy to describe the story of how stress reduction mitigates cancerous cells from propagating. For two years, I was in a state of pure bliss—creating and running programmes that emphasised purpose, connection, and joy. After twenty years of medicine, it was clear to me that these elements are the most healing prescription available.

As I joined the CHC, a friend put Social Innovation on my radar, which is defined in literature as "innovative activities and services that are motivated by the goal of meeting a social need," (Mulgan 2006). She let me know that it was a way to change systems. I supposed I had said one-too-many-times that I wanted to blow up the health care system… I enrolled in a Certification course and quickly became enamoured with Jill Andries. She has become a mentor in this realm; we speak two or three times a year to forge my path with intention. I also successfully participated in 2018 in a limited residency programme at the Banff Centre for the Arts and Creativity—they had a leadership stream with a one-month social innovation residency called *Getting to Maybe*. It was quite competitive, as the faculty were internationally-renowned. Twenty-one of us participated in a fellowship where we learned design thinking and systems entrepreneurship based on multiple ways of knowing—rational, creative, Indigenous, nature-based, and more. They asked us to first examine 'systems in self' and then 'self in

systems,' something I think is useful to frame this autobiography. Both looking inwards and outwards with intention, exploring shadows and light.

Studying social innovation helped me understand that addressing the root causes of ill-health is much more meaningful than putting out fires—which tends to be the traditional role of physicians. We put out the same fire over-and-over again, a fast path to burnout and cynicism. I am at the stage of my career where I want to prevent the fires and find water sources.

In 2015, I was accidentally in central Nepal during the earthquakes of 7.8 magnitude—I survived over thirty aftershocks in an apartment in Patan, in the Kathmandu valley. There was a flurry of publicity, as I was one of the few travellers with intact internet access. I managed to raise $40,000 CAD for the medical school in Patan where I'd been volunteering. But there were personal aftershocks too. I evacuated to Singapore and onward for the planned teaching in Myanmar. Every time the ground shook from a bus, or a garage door opened on the lower level, the tremor set off a series of unfamiliar physiological responses. I called my travel insurance and asked to speak with a psychiatrist in Singapore. He told me, "You're having a normal response to an abnormal situation." It wasn't PTSD… but it was something.

When I did some superficial reading about trauma, I quickly ascertained that most of my patients (at the CHC) had experienced significant trauma. It was the underlying factor in most of their presentations, whether physical or mental, as evidenced by the study on Adverse Childhood Experiences that was conducted the year that I graduated from medical school but has yet to sufficiently influence curriculum (Felitti 1998). A friend had sent me a link to Dr. Lissa Rankin's TEDx talk about 'Mind Over Medicine,' so I joined her Whole Health Medicine Institute class later that same year. It was a journey to unlearn and relearn much of what I had believed about healing. It was at this moment that I believe the universe began to send me clear signals of when I was on my path, or when I diverged.

Once I had a clear understanding of the impact of trauma on health outcomes, I noticed that it was mostly cognitive therapy focused on behaviour change that was offered to our patients. I was determined to study trauma skills that would help shift their stuck nervous system responses that were locked in after traumatic events—both incidental and relational. I studied for three years consistently, reading dozens of books, and taking every course that came my way, which has taken enough hours to be equivalent to a part-time job.

I have often explained to people that the earthquakes shook more than my body. They shook me foundationally and energetically. Call it a 'near death experience,' which it was, but it also helped me

find a more meaningful and impactful way forward. Since this time, the most extraordinary things have transpired—a TEDx talk, early Bitcoin investments, phenomenal experiences around the globe. And every time that my mind asks a question, the answer falls in my path. This is why I have not shown a lot of discernment in the courses I explore—it has seemed that they come into my awareness at the right time. Who am I to question what the universe deems to send my way?

I studied energy medicine like Emotional Freedom Techniques and (even unproven) facets like Psych K. I have become an Ayurvedic Counselor. I took a year-long Certificate in Trauma Stress Studies with Dr. Bessel van der Kolk and then met him at the Esalen Institute in California to learn psychodrama first-hand (the infamous cliffside village where beat-poets and psychedelic practitioners dipped into the hot tubs naked—and still do). Incidentally, I also studied three separate courses to be a psychedelic journey guide. Since the companies doing the work in my city seem to ascribe to a capitalistic model, I have yet to perform this duty. I believe this unboundaried, enthusiastic exploration qualifies me as an "intellectual risk-taker," a characteristic of transdisciplinarians (Augsburg 2014).

In 2016, Medical Assistance in Death (MAiD) became legal in Canada. I knew it was time to stand up for something that I believed in and became the first physician at my hospital and the solo provider for a full year (of the 400 physicians at my hospital). This took its toll on me. There was a lack of support amongst the religious nursing staff, some of whom howled during my first provision. There was a distinct lack of support from my administration, who told me to find another role as this was outside my scope of practice as an inpatient doctor (it certainly was not). But I realised, to make systemic change, the biases needed to shift. And the power of storytelling was not lost on me, given my proclivity for writing. I enlisted the assistance of a friend who was a journalist, who wrote up my first case of MAiD (Frangou 2017). It was evident how one could leverage media for positive change. One major decision I had to make in this publication was whether I was willing to be identified. I chose to remain anonymous as it was so early in MAiD, I was genuinely worried that a religious zealot would target me or my family. Since this time, I have become more courageous (self-identifying on social media) but that is likely because there are more prominent voices than mine. I wonder how much of my advocacy work I would do without a community of support.

When I joined TikTok in 2021, I was astonished to realise how much of my biases would be challenged. I deliberately followed Black and Indigenous content creators, as well as transgender and other non-binary people. While my own account gained a quick following, there were two surprises on this platform—how much anti-oppression and advocacy work takes place here and how quickly I would feel like part of a community. It had always been my assumption that online forums were not a suitable meeting place.

TikTok is a medium of the present moment. It exists for short attention spans that do not desire deep intellectual processes. Youth of today tolerate sound bites, shock, and variety. The algorithm feeds us whatever keeps us engaged. I have managed to stay relevant through consistency—posting almost daily (that work ethic passed down from mom) and ensuring quality yet diverse content (that transdisciplinary focus passed down from dad).

Will TikTok be swallowed into the next communication craze, artificial intelligence, or simulated universe? Perhaps, but in the meantime I have over 131,000 followers who will listen to my message.

Can I learn beyond my own context? I hope so. Because I have leveraged an unexpected platform and have unforeseen positional power. This account was a large part of what garnered me not just a book deal with a 'big 5' US publishing house, but also a reasonably large advance. My book The Modern Trauma Toolkit launched in May 2023 and I hope to continue to leverage these platforms, with two further books whose outlines sit in my Notes tab on my phone.

This book was written with the awareness of the gaps in trauma literature that was fully accessible (language, culture, health literacy) and solution-focused. I was able to embed concepts of health equity and systems thinking in its pages. This was important in my proposal and I was fortunate that the publisher was in agreement.

When I look at my motivation for this, it has to do with being bullied—finally having respect and a voice. It has a lot to do with wanting to create a legacy—as someone who is childless by choice. But there is something deep within my subconscious that drives me to serve in ways that are generous and generative. My desire to explore this is part of the impetus to do a Doctorate—I already have the title with my MD. Yet there is more to uncover.

The Story of We: the Family

I was raised by deeply loving parents who wished that I would reach my full potential. I was fortunate to be supported through a compassionate guiding hand as well as hypercritical feedback. It's become such an ensconced pattern in how my family communicates that we do not even see it anymore. The inner critic is especially loud. Even before I decided to go to medical school, if I got less than a 90% grade, my mind deemed it an abject failure.

My dad was forced to drop out of high school as a young man growing up in a coal mining town in Scotland. He moved to Canada to get away from the significant cultural boundaries imposed on him through this phenomenon—he had the wrong accent, poor education, and no suitable network. He could write his own story across the ocean.

I know I inherited a lot of his charisma and confidence, along with his insatiable curiosity. His bravery at taking a risk and upending his life at age twenty is something that reflects in my own ability to learn from new cultures and travel the world with no apprehension.

Dad met my mother when she was twenty and a young, beautiful computer programmer. This was her third engagement, but she knew that this man had the most potential. Something she could guide. The same way she has consistently propelled my own choices. They met on a Friday, got engaged that Sunday, and married a few months later. My Ukrainian grandmother told her that she could not understand a word my dad said, but she also knew that his kind eyes heralded a good match. Husband material. Father material.

They both grew up in poverty. Dad remembers plugging in coins to a wall metre for electricity or gas each week; some weeks there was a choice, and other weeks no choice at all. Mom's parents left in a trailer to Mexico when she was sixteen, leaving her to fend for herself by collecting rent from upstairs tenants. Dad's father was a veteran in the coal mines. Mom's mother hand-made most of her clothing, until she could get a job and buy her own.

From mom, I inherited a determination that my efforts would prove fruitful and an innate ability to see the pain in others. She had significant developmental trauma (which is her story to tell, not mine)—I only discovered this when she knew I had developed the expertise to handle the details. It was like she handed me a delicate tea cup, where I could not spill or harm the ceramic. Once I understood her backstory better, the fears that she expressed made sense. I had a proclivity for fearlessness, which always made her nervous. She does not sleep soundly when I travel out of the country. I hold so much more compassion for her now, which I was not always able to do as a younger adult.

Neither of my parents achieved traditional success when they were younger but managed to overcome their start during their adult career. Perseverance, grit, and dreams fueled them, which were passed on to me through modeling and genetics. Their journey started me off at a much more comfortable position than either of them—but the persistence and determination remained a living spark in their daughters. Likely also a scarcity mindset, which creates an extra strong drive. There is a generational trauma that is unspoken and unacknowledged, despite their overcoming their own childhood environments.

I wonder if this scarcity mindset is a part of what fuels my ontology. If I have more financial security, if I have solid employment options with a perpetual income stream, if I pay off the mortgage… these objectives have seemed like chasing ethereal clouds that dissipate once I reach one goal.

Dad recalls grey skies and smokers' coughs in rural Scotland. While there, he escaped into a bottle and a pub band, arriving in Canada with a guitar slung over his shoulder and a scraggly Beatles haircut. He craved sunshine. Mom helped him realise that his brains and personality could help him achieve so much more—he went to night school for ten years to earn building engineering certificates. His colleagues presumed he had a professional engineering designation; he was on the Building Code Commission of Canada. He was so proud of his accomplishments; his last project was creating over fifty schools through public-private partnerships. Both of my parents saw their work as innovative. Both of them were hardworking beyond measure. I strove for perfection, to make them proud, and to go beyond their limited horizons. For example, I did not miss a day of school, even the one where I had fainted that morning. There may be a tinge of resentment as I reflect on this; part of me yearns for a day coddled in bed with homemade chicken soup.

My dad always said things like, "You girls are absolute magic." He would cheerfully proclaim his love every time we saw him, right to the end. The end was a FaceTime call, as I sped in a taxi through the streets of St Petersburg to catch my flight home from Kyrgyzstan. My sister knew it would be his last breath that evening and tried to help me catch it.

His loss comes right before the pandemic. Right before the loss of my grandmother, the two greatest sources of unconditional love in my life. And a great impetus to be more self-reflective because I no longer have these caring sounding boards.

My grandmother lived to be 104. She was healthy until a cataclysmic stroke, so her influence was consistent until early 2020. The pandemic allowed me to place a camping mattress on the floor of her lodge, administering her some palliative narcotics and entertaining her with stories, as well as my patient visits over virtual care, for the last days of her life. In the final moments, I held her in my arms, wrapped my legs around her frail birdbody, and told her over and over that she was loved.

As I was.

My own marriage was only one year long. I eventually hired a private investigator to dig into the suspicions that I held; more than those were sadly confirmed. The relationship that brought me

tremendous joy brought me to my knees. One of the many women he cheated with was one of my best friends. Our marriage counsellor told me to change the locks—that a charismatic man who deems himself above society's laws and has issues with impulsivity can be a risk during separation. I acquiesced, while feeling that she was exaggerating needlessly. The police sent me a notice two months later that he had bought a gun.

While I remained childless by biology, I have many children in my life—from the students I influenced during my role as Health Equity Programme Director to my niece and nephew. I have one sister, Cathy; she and I are so different but share a deep love. We are both eager to contribute; while her mission in life was to be a parent, as well as an influential teacher, I was less sure how my contributions would evolve. After the dissolution of my marriage, it became clearer that biological children would not be part of my own legacy.

I met a young woman named Aishwarya when she asked me to speak at the University of Calgary's global health day for undergraduate students. When I presented on the 'shadow side' of global health, describing its innate colonial properties, a few brilliant young women (all racialised) asked if they could remain in contact. Initially, Aishwarya took on the role of mentee but soon it became much more. We have remained very close, with my influence over her education at Cambridge to her co-founding a company with me. Likewise, another young person entered my life in 2022—Marina was invited to stay with me alongside her two family members as they escaped the war in Ukraine. She lives here sixteen months later, and I suspect for much longer. She has become like another daughter to me, and I cherish this gift. It is clear that not having children may have influenced some of my drive to create in the world and give in other ways, not just to people but also in choosing non-profit activities.

I had gone from a family with foundations of love to building one on my own that was built on broken promises and bad faith, then a chosen family full of love and possibility. These were critical incidents in my adult life whose grief will ripple. My issues with trust remain. I suspect one reason I am so intent on working and studying is that it remains a socially-acceptable form of dissociation. Also, likely some ongoing desire for external validation from the people no longer here to provide it. It is likely that many change-agents have both extrinsic and intrinsic factors that promote their resilience and industrious spirit.

The Story of We: the Community

I grew up in Edmonton, Alberta in the 1970's. My parents played bridge with their friends. I had a trampoline in the backyard. We performed lip-synch battles at school.

This decade in Canada was marked by the government of Pierre Trudeau (father to our current Prime Minister). He encouraged bilingual studies, which allowed me to access French immersion in my formative years. It was a time of examining the inequitable ways that Canada was forming and to shift the discourse. Residential schools for Indigenous children were still stealing young lives from families. Women were still expected to be stay-at-home mothers.

Some of my fondest memories were of my mom baking cakes with huge shapes (sometimes requiring three separate cakes cut into circles). She would wrap a dime in wax paper and hide it inside. She was ever-present if my knee was scraped or my hair was pulled. But she was also unsatisfied and eager to return into the workforce, which differentiated her from many of the other neighbourhood mothers. I think her desire to be of service and to contribute was formative of my own sense of limitless potential. She believed so much in our capacity that it was something that I almost took for granted. Certainly would not have been the case for her generational cohort. My own grandmother (her mom) had remarkable intelligence that was stifled by the inability to achieve any further education. She ended up tutoring students on their street in high school maths.

During my high school years, the Berlin wall fell, and the USSR dissolved. I would not have guessed that, thirty years later, Russia would try to regain control of the dissident states. What it meant, for me, was that ginormous change was not only possible, but likely. Elements of larger systems that we take for granted can shift.

I knew that I wanted to be part of such major changes.

Canada remains a geopolitical region with a relatively young history—my parents were married on its 100th birthday, now over 50 years ago. Its foundations were colonialism, with the Europeans (English and French) fighting over what was then Upper and Lower Canada territory until the push moved westward. This was what brought my Ukrainian side (mother's mother, both her grandparents) to rural Alberta—the promise of land. It would only cost $10 for thirty acres if a homestead was built and sufficient trees cleared during the first year. I studied this remarkable feat to write a yet-unpublished novel that includes historical fiction about my family, as well as an eco-fiction with a more modern protagonist facing the same scarcity. Researching this book brought me to Ukraine for my 35th birthday, where I learned to read Cyrillic in order to mount the buses to the farm-land where my ancestors had once lived. It looked a lot like rural Alberta, with the Ukrainian Carpathian mountain range replaced here by the majestic Rockies.

But what we had here was opportunity. Both of my parents, because of their skin colour and innate gifts (of intelligence and drive), were able to surpass their own origins. And propel me into a realm of infinite possibility.

Synthesis

I am writing the Doctoral thesis at a time of great transition. I do not mean the 'great reset' that the anti-vaccination *Plandemic* crowd are describing. I mean the climate emergency and the polarisation of politics. The inevitable failure of financial systems and the tragic neoliberal premise where they falter. People are beginning to see it—and it is my opinion, based on my experience and training, that this is leading to a collective dissociation. Doubling down on climate collapse. Entrenching the paradigms that have furthered the inequity of colonialism and capitalism, which will eventually destroy everything built on their 'Swiss-cheese' foundations.

As will emerge through this narrative, I can thrive in chaos and uncertainty.

In social innovation parlance, I am adept in the 'back loop.'
When things fall apart.
When the trauma is revealed and there is something smaller and sweeter,
a gentle pearl, yearning to be generated.
To be seen.
To be dreamed audaciously.

I also have a keen understanding of how meaningful advocacy is part of the role of a systems-thinker. As a physician, I hold social positions that allow me a certain credibility. Despite having studied some complementary pathways, I remain ensconced in academic surroundings. I have two further papers pending publication. Each year, I am invited to speak at medical conferences. Yet advocacy means speaking and learning outside the ivory tower. I designed a curriculum for the CanMEDS role of advocacy, which is central to all students from medical school to residency. So I have practised this considerably in the last decade, far more since the pandemic. Writing op-eds, posting threads on Twitter, doing television interviews (sometimes more than once in a day) have become part of my weekly routine.

My abilities as a lifelong learner, driven by curiosity and hope, will help in such times. Change-agents are not necessarily benign in systems. In capitalistic society, they are often driven by greed and a desire for control. To be a positive change-agent, endeavouring to the betterment of systems, can be a daunting task. For one thing, it entails unlearning some codified moral codes and expectations. Enhancing one's

self-importance can create an Icarus-like hubris, which can cause not only personal but systems-level downfall.

When I consider the ways that I have been gearing my training—centring advocacy, trauma, community engagement, and innovation—it seems that I might have been preparing for some further transitions. Not just for me, but for these ecosystems.

Looking back at the winding road and my ancestral roots, I can see how my journey was led in these directions. My parents background, both culturally and personally, created a penchant for equity-deserving populations. My struggle to 'fit' led me to carve my own path, which had many diversions and stopovers (international travel, 5 Universities, more than ten employment situations thus far). There remains a strong desire to be of service in these times, and I count on the concept of 'flow' to bring me where I need to be.

In the following chapter, I will explore why the dichotomy of my left and right brain thinking led to a specific pair of lenses for this doctoral journey and why it is a good fit for a transdisciplinary, holistic practitioner of many arts—healing and otherwise.

Transition Poem 1: Explorations

We are scratching at a surface.
Noticing there are thorns
and yet-healing wounds.

Worlds to navigate,
gifts to uncover,
illuminate tangled pathways.

How to dive deeper?
Into murky depths,
where light does not shine.

There is one path possible
with a lens that can penetrate
to focus on vibrant life
that is hidden at depth.

And so we shall next explore
the ethnographic lenses.

Chapter Two: The Lenses

This chapter will outline the critical lens with which I examine my public works. I was encouraged to consider ethnographic self-reflection, but struggled to limit myself further. Between the choices of left-brain critical analysis and right-brain creative spirit, I am called to a balance between the two. Much as my work as a transdisciplinary practitioner, I could not fit inside a singular box; I could not choose a singular lens as my work and my self are multifaceted.

In determining whether the approach for this doctoral process would be analytic or evocative autoethnography, it became evident that both methodologies are reflections of my strengths in both the logical and the creative. Parker Palmer calls the duality of action and contemplation “a living paradox,” (Palmer 1991) noting that our culture values action—where my own comfort and proclivity lies. My enrollment in the doctoral process was to set a time for deliberate, authentic, and guided self-reflection.

Being a transdisciplinary professional, who integrates systems of thinking (McWhinnie 2021), it was difficult to select a limiting lens. A transdisciplinarian is inherently “beyond disciplines” with a goal to understand the complexities in our world through multi-perspective problem solving (Nicolescu 2010). To be transdisciplinary is to invoke complex, transformational, evolving, purposive, and transcendent methodologies (Gibbs & Beavis 2020). My intention with both my career, and the academic self-reflection at this stage of it, is to escape the confinements of silos, to model flexibility of thought and paradigm (Russell et al. 2008).

One such living model is sociologist Dr. Arthur Frank, author of many works that reflect on positionality as both academic observer and direct participant in health systems (Frank 1995, Frank 2002, Frank 2010). He examines the pedagogy of suffering from one who has experienced it as well and can describe it evocatively and sensitively, but also from the perspective of a thought leader in medical humanities. He examines the challenge of intersubjectivity, that when we cannot understand one another deeply, we can impose harm. Using both methodology of social science and literary arts can infuse writing with tremendous meaning. My goal is to “animate” the story of my journey with both styles with resonance, imagination, and self-compassionate symbiotic awareness (Frank 2010). While medicine encourages conformity and perfectionism, I am granting myself explicit permission to be a more holistic human (Bochner 2012).

Calls for enhanced “transdisciplinarity in the public health workforce are increasing, particularly to respond to complex and intersecting health challenges, such as those presented by the climate crisis, emerging infectious diseases, or military conflict,” (Sell et al. 2022). While I do not work directly in public

health, I have trained in the subject in a three-month diploma through the London School of Hygiene and Tropical Medicine. I also think that a systems-lens to health necessitates a public health view, as it is the macro-level counterpart to our daily micro-level work with individual patients. Modern medical research and our ability to grapple with all systems simultaneously is challenging yet necessary, (Rosenfield 1992, Kessel and Rosenfield 2008) so that we integrate the behavioral, social, medical, and biological sciences (Zerhouni 2003) and rebalance worsening inequity amongst humans and communities (Gehlert et al 2008).

Transdisciplinary perspectives are what allows family physicians to grapple with the complexity of the biopsychosocial model, as opposed to the single organ or disease state that many specialists can develop comprehensive expertise. Such study was described as *complexity medicine* in the British Medical Journal; an acknowledgement that human bodies are complex adaptive systems that function with complex dynamic social, political, and cultural systems (Pisek & Greenhalgh 2001, Wilson et al. 2001). Medicine is moving from the science of problem-solving into a merging of rational scientific methodology with curiosity and intuition (Dubos 1966 and Rambihar 2010). Within the residency programme that I created, inequity forced us to consider context and "transdisciplinary synthesis enables doctors and patients to develop coherent patient-centred care incorporating physical, social, emotional, environmental, legal, financial, and housing needs." (Martin 2003).

Throughout my childhood, I would write a short story or poem, then excel on a physics examination. Throughout my career, I have created video clips and innovative teaching tools, while also maintaining competence with rigorous clinical skills. Both the right-brain creativity and expressive artistic activities, as well as the left-brain logical and intellectual activities have been explored. I see both my inherent intrinsic characteristics as well as my work in the world as the corpus callosum, bridging the hemispheres.

Thus, a combination of analytic and evocative auto ethnography would be the only path forward.

Autoethnography allowed me to examine my public works through a lens of deep self-reflection. Having been formally working for twenty-two years, I anticipate my career to be at around the midpoint. My success has allowed me to leverage significant platforms, exerting potentially greater impact on larger health and related systems. This doctorate represents a moment of self-examination, where the insights will invoke a direction towards more thoughtful and deliberate future endeavors. Rendering my life's work sensible in much the same way as "to the artist's gaze, the landscape presents itself not as a multitude of particulars but as a variegated phenomenal field, at once continuous and coherent," (Ingold 2021).

Putting my self-criticism on display will be uncomfortable. We keep our innermost critic and self-saboteur as quiet and as internalized as we can. But in making these private ruminations and reflections public, I can hope to achieve a level of understanding about my path. The decisions, the impact, the complicities. “For unless I am willing to profess ignorance regarding my beliefs as to what is true, I will inevitably seek to impose those beliefs on others,” (Petranker 1997, p.241). The goal in self-exploration is to examine what can include self-aggrandizing spotlights but also to shine light into the shadows—those nooks and crannies where we fail to identify and assimilate the harms we may have caused.

Autoethnography allowed me to quantify the impact, wherever possible. It encouraged investigation into not just the positive outcomes, but also the shadows that I have inadvertently structured into these artefacts. As physicians, we value personal interactions, but it is incumbent on me to take a systems lens. There is danger in this journey, “if we reject the self, with its emotions, its claims of identity, and the pain it inflicts in deceiving itself and others, we will close the only gateway through which a founding and conducting knowledge can emerge. To arrive at the prior, we must first fully inhabit our presenting world, whatever its content and obscuring pattern,” (Irigaray 1985). The author is suggesting that only through self-awareness in the present moment can we gain an opportunity to hold compassion for our past and hope for our future.

Truth and Reconciliation Commissions exist around the world to acknowledge and right the wrongs that have been done to historically oppressed communities. Here in Canada, there were tribunals of Indigenous people who testified to the harms of residential schools, scooping children into foster care, and cultural genocide. From the lived experience statements, there was a path laid out for our nation to correct course (Stanton 2011). Sadly, much of the work is yet to begin (Banning & Vogel 2022). The concept of truth before reconciliation is meaningful to me. When I applied for a role as an Assistant Dean of global and local partnerships, I inquired as to whether the medical school was willing to face the harms we had collectively committed by doing rigorous research into these events. I suspect this was one of the reasons why I was not hired. But I do have the opportunity here to look closer at my personal truth in order to reconcile. Truth can come from facts, but it is the stories that move us to action. While I am interested in the quantifiable and overt, I also want to feel the cathartic emotional response to this knowledge.

In medicine, there is a saying that doctors are always rescuing drowning kids from the river. But we rarely walk to the bridge to see who is throwing them in (attributed to Desmond Tutu but no source identifiable). Moving further upstream of the resulting ill-health, a preventative take on the health of individuals and society requires a skyward view. Perhaps a drone. Taking time to thoroughly examine this perspective means that I cannot just consider my impact and possible harm, but also the complicity of my work within

larger systems of oppression. As somebody who travels within health equity spaces, it is difficult to acknowledge that my work has upheld the systems that I intend to dismantle. But if I fail to look inwards towards implicit biases and outward towards the negative implications of my work, then I will continue to embed the harmful structures related to the context where I was raised and have studied.

Analytic autoethnography is described by Anderson (2006, p.378) as consisting of five key features: complete member researcher status, analytic reflexivity, narrative visibility of the researcher's self, dialogue with informants beyond the self, and commitment to theoretical analysis. Considering what 'membership' I might possess, it could be within the field of medicine, as a foundation, but I think what distinguishes me considerably more is the 'transdisciplinary' identity. Finding peer understanding within my cohort at Middlesex University, practitioners who defy boundaries—has been closer to the membership that I intend to explore.

Regarding analytic reflexivity, or "self-conscious introspection guided by a desire to better understand both self and others through examining one's actions and perceptions," (Anderson 2006 p.382) there is a clear desire to analyze my impact on systems—both individual and systemic—and thereby to understand these systems with new clarity. Narrative visibility is already established in the text and my personal interpretations of events; context is intrinsic to the discussion. I appreciate the reminder that ethnographic reflection is a "relational activity," as stated by Anderson, which allows me to interact with my professional colleagues, cohort and supervisors, and even contextual relationships with a more interpretive gaze. Having mentioned this pursuit with most of these communities, there has been an opportunity to question my own interpretations through others' lenses. Examples of this would be when I asked my mother about my remembrance of historical context when I was growing up—her subjective perceptions differed. Or when I spoke to my partners within my global health foundation GFF, they were less convinced of the colonial nature of our activities. There has also been uncertainty around this principle. Vryan argues that analytic autobiography need not require a set of informants (Vryan 2006). Lastly, commitment to an analytic viewpoint beyond "rendering the social world under investigation but also transcending that world through broader generalization", (Anderson 2006 p.388) allowed me to extrapolate beyond my own achievements to see the contributions of others and how my own shoulders might be those where future generations can stand.

Evocative autoethnography facilitated me to do much of this work through the power of storytelling. I have appreciated the quantifiable metrics, and boundary-led checklists within medical diagnostic criteria and treatment plans, but this is not the time for lists and accountability. This is the time of metaphor and exploration, a metaphysical and subconscious deepening. If my intention is to truly map out the values

and objects for the next steps in my career, it is of vital importance to have an honest and authentic dialogue with myself.

As described by Ellis and Bochner (2000 p.744) related to evocative autoethnography, “the mode of story-telling is akin to the novel or biography and thus fractures the boundaries that normally separate social science from literature.” I have been a storyteller and story-seeker for my entire life. I attempted to regulate my emotions—about relationships, about patient outcomes, about my stress level—by writing poetry. Something about expressing pain and sharing it (sometimes) made it feel manageable. One important facet of healing trauma, as I now understand it, is to notice it. To turn it over in your hands like it is a gemstone, possible to examine from all sides. Observe the weight, the texture, the color, the temperature. Evocative autoethnography provides this outlet. There is an option that “evocative autoethnography requires considerable narrative and expressive skills,” (Anderson 2006, p.377) whereas I believe that such talent is subjective and personal. Not all people will feel moved by the same passage in the same way. My only hope is to evoke some curiosity. While Anderson expects this style of ethnography to publish on “emotionally wrenching experiences,” I will not be spelling out the depths of my personal trauma.

Stories have also been a way that we share lessons since ancient times. They are still a key mode of ancestral lineage for Indigenous communities. I attended a Narrative Medicine conference in 2018, led by the eminent professor Dr. Rita Charon, at Columbia University in NYC. In her textbook *The Principles and Practice of Narrative Medicine*, she states “through working with literary texts - alongside literary, philosophical, and psychoanalytic theories - that we have developed many of our principles and some of our practices.” (Charon et al. 2017, p.15) Indeed, my experience of her perspective was that the literature was a very specific demographic—white, privileged, educated. It is not the stories of the traumatized, the marginalized, the wounded. Humans have a tendency to identify with those whose stories we hear (De Graaf et al. 2012). In the *Narrative Medicine* text, Chapter 6 breaks this pattern, interrupting the historical exploration of dominant voices with those of “cripping, queering, and un-homing health humanities,” by Sayantani DasGupta and she speaks of *narrative humility*, to approach patients with “a sense of wonder and the understanding that some aspect of their stories will necessarily be unfamiliar or unknowable,” (Charon et al. 2017, p.148) to use this as a frame to self-reflect and become more attuned to our innate bias. Charon is insightful about autobiographical writing, in recognizing that “any time a person writes about himself or herself, a space is created between the person doing the writing and the person doing the living, even though, of course, these two people are identical,” (Charon 2006, p.70). She calls this the *autobiographical gap*, imagining it contains fresh knowledge. I recall having numerous conversations about power—whose stories are told, whose voices are shared—at the event. When we speak of literature, it is a relatively heterogeneous field until quite recently. Most of my social identities are

congruent with the dominant narrative—there is neurodiversity and the not-quite-straightness, but I 'pass.' There is a discomfort in that comfort, though. A sense of this being unjust. That I cannot speak on behalf of the people whose voices are marginalized.

In Aboriginal narrative practice, a course I took through the Dulwich Centre in Australia and a book written by their elders, they speak of "having a yarn" with those who have passed and those to come (Wingard et al. 2017). Indigenous wisdom is timeless, lacking temporal and spatial constriction, and therefore holds the stories of our interconnectedness. "Together we will be embarking on and acknowledging small instances of social change," (Wingard et al. 2017, p.69). I wish to use my writing, not just to tell my story or the story of others who present like me, but to be a part of the movement towards collective transformation.

The intersection of creativity and rationale is a place where innovation is possible. According to Actor Network Theory, "every so often, there are scientific revolutions in which one paradigm is overthrown by another, generally speaking… background assumptions are rarely subject to critical reflection," (Michael 2016, p.14). One way this occurs is when "messages connect together divergent domains (e.g., poetry and science) to produce particular patterns of orderings," (Michael 2016, p.21). "The network of associations that actors such as scientists generate entail a process of 'translation'... a persuasive conversion of people's interests into something that aligns with the interests of those scientists," (Michael 2016, p.22). While the theory is inherently about how all beings co-create, the methodology is exactly what I have experienced as a person with positionality between the supposed binaries. I must translate from one group to the other, but by being the bridge—my own context allows for bidirectional flow.

Tim Ingold says, "We need to break down the barriers between disciplines and between different forms of knowledge," (Ingold 2013, p.214). Transdisciplinary collaboration is essential to drive innovation while addressing complexity. Knowledge relates to the cultural practices of a geopolitical and social context (Ingold 2000, p.167). Dissolving these boundaries allows an interaction between pools of knowledge and within multiple domains. Our present challenges and the shifting sands of modernity demand this of us, as "demands for knowledge production to address growing national and international environmental problems" requires transdisciplinary ways of knowing (Russell et al. 2008).

If we can examine complex challenges with a transdisciplinary lens, and then turn the focus to that lens, it allows us to extrapolate this expertise to even more significant work.

Another way of conceiving this combination, whether it's psychotherapy or literature is 'top-down' and 'bottom-up' synergy. In therapy terms, we speak of the former as being cognitive, where brain processes

affect the experience of the mind-body and the latter as being somatic, where the experiences within the soma affect the mind-body organism. Likewise, Bruner describes how top-down processes would come from theories about story and writing anchored in psychoanalysis or philosophy. He also warns that this manner of work "risk[s] producing results that are insensitive to the contexts," (Bruner 1986, p.10). Bottom-up methodology contrasts by examining a text for meaning. This is similar to how one might relate through intuitive explorations rather than rational ones.

In *The Architecture of the Mind*, the degree of flexibility of the human mind is evaluated in terms of context-specific and stimulus-focused variables (Carruthers 2006). One of the ways that my own intellect has proven to be flexible has been its adaptation to myriad environments—from cultural contexts (over sixty countries explored) to professional settings (hospital, community, then clinics for special populations) to leisure (movement, especially mountain sports). Some of the ways it expresses inflexibility are a lack of diverse friendships (most are white women of a similar age) and a dearth of creativity when it comes to professional employment (doctor, teacher, writer).

For a long time, my personal emphasis was on my cognitive processes. I had been acknowledged as an intellectually gifted child for my lifetime. Focusing on the body, when I did not conceive of myself as an athlete or modelesque, was not as comfortable. It has been a remarkable journey to explore the more somatic aspects of growth. I find myself using bottom-up practices for my own self-care (pottery, hiking, skiing, dance) and for self-regulation (EFT tapping or self-acupressure, Havening Techniques, TRE tremoring). Becoming more embodied was a key lesson on my journey.

One instance in which I gained tremendous reflection, almost like a download, was during psychedelic-enhanced therapy sessions. During the writing of this paper, I undertook a guided session where I partook in three chemical compounds. Most of my experiences were of imagery and somatic knowing, but I asked my conscious mind to reflect on the aspect of the bridge. What came up instead was a spider weaving a translucent web, filaments of color and light streaming through and connected with many other webs through the cosmos. As I had been examining this linkage between analytic and evocative styles as a bridge, with the analogy of the bilobed brain—it has been rather expansive to consider instead a network of webbing.

Donald Schön also examines this question of how we develop and share knowledge in *The Reflexive Practitioner*. He poses "fields as medicine… leading professionals speak of a new awareness of a complexity which resists the skills and techniques of traditional expertise… they have come to see the larger system as a 'tangled web,'" (Schön 1983, p.14). In so many realms of medical education, we are taught algorithmic and manualized approaches to care. Whereas the human body and its interactions

with its environment represent massively complex systems, which are more suitable to non-linear patterns and paradigms. He speaks of a solution, the “process of reflection-in-action which is central to the ‘art’ by which practitioners sometimes deal well with situations of uncertainty,” (Schön 1983, p.50). One of the main driving forces behind my desire for this doctoral journey by public works is the intensively self-reflective nature of this particular programme. There is significant uncertainty within the discipline of medicine, my path therein, and indeed the trajectory of human existence. I appreciated Schön linking the professional capacity for responding to complexity with “an artistic performance… evident in [their] selective management of large amounts of information, [their] ability to spin out long lines of invention and inference, and [their] capacity to hold several ways of looking at things at once without disrupting the flow of inquiry,” (Schön 1983, p. 130). Within my desire to translate between the binaries, I have uncovered a world of inherent complexity which requires a new, artistic approach. As Schön relates, medical doctors are seen as “technical problem solvers,” (Schön 1983, p. 168), which binds our hands from painting canvases with color, textures, and the weight of our tears.

Van Manen explores the phenomenology of practice, where theory “thinks” and practice “grasps” the world (van Manen 2007, p.20). He describes how empathic images and passages can allow deeper exploration of the non-cognitive world as it relates to professions. But he also admits that it is easier to describe the cognitive aspects of the world. We have common vocabulary, we have quantifiable metrics, we have objective observations that can be communicated. “But such spaces also have their atmospheric, sensual, and felt aspects.” It is meaningful that he believes anything can be described in such evocative terms, a medical practitioner’s journey included.

From van Manen’s perspective, these “pathic” aspects are connected to empathy and sympathy, which are discouraged in large amounts throughout medical training. I recall in particular—one seminar on Cognitive Behavioral Therapy where the lecturer (a doctor) emphasized that we give out too large a dose of empathy and should be titrating it considerably. He even gave out cards to hammer home this point, an image of a doctor stumbling with a human-sized syringe was on this reminder.

I never think of my empathy as a burden, while acknowledging that compassion fatigue and vicarious trauma are very real. In my experience, the moral distress comes from working within systems that seem deliberately set up to harm those already suffering.

The purpose of garnering further wisdom about this stage within the multi-layered context of my past educational and academic experiences is growing evident. As I expect to further impact global health, systems design, and the field of trauma psychotherapy—I know that a more profound understanding of my path to this point will position my journey to be more thoughtful. Searching and aiming for the north

star of my professional aspirations. The qualities that I possess, the experiences that have shaped me, and those where I have impacted others, and the intentions going forward, will all culminate in laying down new paths.

In the next chapter, I examine my role in global health using both analytic and evocative autoethnography in an innovative way. When I consider my most recent contributions, this portfolio is one where I have the deepest roots—both chronologically and ancestrally.

Transition Poem Two: Showing Up

And so it appears,
we are taking a deep dive
into the unknown

Unknown regions, new cultures,
novel territory to be explored.
How to do this?

Given my ancestral heritage,
the European settler,
heretofore known as the colonizer.

Can we reconcile the intention
and the impact?
How do we show up in the world?

Let's start with me.
How do I show up in the world?

Chapter Three: Global Health

This chapter concerns itself with global health and colonialism; to deepen my own understanding of the phenomenology of my artefacts, I have chosen to self-reflect through autoethnography on my contributions in global health. Global health and colonialism are individually complex areas of study; together, the layers of complexity increase. There has been longstanding debate as to a common definition of global health (Koplan et al. 2009, Claborn 2018), but more recently is defined as “health issues that transcend borders, that require a multidisciplinary response and that probably include a focus on politically and ethically charged global issues such as social justice, urbanisation, rapid climate change and health inequities,” (Abdalla et al. 2020).

When I was determining the best critical lens through which I could express my cognitive and psychological views of my work in Global Health, the format of a debate between legal teams emerged naturally. This lent itself to examining the dichotomy of intention and impact, to surface insights that could inform my future contributions. I am a product of my environments, from family to community to country. Yet the potential harms and mistakes have very real impacts that resonate around the world when compounded. Part of my eagerness to engage in autoethnography is to learn from an observer’s stance, to illuminate what was in shadow, and to shine a light on future paths.

When I worked in Laos for a month each year from 2007-2014, I witnessed the common practice of a form of Buddhism that flirts with secular animism. Most families and businesses have a small red wooden shrine dedicated to their gods and their ancestors. Each morning, it is adorned with saffron flowers, rice balls in silver bowls, and jasmine. I spent some time at a Buddhist temple in Vientiane to walk silently around the building in contemplation, my first experiences with mindfulness. This study deepened in Nepal, where Buddhism is once again intermingled with ancient practices and neighboring philosophies such as Hinduism. I have a set of brass prayer wheels in my kitchen; when one spins these bells, similar to the colorful prayer flags blowing in the wind, the motion sends a prayer skyward.

What fascinates me about my study in Buddhism while in Laos and Nepal, and since that time in a less experiential manner, is its focus on the observer (Trungpa 1984, Kabat-Zinn & Hanh 2009). This chapter gives me the opportunity to embody my inner parts that hold shame and my parts that have a pure desire to serve. There will be more to say about these parts in Chapter 5.

In the following paragraphs, I have exposed these parts in the form of a legal case or debate. While the characters mentioned are real, as are the situations and contexts, I have attempted to anonymise individuals and places, but this cannot fully prevent identification.

The Debate:

"Be it resolved that:
in the case of global health work,
Dr. Christine Gibson has conducted
her professional work with a colonial lens."

The prosecution will introduce the argument against the accused.

Prosecution: Dr. Gibson comes from settler-coloniser origins (Koleszar-Green 2018, Yunkaporta 2019). Her very desire to work in low-income countries with racialized people comes from the coloniser mentality.

She has used the faces of Ugandan schoolchildren on a brochure without appropriate consent. *[gasps in the gallery]*

She has taught medical practice in Laos before she had even trained in tropical infections, which encompasses the majority of disease processes there. *[more gasps]*

She supported a country's academic progress until politics no longer suited her narrative, subsequently abandoning those relationships. *[a distinct wail rises]*

In this debate, we will prove beyond a shadow of a doubt that Dr. Gibson has conducted her international work with a lens of paternalism, racism, and oppression.

While Dr. Gibson may be able to fool many with her equity banter and her earnest motivation, her foundational beliefs remain ensconced in the reality constructed by capitalism and colonialism. Part of her may recognize that decolonial frameworks are needed, but she is incapable of such a vision—because of her intrinsic roots.

Coloniser energy tends to dehumanise and distance. Dr. Gibson's overseas work is a representation of a frozen, detached response. It is a partnership with "the other," and by its very existence problematic.

Good intentions notwithstanding, the work drips in unearned privilege and covert racism.

The defence argument will be given the first rebuttal.

Defence: As Dr. Gibson is a graduate of a medical centre in Toronto Canada, arguably the best medical school in the country, and further completing a Masters in Medical Education from the University of Dundee, there is clear academic superiority.

While the medical curriculum in Canada for family medicine is only 2 years compared to 3-5 elsewhere in the world, we believe that it is exceptional and competent. She was Associate Program Director of Family Medicine for a great deal of her time during the creation of a global health residency, so had strong mentorship throughout her formal academic career from the Program Director. She began instructing medical students within one month of graduating from her own family medicine residency; teaching history-taking for eight years in their communication course. In 2023, she was on a small committee to reformulate this course with a trauma-informed lens. Since, she teaches ongoing classes in ethics, global health, population health, and physical exam. She was the Evaluation Coordinator for public health training for the medical students for five years. Her academic credentials are impeccable, as related to institutional global health.

Dr. Gibson has travelled extensively, over sixty countries, and so has more cultural sensitivity than most physicians. She created a curriculum in global health when she was the Program Director for this residency. From 2008 until 2014, she remained the Program Director for its inception and iterations. So, she clearly has a strong academic understanding of global health, health equity, and anti-oppressive practices. Not only that, but she teaches cultural competence at the undergraduate level and created the didactic training for residents. She lectured at the undergraduate innovation space on the shadow side of global health, which was a wildly popular topic and garnered her relationships with two students that remain mentees to this day.

When she formed a non-profit based on doing this work, Global Familymed Foundation (GFF), she was awarded the ‘Top 40 under 40’ designation by Avenue magazine (Magnan 2011). Clearly, they recognized her outstanding capacity and generosity.

The prosecution will be given a chance to respond.

Prosecution: Certainly Dr. Gibson has spent a lot of time propagating what she knows. It is difficult to argue that GP residency training is exceptional in Canada when it has just recently chosen to extend training from 2 to 3 years (Loh 2023). Obviously, even the Canadian College of Family Physicians (CCFP)

felt that the length was inadequate. Given the insufficiency of her own training, she was in no position to be instructing other academic centres that were developing up to five-year curricula (Tanzania's Aga Khan University).

Our argument stems from the fact that Dr. Gibson did this work from the position of a settler-coloniser, continuing to propagate a patriarchal assumption that there is a dominant perspective and applicable knowledge coming from the Global North. For example, she went to countries such as Laos and Ethiopia to teach without a clear understanding of their epidemiological or political context. She had never heard of the *opisthorchis* liver fluke before arriving in Asia, an endemic infectious agent.

When she worked in Myanmar, the intention of local leadership was to build from a foundation of the GP curriculum from the UK. She ran a workshop with them to go through every item in the UK curriculum to ensure that each disease was understood as relevant to their context, also that diagnostic and treatment options were available in the country. Despite her own lack of regional awareness, the team agreed to hold off the curriculum development for internal gynecologic and prostate exams, as there was no pathologist to read the slides. She was surprised to learn of the number of primary care physicians who would start an IV with fluids or vitamins for patients in their offices. This is not something that is commonly done in the Western context. Yet IV insertion probably creates a powerful placebo effect, if nothing else. She sometimes misses nuance and cultural humility in her explorations, believing her knowledge to be the highest standard of care.

Regarding these superficial accolades, the Top 40 under 40 designation is given out in a reckless manner; the people behind her in line were twin realtors intent on overdeveloping the suburbs. She only sought this as a publicity stunt to raise money for the non-profit. She's since nominated four others for the award, three of whom were granted it easily. It is of very minor significance.

Everywhere she has worked, it has been from the point of view that she had expertise to lend or money to dole out to eager recipients. We argue this propagates a coloniser mentality, creates programs that are based on dissimilar models, and leaves the Global South reliant on aid.

By acknowledging her complicity in these systems, she would have a very real chance to affect change. Self-regulating professionals are obligated to do so, and "the recognition of error, with its resulting uncertainty, can become a source of discovery rather than an occasion for self-defence," (Schön 1983, p.299).

Defence will respond.

Defence: This is certainly not the perspective of her main partner in Uganda. She met him in 2012 and has supported his career. She pays for more than 50% of the tuition for residency training at a large University in Uganda, direct from his recommendations. She has single-handedly funded the construction of their rural residency training housing facility, where community placement occurs. She learned from her southern partners that capacity building and training in the area that matches the intended destination were key to creating health equity in rural Africa, where care is the most under-resourced. And she is funding the Doctoral program that the programme director is undertaking in South Africa. She advised him to do his research on Barbara Starfield‘s primary care assessment tool kit (Shi et al. 2001, Starfield 2001), knowing that if he could further prove the benefits of family medicine in Uganda that the government would be more accepting of the training.

Her Ugandan colleague chose her out of all of the participants at the World Organization of Family Doctors (WONCA) conference in Uganda in 2019, when his faculty were the hosts, to give a keynote speech on how to be an ideal partner in a north-south collaboration.

Dr. Gibson was taken under the personal wing of Dr. Jennifer Hatfield, who was the co-author on one of the most preeminent documents on partnerships (Afsana et al. 2009). Dr. Hatfield explained to her the importance of mutual benefit, of avoiding false presumptions, and ensuring that the southern partner's voice is equal in dialogue.

Prosecution will rebut.

Prosecution: While Dr. Hatfield did guide her early time in East Africa, taking her to multiple countries to explore what was transpiring; there were other people influencing Dr. Gibson during her later work.

Notably, her mentors in Africa included two medical missionaries who had settled in Kenya and were heavily influencing the system with their particular lens of Christianity. One only agreed to create a residency program affiliated with one training centre where they agreed to accept solely Christian students and only treat Christian patients. When they challenged him on these restrictions years later, he left with all of his resources and created a new residency program at another University—where he could influence a formal Christian ideology. When he gave a lecture at the conference she organised in Nairobi, he chose to describe how prayer could cure most illnesses. He showed the video of an exorcism during his presentation, clearly not a medically sound theory.

We believe while Dr. Gibson was well-intended, she does a lot of her work in the Global South to further seek external validation. Because she was bullied so fiercely as a child, she is constantly seeking accolades and praise. It is a sad fact of international volunteer work that people are exceptionally compassionate and dedicated, driven by demons in their past of low self-worth. This lacks integrity and authenticity. It steals the dignity of her partners.

Defence has a chance to respond.

Defence: Dr. Gibson had significant other guiding factors, including being an early member of the Besrour Center of the College of Family Physicians of Canada—their intent was in synergy with GFF in supporting the development of family medicine globally. She was co-lead of the Narratives Group, which collected stories of the voices of our partners in an appreciative inquiry approach to reflection about their family medicine programmes (Gibson et al. 2017).

She spent three months studying tropical medicine and public health (DTM&H) at the London School of Tropical Medicine and Hygiene in 2009. This was an intensive and robust education in the illnesses and epidemiological considerations of the countries she visits. This shows that she intended to learn before presuming to teach, or at least quickly recognised the need.

As a participant in the education working group of WONCA—the World Association of Family Doctors—she became part of a larger collaboration. Attending WONCA meetings in Seoul, Rio de Janeiro, and Kampala as a speaker; she was exposed to global ideas from diverse leaders.

In fact, through her association with WONCA, she did academic consulting work comparing the programs where she consulted with the *gold standards* of family medicine training programs as decided by WONCA council. This led to the publication of a paper that was co-authored by numerous academics at Patan Academy of Health Sciences (Patan, Nepal) and the Myanmar Association of GPs (Yangon, Myanmar). As local leaders in the workshops, these co-authors were instrumental to the background and conclusions. The group in Nepal were re-evaluating their existing curriculum and it was a timely exercise. She had been working with them for six years, so they trusted her to facilitate. The group in Myanmar was starting from scratch in creating a curriculum, but many skills were not a good fit because of a lack of local relevance—for example, they wanted to learn how to do Pap smears for gynecological health but lacked a pathologist who could read the slides. Dr. Gibson helped both groups determine their goals and outcomes, which the paper attests.

The prosecution continues.

Prosecution: Yes, Dr. Gibson went to London to study the DTM&H, but it was clear that many instructors were teaching what they had never learned. Many of the lecturers were famous for writing textbooks, but not all of them had on-the-ground experience. Likewise, some of them had journeyed overseas in a very paternalistic manner, imposing research trials on locals without sufficient informed consent. In fact, did Dr. Gibson not cringe every time someone said they had spent time in “The Gambia”? Each reference reeked of colonial infringement on the country and sounded more like a status symbol than work experience.

Also—does the Besrour Centre run parallel to the work of GFF? Dr. Gibson started this non-profit in 2011 and described her intentions to the person who became the leader at the Besrour Centre. There is significant overlap in mission, vision, and values between the two organizations. How to reconcile this as collaboration rather than competition for scarce resources (fundraising, partners, even mission) is still nebulous.

In her global health work, she has seen numerous partners support the development of a family medicine training centre—only to have the programme fall apart once funding disappeared. The entire residency in Rwanda had such a fate. Why would she think her partnership in Uganda will fare differently? She may be a favoured partner while footing the bills, but she witnessed other funders fall out of favour once funding dried up. She spent a week in northern Ethiopia helping local faculty create a curriculum for GP training, only to see the region erupt in brutal war before her return visit. These programmes are not sustainable, nor even the local priority.

Lastly, let us be accountable about the contributions of the authors on the aforementioned paper. She added them as authors, but did they actually co-write the article? In today's standards, most ethical journals will request a testament that each author contributed significantly to the body of work as well as the writing. If held to scrutiny, the individual contributions would be unlikely to measure up.

We insist—her work is predicated on paternalism and colonialism.

The defence responds…

Dr. Gibson’s choice to list her partners as co-authors was based on their contributions to the workshop and the basis for the research. There would be no paper, no discussion, without them. She came to their countries as a consultant without knowledge of local history or context. It is because she strives to be a good partner that she ensured each was credited.

…but then the defence calls into evidence new information

[*the gallery erupts in surprised, hushed tones*]

The model of the East Africa initiative as a south-south collaboration

Defence: When Dr. Gibson undertook her work in East Africa, her first trip was guided by Dr. Hatfield, a mentor who is very clear on the impact of mutually beneficial partnerships. She was guided to observe how many organisations came to a collaboration with the project plan, materials, and outcomes already determined by the funding body. For example, the program providing HIV treatment in Africa required that the medications be purchased by the far more expensive American pharmaceutical manufacturers (Holmes et al. 2010). She was able to observe in Tanzania how people brought binders full of project plans to give to their southern partner. She aimed to do better, using principles of dignity and reciprocity. In fact, the stated core values of GFF are *education*, *partnerships*, *sustainability*, and *family medicine*. Partnerships are further defined as "relationships that are transparent and mutually respectful. We believe all partners should benefit from joint activities," (Global Familymed Foundation 2023).

The impetus behind the creation of GFF was Dr. Gibson's earlier work through the Laos-Calgary project. At the time she joined, in 2007, both the undergraduate and Family Medicine relationships were under the leadership of an ICU pulmonary physician (Kanashiro et al. 2007). The subsequent project lead was a general surgeon who had a Masters in Public Health. Dr. Gibson participated in this project from 2007 until 2013, living from four-to-six weeks primarily in a rural area of Vientiane province. The Maria Teresa Hospital was a provincial catchment for a large number of nearby villages, and she worked with a young Laotian physician in assisting him create a robust teaching program. She provided him with materials from her Masters in Medical Education, which she began in 2008, so that they could collaborate on creating a learning environment and assessment processes that suited the local context. She was told that despite her experience as the Assistant Program Director of Family Medicine training in Calgary, then from 2009 as the Program Director of Global Health Enhanced Skills, her presence and input was not appropriate within the programme offices in Laos postgraduate education. Despite this, she made friends with the junior physician leaders in the office, and they developed many educational tools together in secret.

The fact that these projects were teaching Family Medicine skills but not led by Family Medicine clinicians was a part of why Dr. Gibson aimed to have clear bilateral collaboration amongst primary care physicians and local leadership. It was not enough to have a champion on the ground—there needed to be champions within the organisation that could speak the same language, share lived experiences, and

express passion about their chosen discipline. Her aim was to approach the partnership with humility and curiosity, rather than arrogance and paternalism.

The East Africa Family Medicine Initiative (EAFMI) was designed to foster a south-south collaboration regionally, by bringing together all the leaders in Family Medicine academics throughout Uganda, Kenya, Rwanda, and Tanzania—the intention was that they could learn from each other. What Dr. Gibson understood from her work in Laos was that regional context was more critical than a sound understanding of family medicine in another context. Not only that, but there were local experts whose knowledge was vastly underestimated.

The EAFMI met annually for five years with full scholarships and conference funding support through GFF. This work fostered a common understanding of their strengths, resources, and obstacles. Some of them were able to express how they did advocacy at the government policy level, as one of the greatest barriers to implementation was a lack of tuition support. There was cross-pollination of educational material, including exam questions. They built long-lasting relationships amongst themselves that led to the desire to create an East Africa College of Family Medicine. So, while her predecessors unfortunately lacked sustainability and a model that was efficacious, Dr. Gibson created mutually beneficial partnerships.

The prosecution responds.

Prosecution: Ah, but did Dr. Gibson not create many opportunities for her to speak at each of these conferences? While she had local input to EAFMI conference plans, did she not create the agenda? Did she not have larger speaking opportunities for her direct partners in Uganda and Kenya, including the residents sponsored by GFF? That speaks to nepotism and favouritism, tools of the colonists.

There was also problematic leadership and input by the aforementioned missionaries. And did one of the medical missionaries agree that his office and secretary would be the head for the East Africa College, which quickly led to dissolution of the entire agreement? A local graduate staunchly refused to cooperate with his previous program lead. He was one of few local champions who did not bend his morals for the sake of outside support.

Not only that, but the difference in curriculum meant that a common assessment process was impossible. Uganda had a three-year training program, Kenya had four years, and the Aga Khan University in Tanzania had designed a five-year training (Arya et al. 2017). Each of them felt that theirs was the superior model. Dr. Gibson herself states, “there is therefore a lack of clarity regarding whether family

medicine is the same discipline globally and what the core features are that define it," (Gibson et al. 2016).

Dr. Gibson's lack of understanding of local context led to yet another program that did not have any significant long-term traction. How is this different from those who approach projects with a full binder? We just heard that GFF believes in sustainability. How can you prove it?

The defence has an opportunity to rebut.

Defence: Dr. Gibson tried to foster local collaboration and self-led efficacy. This was a very different approach than others going on at the time, including the scandals of the WE-Africa projects from the Kielburger brothers (Jefferess 2021). There have been ongoing historical paternalistic styles of fundraising and programming, including the atrocious Bob Geldof-led musical endeavours. These kinds of endeavours contribute to learned helplessness described by Dr. Joy Degruy in her book *Post Traumatic Slave Syndrome*, including the opportunity for "learned self-efficacy" (Degruy 2005, p.164).

While the outcome did not have a definitive resonance, given the College never transpired and the Initiative dissolved, this further proves that Dr. Gibson stepped aside and allowed local leadership to determine the best goals according to their needs and individual strategies. Had she come to the region with a full binder, there certainly would be an established College and a greater drive towards collective work. In fact, the other organisation that was supporting family medicine the most was Belgian-led Primafamed (Flinkenflögel 2014). After the stated intention to create the college, their leader approached Dr. Gibson and asked her to design a joint College exam. She knew enough to be careful in designing a process without local involvement.

For the prosecution.

Prosecution: As the infamous Yoda says: *there is no try, only do*.

Even though Dr. Gibson had good intentions, her mentality is steeped in the society and context where she was raised and trained. Attempting to do meaningful work within a context that has such a significant power differential is fraught with problems.

There have been longstanding false beliefs about aid in Africa throughout her lifetime and education—where aid was justified from the pretence of a poverty trap that can only be solved through international funding (Sachs 2006). There has since emerged a greater understanding that foreign aid hampers

development, from many studies including Hickel et al. (2022) demonstrating the economies of the Global North rely on extracting resources from the very countries the IMF and World Bank maintain in a state of debt. In fact, it has been shown "over 1950-2001, countries with below-average aid had the same growth rate as countries with above-average foreign aid," (Easterly 2006, p.39).

When she created this program, she had not studied any literature and anti-racism. She believed that simply because of her financial privilege and well-meaning purpose, good would result. This has excused behaviours within privileged paradigms for millennia. But we know better now.

The defence rebuts.

Defence: Dr. Gibson has undertaken many courses on health equity, including group work on Layla F. Saad's *Me and White Supremacy* (Saad 2020), Roots Deeper than Whiteness through White Awake, a workshop on power through Harvard Business School, and a new initiative Women in Power where racialized and white women meet to discuss privilege and intersectionality. She has joined the 2023 cohort of *We Will Dance With Mountains* under Dr. Báyò Akómoláfé, scholar of post-activism and transraciality, with the purpose of examining social justice and accountability in community.

In fact, she designed curriculum on learning about racism and advocacy at the undergraduate level and in the Residency program that she created in Global Health. This full-year training is now named Health Equity. As much as is possible–she tries to identify her own internalised racism, misogyny, and classism.

The prosecution summarises.

Prosecution: Can a white person truly beam into the African context, or any other Global South setting, without the partnership being constructed under the umbrella of privilege? There continues to be postcolonial extractive processes throughout these relationships at a national level and industrial level; can academics truly be any different?

The Judgement is In

Dr. Gibson is a product of her times: where racism, classism, colonialism, and inequity were (and continue to be) rampant. Sadly, she was baked in these constructs and cannot escape them.

She must admit that her work is stewed in these paradigms in order for her to deconstruct them.

Trisos, Auerbach, and Katti present a framework for decolonizing ecology which would stand well in medical education, suggesting five actions that would concretely shift the engagement (Trisos et al. 2021):

(1) decolonize your mind
(2) know your histories
(3) decolonize access
(4) decolonize expertise
(5) practise ethical ecology in inclusive teams

They mention language as a key component in decolonizing one's mind - Dr. Gibson always assumed each of her partners would converse in her native tongue and was seeing patients on the wards in Laos and Uganda whom she could not understand. She thus required a translator, which was a further drain on local resources as health care workers are a scarce commodity (Elit et al. 2011).

When she works in Canada, a superficial land acknowledgement of the treaty signed with First Nations people in Calgary (or *Mohkinstsis*, its Blackfoot name) is insufficient to make repairs through the Truth and Reconciliation Commission (TRC) recommendations—which are more to educate the public about the horrific legacy of Indigenous residential schools (Stanton 2011). Decolonizing one's mind in a local context means acknowledging one's positionality—social, cultural, educational, and vocational privilege. And giving up power to others. Paolo Feire calls this *conscientizaçao* "learning to perceive social, political, and economic contradictions and to take action against the oppressive elements of reality," (Freire 1970, p.35). How does Dr. Gibson more consciously take action? How can she be more humble, loving, and courageous (Freire 1970, p.129) as a leader?

In knowing her history, Dr. Gibson can work "to recognize that systemic inequalities (of race, access and opportunity) have defined the fields we know today, but that this is not an historic inevitability and can be changed," (Trisos et al. 2021, p.1207). Knowing more about the history of each region she encounters is of benefit to her comprehension of historical context of the people and their struggle. Such as when her patient of Mapuche Indian descent in what is now called Chile gave her the book *The Open Veins of Latin America* prior to a visit to Argentina, describing the chilling colonial conquests and ongoing corporate greed that wreaks havoc on the continent (Galeano 1973). It would not be too much to ask for her to find similar reading materials to prepare her for all future international visits. While this book focused on the United States' involvement overseas to protect its access to resources, this is something she has also witnessed firsthand overseas. For example, when in Uganda and the group affiliated with the London School of Hygiene and Tropical Medicine imported food to make pasta and lasagna instead of eating matoke and beans (the regional cuisine). It is very likely that much of the produce had originated

in Uganda, travelled to Tesco, and made a return visit. At a larger systems level, many African dictatorships are supported by neocolonial governments and industry in order to continue their extractive processes (Alemazung 2010).

Along the lines of her online courses in *White Awake* and *Women in Power*, examining her own ancestral history of oppression is a beneficial step towards allyship. Both her Ukrainian and Scottish roots have tremendous lineage of cultural and political trauma. A clearer examination of this historical narrative would enable her to see her partners not as 'the other' but as extensions of her own humanity and interconnectedness. What are her ceremonies? Her rituals? What major events happened that changed the trajectory of the countries of her ethnic origin? Does she know of the principles of the Scottish desire for sovereignty? Beyond hosting Ukrainian evacuees from the ongoing war, how does she emotionally acknowledge the possibility of this country falling under a brutal tyrant's rule once again? Each of us comes from a culture that was once Indigenous and we can "reclaim our membership," (Kimmerer 2013, p.377).

This Doctoral process and her social media efforts provide a clear pathway to decolonizing access. Making all writings available and accessible to her Southern partners would be an easy starting point. Participation is necessary but insufficient to form collaborations—projects must be driven by partners who are granted equitable resources. They must be more engaged in any future joint research.

A more engaged awareness that her career was founded on a false meritocracy in a culture of white supremacy means that any action possible to level the grounds will further tip the balance of power. Supporting the education of others (the Doctorate and Ugandan residency tuition costs, a friend's TEDx coaching), enhancing access to opportunities (consider creation of a scholarship fund), and ensuring publication in open-access format are clear paths forward.

Likewise, decolonizing expertise through elevating Indigenous and non-Western knowledge is of utmost importance. Framing research and reference lists that include more women, neurodiverse, non-scientists, and racialized people takes more effort and it remains the best way forward to disseminating non-dominant thinking processes that solidify the status quo.

This would be even more powerful if she took steps to shift decision-making power. While her Ugandan partner remains an agent of GFF in-country, and his recommendations do carry weight, he currently does not attend AGM or other meetings where major choices are discussed amongst the Board. Arguably, given it is his fate lying in the balance; as a local leader, he should not just have a seat at the table, but the table should be designed for his participation. The false presumption of a culture of corruption or

incompetence in African countries is a legacy of historical trauma, wherein all white people benefit, progressive or otherwise (Menakem 2017). It reeks of prejudice, an attitude that causes discriminatory behaviour (Livingston 2021)

Practising ethical outreach in inclusive teams entails “ensuring mutual translation and co-production at every step of the research process,” (Trisos 2021, p.1209). Rather than conducting and piloting research (the WONCA standards paper, the Brazilian Storybooth project), collaborating and achieving consensus should be the mutual objective.

Another framework for inclusivity is presented in HBR (Bourke & Titus 2020), where the key is broken into six traits: visible commitment, humility, awareness of bias, curiosity about others, cultural intelligence, and effective collaboration. When Dr. Gibson does intense self-reflection, she likely has some further capacities to grow in some of these areas. She has travelled extensively and attempted to study and appreciate cultures—this covers three of the traits. However, in the context of visible commitment, this is articulated as an authentic prioritisation of diversity and inclusion actions. In all the leadership roles that she has held, there was no demonstrated commitment to elevating the voices of others. Likewise, in collaboration, she had many opportunities to relinquish her own power and could have focused more on ‘power with’ endeavours.

Many scholars speak of the differences between ‘power over’ and ‘power with’ leadership structures (Brown 2018, Miller et al. 2007). When it comes to a colonial approach, power ‘over’ would be the routine. Something that she needs to be more conscious about is distributed power, where she co-creates rather than creates. Where she understands her own lack of diversity will create further harm to systems if she designs them alone. Ibram X. Kendi describes race as a power construct rather than a social construct (Kendi 2019). In *Being White in the Helping Professions*, it is acknowledged that “the epistemology which leads to racism also leads to a great deal of other conflicting and destructive behaviour,” (Ryde 2009, p.124) and this links to colonial paradigms and neocolonial capitalism.

It is especially true when working with underserved, marginalised, and historically oppressed populations that our own social location influences our interactions (Arya & Piggot 2018). Dr. Gibson’s birthright has created assumptions and biases over which she has only a certain amount of conscious control. The more that she brings this into her consciousness, spends time in deep self-reflection, and answers with genuine (often painful) truths—that can shift her capacity.

Even though the jury has voted in favour of the prosecution, there are no winners here. It is the value of multiple perspectives. It is complexity.

Synthesis

Truth depends on the time, the region, and the context where it is being ascertained. This is the premise of *social constructivist theory*. Additionally, our participation within social relationships determines what we believe to be true. Reality is a subjective construct.

As Robin Wall Kimmerer describes as a possible outcome, “it is this dance of cross-pollination [with Indigenous ways of knowing] that can produce a new species of knowledge, a new way of being in the world,” (Kimmerer 2013, p.47). Searching for a way of being that is interconnected globally yet respectful of my own intrinsic bias and cultural constructs has been helped with this self-examining exercise. There is no blame or shame, only acknowledgment and a promise to myself to do better.

Nicolescu calls this, “resistance,” where reality is framed as resistance related to a “trans-subjective dimension,” (Nicolescu 2012). In this instance, the resistance is evident in the cultural and geopolitical contexts that are interacting. The perception has changed, even within my own career, as we have more of a sense of colonial and capitalistic frameworks in our global health efforts. What was tolerated and even lauded even twenty years ago has changed.

Attitudes and biases shift. “If everything we consider real is socially constructed, then nothing is real unless people agree that it is,” (Gergen 2004, p.5). Thoughts and discourse are limited by the common language as well as the language literacy of the participants. As paradigms are deconstructed, as cultures shift towards or away from equity, as technologies emerge that had never been imagined—truth changes. Reality encounters further resistance.

Collaborating between the Global South and Global North is innately an embodiment of social constructivism. The way that race and privilege dictate expectations of roles is a constant factor. Historical actions and ongoing neocolonial practices will muddy trust and the balance of power within a partnership. My career has spanned the time where the paradigm of aid work and international development encountered much-needed self-reflection on “white supremacy, racism, sexism and capitalism,” (Khan et al. 2021, Chaudhury et al. 2021).

In Africa, when I attempted to do consulting, it became immediately apparent that my own medical knowledge was far less extensive than my colleagues. Any wisdom I was trying to impart was always met with appreciation, but the evidence proved that their own understanding of disease processes often outweighed mine. They took a fawning approach, with the common paradigm that a person lacking

melanin from the Global North should be presumed as more intelligent. It was simply not true. It took about six years of running an international non-profit when I finally stopped going overseas to do academic consulting. Most of what our organisation does now is support the efforts of our partners on the ground. Having found local champions in places like Nepal and Uganda, we ask the partners how we can best contribute. And the answer is usually financial. While the Global North continues to steal the natural resources and even brains from these nations, the most effective reciprocal action on our part is sending these economic resources back.

Even within my lifetime, our views of the Global South have changed dramatically. When I was younger, *trauma porn* was all over the television. African kids with swollen bellies and insects crawling on their face, clearly not formally consenting to partake in national ad campaigns. There was the danger of "the ways in which we ourselves participate in creating the patterns we most abhor," (Gergen 2004, p.141). While events like *Live Aid* and songs like *Don't They Know It's Christmas* had good intentions, intentions do not equal impact. I can acknowledge that my intentions were always good, but my baseline understanding of culture and complexity limited how much I could escape the colonial constructs in which I was steeped.

What this means is that, while I am called to do international work, the process will emerge over time as the systems-level reflection is enhanced and my own self-awareness evolves. I do not feel that this debate had a surprising conclusion, as my own work has changed drastically during my time in global health (which started in earnest in 2007). What was deemed acceptable at that time, a white doctor travelling to a so-called 'third-world' country to teach, is no longer viewed in the same way. I was able to pivot faster than my peers.

Part of the solution is invoked in the name of my newest organisation—I co-founded the non-profit *The Belong Foundation* in April of 2023. There is the possibility of baking a different culture into new systems: an intersectional approach (Tulshyan 2022). My 2015 TEDx talk spoke of shifting the weight of expertise from 'expert in community' to 'community as expert.' In the context of global health, this must be an embodied experience. And the first step is to stop booking flights—to book Zoom calls instead so that I simply listen.

A physician familiar with East Africa wrote a book, *Global Health Means Listening* (Downing 2018). In it, he differentiates between those who learn global health versus those who teach it. Otto Scharmer describes four levels of listening, where the objective for partnership is generative listening (Scharmer 2009, Scharmer 2013). This involves moving beyond emergence (an empathic stance, "in another's shoes") into a deeper dive into our identity. Whilst I have studied facilitation (with the Berkana Institute

and Four Directions) and speaking (with numerous coaches), I have yet to study listening. My current Audible read is putting me on the right path—*How to Be Heard: secrets for powerful listening and speaking* (Treasure 2017). I am also taking a culturally-competent facilitation training with Lee Mun Wah next month. But, as with all these realms, there is so much more to learn.

The dawning of an understanding of the complexities and nuances within global health is one of the drivers for my study of systems thinking. Without examining colonialism and history, one is at risk of perpetuating these dynamics. One might even mistakenly believe that these nations are indeed resource-poor, rather than having ongoing extraction from this same dynamic (Fagbadebo 2023). One of the main drivers in my career is equity, and this can only be understood and shifted from the macro perspective.

An ongoing examination of my work in health equity will continue in Chapter 4, where I will use a framework that considers resources, exploitation, and cycles to look at larger systems. When I consider what creates inequity and what can solve multifaceted challenges, looking to systems theories and complexity science is necessary. In the next chapter, I will take many of my public works, including those in the international sphere, and examine how they fit into a model of transition and emergence.

Transition Poem Three: World Wide Web

The World Wide Web
networks of complicity and complexity,
where history repeats in fractals
and the future is perennially out of reach

The only way to prevent re-creating the shadows
in these fraught systems
is to hold up a candle, flickering nervously,
and see the shadows that I have cast across the landscape,

We are all composed of parts;
some are emergent,
others personify the destroyer.

Can we even reclaim the beautiful collective nature of humanity?
And learn how to dance in the rhythm of a pulsing, drumming, thrumming system?

What have we forgotten?
What can we reclaim?

Chapter Four: Social Innovation

The job of a physician is to see patients individually, try to determine what ails them, and find a cure. After twenty years in clinical practice, many physicians face burnout and cynicism working so far downstream (Chênevert 2021). What gave me hope at this stage was studying social innovation.

In this chapter, I will outline what I learned about emergence as it relates to my own path as a physician and innovator. Using the artefacts from my portfolio, as well as other related examples, I will outline how my career has followed expected cycles of transition, disruption, and experimentation. While these cycles are natural, given my transdisciplinary predilections, I have diverged enough to be a *positive deviant*—where one person ignores societal constraints and forges a new path (Pascale et al. 2010).

Social innovators, according to the book *Getting to Maybe: How the World is Changed*, whose co-author Frances Westley greatly influenced my path, “intend to bring about change, to make a difference, to transform,” (Westley et al. 2009). They challenge the accepted wisdom, trust their intuition, and explore uncharted paths.

The adaptive cycle model of ecology has been extrapolated to study social innovation. In social innovation, the infinity loop demonstrates how a stable preservation of energy and resources is released, re-organized, and then grown in a new way through conservation of what remains. Within the framework of complexity theory and resiliency, the cycle is graphically represented by an infinity loop (Moore & Westley 2011, Biggs et al. 2010). I have chosen to use this model to analyse my public works at systems level because I trained with Dr. Westley and it is a familiar, useful way to frame innovation. Edgar Morin described “thinking that flows in a circle” which allows for enhanced integration, and as a way to conceptualise the relationship between the whole and its parts (Morin 1992). Such feedback loops are a methodology (and ecological metaphor) towards understanding emergence.

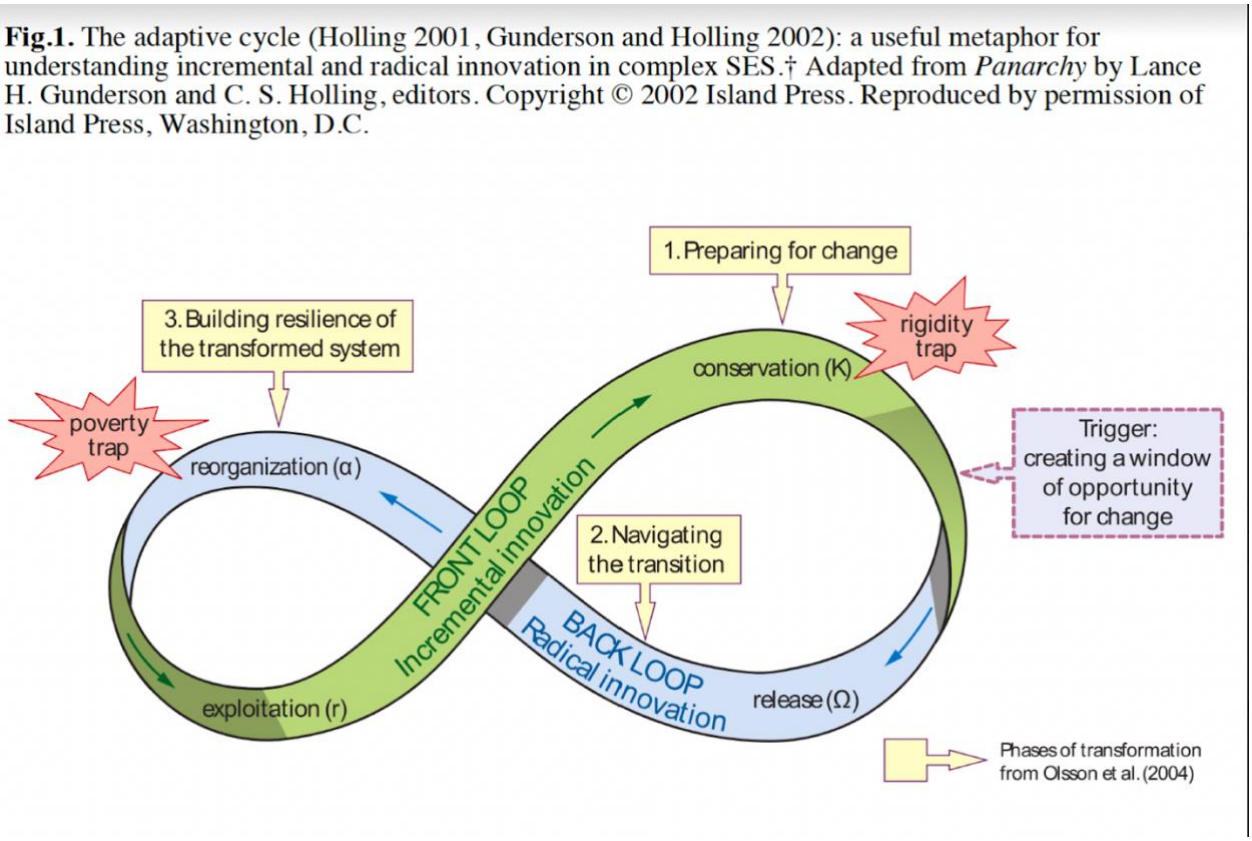

Figure 1. The Adaptive Cycle © Gunderson & Holling 2002

When I trained as a physician, there was not a strong sentiment to innovate. We were taught to follow algorithms, to use checklists, to follow standard protocols. Yet, the more that I worked in health systems, the more apparent it became that transformation is not just necessary but inevitable. “While concerns are mounting about global problems, so has the conviction that governments are failing to solve them,” (Bornstein 2007, pg. 8) and I wondered if this could be a role available for me—to intervene at the health-systems level. Indeed, venturing off the beaten path into the unexpected, the unexplored, and the unanticipated can be the key to solving humanity’s toughest dilemmas (Haraway 2016).

CONSERVATION

This stage is where many systems aim to maintain—a status quo of stability. In presuming such a thing is possible, it creates false assumptions, in that it’s predicated on a belief that resources are infinite and stability is ascertainable.

As stated in *Antifragile: Things that Gain from Disorder*, “consider that Mother Nature is not just ‘safe’. It is aggressive at destroying and replacing, in selecting and reshuffling… In the long run, everything with the most minute vulnerability breaks, given the ruthlessness of time,” (Taleb 2012, p. 8). There was a time when I believed in my own invincibility, the health system’s ineffable strength, and the world’s

tenacity—but with age comes a growing awareness that change is the only certainty. That the adaptive cycle demonstrates convincing evidence that failure, including death, is inevitable.

The most clear and pressing example of how conservation of the current state is impossible relates to the climate emergency. Naomi Klein said, “climate change, if we don't change course, if we don't change our political and economic system, is going to change everything about our physical world,” (Winship 2015). Species extinction (Román-Palacios & Wiens 2020), falling agricultural production (Anderson et al. 2020), adverse weather events (Ebi et al. 2021), and heat waves (Stillman 2019) have hit many poorer nations already but will certainly become more commonplace in the future (Romanello et al. 2021, Sharpe & Davison 2021). While I know that I hold some fear around this, my purpose is to be as prepared as I can be—with skills and flexibility.

From a health systems perspective, Canada is a microcosm of what is transpiring globally. Being familiar with this system, I have seen historical shortages of intravenous diuretics at the hospital and empty shelves of children’s analgesics at the pharmacy. Over the long run, we face “cost drivers that threaten to destabilise healthcare systems in Canada and worldwide, includ[ing] rapid growth in expenditures on drugs and new healthcare technologies, fueled by unbounded public expectations,” (Brown et al. 2022). Despite the privilege of a universal care system and the enthusiasm of medical professionals to provide expensive treatments, our approach is reliant on supply chains, ingredients, and pressures that will continue to shift.

Indeed, the slow wave of change in medicine has been evident for decades. Schön wrote of “no reason to suppose that professionals can be trusted to perceive the coerciveness of the institutions they represent; and even when they perceive it, there is no reason to suppose that professionals alone can act effectively to change the directions of institutional behaviour” (Schön 1983, p.349). Noted in *The Social Labs Revolution*, experts have little incentive to break the rules (Hassan 2014). But we are often ensconced in the power that privileges our ability to try. For much of my career, I was too afraid to challenge the status quo. It was not until a decade into practice that I realised it was essential to do so—that medicine needs innovators.

My personal goal within transformation and systems design was to create a ‘teal’ organisation as described in *Reinventing Organizations* (Laloux 2016) —in the illustrated version of his book, this lens has an evolutionary worldview, requires collective imagination, where decisions are driven by a moral compass that requires us to be of service to an interconnected world. He differentiates it from earlier versions of hierarchy, of top-down control, and of disenfranchised workers with no passion for their projects. What interested me the most in this structure was the potential for each person to bring their full

self to the table and to lose the hierarchical nature of top-down businesses. I felt that I had personally been harmed by such patterns of domination and subordination, and desired to experiment with a new approach. This is not a common model in medicine or health systems, but I hoped that it would survive the adaptive cycle. It was a model that felt emergent and compassionate to me, so I had to give it a try.

Let us see whether it survives the cycle?

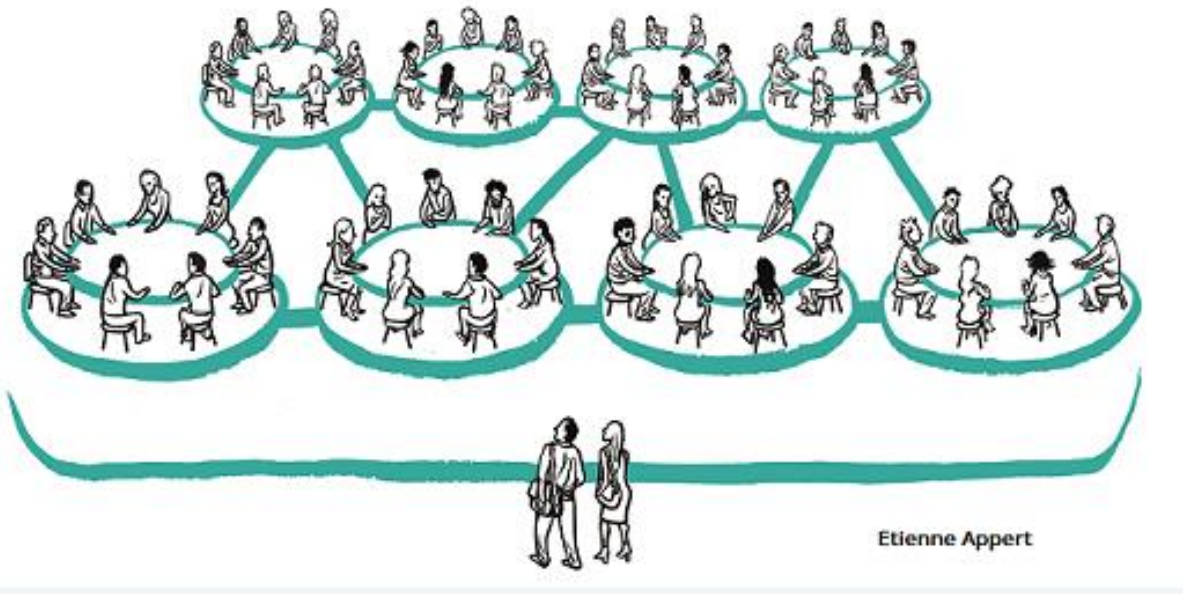

Figure 2. Self-managed Networks of a Teal Organisation © Laloux 2016

Examples of Conservation in Action

Representing the conservation stage of the ecological cycle, my career stages would include events when I was creating novel programs (the residency in health equity) and aspiring to achieve sustainability.

More recently, when I created wellness programmes at a Community Health Centre (CHC), I was operating on a single grant with a two-year timeline. While building up a series of impressive and successful activities, I anticipated that their merit alone would catalyse the way to access further funding. The programmes were designed without conscious consideration that they might be temporary.

My intention to train as a medic might also represent conservation, believing that the career path was fulfilling and a suitable long-term prospect. With the current pressures against family medicine (general practice / GP) in Canada, the push to accommodate a cadre of Nurse Practitioners (NP) in primary care roles–something that I had anticipated retiring from, is less likely. The fact that I had already pivoted away

from comprehensive care and redirected some of my efforts, suggests that part of me was aware of this potential strike against my discipline.

Reflections on Conservation

For most of us, this phase of stability is where we are able to feel certain and secure. Even though the adaptive cycle exists, we want to believe that the status quo will never change. The circumstances that benefit us—financial security, status, privilege, success—are situations we would prefer not to change. People tend to dread negative feedback loops, preferring the dream of consistent stability and balance. From an Indigenous perspective of imbalance growth, "the Windigo is a case study of a positive feedback loop…[which] leads inexorably to change – sometimes to growth, sometimes to destruction," (Kimmerer 2013, p.305).

While this situation is true of most people, it is not necessarily the case for me. I do not find comfort within the status quo. Inequity, the climate emergency, and mismanaged health care all cause me great moral distress. While I was benefiting personally from the positions I enjoyed (on paper, at least), the burnout and frustration were extreme.

I also am a person who desires new experiences and is an early adopter to novel phenomena. I read the field of what's to come and position myself ahead (whether this is Bitcoin investing in 2014 or acknowledging the importance of trauma in modern times). Feeling satisfied with one's position means you are not always available to respond when new opportunities arise.

I left the position as Residency Director of Health Equity, knowing that others' eyes would create the next iteration of the programme in directions I could not have anticipated or led. I took the position running wellness programmes at the CHC knowing that funding was only available for a two-year period. While there was the hope of conservation, I knew that each role would need to be relinquished.

RIGIDITY TRAP

According to a paper on the resiliency of social systems, "the *rigidity trap* occurs when a system becomes so refined in its processes that there is little room for further innovation," (Fath 2015).

While health care claims to be constantly iterating, there is evidence that much is stagnant. For almost two decades, there has been very little new development in psychotropic medications (ones that alter mental health symptoms) by pharmaceutical companies (Tricklebank 2021). In fact, "inflation-adjusted

industrial R&D costs per novel drug increased nearly 100-fold between 1950 and 2010; and drugs are more likely to fail in clinical development today than in the 1970s," (Scannel & Bosley 2016). Life expectancy is decreasing in the United States over the past decade, attributed to lifestyle factors and mental health in middle-age (Woolf 2019).

Reflections on Rigidity

In my career, this rigidity trap is a force that has constantly encouraged me to innovate. It is one reason why I have formed two non-profit organisations, a membership-driven co-operative, and an entrepreneurial corporation within the past decade. If health systems were functioning efficiently and ethically globally, there would be no need to create parallel pathways, alternative ways of doing things.

This is something that is intrinsic to me—a sense of inequity not being fair and wanting to do something about it. I think most health care workers stay within these harmful systems by dissociating or managing moral distress in negative (substance use) and positive (team venting) ways. It is a contributor to compassion fatigue and burnout. While I take more risks to change these massive systems, I am seen as an outlier because I am willing to try to shift these stagnant processes.

Here is an example: The Solutions Studio (Gibson 2018) was a social innovation lab that I set up at the community health centre. I invited people with lived experience to go through an efficient lab process that I adapted from Sprint Labs (Knapp et al. 2016). Our first cohort had experienced mobility challenges, the second were all in chronic pain, and the third had a history of complex trauma. After drawing an empathy map to create a hypothetical case, going through the iceberg model of systems change (from current events to policy frameworks, then to underlying assumptions), we designed a path for interventions. I made a large board where we could map these solutions along two intersecting lines to form four quadrants—from simple to complex, and from individual to systemic.

Partaking in these processes helped all participants break free from the rigidity trap in a few ways. Firstly, it taught people who were disenfranchised within the health system that they had power. I did not empower them—I showed them that they had intrinsic value and expertise all along. Secondly, it gave people the ability to solve their own challenges in community, along with resources to move towards the chosen solutions. We successfully applied for a grant for the mobility group to make a video demonstrating how difficult it was to navigate public transit. We created a men's pain group and gave them the music studio where they could make noise about their suffering. The traumatised group wrote a Charter of Rights and presented it to leadership, demanding dignity and safety from the health care staff. All these innovations transpired because I was willing to ask the people what they needed, rather

than presume to know, and to believe that they would be able to achieve these desired outcomes. People the system had otherwise given up on.

Because the rigidity trap prefers stagnant systems, in this scenario—empowering community members may not have been perceived as a desirable outcome. When the power balance shifted at the CHC, I was viewed as an outlier. Then told explicitly that I did not fit in.

RELEASE

The phase of growth and accumulation is connected to capitalism and consumption. The back loop activities, where release leads to reorganisation, is more disruptive and innovative. Resources still exist in the *release phase,* but they are not as predictable or reliable.

The liminal space between the front and back loops of the cycle is when collapse threatens, something heralded within health systems for decades (Sandy 2002). As the author suggested, this sense of stability was a false "homeostasis." The post-pandemic "great resignation" of health care workers around the world is one concrete instance of how this release will transpire. Those still in the work-force face unprecedented levels of stress and burnout (Jiskrova 2022).

The release phase is characterised by testing a system's "capacity to survive in the face of extreme disturbance," (Fath 2015). Economic and political instability, a global pandemic with uncertain outcomes, and an unrelenting march towards climate collapse with resource scarcity all herald such extremes.

Examples of Release in Action

Much of what I have achieved within health systems lies in this back loop. What is most fascinating is that I pivoted towards mental health and solution-focused approaches to psychological distress even before this became apparent as the most pressing issue in health care systems and health care services (Kontoangelos et al. 2020, Sheridan et al. 2021).

Recovering from crisis, quickly determining what resources still exist, and exploring alternative paradigms all occur in a quagmire that is the back loop. Not only does this apply to health systems, but it also applies to the individual when facing trauma or conflict. In the scenario, we would call it either resilience (a return to baseline) or post-traumatic growth (something new). This is likely true of systems as well.

When the status quo is arguably oppressive and harmful, as we notice in health equity spaces, a change of the rules and hierarchies could potentially shift things towards a more equitable framework. Creating a residency in Health Equity is aligned with moving towards enhanced care with social justice in mind.

There are also examples within my career where the release phase was imposed:

- Having created the East Africa Family Medicine Initiative through Global Familymed Foundation (GFF) in 2013, the initiative collapsed when we did not continue to fund their efforts.
- The abrupt cancellation of wellness programming at the CHC when funds were not sought to continue, destabilising participants and activities.
- Emergence within the Healing Centred Cooperative when the Board of Directors imposed inflexibility and demanded unearned equity from my intellectual property—I dissolved the organisation shortly thereafter.
- The sole project of the Cooperative was a successful pilot that was unable to secure ongoing funding to scale. To be clear, we were awarded funding after three phases of a grant application, but they never came through with the money after having made the promise.
- Creating a residency in Health Equity and being program director from 2007-2014, but then abandoning it to a new director and having very little subsequent involvement.

Reflections on Release

This is a difficult phase emotionally. Society associates this with failure and defeat. I certainly related to this feeling during all these experiences. It's one reason I have three therapists—a talk therapist, a somatic and psychedelic coach, and a social innovation facilitator. All three of them have helped me pick up the pieces in my mind so that I could pick up the proverbial pieces of a project or company.

While I know that ventures need to have a plan for sustainability, I am an optimist who always felt that things would work out. When this doesn't transpire, there was an initial grasp to maintain the entity. It is hard to let something go when you have put so much time, energy, and sometimes funding into it—the sunk cost fallacy, controversially unclear as to whether this is driven by negative affect or negative rationale (Dijkstra 2019). Society tells us messages that we can put sufficient effort into a project, that it will work out. In all of these cases, I do not believe that it was a lack of enthusiasm or commitment on my part—it was just not the right time for the projects to be sustained.

I have gained insights from these perceived failures—developing plans for sustainability with my newer venture (Safer Spaces Training) by creating a perpetual income stream through a SAAS model. We will offer at least four programs to organisations and professional colleges (trauma-informed onboarding,

safer communication strategies, trauma-informed DEI, and psychological first aid). We are moving deeper into release and reorganisation, having conducted two pilots so far.

As a writer, I have immersed myself in the concept of the "hero's journey," (Campbell 1972) where a protagonist crosses a threshold to a new land, discovers an elixir, battles demons and tricksters, only to return home both destroyed and invigorated. These battles, that change you forever, lie in the release. Interestingly, I have also studied a feminist version of this journey during an online course on *The Heroine's Journey* (Carriger 2020) where the instructor used archetypes to show that the end of the literary trope would be an embrace of community, from a different gendered perspective. I studied both tropes when I was writing fiction—a work that has yet to breathe in the public domain. While I finished my novel, and it was requested by the publishing house I hoped to work with, they did not offer a contract. I have worked on this piece for fifteen years now and am not yet willing to let it release.

While I believe that both "hero" narratives are a part of my work and storytelling, I am more drawn to the feminist approach—that a solo practitioner is rarely able to complete the quest alone. In release, part of what might have to be dissolved is one's ego. When one's desire is to conquer a challenge solo, to discover a valuable concept or invent a novel intervention; this is often based in a narcissism that can muddy the process (Mathieu 2013). What I have come to understand about narcissism, that the wound is based in shame and self-loathing as Brené Brown described on Tim Ferriss' podcast. She calls it "the shame-based fear of being ordinary." I can admit that this is a driver for me. Yet, when I self-reflect on the primary drivers of my work, it is that of a servant-leader.

The characteristics of a servant-leader (Greenleaf 1979) may be, while not having strict consensus (Pawar 2020) according to a literature review (Coetzer et al. 2017):

1. Authenticity
2. Humility
3. Compassion
4. Accountability
5. Courage
6. Altruism
7. Integrity
8. Listening

Nowhere in this list do they mention market growth, stakeholder expectations, or capitalist ideologies. I would like to think that these match my own values when it comes to organisational principles. While the origins of this theory are religiously based, I find the list of traits compelling.

Appreciative leadership defines the strategies of relational capacities, positive changemaking, and potential-seeking (Whitney et al. 2010). Key features are defined as: inquiry, illumination, inclusion, inspiration, and integrity. The experience of illumination was the least clear to me—upon investigation, it is summarised (Whitney et al. 2010, p.23) as the process of helping others examine their strengths through confidence and encouragement. When I took a course through Canadian Leaders in Medical Education in 2013, they analysed our leadership styles. Mine was 'orange,' which was between the red instigator and yellow advocate. The orange leader inspires, like a pied piper of enthusiasm, towards a common values-based goal. This is definitely how I show up when at my best, but can easily dip into red (authoritarian) when under duress.

One of the ways that I instill a values-based measurement is the use of principles-focused evaluation—I took a workshop with its creator, Michael Quinn Patton, just as I was creating the wellness programmes. Our team managed to insert these features in our internal evaluation strategy—which was not quite quantitative enough for the leadership (Patton 2017). What really resonated with me was the desire to illustrate behaviorally how you aligned with the values - what he called 'principles in action.' Even while the wellness programmes were released, it was of great comfort to me that the activities had been aligned with a deliberate 'North Star.'

REORGANISATION

The phase of reorganisation in the back loop can also be expressed as *emergence*. Essentially, it is the restructuring that rises from the ashes of what has burned, from the ecological model from where the adaptive cycle was initially designed.

The books *Emergent Strategy* (brown 2017) and *Leading from the Emerging Future* (Scharmer & Kaufer 2013) are two key texts that have guided my journey through such murky endeavours. Both describe the open-heartedness and vulnerability intrinsic to emergence. Both recognize change-makers as pluripotential beings who bring their full selves to the table at any endeavor—both the artist and the scientist.

According to Fath, Dean, and Katzmair—the system is successfully reoriented when it continues "along a new trajectory for future development," (Fath et al. 2015). This requires a network that has learned from historical cycles, a new shared vision of what's possible, and even imagining what had previously been considered impossible (brown 2017). Success stems from a strong sense of agency, a collaborative and iterative approach, and a splash of unmerited hopefulness.

Scharmer and Kaufer mention twelve principles (2013, p.169-172) that can accelerate the potential for emergence, with a focus on: deep listening, connecting to intention, leveraging the apparent cracks, iteration with reflection, and perseverance.

Examples of Reorganisation in Action

There have been multiple instances of emergence throughout my artefacts. Reorganisation tends to include shifts in leadership. Determining the resources that remain, establishing new forms of capital, and creating pathways forward through relationships are the skill sets that allow the system to move through the back loop. In my study of leadership, social innovation, and trauma, this is the piece of the ecological framework where I am most adept. Given most of society (and individual humans) prefer and even crave stability, it is one of the reasons why I am uniquely positioned as a change-maker.

Some of the most prominent activities include the ongoing support of the Family Medicine programme in Uganda. Their government continues to refuse to provide tuition for their residents in training, which renders their department in constant search for sustainable solutions. My non-profit GFF has single-handedly provided most of the tuition for their students in the past five years, which has kept the specialty afloat. This gives the graduates a chance to make an impact, which could create the critical mass needed to allow the discipline to flourish—what our local Ugandan partner calls the necessary *tipping point* (Gladwell 2006).

Another example is that of launching a trauma-based practice on the periphery of primary care. When it seemed that being a holistic family doctor was not feasible, having attempted Healing Centred Homes with virtual care and home visits which was financially unsustainable, it was a further risk to become a GP therapist. One that has paid off with a publishing deal, a social media channel, and the opportunity to speak and facilitate.

It remains to be seen whether Safer Spaces Training emerges from the ashes of the Healing Centred Cooperative… The leadership structures have taken two from the original Board of Directors, but my mentee Aishwarya has stepped aside. The fire of the HCC collapse burned her too; she said that it was not worth risking our personal relationship to be co-founders of a company again.

Reflections on Reorganisation

When I was in Dr. Frances Westley's training in social innovation in Banff, we did personality analysis prior to arriving that demonstrated that I had skills that thrive in what's called *the back loop* of release

and reorganisation. Emergence. I think it is the same skill that lets me feel more comfortable in spaces related to trauma. The comfort in uncertainty. The acceptance of change. It was interesting, in that she sent each of us with adaptation to one phase of the adaptive cycle to a corner of the room—I felt like I had “found my people.”

Prior to arriving in Banff, one of the exercises we were asked to do was to solicit the opinion of twenty people about our leadership style. I created an Excel table in order to better organise the responses. In terms of how I show up, I was described by my colleagues as “committed, caring, passionate, and open to feedback.” But it was in the area of complexity where my personality was more defined—they used words like “you quickly absorb new concepts,” “your ability to see connections between fields,” and “applying knowledge from so many separate places and topics in a beautifully integrated way.” Specific skills mentioned included “always up-to-date on policy changes that might impact less fortunate populations,” “you try new things and learn from it,” and “creating resources to tell important stories.” The theme with the most comments from almost a dozen people was that of curiosity. A “quest for knowledge”, the “insatiable desire.” An “almost restless energy to improve.” A “passion to learn.” “Constantly seeking self-knowledge and improvement.” “An intricate kaleidoscope in your brain.” Getting this level of authentic, positive feedback in 2018 was an exercise I will always remain grateful for, because it helped me learn more about my specific talents. There were many appreciative tears reading these answers.

In reading about intersections of mental health and other fields in *Convergence Mental Health: a transdisciplinary approach to innovation*, certain essays stood out relating to my journey. “The ideal convergence scientist or physician has deep expertise in their field, alongside literacy and understanding of a broad range of disciplines. This recognizes that many of today’s global problems are too complex to be addressed by a single, specialized discipline,” (Turnbull and Freeman 2021, p.59). This speaks to the depth and breadth I have sought and why it has felt so restrictive to look at complex problems from a single domain.

When I think back to why I might have a higher tolerance for the release phase and the back loop, it might have to do with some innate characteristics. As mentioned in the exercise above, I like learning new things (my travel history corroborates this) and I like challenges (creating something novel). There may also be something related to the external circumstances that also provided some congruence for me of the shifting landscape—my father’s travelling throughout my childhood, my awful divorce that required a private investigator’s assistance, and the practice of generalist medicine. You never know what is going to walk in the door. In these scenarios, I generated a tolerance for uncertainty.

POVERTY TRAP

The poverty trap occurs within the (re)growth phase, where development is active, and resources are flowing. Scarcity, lack of trust, and unstable leadership can lead to impossible dynamics at the stage. It has been described as “when diversity and competition does not result in a dominant subset of the ideas, organisations, or initiatives that can secure enough resources,” (Moore & Westley 2011).

In my career, this has manifested when I tried to leave my family practice and create a solo endeavour, Healing Centred Homes, where I practised with virtual or home visits. It quickly became apparent that this was not an economically viable alternative. In the reorganisation phase, recognizing the resources that existed, my work in trauma was the clearest part of abundance, and pivoting to focus on this created a successful but unexpected transition.

While it seemed that the path of a physician was carved in stone, I have managed to create a social media presence and become a more fully actualized (Renaissance) version of myself. This was through some personal as well as professional reorganisation.

The rapid prototyping that characterises the phase of innovation and growth is something that can be unsettling to some and terrifying to others. My work and eventual split from the CHC best illustrates how my ability to engage in rapid prototyping was viewed as insurgence and transgression, from the systemic leadership wanting to remain at status quo. Constantly hearing feedback such as I was trying to create more change than they were ready for, not going through the proper approval channels, and pushing for patient-driven solutions they were not ready to accept eventually stole my agency.

I also believe that I am positioning myself to be of most service in future times. This is a way of cultivating individual and collective resilience for the potential catastrophic future events. Questions that continue to interest me as I use this framework to examine my future direction include how I can build a seed bank that recognizes knowledge that has existed within the system. We do not want to lose this lineage of heritage perspectives. Likewise, how to avoid the poverty trap that tends to accompany scarcity. I joined my city’s Climate Advisory Committee in 2022, and the OECD invited our group to workshop the scenarios that were constructed by their Strategic Foresight division. All of these scenarios are horrifying, but none surprised me. My imagination is ready for inequity driven by ‘edited’ people with biotech implants or a hothouse earth scenario of food scarcity. In fact, my yet-to-be-published fiction novel is half historical fiction (my great-great grandparents’ journey from Ukraine to Canada) and half eco-fiction (a vaguely apocalyptic future of environmental catastrophes). It is a fictionalisation of the poverty trap.

Reflections on the Poverty Trap

The poverty trap is one that can be alleviated through power (Battilana 2021). As I studied during a course through the Harvard Business School *Power and Influence for Positive Impact*, I have the three main forms—personal power (my academic credentials, insatiable love of learning, and congeniality), relational power (networks across so many countries and disciplines), and positional power (directing many organisations, being less tied to one employer). The latter is worth mentioning—now that I have left the hospital and community centre environments, I work in four different part-time positions. This means that I can be more flexible when it comes to my advocacy efforts and my innovative drive (less accountability). It also means that I can invest time in figuring out next steps when things stall.

The poverty trap results in more frustration and resentment than the rigidity trap because one feels like things would work out if more resources were present, as opposed to feeling like the endeavour was doomed.

EXPLOITATION

More amiably seen as the growth phase of the adaptive cycle—exploitation refers to a time where resources are consumed, prototyping is rapid, and a path to sustainability is crafted.

Success at this stage can be like post-traumatic growth from an individual human perspective. Like an individual, systems (organisations, economies, health care) can emerge from challenges (even chaos or disaster) having learned and shifted. It can create a new paradigm, intensify learning, and allow for greater insights. While it is difficult to go through these difficult and vulnerable periods, this growth phase demonstrates how purpose can be restructured to achieve an even greater vision.

I commissioned an illustration in my book, to make an implicit metaphor about how post-traumatic growth happens (Figure 3, following Chapter 5). When we float along, that is the apparent conservation phase. Trauma or challenge strikes, throwing an individual or organisation into the back loop of release and reorganisation. It feels overwhelming, unpredictable, even dangerous. Once reorganisation creates some stability, this is like being thrown a life preserver—one can float again. Exploitation, growth, is learning how to swim. Destination unknown.

Examples of Exploitation in Action

During my career, I have been involved in many changes as an early adapter. One such transformation was the inclusion of Medical Assistance in Dying (MAiD) in the listed services provided by the public

health system in Canada. My involvement in MAiD from the first month it was legal was a huge personal and professional challenge.

As outlined in the article by a journalist friend (Frangou 2017), my decision was that of protecting autonomy and dignity. But being an early adapter can be disquieting and lonely. I chose to remain anonymous in her description of the physician who administers death, but my hands were photographed and my tell-tale shoes described.

Likewise, emerging from the earthquakes in Nepal, the shifts that occurred as I examined my own fragility led to an incredible flow of opportunities. From connecting with Dr. Lissa Rankin's Whole Health Medicine Institute (as a student and now faculty), to learning more about trauma from renowned experts, and finally studying social innovation and design thinking.

It is wondrous to recall the early enthusiasm for the Cooperative efforts. When I invited the disruptors in my life to join in an exploration, almost all of them showed up—there were forty people crammed into my kitchen, straining to see the whiteboard. (True innovators have a whiteboard on the wall of their kitchen). We determined that the structure needed to reflect a co-created vision, so discussed *holacracy* (van de Kamp 2014) where self-organising circles each determine their independent path without hierarchy. We debated a *sociocracy*: double-linking, semi-autonomous circles (Eckstein 2016) and were drawn to its principles of consensus and agility. We landed on the cooperative model because we saw everyone as equal participants. It should have been the epitome of an equitable, *teal* organisation. That was, sadly, not what transpired.

This kind of innovative perspective led me to launch initiatives such as the Solutions Studio, a patient-led Advisory Council, and now numerous entrepreneurial activities. Being the newest physician at the CHC created a brave mindset, that anything was possible as it was being catalysed in the crucible.

Reflections on Exploitation

Rapid prototyping can be mentally and physically exhausting. It is consumptive, both of internal and external resources. The feeling is frantic, which is not comfortable for me. I have likened it to 'drinking from a fire hose.' Sometimes my energy level can keep up with the pace of iteration and emergence, but often it can be so draining that the rest of life's activities (and pleasures) take a back seat.

I have described overwork as a trauma response on my TikTok channel, which is something I know firsthand. The demands of the exploitation phase require such dedication and discipline that it is not a

place where you can linger. It is similar to having a full emergency room while you are already looking after a full ward. Everyone has different demands. Everything is complicated. And everywhere you look, there is more to be done.

The cycle continues…
Sadly, my strong inclination is to believe that humans will put the entire ecosystem through collapse. I hope that my skills and moral compass place me in a position to be of service in these coming times.

Synthesis

Using the adaptive cycle to analyse and reflect on my artefacts brought a few key points into focus. Importantly, “a new knowledge of organisation is capable of creating a new organisation of knowledge,” (Morin 1992). It also helps me to see the interconnectedness of my experiences, how one builds on the other and would not have been possible if it were not for the release of the old. Such systemic problems are inherently interdependent and require radical paradigm shifts (Capra 2014).

First, in examining the complex dynamic of emergence, I can see that my predilection for change is one factor that makes me seek the full loop of the adaptive cycle. I have held many more jobs than most physicians—more than anyone else I have met. While it is never a deeply comfortable state to face dissolution of an organisation or beginning anew, it is one that I prefer rather than a status quo. I do not think that I could have thrived in a career that kept me locked in a single position. Part of this is my innate curiosity. Another part has to do with the diversity in my interests—I have always enjoyed arts and sciences and everything in between.

A large part of this has to do with my ability to foreshadow the needs of these systems. When I became involved in global health, I also studied anti-oppressive practice. When I endeavoured to understand complex systems, that led to a Certificate and residency in social innovation. When I learned about cryptocurrency in 2014, I jumped on board (which has funded most of my GFF work in recent years). I have started to shift my focus towards the climate emergency, which I believe is the largest systemic trauma of our times.

Many consider the release phase of the adaptive cycle to be one of pain and discomfort. When we think of this phenomenon as necessary for innovation, it makes our personal and professional trauma easier to bear. While I have experienced setbacks and even disasters—I have a strong belief that these were necessary to fuel my reinvention (from physician to trauma therapist and author), my innovation (from

prescribing medicines to prescribing storytelling and somatic practices), and my capability to manage distress. This is the seat of resilience and post-traumatic growth, the subject of Chapter 5.

In the following chapter, I examine my personal and professional interest in trauma with a view to how it has influenced my recent career. There is an undeniable traumatic shift with every release phase of one's career, one's relationships, and one's expectations of life's trajectory. It is a useful skill to be able to manage this traumatic response in order to continue through the phases in a calm flow state rather than an anxious or threatened state.

Transition Poem: Dissolve

The undoing.
The dissolution
The disaster
The distress

In acknowledging that all things must end
discover uncover a new aligned life,
letting go life as we knew it.
Systems that weave anew

The changes punch holes into surfaces
shoot cannons into still water
pierce with sharp arrows into the softest flesh

I can build my armor of white coats and credentials.
hone my craft with expert flair
but nothing protects me from the natural flow

I am gone with the wind.
Adrift at sea, yet anchored.
The storms roll through and release
I have resilience in a bottle

Turning the lens inward, then outward.
And then inward once more.
Because before we can understand our place in systems,
we must trace the origins.
The complexity woven into our own gentle skin.
Fragile chopsticks of DNA, shaving methyl

Learning to swim
Gasping for air
Propelling through screaming muscles
Island to land to island
Sometimes losing sight of the support vessel
but never forgetting the sun flickering crystals into the glassy water.
The glow of hope.

Chapter Five: Trauma

Physician, heal thyself.

This chapter encompasses the most overt distinction between the evocative and analytic autoethnography styles. While there is a distinct narrative—the critical reflection, both of my psyche and of the emergence, is overt, and the balance deliberate, bringing what may have been subconscious into the conscious realm. If the deepest layer of autoethnography is *self-psychoanalysis*, where I dive deep into the intentionality and context of my thoughts and behaviors so we can understand the dynamics of how we are shaped and shape others around us, this is the chapter.

This chapter encompasses explanations, demonstrations, and applications of the myriad forms of therapy that I have studied. In our search for understanding the human psyche, we have developed protocols and paradigms that insist on a truth that remains evasive and ever-shifting. My analytical side desires a clear descriptive analysis and neuroanatomical path towards my psychological evolution. My sensitive side wants to be seen, to be loved, and to be appreciated.

I was an empathic child. When I was bullied, I incorporated that pain into internalised shame. When I see systemic violence, it wounds me. This sensitivity to the pain of the human condition (whether it be ancestral, cultural, violence, or personal trauma) is something that I embody. Sometimes this sensitivity comes at the expense of my capacity for joy. Sometimes it enhances my awareness of beauty and awe—at the human body, at the earth body that we share. But I am aware of the personal cost of this capacity.

Medicine is a traumatic profession.

Getting into medical school is competitive beyond reason. In my first year of undergraduate education, I had a mediocre score in a statistics class. This meant that I had to have the highest possible grades for the next three years to be considered a candidate for medical school. The sacrifices I made to achieve this impossible task were quite astounding. Nights in the University library (of course, I chose the one situated in the hospital with the other pre-med students) until midnight or falling asleep at the desk.

It fostered significant anxiety symptoms, culminating in panic attacks for the first time in my life. I would try to sleep, with a pounding heart and tight chest and overwhelming sense of doom. I was volunteering at a local hospital, as one does to pad the résumé, and starting to understand the medical profession from an awe-inspired observer perspective. I remember calling the hospital and speaking to the triage

nurse (I was a volunteer to help navigate the emergency department). I told her that I was dying. I told her I was certain this was a heart attack. She told me it was a panic attack. I crawled into bed with my parents. Fortunately, I was studying undergraduate psychology at the time and was able to speak to a trustworthy professor, who provided me with a book on biofeedback. Because I have the discipline that I may have lacked in confidence, I was able to intervene when I noticed the physical symptom onset and used my significant cognitive capacity to reassure myself that this was a psychophysiological cascade. Eventually, I learned, through journaling my triggers, that the spells only happened when I was drinking too much coffee. More than two cups in a day. I have since discovered that I am a very slow metabolizer of the caffeine molecule and was sensitive to its sympathetic effects on my nervous system. I have avoided it almost completely since the age of twenty, no small feat when studying to become a physician.

The interview process was equally gruelling; what seemed to be a distinctly a life-or-death prospect. While I did have other skills and interests, by this point, I had convinced myself that the only possible path forward was medicine: the perfect marriage of sciences and intellectual curiosities, while being inherently focussed on relational aspects of care. Mom and I purchased my first skirt suit-set, something I still consider stylish thirty years later. While my parents had a decent income, they had not supported me financially throughout my undergraduate degree, nor would they contribute to the medical one. I earned sufficient scholarships to pay my tuition and, when I was achieving perfect scores, even a little bit extra. This allowed me to travel to New Zealand for the summer before studying for the MCAT, the entrance exam. I think I was in denial about how much studying this would entail, because I delayed my return flight twice.

The amount of anxiety that writing this exam brought to the surface was beyond intense. Like has been known to occur after childbirth, I think I have blocked out the worst memories. Hundreds of kids, all lacking their frontal lobes, competing for a tight number of spots. Average executive functioning does not come into its fullness until the age of 25, the year I would graduate (Siegel 2020). So, in undergraduate education, we were hampered by other students stealing our books or notes, refusing to share their transcriptions if we missed a class, and even misleading us as to the date and timing of the exam. One such transgressor is a successful obstetrician now.

I did get into my local university medical school on an early admission, which removed a lot of pressure. Unfortunately for my younger self, my desire was to go to Toronto, with its reputation of excellence and its stature as the best medical school in Canada. This would take a lot more financing than I had available, so I worked three jobs the summer before: recreational leader at the playground for free summer camps, waitressing at a burger bar, then lifeguard and swim instructor at the YWCA pool. This work ethic was instilled in me by my mother and would be a tremendous boon during my training and career—I would

only miss a single day of work in all my professional life, the day that I passed out on the job after having lost twenty pounds due to a parasitic infection from Guatemala. Even with my temperature of 40°C, as a young woman, I was gaslit by my internal medicine peers who insisted that anorexia was a choice, and that I should "just eat." In addition to the rampaging parasite, I turned out to have *clostridium difficile* bowel infection, and a serum sickness response to the antibiotics I had self-prescribed (both of which could have been lethal).

I received the letter of admission from the University of Toronto a mere two weeks before the start of our term, likely the result of someone having to turn down their position due to lack of finances. I gleefully accepted, and then realised I had been living at home for my first 21 years and would soon be on my own on the other side of a very large country. So, as a family, we decided that living on campus in residence was the smartest choice. Of course, at this point, there was not a lot of available accommodation. I was accepted into a convent. I was raised atheist. The nuns were unreasonable, not allowing my father to come and help set up my computer printer because he was a person hosting a Y chromosome after the witching hour of 8 PM. They were strangely cruel: while we had paid for our meals, they held them at 5 PM before our anatomy lab closed and so I ate a lot of dry Cheerios cereal in my chambers. At the time, I was not yet diagnosed with Celiac disease, and so I am sure it is one of the contributing factors to my lithe appearance. I was malabsorbing. But when you first start on the path towards ignoring your interceptive signals, your body telling you exactly what it needs, it is inevitable that these kinds of nutritional transgressions become the new normal. This would be fodder for my ability to work an entire day without any food intake or even drinking for eight, twelve, sometimes considerably more hours. I remain convinced that I left many hospital shifts in mild renal failure.

In medical school, I was no longer one of the most gifted in the class. I still graduated among the top ten percent, but having been an exceptional student in undergraduate biosciences, I felt more average in Toronto. When I let my faculty know my interest in primary care, they immediately dismissed my intelligence and drive. I would often hear comments like, "Well, you do not have to do these procedures because you will never use them again," totally ignoring how many family doctors work in rural areas and resource-poor settings.

I chose to come to Calgary for residency because it was closer to my family and closer to the Rocky Mountains. At this stage, most of my artwork depicted some kind of peak. I also wanted the challenge of doing rotations through the ICU and cardiac care units, which was not common in most family medicine residencies (GP training in the UK). It turned out to be considerably harder than expected, but not because of my cognitive capacity.

My best friend during residency, whom I met in Calgary, was diagnosed with a brain tumour a couple of months before she began speciality training. Her cancer was inoperable upon discovery. As part of her residency training, she was made to rotate through the very same services that were doing her follow up care; seeing her own neurosurgeon on ward rounds was traumatic and she failed to pass her ICU block. At the same time, I was written up on an emergency rotation because of a single night that a family member died of an overdose and I had to leave on time, declining to stay late to reduce a shoulder dislocation. Note that I did not leave early—simply on time. I was told this was unprofessional by a preceptor, who knew my circumstances. We both ended up having to repeat our rotations in a rural area in southern Alberta. The next reprimand I got was on my pediatrics rotation because I caught mononucleosis during the emergency portion and was not able to stand for the hours of morning rounds in the NICU. This was after I confessed about my illness and asked for accommodations. They allowed me to avoid overnight call shifts for the first two weeks and stuck them all towards the end, working every second or third night shift. It was deemed insufficient. I had to repeat pediatrics, the very subject I had been thinking about applying to in medical school, briefly desiring pediatric neurology as a specialty. I had already done months of pediatric electives then, yet had to do an extra month in residency instead of a vacation block.

This is where I learned that the culture of medicine is inhumane and cruel.

So it was no surprise that when I tried to pay off my loans by working as an inpatient medicine physician, a position we call Hospitalist, I succumbed to working 80 - 100 hours each week. It seemed almost normal to be completely lacking sleep and ignoring my body's basic needs. We were all either irritable or dissociating. We moved like robots from one room of serious illness to the next room of palliation—no chance for processing our own emotions (Charon et al. 2017, p. 54).

Specialists would berate me on the phone for not doing the proper work up, usually procedures I had never heard of or tests I could not order. Patients would fail to recover from their illness—we would internalise the guilt of having harmed them, even when it was clearly the disease process taking its natural course. After a death, or a significantly negative outcome, we would simply go to the next patient in the next room.

It was not until I took a blood pressure monitor with me on a night shift that I recognized the symptoms I had been experiencing (nausea, dizziness, chest tightness, and headache) were from stress. My blood pressure averaged over 200 systolic and over 110 diastolic. These numbers are sufficient to cause spontaneous stroke. Specialists did a massive work-up to ensure I did not have an adrenal tumour or stenosis (narrowing) to my renal arteries. Then my brilliant primary care physician thought of doing a

blood pressure monitor on a day off, while I spent time with friends and went on a bike ride. Normal readings, 120/75. The diagnosis was clear—the job made me ill.

I moved to community medicine in 2017. Here, the demands were much more regulated between the hours of 9 to 5. But because of my proclivity towards health equity: working in a low income, highly traumatised population, it was still hard to leave the medicine at home. I would think about my patients every evening. I would worry about them constantly, which never seemed like catastrophising because negative events were so common. Overdoses. Suicide. Relapse of addiction or mental illness. Uncontrolled chronic disease. Hospitalisation. Early death. People who are unhoused or precariously housed have a life expectancy decades younger than average (O'Connell 2005). People who have a background history of significant adverse childhood experiences (ACEs) have exponential increases in their risks of every medical, psychological, and social outcome measured on every research trial thus far (Felitti et al 1998). This study was released the same year that I graduated medicine, so I did not learn of its impact until I was serving in the community where it impacted the most. This study should have changed everything in medical education. (I was honoured to send Dr. Felitti an advance copy of my book.)

The Adverse Childhood Experiences (ACEs) research trial came out around the time that I graduated from medical school. Dr. Vincent Felitti had observed at a weight loss clinic that the majority of the patients would regain adiposity very quickly. He accidentally asked one of them about childhood sexual abuse and got a very shocking reply. Then he started asking the rest of the patients and found the overwhelming majority of women had experienced significant childhood sexual abuse. He designed the ACEs questionnaire as a public health survey, using the Kaiser Permanente network to recruit around 10,000 patients and determined the incidence of the 10 risk factors that he chose to examine. Note that these were never meant to be inclusive despite the fact that sometimes people promote using the survey as a screening tool now. It misses key items like racism, bullying, and other forms of oppression—Dr. Nadine Burke-Harris addresses these additional screening questions in her book *The Deepest Well* (Harris 2018). That being said, the original study illustrated a previously-ignored set of risk factors for ill health.

The team measured the ACE score, examining abuse or neglect or particular events (out of 10) against a large number of physical health, mental health, and social health outcomes. Note these were done retrospectively rather than prospectively, but I do not think that this distracted because the study participants were not aware of the hypothesis. What was uncovered consistently was an exponential increase in every metric related to health (Felitti et al 1998). Biological issues like diabetes, cardiac disease, and cancer. Mental health diagnoses like depression, anxiety, and substance use. Social issues

like poverty, having a child at an early age, and struggling with relationships or employment. The ACE score is one of the single greatest risk factors for every possible challenge we might see in medicine.

Sadly, despite the meaningful nature of the findings and possible path to intervention, this study is not currently enjoying the awareness and integration into medical curriculum that it deserves. From my perspective, it should have been a substantial object of focus. If we can intervene preventatively, providing parental support, and helping them avoid outcomes of traumatic events—this would be impactful primary prevention. So much of what we do in medicine is catching illnesses like high blood pressure or high blood sugar after the pathology is already present. The ACE study offers primary prevention in childhood, but also secondary prevention in adulthood. This is one of the reasons why I shifted from primary care into trauma therapy, curious as to whether I could modify these outcomes through secondary prevention.

Awareness of this study changed everything for me. I knew it would take years of academic study to learn how to mitigate the effects of ACEs. The risks were high professionally, because physicians are supposed to fit in a tiny box: Checklists. Prescriptions. Standardised guidelines. It was not long before the community health centre told me that they had hired me as a family doctor, not a psychologist, even though our mental health workers are only mandated to see people for a maximum of six visits and had not trained in any trauma processing therapeutic tools. Soon, my own patients were benefiting so much that other family physicians were referring their cases to me when there was a history of trauma. Yet, the administration could not see the importance of this, especially for communities that could not afford upwards of $200 for an hour therapy sessions. But I had found my calling.

As Nicolescu writes (2010) about defining transdisciplinarity, objectivism inherently turns subject into object. As the experimental object of concern, in this autoethnographic thesis, I will be using a distinct tool of knowledge translation—the video format found on TikTok—to demonstrate a multi-perspective interpretation of the object. TikTok provides me with a platform and leverage points but also communication strategies that deliver understanding and meaning at different levels—information, emotion, metaphor, humor, and empathy are all available through seconds of film. They are inherently provocative and evocative.

The following interludes are ethnographic methods that will centre myself as both object as well as observer. These represent discussions that may happen at a subconscious level within the parts of my own mind. Each ‘inner therapist’ takes the point of view of one branch of psychotherapeutic analysis.

DEVELOPMENTAL: In my therapeutic lexicon, developmental therapy represents the NeuroAffective Relational Model (NARM). While there is historical philosophy about childhood attachment, from Freud (1895) to Bowlby (1969), I find a practical utility to the NARM model. The premise is that children develop both a desire for, and a simultaneous fear of, various human needs along a chronological trajectory (from connection to attunement to trust to autonomy to intimacy). In disidentifying with stuck emotions and uncovering agency interventions, the adult can find insights and resolution (Heller & Kammer 2022).

PARTS: My use of the language of 'parts' refers primarily to modern-day Internal Family Systems or IFS (Anderson et al. 2017, Schwarz & Sweezy 2020). In IFS, one would imagine younger versions of each person that is stuck at the time of a traumatic event with the more primitive responses and ideas at that time. Such parts (or Exiles) can be integrated by Self, or adult consciousness, through self-compassion and reassurance that their needs can be met within the system. Historically, parts may have been addressed using an empty chair in Gestalt models (Perls 1951) where one might speak to a part explicitly. Carl Jung (1934) also used a similar verbiage in his work with inner archetypes, but I have not studied Jungian philosophy to a great extent.

COGNITIVE: I explain this on TikTok as the 'top-down approach' where the brain is used to change the mind-body system. The most commonly employed methodology is Cognitive Behavior Therapy or CBT, whose premise is that there are fundamental flaws in thinking which results in actions that are undesirable. The therapist helps to reframe thought patters so that behaviors will also change. Within this category is also Acceptance and Commitment Therapy or ACT, which I prefer as it is less shame-based and focuses on values (Harris 2019).

SOMATIC: This is the 'bottom-up approach' where the body is used to change the mind-body system, a strategy particularly useful when trauma is preverbal, ancestral, or otherwise inaccessible to the conscious mind (Ogden et al. 2006, van der Kolk 2014) or when an incident causes physical harm (Scaer 2014). It may entail psychosensory modalities such as Emotional Freedom Techniques (Church & Craig 2013, Ortner 2013), Havening (Ruden 2011, Pickens 2017), or Tremoring (Berceli 2008)–easy movements, all of which are detailed in my book (Gibson 2023). It may be more formal manualized work such as Sensorimotor Psychotherapy (Ogden & Fisher 2015) or Somatic Experiencing (Levine 1999). This work is often predicated on the polyvagal theory, a neurobiological explanation for fight, flight, and freeze states (Porges 2011, Porges & Dana 2018, Porges 2021, Dana 2021, Porges 2022). While this theory has some backlash due to lack of correlation with dorsal vagus nerve mechanisms and phylogenic origins, the clinical application of this theory is a much better understanding of traumatic response than anything I have found in the DSM-V (Diagnostic and Statistical Manual is the main textbook for psychiatry).

NARRATIVE: Stories are a powerful means to transmit information, to share history, and to transform our perspectives. Formal narrative therapy shifts dominant plots and creates alternative meaning (Morgan 2000, Denborough 2008). We consider the road map of one's life, the history that came before us (Wolynn 2017), and the pluripotential possibility of our future. I am less inclined to follow the more academic path of narrative medicine (Charon 2006, Charon et al. 2017), as this practice seems to be more about the practitioner's perspective than the patient.

PSYCHEDELIC: Researched extensively sixty years ago (Hall 2022), banned due to its association with Vietnam War protestors and the racist 'war on drugs' (Earp 2021), and reinstated along with an enthusiastic resurgence in positive studies for trauma (Mitchell 2022) and addiction (Zafar et al. 2023). Feeling called to learn how to facilitate a psychedelic journey (Bourzat 2019), I undertook guide training through the Polaris Institute, Fluence, and Synthesis. Psychedelics have the potential to decrease activity within our 'default mode network,' (Gattuso et al. 2023, Soares et al. 2023) brain regions connected to our self of self (Lanius et al. 2020).

Interlude 1

The Therapists Respond

Transcript

Medicine as Trauma

>>See Clip 1<<

Developmental therapist: You see right away, how she takes this burden on single-handedly. She feels personally responsible for fixing childhood trauma of her patient panel, eventually consulting to the other physicians on her team. Even knowing this is a drop in the ocean, she strives to fix the problem. This so clearly relates to her survival strategy of connection. As Dr. Heller describes in the neuroaffective relational model, "individuals with the Connection Survival Style have retreated into frozen and dissociated states," (Heller 2012, p. 203). She wants to be the person that's the most important in their lives, to fix the root cause of their problems.

Parts therapist: Yes, you can see her firefighters are used to trying to put out the flames. The hospital was so busy, pagers were constantly going off, that she had to find a congruent state of her nervous system, even while in community. Delving into trauma made that part of her satisfied.

Somatic therapist: You could hear the desperate cries of her nervous system as it ignores the signals from her body. It's not just interoception, regular messaging, but neuroception of danger (Porges 2009, Dana 2018). She's trained her physiology to ignore these threatening signals, coming from within and externally. It's almost like disconnecting from her human self and becoming a robotic being. When she was in community, doing longitudinal practice, a different way of approaching it was necessary. She had to be embodied in the moment.

Cognitive therapist: She had to change her behaviours. Learn to slow down. And because this was so unfamiliar, she decided to basically take on full-time school to learn how to be a trauma therapist while working full-time as a primary care physician. This was the lack of peace she was used to. She didn't consider how unnatural and unhealthy this was. Her behaviours were locked in, just like the earlier time while trying to get into medicine. The pace of the race became so familiar. Even when she understood how unhealthy it was and innately knew the consequences if she continued on this path.

Narrative therapist: Angus and Greenberg (2011 p. 25) describe *autobiographical reasoning* as how a person develops their narrative schema to make meaning of their lives. It's very puzzling, the story that she tells herself about who a physician is. Did she learn that they are superheroes? Superhuman? Why would she have this expectation of herself? Is she trying to create a legacy? Somehow in these people's lives, or in her own lived experience, that might transcend the natural world.

Parts therapist: This is a part of her that really wants to be good enough. And it's so clear that it will never be enough, no matter how many hours she works, or how many lives she saves. Even this panic to address the root cause, knowing how insufficient her efforts would be. She's lacking her integral Self contributing with clarity of thought, curiosity of her strategies, confidence on her path, courage to be different and to stop looking for external validation. (Schwartz & Sweezy 2020).

While my job as a physician was traumatic, both emotionally dealing with vicarious pain and physically dealing with 100+ hour work-weeks, my awareness of this fact was elusive until I was forced to examine my relationship with trauma.

My first encounter with an explicit traumatic event happened after a natural disaster while volunteering overseas. As Dr. Judith Herman describes in the seminal text *Trauma and Recovery*, "traumatic events… overwhelm the normal human adaptations," (Herman 1992, p. 33). In 2015, I was working in the

Kathmandu valley of Nepal. I had been running Global Familymed Foundation for a number of years and was participating in academic consulting for the medical school at the Patan Academy of Health Sciences. Nepali doctors work six days a week, with Sundays being their only day of rest. But this particular Saturday was a festival day with a lot of outdoor parades. A real blessing.

I was in my apartment in an ancient district of Patan city when I noticed a faint rumble. Soon, dishes were tossing themselves off the wooden shelf. Even my ten-litre water jug flung itself to the floor. As I ran down the stairs, the tiles seemed to have turned into liquid, each footfall surfing a slate wave. When I made it to the front door, it was jammed in its frame. I was able to yank it free only to find that the courtyard in front of the apartment complex was filled with a landslide of bricks from the neighbouring buildings. Coughing from dust, I could hear booms as other nearby structures collapsed. I closed the door, fear pounding in my temples. I crawled underneath what appeared to be a sturdy table and hung onto its legs as it bounced, ignoring the bruises quickly forming on my knees against the slate. It all settled in under a minute, while it felt like hours.

Waiting to be evacuated, I survived over thirty more earthquakes in the apartment—with huge cracks running down at walls. I gave my first TEDx talk about this experience, feeling like I should have been more useful than I was. The hospital was prepared for this natural disaster, as severe earthquakes happened regularly in Nepal. Trained government-sanctioned professionals were digging victims out of the rubble, and I did not have a way to transport food from the grocery store to the communities huddled under tarps. What was my purpose?

Interlude 2

The Therapists Respond

Transcript

Evacuation

>>See CLIP 2<<

Narrative therapist: You can see how she's trying to tell the story of what happened in a way that creates a visceral sensory experience for the reader. It's important for her to feel heard and validated.

Somatic therapist: I agree with that visceral component, but she goes straight into a rational explanation about how she's feeling. There's no centring in the body. I wonder if she dissociated (Scaer 2014). For academics, it's often easier to intellectualise experience rather than deal with the raw emotions.

Developmental therapist: Rescuing is a common survival strategy for people who are more people pleasing. Heller and Kammer (2022 p.71) describe it as "responding with what they think is expected of them" to avoid "feel[ing] abandoned, invaded, or crushed." It would make sense that she would want to be a fixer and try to create solutions. This is related to the core wounding around connection and autonomy. When her control was taken away, she quickly tried to find the elements of the situation where she had some control.

Parts therapist: Of course, there's a part of her that would want to be seen as the hero. She comes from a colonial mindset. But she must have been quite terrified, this was after all a near-death experience. So there's a part of her that just wants to be rescued. I don't feel like she's fully acknowledging that part.

Cognitive therapist: I think it's a healthy reframe, trying to find out how to be useful in the situation. Rather than going into freeze-mode and pretending she's a victim when ten thousand people died in the disaster.

Somatic therapist: She might not have gone into freeze-mode because the fight-or-flight sympathetic tone is more familiar to her. We always gravitate towards congruence. Perhaps it would have been a reasonable time to pause and take stock of what had just happened.

Developmental therapist: She did call her parents and ask them to calm her down. So she did seek out connection and intimacy in the moment of near-death. It's possible that they gave her enough reassurance that she felt it was resolved.

Cognitive therapist: She was able to return to Nepal for two years and even stay in the same apartment. If she had significant trauma, surely the symptoms would have come to pass during her return visits.

Parts therapist: Perhaps, but she was a stoic kid whose coping mechanism was always to ignore her own internal suffering. It's possible she got good enough at that so she could bypass the true emotions, and just focus on the tasks at hand.

Narrative therapist: That would make sense based on the story. She does tend to intellectualise and rely on rationalism for her recovery. In all the news interviews that she did at the time, she was poised and articulate. Did she suppress these emotions? What's the story that she tells herself about the event?

Shadow: The story? It's obvious, it sits in the collective unconscious about her survival while so many perished.

Narrative therapist: Who's THAT?

Cognitive therapist: Oh, that's psychedelics–ignore them, they're not legal yet.

One of the first emails I got after evacuation was from my friend Zahra, a fellow physician. To this day, she has never shared why she sent it to me. It was a TEDx talk of Dr. Lissa Rankin, now a friend and collaborator. In the talk, she described her growing unease with Western medicine, how it failed to harness the power of the placebo effect and understand the context in which symptoms take place. Less than a year later, I gathered with seventy other jaded and burned-out female physicians as Lissa described new ways of being.

The earthquake shook me physically and existentially. I have had a strange sense of being connected to universal flow ever since.

Arriving into Singapore, I found myself wondering if I had PTSD; I continued to feel shaking at an intracellular level. It would wake me from slumber. It would produce a tremor of fear, to the point that I asked Google whether the island was built on a fault line.

What I did not understand then, was that my curiosity and newly-lived experience would take me down a new path. I had always been enrolled in some kind of schooling, but this event has shaped much of what I have studied in the intervening years.

After going on the retreat with Lissa, a small group of six continued on as a Mastermind, a peer network designed to support and invigorate each other. A fascinating aspect of Lissa's course is how many of the participants leave their job or otherwise transform professionally. Within my Mastermind, I think all but one of us has now shifted positions. I started off looking for an academic position within the family medicine department, but realised I was not keen on the primary research this would entail. In 2016, I approached the CEO of a local community health centre. I had been running a residency program in health equity, and I had an understanding about holistic health from my own explorations since the earthquake. Because the universe seems to send me strong signals when I am on track, this health centre had just been granted a half million dollars to put towards early cancer prevention. When I described during one of our early meetings how our bodies are meant to heal metaplasia through intrinsic cancer-detecting immunity cells, which turn off while we are stressed and driven by our sympathetic nervous system, it was an easy connection to make for the leadership team. I pitched programming to

reduce stress and thereby help innate immunity fight cancer. This grant gave us two years of programming.

Working at this CHC opened my eyes to the impact of trauma on one's health. If I had not already experienced my own existential crisis in Nepal, I may not have been open to seeing it as clearly. Most of my patients had extensive childhood trauma; many of them also faced relational and event trauma as adults. What I quickly realised was that I needed to learn more in order to adequately care for this community.

I dove into the work of Dr. Gabor Maté, a fellow physician who has endorsed my book. His book that influenced me the most is his understanding of addiction, *In the Realm of Hungry Ghosts* (Maté 2008). At the community health centre, many of my patients coped using substances and behavioural addiction patterns. Those of us without any understanding of how this was an effective survival strategy believed that they could be released from its grip through motivational interviewing. Not understanding that the addiction was a symptom of the underlying trauma. Gabor's books *When the Body Says No* (Maté 2011) and *The Myth of Normal* (Maté 2022) describe how autoimmune and cancer illnesses increase when the body does not live a life that is authentic and congruent with values. He talks about people-pleasing and suppressing anger. While I am not convinced that personality dictates the exact disease, the disconnection of the mind-body system was a critical factor in making the link towards stress reduction and trauma processing to improve overall health.

Gabor has been a mentor since I completed his Compassionate Inquiry training in 2018. I approached him after the third day's session and mentioned that I was a fellow physician in Canada, also keen to address trauma. He responded to an email and we began a casual correspondence. When I partook in the residency program at The Banff Centre a couple of months later, I asked him if he would be a part of my mentorship team. He acquiesced and I phoned him each week to touch base during the program. He asked me, on numerous occasions, why I felt that I was somebody to do systems work—particularly examining my motivations. His questions were uncomfortably probing: "When in your childhood do you think that you felt that you had to rescue people?" and "This sense of urgency points to your need for external validation and a sense of not feeling good enough. Can you recall where these feelings first started?" I had not expected to be psychoanalysed during my mentorship—especially when I discovered that he has never been certified in any trauma therapy himself. It was disconcerting. But also helpful. Gabor had promised that two stories would make it into his most recent book *The Myth of Normal* (Maté 2022) —my childhood educational struggles and also the social innovation lab (spoiler… neither did). I wrote a short play of these talks—I asked my local Indigenous mentor Don McIntyre to re-enact it with me on stage. In the production, I vulnerably took off layers of my clothing as I spoke about my need for

external validation, until I was on stage in a tank-top and jeans, with a flimsy pink paper heart pinned to my chest. I felt like Gabor had catalysed peeling of the onion. And I felt more ready to be open-hearted than ever before.

It was not long after that Aishwarya Khanduja, a young person in my life who has become like a daughter, convinced me to join TikTok. I watched YouTube videos for a week or two so that I could see how people create their short videos. After my launch, I had two videos go semi-viral. Within six months, I had a massive following of 60,000 people and a video with over a million views. Three years later, the followers reached over 130,000 and the engaged community I have discovered there is incredible. I have faced surprisingly little backlash from the medical profession; many of them also foster an online presence including some prominent leaders within the Canadian Medical Association.

When I pitched my book, through my agent, to publishing houses, this platform was the selling feature. I was given a moderate advance for a new author. I was fortunate that my agent, Sam Hiyate from The Rights Factory, was more concerned with my happiness than his cut of the advance—I turned down a much larger offer with a publishing house that did not feel as aligned. He negotiated a reasonable deal with a reputable international publisher and *The Modern Trauma Toolkit* (Gibson 2023) was green-lighted.

Writing this book was one of the single greatest sources of pleasure in my life. The extensive research and training I had undergone in the field of trauma found a home; its purpose was to share a toolkit of skills that could be personalised. The resulting book was practical, generous, and inclusive—I hired beta-readers who were women of color (one was trans) so that they could help me establish safety. The publisher's in-house talent taught me how to read an audiobook and I was able to record it at their New York City studios six blocks from Times Square and across from the iconic Radio City Music Hall. Early feedback was reassuring, in that the writing felt nurturing and accessible, while delivering important information and clear instructions for skill-building. This should be a legacy project and, while it is early days from its launch, I remain hopeful that word-of-mouth will continue to grow.

When I think about how much trauma has changed my life, both the paths I have chosen as well as the meaningful work I have found—it is remarkable. The thought reminds me of *kintsugi* pottery, a ceramic that is mended with gold resin. All the more valuable for having been broken.

Interlude 3
The Therapists Respond

Transcript

Urgency

>>See CLIP 3<<

Cognitive therapist: Well, I'll take the lead and state right-out that acceptance and commitment therapy, with its connection to values, is a good frame for this issue. She feels a sense of urgency because her values are under threat. Equity, the environment, health systems.

Developmental therapist: Of course, that's a piece of it, but we also have to understand it from the perspective of her childhood wounds. She strives for affection through perfection, hoping that if she learns just enough and becomes interesting enough that this will gain love and intimacy. She has had numerous careers - from hospital to community to therapy, from global health to residency director to academic, from entrepreneur to founder to philanthropist. Who is she impressing?

Parts therapist: It makes sense that a part of her is stuck at the age where she was bullied so heavily. This injured Exile (Anderson et al. 2017) might be feeling like she just wanted kids to like her, an experience that definitely has made a lasting impact. She seems to be constantly striving for expertise. Will it even translate into likeability?

Somatic therapist: All of this urgency leaves her very much stuck in the fight-or-flight stress response between work and all of this extracurricular study, she's not taking enough time to rest.

Psychedelic therapist: (snorts)

Narrative therapist: She finds emotional processing and recovery through artistic expression. She's been writing poetry since she was a child. And of course there is that unfinished book.

Cognitive therapist: That issue about unfinished, how prevalent is that? Does she need some motivational interviewing to be able to help her through these obstacles?

>>See CLIP 4<<

Developmental therapist: I'm not sure this is a cognitive issue. It might have more to do with interpersonal relationships and self esteem.

Cognitive therapist: I've got worksheets for that too. DBT! ACT! CBT!

Somatic therapist: The last thing she needs is more worksheets. That just keeps her in the intellectual brain (van der Kolk 2014, Stanley 2016). The sense of urgency might be a direct response to her overactive nervous system; those familiar patterns make more sense when you're constantly running.

Parts therapist: It's very interesting that when Gabor psychoanalysed her, something she does all the time, she got her back up about it. Did he hit a sore spot? She always says that she wants to handle things in a different way, but the people who seem to bother her the most are the ones doing the things that she dislikes the most about her own self. She has so much shame around these exiled parts.

Narrative therapist: It almost makes you wonder if the entire exercise, Doctorate included, has to do with her own relationship with shame. If she can only achieve so many things that it might dissipate.

Psychedelic therapist: I've got some medicine for that. Every time she explores a psychedelic journey, it's like two or three years of therapy. The depth of her shame has certainly shifted. She's learning to be a closer approximation of who she chooses to be (Gentry 2016).

Somatic therapist: So why is she still running?

The ability to see the self across time is *autonoetic consciousness* (Pace 2012). While the intention of becoming a trauma therapist was not to self-heal, there has been an inevitable opportunity for self-reflection and processing. I have been working for the past few years with a cognitive therapist, a somatic and psychedelic practitioner, and an innovation coach. It is no mistake that personal growth ensues from leaning into the healing arts. For practising therapists, "self-care is not an indulgence or afterthought but rather as essential to their physical and mental health, and to their ability to engage constructively with their clients," (Ford & Courtois ed 2009, p.195).

Ancestral patterns of epigenetic trauma will transmit until they are processed (Wolynn 2016, Nakazawa 2015). For us to be cycle-breakers, it takes a determination to dive into these patterns and forge new ones until they are no longer stuck. Looking at my biography from fractals of the individual body, the

family body, and the community body helps me understand the locations where trauma can be positioned (Haines 2019).

While I do not self-identify with having trapped trauma responses any longer, I do believe that most of us have experienced complex trauma. Trauma is baked into the systems where we live and work, into our families and communities, but more importantly—in our histories. By exploring what has motivated and catalysed my journey has examined the privilege of my social position but also the forced transformations created by traumatic events. There is ongoing professional bullying, an episode in 2022 while in Malta when the old-guard of addiction medicine physicians accosted me at the reception. One got his cane a little too close, accusing me of promoting therapies without sufficient evidence, while they continue to recommend ones that are no longer commonly used by practicing clinicians. It is factually true that prolonged exposure therapy is considered a gold-standard (Rauch 2012), the ongoing replay of triggering content can be emotionally exhausting (Hembree 2003). The other commonly-touted treatment is Cognitive Behavior Therapy (CBT), but I find its premise to be that there is something wrong with the patient's thought process and more modern therapies (IFS and NARM are examples) would argue that their thinking makes sense and is adaptive. Patients have mixed experiences with it and the research is actually not convincing (Leichsenring 2017).

Therapy is also becoming more acceptable (Law 2022, O'Connell-Domenech 2023). People are more willing to open up about their struggles, including physicians (Harvey 2021), yet stigma and trust remain issues (Jilani 2022). Self-compassion is a step towards healing (Licata 2020, Neff 2023), even when cure is not possible (Remen 2006). When we heal ourselves, we heal the collective (Hübl 2020).

There have been many transitions at the crossroads of my professional and personal life that have influenced the direction that I took my career. Many of these have been traumatic. From the dissolution of the cooperative and losing significant friendships to the study of global inequity and the resulting understanding of the deranged systems where I am complicit.

As I consider the navigational threads within my career, it is essential here to mention my concept of post-traumatic growth. I will use an illustration from my book (Gibson 2023), which I commissioned based on a metaphor that speaks to me.

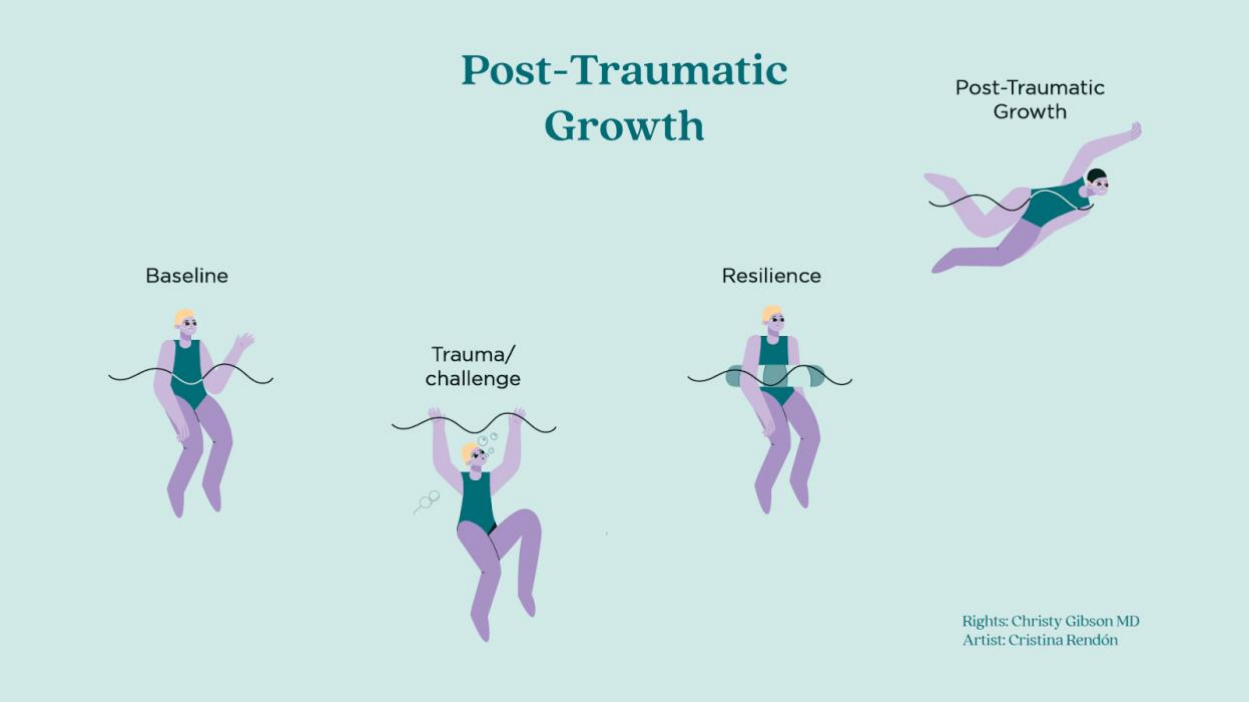

Figure 3. Post-traumatic Growth © Gibson 2023

When a person, whether they are a professional or otherwise, is floating through life, they do not have to think too much about their direction. They just float. Sometimes a challenge will disrupt their reverie, and they might feel like they are drowning underwater, gasping for air, and truly struggling. If they do manage to float again, they are often exhausted. They may need the assistance of flotation devices and other artificial means to maintain this position. This position would be a return to the status quo, and this is the definition of resiliency.

What I am far more interested in is post-traumatic growth. *What would it take to learn how to swim?* Many people are forced to, by the onslaught of waves. Others are taught by mentors and ancestors. Still others never achieve this ability. Resilience is a learnable skill and post-traumatic growth can evolve because of the challenges we face (Johnstone 2019).

I hope that these reflections have provided some evidence of my swimming ability. I wish to learn new strokes, gain strength, and have a purposeful destination.

Writing a book and doing my best to get it into people's hands was a way to create more systems-level change than one-to-one therapy is able to provide, or even regional community work. It may also have been an ego-based endeavour. While this is plausible, I felt that I was in my highest consciousness during the writing.

Of course, that might have been related to microdosing? Without getting into details, to maintain my professional license as this is not a legal practice, I learned that one's creative spark can be catalysed in this manner and chose to experiment (Asprey 2018).

Synthesis

A key element in scientific research is hypothesis testing. Through social constructionist theory, this can be interpreted in an understanding that truth is relative (Gergen 2004). The premises within scientific advancements are constantly changing. The term *epigenetics* (how trauma changes the genetic code permanently) had not even been coined when I studied at medical school. The study on adverse childhood experiences by Vincent Felitti (1998) had not yet been conducted. These two theories have completely changed my practice but have not yet deeply penetrated the established academia of medical education. I remain committed to promoting healing these responses as a means towards neuroplasticity, autonomic nervous system regulation, and the hope that epigenetic changes can pass not only trauma but also post-traumatic growth.

In bringing in the wisdom from the previous chapters, the social constructs related to health paradigms are not universal. They are also constrained to a timestamp and geopolitical climate. Mental illness, among many other diseases, looks very different in every country. Working at the refugee clinic, I see many patients whose somatic symptoms are related to their mental health complaints. I see abdominal pain or headaches or a panic about vaginal discharge more than I would see an actual panic attack. Somnolence and low energy would be seen as a medical concern rather than a possible depression. In many countries in sub-Saharan and North Africa, mental illness is seen as an energetic hex placed by a vengeful neighbour or relative. I remember having to work with a spirit *djin* for a woman from Iraq, who believed that she was possessed. When we consider that mental health, like all medicine, has any truth to its science, "it is simple to presume, without reflection, that mental illness is real, that unusual behaviour is a symptom of mental illness, that pharmaceuticals are curative, and so on. If we understand all these concepts as socially constructed, then new options are opened," (Gergen 2004, p.175).

In the book *Mental Health, Race, and Culture*; Suman Fernando describes how western psychology is merely one way of conceiving of the mind (Fernando 2010). While I live in the dominant culture, it may be misleading me in how to best approach mental health. The epistemology of mental health in my current timeline may change drastically—as demonstrated by awareness of epigenetic influences and rejuvenated psychedelic research (which seems to have transcended the back loop of the adaptive cycle). There is also a movement towards 'liberation psychology,' which emphasizes inclusion,

responsibility, and re-orienting towards a just future (Watkins & Shulman 2008). I look forward to staying curious and emergent when these paradigms shift. Having built a relatively large toolkit for professional intervention, my hope is to be useful during the transitions that are likely during my lifetime.

Part of the journey I have travelled related to trauma has to do with figuring out my own mental state, for my personal growth. Another part relates to the strong knowledge that this field is in flux. If we have more understanding of the fact of our individual and collective trauma and potential for post-traumatic growth, we will be ready to face the times that come with the climate emergency and other systemic challenges. The reason that I study both systems theory and trauma is so that I will be prepared for the shifting tides. Russell et al. (2008) claimed that environmental imperatives have driven the academic focus on transdisciplinary studies.

In the final chapter, I will examine the impact of my portfolio of work to date and speculate on the possible contributions in the second half of my career. Acknowledging that this work is global in scope, premised on my biases and limited experience which includes personal and professional trauma, and that leveraging opportunities for systems-change is within my influence.

Transition Poem Five: Reflection

I am a moving reflection
Shattered mirror
The ego loves such attention
Oh, the destruction of Narcissis
drowning in awareness

Lying on the grey beach
shuddering with cold
palms and knees embedded with gritty sand
Each wave swallows the evidence
of the effort and sacrifice
to get to the shore

Building a scrappy foundation
finding community and sustenance
Learning about brave new worlds
then creating them together

The knowing field
smirks or smiles
opens the door to universal consciousness.
Systems, so profound
they are virtually unknowable.

The grandmothers call
They understand healing potions
We are the witches
ushering in the storm.

Can you feel the wind?

Chapter Six: Themes and Schemes

In this final chapter, continuing to build on both an analytic and evocative framework of autoethnography, I will take a macro-level perspective on my past and future journey. Having explored the context from where I began my career, taken a critical look at recent activities, evaluated my agency interventions and purpose—there is now a chance to be self-reflective about the entirety of my life's work. This is the search for coherence, for reconciliation with self and the external variables that influence or respond to my human experience.

Like the Buddhist parable of blind men describing an elephant by looking at its component parts (with the expected subsequent disagreement), we need to now consolidate these fragmented examinations into a coherent whole. Rather than assuming any one of these subjective perspectives holds relative truths, I will take a more holistic lens to look at these outputs. Where have I been, where am I now, what possible directions could I go…

It is transdisciplinary practitioners who are best suited to enter uncharted or ambiguous spaces, according to McWhinnie (2021), which leaves me feeling like the possible paths forward are of an almost overwhelming number. The act of completing this Doctorate had as one hopeful outcome: of assisting me to determine my specific skills and bring my purpose into clearer consciousness.

Along this path, I also hope that I have proven to have satisfied Anderson's (2006) criteria for autoethnograpic reflection. Whether I have satisfied the criteria for evocative autoethnography is entirely subjective; the reader would need to explore within themselves whether any emotional connection or pathos resulted from their perusal of my expressive skills. Whereas for analytic autoethnography, I must return to five distinct criteria as laid out in Chapter 2:

Complete Member Research Status: As this work ultimately has my own self at its core, then I must inherently be immersed in the world under study. Being both active participant and introspective observer was exactly the purpose of this undertaking.

Analytic Reflexivity: This involves the "reciprocal influence between ethnographers and their setting" (Anderson 2006), which is an embodied understanding throughout this writing but particularly in the first and final chapters. I made this overt in describing my biography, the social context of the moment where my public works were achieved, and the internal and external influences on my path. I examined all manners of personal influence, from mentorship to bullying. It was especially apparent in my examination

of the effects that both developmental and event trauma had on my career choices. *Reflexivity* entails acknowledging one's role within the research. This dual role was part of the process within my writing but also within my role as therapist and subject; moving between that of observer and participant. Being aware of the social context and cultural understandings of my generation and region naturally shifts my own perceptions.

Narrative Visibility of the Researcher's **Self**: As a visible narrator, all writing is done in first-person omnipotent perspective. Beyond simply outlining experiences, a deep dive into intention, purpose, and motivation was sought. Being a retrospective analysis, I am relying on my current understanding and insight while attempting to recall accurately the way that I might have moved towards creation of my public works. An indicator that I understood this assignment was that I described this process as "academic naval gazing" when I was asked about my Doctoral writing, while Anderson (2006) suggests to avoid self-absorbed digression. It was necessary to engage in self-reflection to this extent in order to reasonably ascertain whether my public works made an impact and the construct in which they took place.

Dialogue with Informants Beyond the Self: This is likely the weakest aspect of my analysis, as there is a lack of interaction with others while examining my own works. In Anderson's (2006) recommendation, this dialogue can be with either "data or others," which was not a dominant characteristic of this Doctorate. That being said, I did reach beyond the self-experience when I examined the works using specific lenses, in referencing opinions of scholars and professional peers, and in my discourse with supervisors. Likewise, in critiquing one's own works, it is less primary research and more of a transtemporal and transcontextual dialoguing with established and novel ideas. This process is fundamental to the establishment of new insights.

Commitment to Theoretical Analysis: My commitment is evidenced by my desire to use this information gleaned within self-reflection to change broader social phenomenon. In undertaking this writing, my goal was to provide a pathway for others to follow in decolonizing global health and forming an anti-oppressive approach to knowledge translation. This was not a biography or memoir, but a scholarly appraisal of public works through multiple, defined lenses. The intention is to carve my own possible paths, but also to provide a map others may follow. From this work has emerged a process of *concepting* a precursor to theory. All theory is a social construct, limited to the geographic and time-based boundaries when it is conceived, changed with new experiences. By concepting, I have formed new ideas and theories by diving into informal practice and daring to envision with a new lens, to form new insights and understandings.

While modern theory uses the framework of ‘what / so what / now what,’ of Rolfe’s reflective practice model (Rolfe 2001), I was able to trace the origins of this in Action Research where specific questions are posed (Lewin 1946):

1. What is the present situation?
2. What are the dangers?
3. What shall we do?

Both of these frameworks are useful explorations. I will frame the headers using Rolfe’s inquiries but incorporate Lewin’s original posits. In investigating the shadows within myself and my artefacts, this observing process makes it less likely that I will recreate these shadows to the same extent in future endeavors.

The ‘What?’ Question: Thematic analysis

While my portfolios reflect a diverse body of work and the manner in which I investigated them was distinct, there were emergent themes.

Justice

Much as the capitalist modern world has brought comfort and ease to some, so-called progress of so-called civilization has been on the backs of others. The global majority, in fact.

Spiral Dynamics (Beck & Cowan 1996) insists that humanity has a ‘master code’ which follows a path towards a ‘noble purpose’ and ‘transcendent growth.’ It posits to be a theory of social evolution, described by *Figure 4* below. Our human potential for compassion and interdependence is within our nature. The overall health of all life is paramount at the top of the pyramidal schema.

Figure 4. © Ben Levi (date unknown)

While I struggle with this model—in that they presuppose the colonial construct that many African and Indigenous nations are in the bottom tiers while I might argue they are closer to the top—there is some merit in the search for equity. A recognition that humans are not separate from nature, but part of the natural cycles. Interestingly, the necessary cooperative actions are those seen within tribes. So perhaps a better image would be a circle—a more familiar one in Indigenous narratives (Shiva 2019, Yunkaporta 2019). Complex phenomena do not resonate with orderly categories.

Similar to the work of Maslow (1943) and the subsequent modeling into a pyramid the hierarchy of human needs, it is an oversimplification. In the case of Maslow, these states were influenced by his field work with the Blackfoot First Nations tribe in Treaty 7 territories, now called Alberta in Canada (Feigenbaum 2020). He was determined to research the sociological theory of dominance, which he did not encounter during his six weeks with the Siksika band; instead, he formulated his theories on self-actualisation which was more individualistic than the community-focused pedagogy of Indigenous ways of being (Ravilochan 2021). His wildly popular theory misinterpreted the teachings because his epistemology could not account for communal objectives. Part of my intentionality in this process is to unlearn the individualistic concepts that drive the 'hustle culture' and external validation in modernity.

In his essay *Culture, Nature, Environment* (2000), Ingold describes how each of us has a construction of reality that provides divergent interpretations of our experiences. His ontology is more attuned with Indigenous wisdom; he presupposes that the organism within its environment is an indivisible system. This is why it was key to examine not only my portfolios of artefacts but also the internal and external

environments intrinsic to their existence. While I do not attempt to get overly entangled in the narrative of shame, I can see that my individualistic desires are not as aligned with the holistic purpose of the entire organism (ecosystem) where I dwell.

Justice can only be achieved when the bulk of human activity transcends the lower tiers. Conditions for change are ripe, in that we collectively must find new solutions to the challenges that are fatal. We collectively face extinction—not some media-produced nuclear threat, but a tangible, visible (if we are watching) danger. Beyond the ego of self-actualisation lies an opportunity for a greater engagement with our interconnectedness. Becoming stuck in ego-states and individual achievement can contribute guilt and shame.

The Practical Approach to Spiral Dynamics (Beck et al. 2018) demonstrates how we all operate under different frameworks. The construct of Western society in this geopolitical time is that of a false democracy—while we are free to vote for our government leadership, we are all caught in the web of complicity and lobbying (Farmer 2004, Klein 2015). We all must find a path forward to earn a living in industrial society while participating in activities that harm other beings and our planet (Bendell & Read 2021, Wray 2022).

Is it no wonder we learn to dissociate?

When I reflect on my upbringing and the exposures I have encountered, it makes sense that I have a passion to work towards equity. Both of my ancestral lineage streams, from Ukraine and Scotland, underwent a cultural genocide (the former a literal one during this writing in 2022-23). The women in my family had unfulfilled potential. Some likely were shunned for their unique points of view and abilities.

My work in global health, creation of a health equity residency, and clinical trauma aimed at communities placed at risk have all been overt examples of this theme. I cannot imagine any work that brings me purpose without a focus on justice.

Trauma

When I examine the direction of my public works and professional career, there have been distinct external traumatic events that have shaped my path. Likewise, my own resolution towards self-regulation has allowed me to become more pluripotential and aware of my mission.

From the earthquake in Nepal to the dissolution of many programmes of my creation, trauma is a catalyst for personal and career transformation. An understanding of the adaptive cycle helps reframe this as an emergent property rather than a problematic outcome.

In self-reflecting about my artefacts, it appears that the release and reorganisation phases of systems can create inherent trauma in both participants and those affected (beyond a single industry, into our shared ecosystem). In gaining skills for navigating systems change and social innovation, a background in trauma—interventions at both the individual and community level—became necessary to learn.

Education

My obsession with learning, indeed the sizable amount of training experiences on my CV, represents a concrete manifestation of my curiosity. Both of the worst events related to personal trauma—bullying in school and work—took place in academic environments. Yet these circumstances led to my desire to learn more about the human condition. To truly root into the way to turn “What’s wrong with you” into “What happened to you,” (Kidd 2017, Winfrey & Perry 2021). Both for enhancing self-compassion and also for focusing on acts of service.

It has been such a blessing for me that learning about trauma has allowed me to be more gentle with myself and others. To be more free to take a mindful observing stance to how others' behaviour is complex and often confusing.

When I studied social innovation and systems entrepreneurship, I finally had a model where I could envision being a more effective change-agent. The small projects that have come to fruition are a fraction of what I hope to accomplish. As I undergo more educational mindset shifts, I also embody a deep practical sense that I will never be satiated. There is always more to know. My thirst is unquenchable.

Factors that contribute to transdisciplinary individuals are divided into four key categories (Augsburg 2014).

Transdisciplinary Skills and Traits: I am hopeful that this analysis has proven I possess specific skills and traits such as mutuality and networking, openness to novel perspectives, a strong societal consciousness, and an ability to think through complexity (I will hold off on claiming false modesty).

Intellectual Risk Takers and Institutional Transgressors: Augsburg describes such people “adopt a humble attitude towards the immensity of knowledge,” (Augsburg 2014, p.240). I continuously am

amazed at how much there is left to know once I have studied one area (this week, I signed up to certify in Lifestyle Medicine). My personality is designed for action-oriented planning for issue-driven causes. One phrase she uses is “co-producer of hybrid knowledge” and this is key for my future directive, as I have not sufficiently co-produced enough of my current artefacts in a meaningful way.

Transdisciplinary Practices and Virtues: I thrive on abandoning my foundational discipline (medicine) to interact with its complementary and alternative adjacent possibilities. What she mentions that I did not relate to is a pain in transgressing from one’s comfort zones; to me, this is deeply comforting as I do not believe that any one discipline has successfully solved complex challenges.

Creative Inquiry and Cultural Relativism: Regarding this category, her descriptors seemed a good match of my key characteristics (inquiry-based, integrative, creative and complex thinking, cultural relativism, going beyond established ways of thinking).

Bruce et al (2004) describe the qualities of transdisciplinary researchers as including willingness to learn from other disciplines, flexibility, adaptability, open mind, creativity, good communication and listening skills, a capacity to absorb information, and teamwork. These are the same competencies to be successful throughout the adaptive cycle. Ones that I am continuing to hone include adaptability and better communication. A trait that I excel at, as is evidenced throughout the exploration of my works, is that of translating across disciplines. The quest for learning is key.

Innovation

Embodying lifelong learning has led me to social innovation, where more possibilities for downstream intervention exist. A main driver of burnout is hopelessness, so this shift has reinvigorated my recent momentum. When I reflect on my work in creating a residency program and a portfolio evaluative process, in starting a global non-profit, and in believing that I could make a difference in ‘wicked problems,’ (Rittel & Webber 1973) —there is an intrinsic drive to make a difference at the systems-level.

I believe that, because I have the ability to take both a micro and macro approach to problems, I can leverage my social position along with my transdisciplinary skills in order to affect change. There are few physicians who have ventured as completely into social media as I have, yet this platform on TikTok of >130,000 followers (as of July 2023) has allowed me into spaces where I might otherwise have struggled to get my foot in the door. My publisher confessed as much, stating outright that my large advance for the book deal was predicated on my ability to reach many people with my own marketing strategy. While

it might have seemed like a lucky break to some, I have designed these efforts with intention. There are so many hours in our short days, yet I deliberately and methodologically choose where to focus.

Systems, in health and related fields, seem determined to fight the natural adaptive cycle of release and are hanging desperately onto the status quo, despite clear evidence of unsustainability. Medication shortages (Lin et al. 2022). Staffing resignations (Poon et al. 2022). Health care systems collapse appears imminent in the UK (Edwards 2023), the US (Glatter et al. 2023), and globally (The Economist 2023). There has never been a better time to be a positive deviant (Sternin 2002).

While I have explored leadership in the context of non-profit work, in 2023 I have launched my first corporation: Safer Spaces Training Global Inc. This is a new phase in my confidence, and hopefully competence, in systems entrepreneurship.

The 'So What?' Question: Personal and Professional Transformation

While it was clear that medicine itself would allow for some innovation—within professional parameters—my career has transcended that of a traditional physician. I have also been blessed to have considerable mentorship from those whose careers also verge on the non-traditional and touch on the transdisciplinary: from Jennifer Hatfield to Bob Woolard in academics to Meg Wheatley and Frances Westley in systems design to Gabor Maté and Eric Gentry in trauma studies. I have sought out training and relationships that will allow me to foster emergence in systems.

As stated by Meg, systems cannot be understood by simple analysis of their component parts (Wheatley & Frieze 2006). In emergent strategies, we must *imagineer* the impossible and dream audaciously (brown 2017).

In *Transformative Innovation*, the steps for true transformation are described as encompassing ten steps (Leicester 2016) which I will analyse from the context of my current state:

Balanced innovation brings along the traditional cultures while introducing novel iterations. A lot of what I have managed to do has been outside the 'ivory towers' of academia. What would be more impactful would be to find a better balance between stewarding the old ways while prodding towards new paths. Part of this balance must be between power and love (Kahane 2010).

Hopeful innovation acknowledges the unease that underlies the need for innovation. I do think that my leadership style is amenable to being more inspirational and intend to use my existing (and emerging)

platforms to leverage hope. This is one reason why my book's design is solutions-focused and intended to foster post-traumatic growth and self-efficacy.

Innovation with a **long-term perspective** accounts for the most likely possible futures. My sense is that I am tapped into the knowing field around what might transpire and am setting the stage to participate in these (likely challenging) outcomes. It is my hope to incorporate more future-oriented perspectives, so that any value might stretch beyond my own lifetime. This would be a decolonising methodology; many Indigenous communities look seven generations into the future when making a decision (Kimmerer 2013).

Processes that are based in **learning** with **small** experiments have the potential to bring great change, like small rodents gnawing at the rotting foundation will eventually topple the edifice. When I consider the times that I attempted to make a leap, towards a cooperative organisational model or major changes in process at a health centre, it was quickly snuffed out. Time will tell whether smaller iterations, like the pilot programs of Safer Spaces Training, might be more successful.

Focusing on the complex **reality** that we face is essential. I believe that I have done this to a greater extent than many of my peers. Those in medicine deny that the system is dysfunctional, harming both providers and patients. We deny our own trauma. The general public seems more comfortable with dissociative tendencies–ignoring climate, conservative rhetoric, and the powerful elite agenda. If we see this for what it is, or at least could be, we will be more prepared for a future with less comfort than what we have recently enjoyed–the signal of heading in this direction is the lowered life expectancy already noted globally (Schöley, 2022). The Lancet names our ongoing threats as 'the three C's' of COVID-19, climate change, and conflict but also warns of antimicrobial resistance, inverted population pyramids, eroding sexual rights for women, food insecurity, and fraying multilateralism (Kanem et al, 2023).

Stepping **out of a formal role** and **bringing my full self** to meet future challenges is, as yet, aspirational. There is still the valid risk of speaking my mind to powers that could fire me from clinical roles. And, if I am honest, there is the intrinsic fear of being seen as different, as 'other.' While these last two years of self-reflection have helped gain clarity on my skills and resources (internal and external), it has also demonstrated the failures and shadows that continue to cause some measure of uncertainty—in my own confidence and in acknowledging my complicity.

Attempting **not to cause harm** while well-intentioned is a contentious issue within my profession (medical error is the third leading cause of death in the USA, as per Makary and Daniel *BMJ* 2016) and certainly within my own artefacts. Ironically, I did not take the Hippocratic Oath after medical school as the

ceremony interfered with my plans to spend two months in Costa Rica. But, more seriously, examining the shadows in my artefacts has been an essential component of this time of transition as my hope is to move forward with less blind complacence of how things are done and the imposed boundaries on action. Likewise, creating in community will be of greatest benefit (Hacker 2013).

Operating from abundance rather than **scarcity frameworks** is something I grapple with—it is, after all, the presumption of abundance and limitless resources that has created a lot of the mess we face. But the idea that hidden resources may emerge is one that I welcome. It is difficult work to face alone. If there is one main takeaway message from the systems constellation session, it is that this needs to be done in community.

If the work can be done holistically, there will inherently be more **integrity and coherence**. This is a concept that I studied in TheoryU with Otto Scharmer (2009), and then at The Banff Centre's social innovation residency. The idea of being more authentic in my own approach and in consistent alignment with my own values is appealing.

Resisting the ease of the status quo is not something I would imagine appeals to me anymore, as I cannot unsee the harms that it does and the risk we take without significant, conscious innovation away from these paradigms.

The International Futures Forum describes *Three Horizons*: the present timeline, a transition, and a long-term future (Leicester 2016).

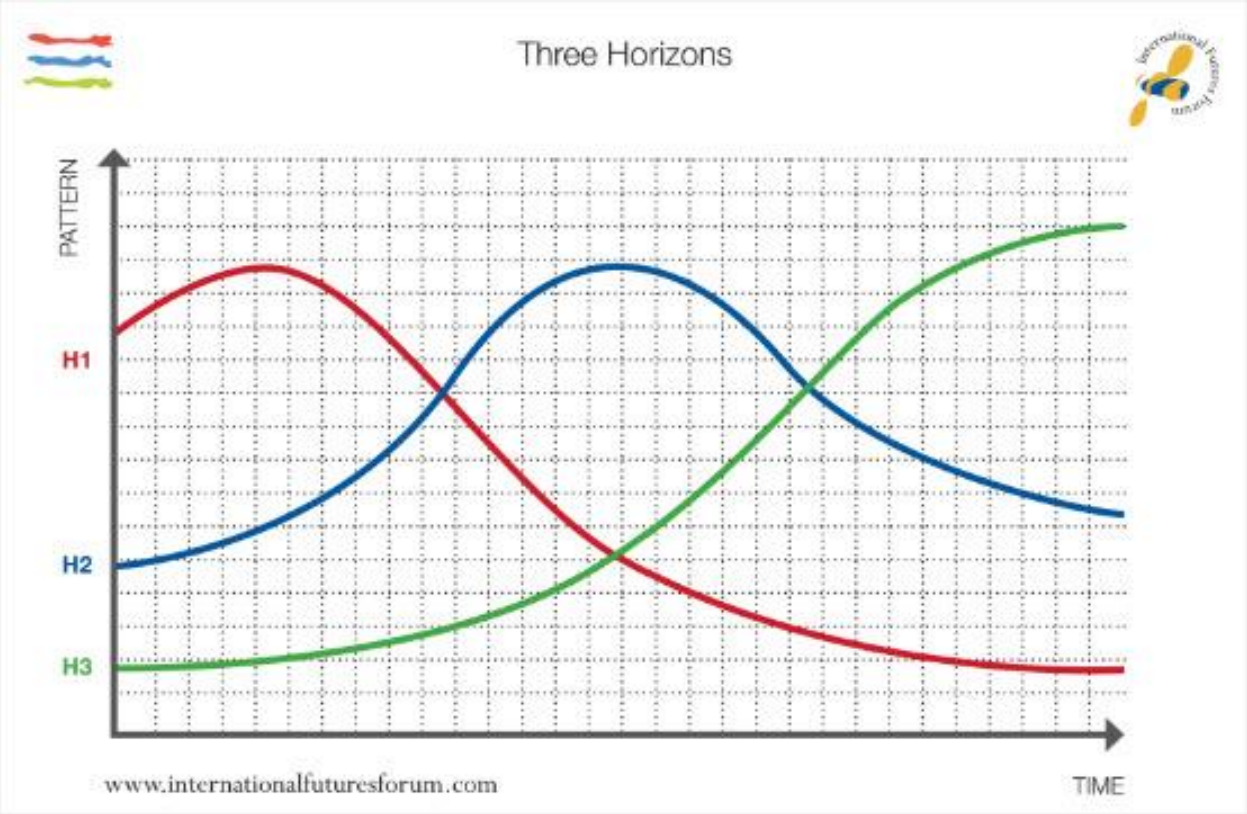

Figure 5. Three Horizons © Leicester 2016

Our current predicaments—unstable global health, unsafe global politics, and treacherous global climate—have forced our timeline into a place of transition. Much as humans have evolved urbanisation, civilisation, and industrialisation; we are entering a new era. Some harken a dystopian Anthropocene (Lewis & Maslin 2015); others tell stories to help convey the urgency (Macy 2007, Ghosh 2016, Robinson 2020).

We all experience the dichotomous pull towards what was deemed comfort (for some, albeit vast inequity dominated). We all yearn for a future that guarantees a sense of stability.

Within this framework, the three horizons are 'always present' and fluctuating. My hope is that I have the courage to leap into a timeline of discovery and emergence. In assessing my position, I am able to work within the third horizon yet remain stuck within systems that are still in the first and second. There is no place for shame or a sense of failure if the work is not perfect (Shotwell 2016). For example, I can advocate for climate mitigation measures, eat a plant-based diet, and drive a solar-powered car while still enjoying traveling.

So much of what I have accomplished has been within the framework of potential—for my own as well as for the systems where I have influence. "Constructionism invites a certain humility about one's assumptions and ways of life, fosters curiosity about other perspectives and values, and opens the way

to replacing the contentious battles over who is right with the mutual probing for possibilities," (Gergen 2004, p.27). While I am firmly nestled in consensus reality, I do not believe that this limits what we can achieve. This has allowed me to have a vastly more creative career than most physicians and find ways to influence systems in novel ways.

Have I made progress? I presume that technological investments and rampant worsening of inequity has led to the downfall of this civilization, what we have considered progress was a social construct. It's very likely that my generation will have experienced the peak comforts of humanity. Places where they can live off self-sustaining gardens, grey water supply trapping, and innovative simple technologies may fare better in the coming decades. So, I may be a cog in the wheel of a system that is stuck in a muddy back-road.

When I have presumed progress within any of my global partnerships towards the western medicine paradigm, this may not be to their benefit at all; such progress is measured through the lens of colonialism and an assumption on my part that our models are better. What if there comes a time where our knowledge of local herbs is more important than an encyclopedic knowledge of pharmacopeia? What if there comes a time where we have such a different understanding of the autonomic nervous system, which I suspect through my studies over the last five years, that our medical paradigms in the western world are deemed suboptimal? Who will we reach out to in reforming our understanding of the human mind-body-spirit connection? Especially in our environment that classifies such a fundamental understanding as backwards. It would be beyond irony and cause further harm to believe that our Indigenous communities will help us reconnect in these ways after the genocide perpetrated by most countries and colonisers. This is one reason that I am curious about my own Indigeneity—those ancestors that shaped my DNA through epigenetics (Lipton 2005, Bird 2007). Whose traumas and proclivities I have inherited.

The 'Now What?' Question: Systems Constellations

Following my curiosity, I consulted Diana Claire Douglas for a systems constellation session. She is a world-renowned expert, the author of *Whole Systems Design: inquiries in the knowing field* (2022), and the mother of my fellow Director for Safer Spaces Training.

The video and write-up, with a diagram of the process, are available in Appendix B, but I will provide a brief summary.

Diana asked me what question I had for the knowing field. I inquired as to my future path in leadership. She insightfully suggested that I use a process where a line is drawn in the field (a floor in my home marked in clock-fashion), where the more aware and higher consciousness lived in the top half. Over the course of an hour and a half, about twenty cards moved through the field. During the session, it became apparent that below the line was a representation of individualistic motivations. Above the line was the more collectivist and interconnected approach. Not only that, but above the line had transformative energy powered by females in my lineage, which showed up as 'grandmother energy.'

What was fascinating was how many different descriptors were laid in the field around both the desire to serve, and the fear of serving from separate motivations of self-awareness or selfishness. She asked me to spend extra time after the session to see how each of these felt. I believe this is one of the unconscious exercises pointing me towards my future goals, at least to understand my own intentions.

The desire to serve from awareness was deeply connected to the energy of the grandmothers. I experienced a sense, during the session, that there had been persecution on my lineage of the females on both sides in Ukraine and Scotland. That the innovators of these bygone times were often feared and loathed. I think this helps me understand how the bullying in my childhood and even in professional environments is an ancestral inheritance. People who are disrupters can be vilified for interrupting the status quo. People who are innovators can be looked upon as freaks and be deeply misunderstood. I certainly identify with these challenging perceptions.

What I came to understand is that, while not always comfortable, these positions are aligned with my destiny. As a transdisciplinary practitioner in a traditional field, I have been an outlier in many ways. In exploring Global Health, systems change, and psychotherapy—I am not on the traditional family physician career pathway.

What I believe in my heart is that system disruption is inevitable and accelerating. Between the climate emergency, food scarcity, global migration, and political polarisation—the times are changing. And fast. I believe that my particular skill-set around trauma and leadership will be a critical factor to our local resilience, if not a greater global impact. Certainly, I have been putting a lot of investment of time, energy, and financial resources towards positioning myself in a way that can best be of service. Service that comes from awareness, which I believe is rooted in a deep connection to the knowing field.

After surviving the earthquakes in Nepal in 2015, I began to feel that I had been instructed by the flow of the universe as to whether I was on the right path or not. I receive strong signals. I do not think this is an ego-driven presumption, because it has been so consistent and personal. What I have come to believe

is that these signals are available to all of us, but sometimes there needs to be a disruption in the way that we perceive and experience the world in order to connect to them. But in doing so, the opportunity for manifesting tremendous emergence becomes possible.

To shift from the methodology that I have created with my early artefacts and to follow the signals from this field, I need to be participating more in community-driven efforts and find collaborations that are a values and mission match. What will shift the culture, our subconscious attitudes, and our collective unconscious is for more of us to demonstrate new ways of being and knowing. I have read of emergent local movements that respond to complex challenges we will all face (Solnit 2010, Marya & Patel 2021). Within my network lies teachers of community-building efforts (Wheatley 2009, Block 2018) where one can build resilience to traumatic events (Watkins & Shulman 2008, Miller-Karas 2015, Lerch 2017). This capacity holds all four of the emergent themes from my existing works—justice, trauma, education, and innovation—while also taking much pressure off my shoulders. adrienne maree brown says, “The more people who co-create the future, the more people whose concerns will be addressed from the foundational level in this world,” (brown 2017). As I have uncovered more overtly, part of this process is an essential decolonisation (Johnson & Wilkinson 2020, Topa & Narvaez 2022) which is a journey without a destination. There are many people working on this struggle within economic systems (Raworth 2017, Giridharadas 2018, Trzeciak & Mazzarelli 2019). We need more people rethinking health and wellness systems (Montori 2017), what Monbiot calls the “politics of belonging,” (2017).

In 2023, I co-founded a new non-profit organisation, The Belong Foundation. The intention is to provide services similar to Safer Spaces Training, but the way to execute our yet-nebulous mission is still being formulated. Having experienced far too much release of the adaptive cycle (Chapter 4), I have been nervous to create a formal mission in case it creates an opportunity for internal tensions.

I need to conceive of the shadows of my own self within systems so as not to recreate these in the innovations. If my role is that of connector rather than knowledge expert, it takes pressure off me to continue to learn so many different subjects; my role is perhaps not simply transmitting knowledge but enabling the agency of others. Continuing to hone skills of transmitting accurate information, facilitating authentic and purposeful dialogue, and enabling the potential of those who are historically unheard (Nieto & Boyer 2010) will be part of this path.

One space I have had the fortune to encounter is the Gesturing Towards Decolonial Futures community, led by my friend Professor Vanessa Andreotti, author of the powerful book *Hospicing Modernity* (2021). Their work consists of experiments and cartographies that focus on Indigenous perspectives. They offered a course entitled: ‘Facing Human Wrongs: Climate Complexity and Social Accountability’ and I

participated in their first cohort in 2022. During a small-group session, they asked us to examine our work in the world with the following queries (published by Stein 2022), and I will re-examine some of these now:

To what extent are you reproducing what you critique? A critical purpose of inquiring into my motivations and perspectives through the lens of colonialism, trauma, and emergence was to shine a light into these shadows. At this half-way milestone in my career and life, it mattered to me to at least reflect on my complicity in the systems I hope to change. With global health, academic participation, and social innovation; I believe that I have been more intentional and produced less harm than average. I cannot prove this; it is more of a felt sense and hosting genuinely caring interactions with others. My differentiator is that I let myself love. There are definitely boundaries, but far less strict. I deeply love the planet and its people; this plays a role in how I show up.

Who are you accountable to? I am accountable to everyone with who I am in relationship, particularly patients, as I hold a position of power, but also these greater communities, because I hold influence and privilege. I am accountable to making this world a better place for my niece and nephew, not simply presuming that the next generation will clean up my mess. I am accountable to professional bodies, regulatory colleges, and institutional ethics. While this may sometimes feel limiting, these are important ways to maintain my integrity as I navigate complexity.

What would you like your work to move in the world? I love the word 'move' in this question, because it is far too easy to be complacent and go along with the status quo, especially when it benefits me. My hope is my work will move people: physically, psychologically, and spiritually. Allowing them a greater sense of agency over their response to stress. This will open more movement towards solving the wicked problems that we collectively face. I may see myself as a catalyst and wayfinder (Ingold 2000).

In what ways could this work be read as self-serving or self-congratulatory? It is important not to deny that my psyche is predisposed to search for external validation. Whether these are professional accolades, personal achievements, or greater recognition through legacy outputs. My only hope is that, because my intentions are to serve the greater good with my work, that there will be value to both individual and community. I see many so-called 'gurus' in the trauma space, which has made me reflect whether or not this is my goal. There appears to be considerable ego-driven infighting and people who do not embody the safety that they profess to understand. What motivates me is to show up in a nurturing and compassionate way, both for myself and others. To truly model how this shift could express itself. It is a work in progress.

What would you have to give up or let go of in order to go deeper? Some family members have argued that I have given up a traditional marriage and children to be so prolific in my work. While this was not the path that my life took, I do not see that I have given anything up. I have tremendous material comforts, fulfilling relationships, and many hedonistic pleasures. What I believe will have to be released is what I consider the peak luxury of human extraction from the planet. I ask myself daily how I am preparing for this. Personally, what I need to let go, is the urgency that I am responsible and the entitlement that I alone have the capacity. This work needs to be done in communities of practice, which is not something I am always adept at joining. My perfectionist tendencies find faults and shadows everywhere, not just within. Letting go of certainty and finding comfort in chaos will be tools to hone (Mindell 1990, Chodron 2008).

An influential book in my learning journey is *The Answer to How is Yes*, where a social architect might encourage all people to ask ideal questions related to values and live a life of purpose (Block 2001). It has encouraged me to continue to disrupt the capitalistic paradigm, to bring my deepest self to work on complex problems, and to choose accountability. One resonant concept related to the Doctoral process is that a place of profound meaning can be found at a crossroads–career transitions, forks in the road. I find myself deciding if next I will propose to my publisher two further books (the intersection of trauma and pain, then of trauma and addiction), a docuseries about systemic trauma to Netflix, or continue on a learning path. (I hope that the answer to these questions will be answered with *yes*). Meg Wheatley once proposed to me that I need to be more discerning, recognizing that perpetual growth is not even possible within my own system (Meadows 2008). Yet, as a transdisciplinary practitioner, I believe that I can learn, share, contribute, and co-create in an infinite possibility of ways. Time, energy, and the need for sleep limits me—but beyond that, all dreams are worth designing.

One facet that I plan to spend considerable energy on is the intersection of physical and mental health with the climate emergency—while I have joined advocacy groups and conducted a variety of interviews (print and media). Keen to catalyse dialogue around climate and mental health, I paid a consultant to assist in creating a second TEDx talk–yet to find its home. I believe that anyone looking closely at systems can comprehend there is nothing more imperative in these times. The climate emergency is a transdisciplinary problem, inherent to environmental science but essentially about relationships “climate change is… about human development, social justice, equity, and human rights,” (O’Brien 2010, p. 65). Russell et al. (2008) stated that transdisciplinary practice is needed to solve the environmental crisis, to engage community participation and capacity. In the book *Transformational Resilience*, the authors make it clear that “no response to the climate crisis will… succeed unless individuals and groups of all types around the globe understand how trauma and toxic stress affects their minds and bodies, and use skills to calm their emotions and thoughts, learn from, and find meaning, direction, and hope in adversity,” (Doppelt 2016, p.67). This demonstrates how the intersection of my skillsets—in global health, social

innovation, and trauma—could be a foundational confluence to my contributions during any future disruption.

Many people are working in transdisciplinary ways for the climate crisis; finding my tribe (as described by Godin [2008] as folks who share an interest and means of communication) was quick through the Canadian Association of Physicians for the Environment. This week, I have done two local news interviews on eco-anxiety related to our ongoing wildfire smog. There are countless books on ecoanxiety written by others in the field of psychology (Ed. Roszak et al. 1995, Davenport 2017, Kelsey 2021, Kennedy-Woodard & Kennedy-Williams 2022) but also environmental studies (Ray 2020, Wray 2022). Some have little hope and reinforce how we may steward the hospicing of our planet (Wheatley 2017, Ozarko 2018, McKibben 2019, Bendell & Read 2021) while others offer concrete solutions (Macy & Johnstone 2012, Canavan & Robinson 2014, Macy 2014, Morton 2016, Solnit 2016, Schmidt 2023). There are authors who specifically link the healing of trauma within to that in our ecosystem (Hollick & Connelly 2011) and others who link Indigenous wisdom to what is transpiring (Raygorodetsky 2017, de Oliveira 2021). I feel compelled to contribute to this space from a place of emergence, equity, and an embodied awareness of the trauma it causes in individuals and larger fractals of systems.

This dream of imagining whole health for planet and people is possible in community; I was interviewed on a podcast this year by another Canadian physician aiming to bring our humanity into re-envisioning healing service, recognizing we need to provide personalized and relational care (Mintzberg 2017). Also key to consider is that those with lived experience need to be at the forefront of transitions, leading the way beyond participation (Forester 1999, Kotter 2012). The more that I am able to separate my desire to serve from ego and selfishness into pure acts of service, the more I will be in alignment with this mission. Having tried self-organising systems with the Cooperative, I can more plainly see there must be a balance between this and bottom-up hierarchies (Meadows 2008). By leaning into my own complexity, by examining and designing complex systems—this seems to be the only potential to shift (or transcend) paradigms.

Much of my work is predicated on what has come before and will continue to be positioned in ways that others can add synergistically. This time of self-reflection and bringing the implicit into consciousness has helped me see that the way I have sought mentorship and found myself adjacent to thought leaders has paved a path towards the community I seek. If a transdisciplinary practitioner is one who “recognizes their own complexity, incoherence and potential to become,” (Gibbs & Beavis 2020, p.5) then I am hopeful to have proved my worthiness of this designation.

Transition Poem Six: Weaving

Bursting free
of constrictive boxes
but trying not to blow it up
messily

a mouse chewing through cereal

So we examine
our complicities
our complexities

a mouse in the labyrinth

Beginning with a bridge
uncovering the web
not of thin delicate silk
but of braids upon braids of rope

a mouse in the countryside

Finding others who are weaving
sharing a yarn
creating with strength
finding joy in it all

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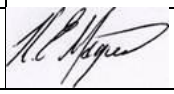
Appendix A: Ethics Form

Ethics Form for Doctor of Professional Studies by Public Works

	Questions required to be completed	YES	NO	NOT YET	N/A
1	Do you have written agreement to use co-authored/co-created/collaborative works for the purposes of a doctorate. Provide evidence			✖	
	Comment: I have not yet sought any agreements for co-authors of journal articles as I do not believe they would have any problem with my use of these articles for this purpose. I am comfortable with them reading my analysis herein and would share it with them if that was recommended. No other works were co-created in a significant way.				
2	Do you have testimony as to your role in those works. Provide evidence				✖
	Comment: Any co-authored works were submitted in journals where we attested to our role. Most of these works I was first author and wrote the body. Any of the works where I am first author were written as a first draft by myself and I have numerous drafts of each article available if required. Regarding my book and video artefacts, I also have many drafts available to view as well as notes of early versions.				
3.	Do you have written permission to use personal data that may identify a person you are including in your research. Provide evidence				✖
	Comment: I have written most of this in a manner that will keep people anonymous if their role was at all inflammatory. For those where I have outlined some behavior that was egregious, while I have rendered them mostly unidentifiable, this was something I had already expressed to them in person and would not be a surprise for them to be made aware of it here.				

4.	Do you have permission to use images to illustrate your work or images of contributors, participants in your works. Provide evidence	✖			
	Comment: I have used very few illustrations in this work, but all were from the public domain and attributed in the same way I would as if I were writing an academic article.				
5.	Will your critique disclose information that was confidential at the time the works were created (such as privileged access, professional / personal/relationship)		✖		
	Comment:				
6.	Have you named anyone in a way that be a risk to them or their organisations or their reputation		✖		
	Comment:				
7.	Have you named any organisation in a way that will bring their reputation into disrepute		✖		
	Comment:				
8.	To your knowledge have any of your works resulted in harm for individuals or organisations		✖		
	Comment:				
9.	Will your critique have the possibility of bringing harm to you due to changing geopolitical and social contexts			✖	
	Comment: There is a risk to myself in disclosing some of the more personal opinions around racism, misogyny, politics, and my background including MAiD participation. These are risks I am willing to assume.				
10.	Are there patents/publications pending related to your existing works		✖		
	Comment: none at present				
11.	Has your work been through Turnitin	✖			
	Comment: score was 15				

Your Name	**Your signature**	**Date**
Christine Gibson		September 7, 2023
Name of DoS		
Kate Maguire		September 10, 2023

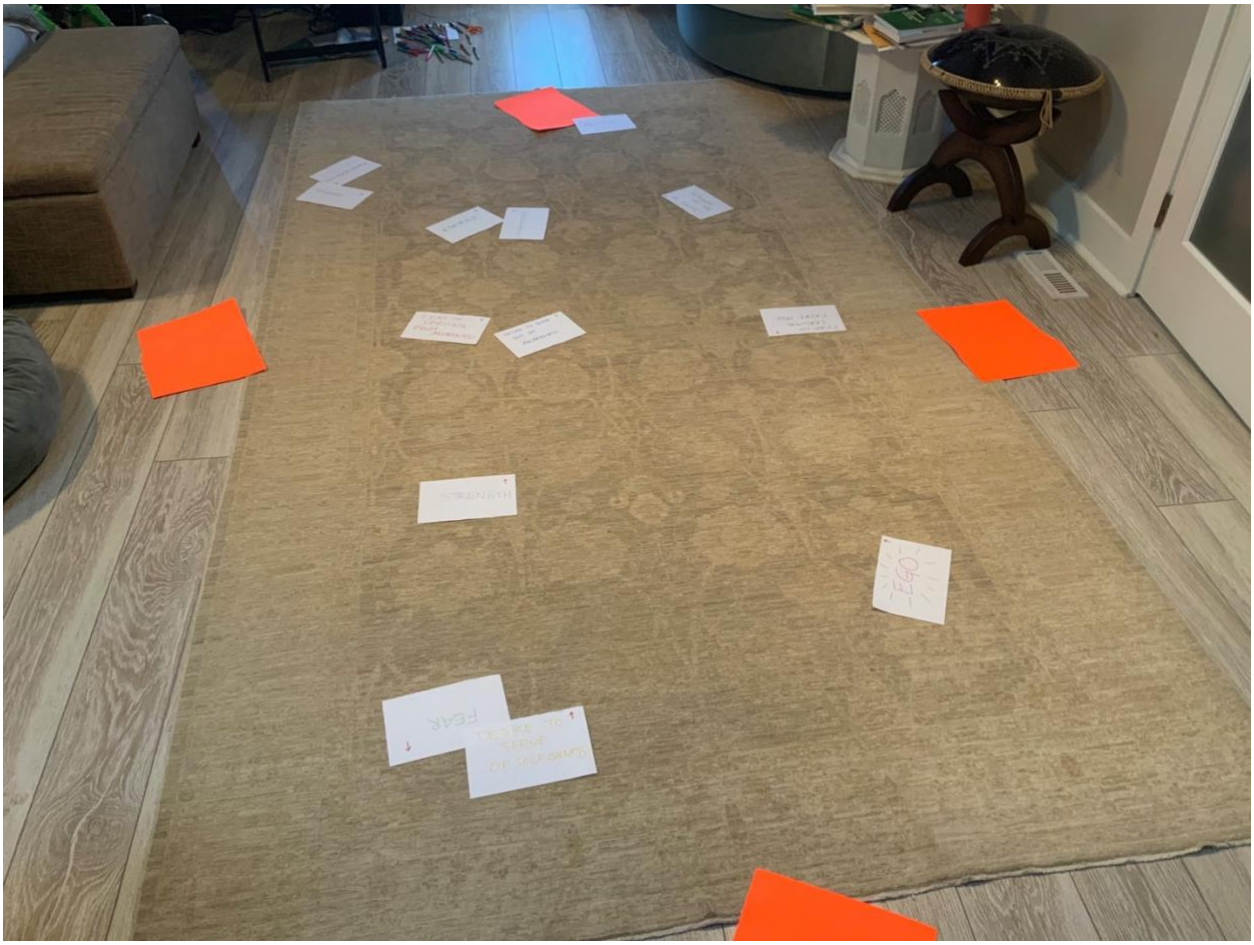
Appendix B: Constellation Consultation

Systems Constellation Work
With Diana Claire Douglas

Session April 4, 2023
For DProf

Full video available here

End of Session Image:



QUESTION
"What is my role in what's to come?"

Pre-session Discussion
Insights "the lifelong learners are the ones who see the changes happening"
"maximizing my human potential, being more than a physician"

Protocol from the Conscious Leadership Group – Jim Dethmer and Diana Chapman
"*Draw a line, we would work above the line and below the line.*

Below the line is when we are not in full consciousness, in victim / tyrant / rescuer / rebel. Above the line is wholeness, there's less fear and more love."
"We would look at what deeply drives you, we would see what is left below the line. Above the line would be closer to your future."
The plan is to see what my role is within future systems.
Above the line is various stages of consciousness until you're "one" in a place of interconnection.

Below the line – **Desire to serve from selfishness**
Above the line – **Desire to serve from awareness** became **Desire to be of service** so both were created
She suggested **Fear of serving from ego**
and **Fear of serving from awareness**

Both **Fears** ended up being on the dividing line
But the **Desire to be of service** felt like it had some shadows, "it's complicated" and was pointing downward towards the area below the line (has some selfishness)
Ego is not the bottom (lowest state)

Desire to serve of selfishness "is looking at" **Fear to serve from awareness** "so there's an awareness there"

Diana asks me to try to allow my cognitive mind to be less busy and to represent each square (stand on it). Check the physical body (strong / weak), take a position (lay, stand), direction of gaze (same or shifting), look for words or images… but not to give meaning to the position just yet. When stand on the marker, state "I am…" the marker…

Desire to be of service "seems to have an awareness of the whole field, it's a macro feeling. I feel very aware. I feel like I'm looking from above. Feeling in body is light, floating, hyperaware. I feel very tall here." It seemed tethered, a pull in the direction to both the **Fear of of Serving from Awareness** and also to **Desire to Serve out of Awareness**. Like a balloon with two strings holding it, but stronger towards the Fear.

She asked about family loyalty, anyone who would have been living this. "There's no one person but the word **Grandmothers** came up." She asked which line, it was not a particular person but generalized ancestors. I was not sure which lineage. It was placed next to **Desire to be of service**. "It's grandmother energy, the energy of older women in my lineage. It's the energy of elderly women."

Next, I stood on **Desire to serve out of Awareness**. "It's looking around, also has an awareness of the field. But it feels more grounded, it feels more low." I crouched to my knees "kind of like an owl if it was sitting in a tree, and pivot its head to look all around." I noticed this had a connection to the **Grandmother** energy. "It feels a bit constrained" It reminded me of the drum I'd drawn of an owl inside the trunk of a tree. "It's not that it wants to get out of the container but there is a container. There's a feeling of protection. Of groundedness and rootedness." She asked

again about ancestral connections. I had a sense of roots coming out of my back. It felt more like collective humanity than my own ancestors. “It’s like an interconnection into the network.”

Next, I stood on **Ego**. “Interestingly, it doesn’t mean something bad – selfishness – it means individual. I thought the line was selfishness. Now I see the line is a difference between individualism and collectivism. I had thought the line was going to be a division of selfish behaviors. This feels very lonely here. A little bit sad. Powerless, like a hollowed-out feeling, thin. Here I feel like an island; above the line feels like a web.” “I can see the individual people like dominos. Everyone has felt very individual. This is a familiar feeling on both sides [family].”

Is **Ego** connected to any elements of Service? It was connected to **Fear of Serving from Ego**. “This is dark energy. Selfish and icky and murky here. Like power-over instead of power-with. I feel power-with above the line. It can’t even see above the line from here. It only has downward energy.” The ancestral connection “It’s dad… well, maybe it’s more male energy. But my dad was a part of that.” “It’s about personal power, not elevating the collective. It’s for accolades and awards. I’m uncomfortable here. It’s prickly here. I don’t like it here.”

Then I stood on **Desire to serve out of Selfishness**. “This one feels very small.” I curled into a ball. “I feel like a seed that’s been planted. I don’t know why. This one doesn’t have a lot of awareness of the rest – it can’t see them, it seems far away. It can sense the **Ego**, but everything above the line feels very far. It doesn’t have a lot of insight. It feels small and simple.” When she asked about ancestral connection, “I want to tether it to the **Grandmothers**. The image that came up was – it’s a little seed and wants to jump into their apron. It has a desire for growth.” “As I said that, it’s changing a bit. I notice the desire to connect to others. There’s a sprouting now, like a spring seed, an early shoot or seedling.”

She asked if it was changing, the **Desire to serve out of Selfishness**. “It’s morphing towards the **Desire to be of Service**. The planting is making it want to grow there.” “The **Grandmothers** can plant this and turn it into the **Desire to be of Service**. It’s definitely transformed.”

I stood on **Fear from Serving from Awareness** next. “At **Ego**, I felt an island feeling. Here I feel like I’m on shore. There’s a line and this is the border.” When I said “I am,” I noticed “This feels scared.” She asked if there was any trauma. “OH, I just got a big download. The **Grandmothers** who served from awareness were punished for it. Really harshly.” “When you Serve from Awareness, the Ego wants to pull you down. There’s a real risk. The Grandmothers faced that risk. There’s a punishment. A risk of ‘them’ finding out and being punished.” This related to witch burnings. It felt like it happened on both sides. “This is trying to serve, but in a small way. It’s trying to contain its power, because it knows what happens.” “This is standing on the borderline between the possibility of violence and pain – then the possibility of enlightenment. There’s this scared feeling.” “it also wants to connect to Grandmothers.”

So **Fear from Serving from Awareness** moved towards the center, “if it moves here, it’s still connected to **Grandmother** energy but with more strength.”

I added the words **Strength** and **Fear** to the field.

But I stood on **Aware** which was at the top of the field. “This feels very powerful. The image of a sun came up right away, like a brightness. Light, openness, it’s very easy to breathe here.” I moved it from pointing sideways to pointing up. “This is the opposite of **Ego**. A strong sense of interconnectedness; we are all stardust.” “there’s a lot of energy. It’s not power, it’s energy.”

She asked me to turn towards 11 o’clock in the field. I wrote the word **Energy** and placed it next to **Aware**. It was looking at 11. She asked “Does it want to say something?” I noticed a sense of urgency. “**Aware** is the state. **Energy** is the movement, the behavior, the action. It wants to do something.” Diana asked “Can **Energy** see what’s happening there?” I noticed “That’s the **Transformation**. [*Wrote new card*] The **Energy** wants to move towards **Transformation**.” So I placed it near 11 o’clock.

Next, I stood on **Fear**. “My stomach totally dropped.” “I feel nauseated.” “this is really dark here. This is hopelessness. And the patterns of violence. And it’s connected to **Ego**.”

I stood on **Strength**, “just impervious. Just concrete, a sturdy foundation. Not a lot of emotions here. Just very solid.” “It seems to be supporting the energy above it.” I moved it closer to the line, “not at the line but supporting the line.”

Diana asked about ancestral connection here. “Yea, it’s bones.”

I stood on **Transformation**. “This is the dream. It’s up in the clouds.” “I’m seeing the internal working of a clock. Kind of that mechanical, a lot of movement here.” “It’s not pure, like there’s a connection to awareness, but not totally aware.” She asked about a connection to service. “It’s the centre – the **Desire to Serve out of Awareness**.”

I noticed a path from the centre through the **Grandmothers** towards **Transformation**. “It feels like a train with different destinations. If you’re on the train, it’s just going. But the **Grandmother** energy is powering the train. The word **Engine** is coming up.” This felt different from **Energy**. “This is like momentum. Which is funny because everyone always asks how I keep doing all these different things.”

Diana asked if anything else needed to shift before we close.

The **Desire to serve out of Selfishness** was rooted in **Fear**, so had to move under it. “It transformed using **Grandmother** energy but it belongs down here.” (closer to 6 o’clock)

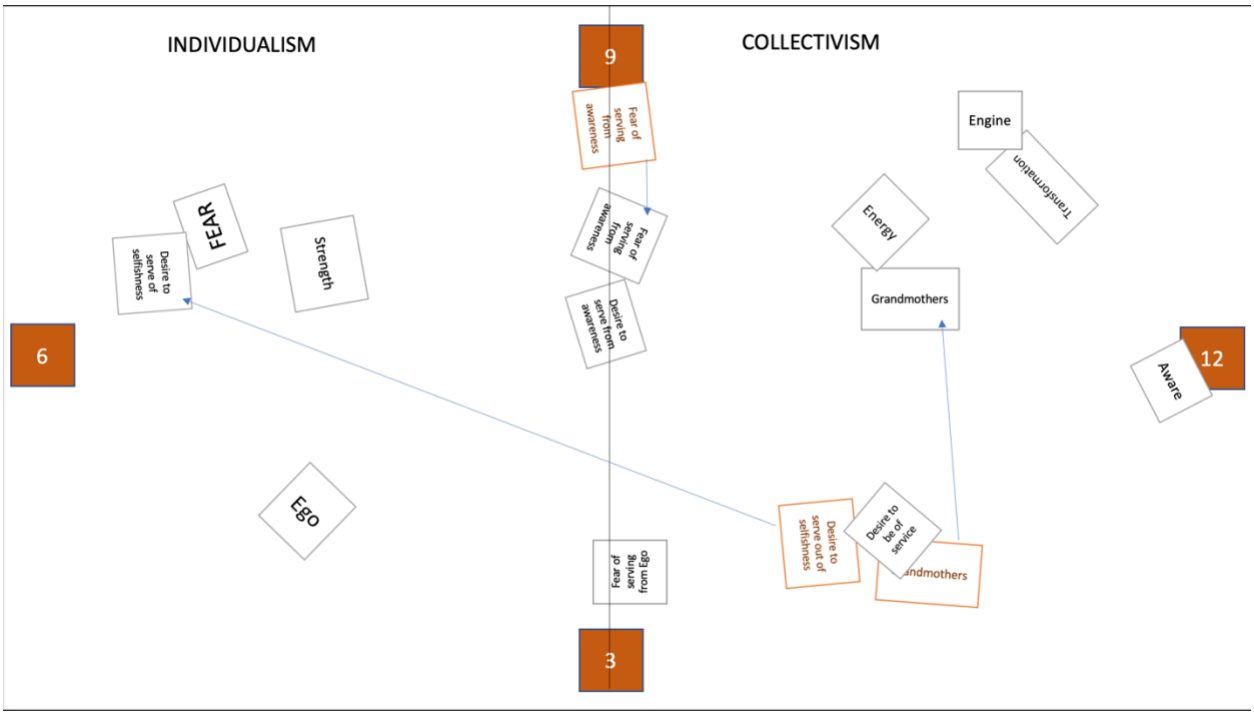
I asked her if I should stand on **Transformation** and find out what I learn. “Is that too much?” Diana asked if I’m told this, “Are you told you’re too much?” which I confirmed.

What would service look like from each of the different kinds of service? This would include the messages from Transformation. What does service look like when you’re polarized on Desire and Fear? When you’re in these different energies, how do you show up? And obviously, the Grandmothers have lots of gifts to give you.

I responded that I thought that my work in equity had something to do with their lessons.

She invited me to close the field – thanking the resources, the mother and father lines, the sacred teachings. Thank "the knowing field."

Movement of the Field:



Appendix C: Resume

(Word version available)

CHRISTINE GIBSON MD

W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
T | @tiktoktraumadoc

My career goal is to promote individual and community well-being through promotion of agency, connection, and nourishing of post-traumatic growth. Focusing on social innovation allows examination of complex challenges from a system-level perspective, in order to build adaptive resilience.

SUMMARY

Author, Tiktok Mental Health Influencer
Doctoral Candidate: DProf by Public Works
Social Innovation Certificate and Leadership
Masters in Medical Education
Engaging Facilitator and Speaker
Commitment to Lifelong Learning
Passionate about Inequity and Resilience
Community Development Work and Advocate
Advocate in Health Equity, both Local and Global

CAREER HIGHLIGHTS

TEDxYYC **speaker** in 2015, highlighting the importance of listening to community members, of curiosity and humility.

Founded and remains Executive Director for a Canadian non-profit Global Familymed Foundation in 2012, which supports medical education capacity building in low-income countries (Uganda, Nepal) and **founder** of The Healing Centred Cooperative, followed by Safer Spaces Training and The Belong Foundation

Promotes narratives through publishing of The Modern Trauma Toolkit, writing a historical fiction novel and poetry, through digital storytelling projects, and was podcast host of the Emergence series of Canadian Family Physician examining the global response to COVID-19.

EDUCATION

Doctoral in Professional Studies by Public Works
Middlesex University (candidate, commenced 2022)

Masters in Medical Education
University of Dundee (2010)

Diploma of Tropical Medicine and Hygiene
London School Hygiene and Tropical Medicine (2009)

Doctor of Medicine
University of Toronto (1999)

Bachelor of Science with Distinction
University of Alberta (1995)

PROFESSIONAL EXPERIENCE

CO-FOUNDER AND DIRECTOR — 2023 – PRESENT
Safer Spaces Training Global Inc / The Belong Foundation

- Runs workshops around trauma-informed spaces and belonging with a coordinated team of educators and psychologists
- Developing software for HR onboarding around psychological safety in workplace
- Aims to create standardized curriculum for self-regulating professionals

MENTAL HEALTH CONSULTANT — 2019 – PRESENT
Alberta Health Services, Calgary AB

- Collaborates with a variety of clinics: Mosaic refugee clinic, East Calgary FCC, RAAM Addictions clinic as a mental health consultant
- Uses integrated trauma-specific tools providing agency, somatic techniques, and root-cause healing of complex traumas

LOCUM FAMILY MEDICINE PHYSICIAN — 2015 – PRESENT
Mosaic Refugee Health Clinic, Calgary AB

- Working in interdisciplinary team, provide complex holistic care to refugees for first two years in Canada. Consultation services to those requiring enhanced mental health care.
- Using translation services, embodying cultural humility, and approaching all health needs with compassion and safety

ACADEMIC CONSULTING — 2013 – PRESENT
International Medical Education Institutes

- Worked with Patan Academy in Nepal to create internal evaluation processes
- Developed a plan for family medicine residency training in Myanmar
- Ran workshop in Gondar, Ethiopia on the contextual application of family medicine
- Built long-term relationships at Makerere, Uganda around supporting resident training including research supervision and leadership development
- Volunteered with University of Calgary Laos project for seven years, to build capacity for rural family medicine training

EXECUTIVE DIRCTOR AND FOUNDER — 2011 – PRESENT
Global Familymed Foundation

- Created and leads a local not-for-profit whose aim is to support the development of robust primary care overseas in underserved regions
- Runs a team of Directors, Volunteers, Advisors, and Consultants to focus on our core values (sustainability, relationships, education, and Family Medicine)
- Provides scholarships, facilities, and equipment to run programs in East Africa, Asia

CHRISTINE GIBSON MD

W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
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SUPPLEMENTARY EDUCATION

SOCIAL INNOVATION
Certificate in Social Innovation, **MRU** (2018)
"Getting to Maybe" Leadership Residency, Banff Centre for Arts and Creativity (2018)
IDEO U coursework in design thinking

LEADERSHIP
City of Calgary Climate Advisory Committee
Margaret Wheatley "Warrior for the Human Spirit"
Board Member, Mosaic PCN WONCA Working Parties on Education, on Mental Health, and on Indigenous / Minority Health Issues
CLIME – Canadian Leaders in Medical Education
Avenue Magazine "Top 40 Under 40" (2011)

FACILITATION
Integral Facilitation, Ten Directions
The Art of Hosting, Berkana Institute

TRAUMA STUDIES
Certified Clinical Trauma Professional – IATP
Certificate Program in Trauma Stress Studies
TRE – Tension Trauma Releasing Exercises
Sensorimotor Psychotherapy
ART – Advanced Accelerated Resolution Therapy
EFT, Havening, ACT, DBT, IFS, Guided Imagery courses
Compassionate Inquiry – Gabor Maté, Polyvagal Institute, Unyte SSP

ANTI-OPPRESSION
Roots Deeper than White, White Awake
Me and White Supremacy Workbook Layla F Saad
Indigenous Canada, UofA via Coursera

COMMUNITY DEVELOPMENT
Principles-focused Evaluation, Michael Quinn Paton
Tamarack Institute Workshops
Bridging Health and Community Conference

HOLISTIC MEDICINE
Qigong Group Leader
Mindfulness in Health Care, Mark Sherman
Ayurvedic Counsellor, Kerala Academy
Whole Health Institute Medicine Certified (Lissa Rankin)

NARRATIVES
Oral History for Social Change
Podcasting 101, Knight School of Journalism
Narrative Palliative Medicine, Rita Charon
Writing workshops, Alexandra Writers Centre

CLINICAL ASSISTANT PROFESSOR — 2001 – PRESENT
Cumming School of Medicine, University of Calgary

- Teaches small group learning including history taking, physical exam skills, global health and population health
- Was Evaluations Coordinator for Population Health course for five years, developed a community-based project and unique assessment process
- Cross-appointed to Departments of Family Medicine and of Psychiatry

FAMILY MEDICINE CLINICIAN — 2017 – 2021
The Alex Community Health Centre, Calgary AB

- Comprehensive clinical care for community members with complex health and social needs within interdisciplinary teams
- Applies trauma therapy for mental health needs of community

SOCIAL INNOVATION WELLNESS SPECIALIST — 2017 – 2019
The Alex Community Health Centre, Calgary AB

- Designed programs to mitigate aspects such as social isolation, maladaptive coping, lifestyle choices, and addiction using biopsychosocial lens
- Created a patient Advisory Council, where community members designed the logo and principles for our space
- Ran social innovation labs (Solutions Studio) to implement community solutions based on lived experiences as diverse as chronic pain, recovery, and disability

HOSPITALIST PHYSICIAN — 2001 – 2017
Peter Lougheed Centre, Calgary AB

- Clinical work in acute care setting, managing spectrum of adult care of complex multimorbid presentations with myriad of social challenges. MAiD provider.
- Developed a training manual for all Internal Medicine learning for Family Medicine residents, based on common presentations to our service
- Was site lead for Family Medicine resident teaching

PROGRAM DIRECTOR, GLOBAL HEALTH ENHANCED SKILLS — 2008 – 2014
Department of Family Medicine, University of Calgary

- Created a novel residency program to study health equity issues, including immigrant / refugee health, Indigenous health, inner city medicine, international work, and advocacy
- Developed a unique portfolio method for assessment that has been adapted locally and globally
- Graduates work in medical environments that are historically underserved

ASSOCIATE PROGRAM DIRECTOR — 2008 – 2009
Department of Family Medicine, University of Calgary

- Co-led a residency program for family medicine training, including serving as Evaluations Coordinator and resident selection
- Was faculty advisor for one third of the residency program

CHRISTINE GIBSON MD

W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
T | @tiktoktraumadoc

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PUBLICATIONS

OP-EDS:
Climate Response as Collective Dissociation (2021)
The Long Game on COVID (2021)
The Urgency of Masking (2020)
Parental Income for Child Health (2016)

Cubaka V, Dyck C, Dawe R, Alghalyini B, Whalen-Brown M, Cejas G, and Gibson C. A Global Picture of Family Medicine: view from a Storybooth. *BMC Family Practice* 20:129 (2019)

Gibson C. The Solutions Studio: A physician-run social innovation lab. *Social Innovations Journal*. 50 (2018)

Gibson C, Hull, A and Chandratilaki M. Use of Portfolios for Assessment of Global Health Residents: Qualitative Evaluation of Design and Implementation. *CMEJ*. 9:2. 2018.

Arya N, Gibson C, Ponka D, Haq C, Hansel S, Dahlman B, Rouleau K, and Ponka D. Family medicine around the world: overview by region. *Can Fam Phys.* 2017. 63(6):436-41.

Larson P, Chege P, Dahlman B, Gibson C et al. Current Status of Family Medicine Faculty Development in sub-Saharan Africa. *Fam Med*. 2017. 49(3): 193-202.

Gibson C, Woollard B, Kapoor V, and Ponka D. Narratives in Family Medicine: A Global Perspective. *Can Fam Phys*. 2017. 63(2): 121-127.

Gibson C, Arya N, Ponka D, Rouleau K, and Woollard B. Approaching a Global Definition of Family Medicine. *Can Fam Phys*. 2016. 62(11): 891 – 896.

Gibson C, Ladak F, Shrestha A, Yadav B, Thu K, and Aye T. Use of WONCA Global Standards to Evaluate Family Medicine Post-Graduate Education in Nepal and Myanmar. *Educ for Prim Care*. 2016. 27(5): 351-357.

Gibson C. Educational tool for hospital-based training in family medicine. *Can Fam Phys*. 2014. 60(10): 946 – 948.

PRESENTATIONS

"Trauma Informed: what happens when your own body is the source", Eunoia Women's Mental Health keynote, Banff Centre	2023
"Path to Post-Traumatic Growth", Tackling Trauma Conference keynote, Saskatoon	2022
"Somatic Therapy in the Treatment of Trauma Underlying Addiction", International Society of Addiction Medicine, Malta	2022
"Global Inequity related to the COVID-19 Pandemic" World Health Network (on YouTube)	2021
"Migration on a Changing Planet" Office of Sustainability, University of Calgary	2020
"Global Health Partnerships" WONCA Africa; Kampala, Uganda	2019
Global Health: The Shadow Side" CCGHR UNIVERSITY OF CALGARY STUDENT CHAPTER	2019
"Assess adaptability: a qualitative assessment of residents using portfolios" POSTER, FAMILY MEDICINE FORUM, TORONTO	2018
"The Besrour Storybooth: Narrative competence towards social accountability" WONCA GLOBAL CONFERENCE; SEOUL, KOREA	2018
"Social innovation lab towards community engagement in primary care" TUFH SUMMIT, LIMERICK, IRELAND	2018
"Evaluating WONCA standards for post-graduate family medicine programs in Nepal and Myanmar" POSTER, FAMILY MEDICINE FORUM, MONTREAL	2017
"Trauma-informed care in the context of MAiD" CANADIAN ASSOCIATION OF MAID PROVIDERS, OTTAWA	2017
"Harvesting and Healing: narratives towards social accountability" TUFH SUMMIT, HAMMAMET, TUNISIA	2017
"The WONCA Storybooth" WONCA GLOBAL CONFERENCE; RIO DE JANEIRO, BRAZIL	2016
"Family Medicine: coordinated care, comprehensive care, patient-centred care" MEDICINE FACULTY OF UNIVERSITY OF GONDAR	2016
"Compassion and resilience" INNER CITY HEALTH SYMPOSIUM, UNIVERSITY OF CALGARY	2016
"From hero to humility" TEDXYYC, CALGARY AB	2015
"A balance in global health and primary care" PECHA KUCHA NIGHT YYC #21	2015
"Narratives in Family Medicine" BESROUR CENTRE, FAMILY MEDICINE FORUM, QUEBEC CITY	2014
"Updates in Family Medicine" and "Research techniques" EAST AFRICA FAMILY MEDICINE INITIATIVE; NAIROBI, KENYA	2014

CHRISTINE GIBSON MD

W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
T | @tiktoktraumadoc

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PODCAST GUEST

- The SprawL - with Jeremy Klaszus (released 2020)
- Women of Alberta Poli - on sDOH (released 2021)
- Lessons to My Younger Self - with Sam East (released 2022)
- Make Some Noise - with Andrea Owen (released 2022)
- Culture and Leadership - with Marie Gervais (released 2022)
- Mood Ring - with Anna Borges (released)
- Sujin Lee on Facebook Live 2022
- Canadians with Disabilities and their allies on Twitter Live (released audio 2022)
- Interview with Lawrence Yang - on YouTube
- Unhinged and Dysregulated - with R Renee (recorded 2023)
- Just Mental - with Kendal Russell (released)
- Voices of Women Physicians - with Dr. Tatyana Reznik (recorded 2023)
- National Arts Centre Ottawa - with Dr. Jillian Horton (on Facebook live February 2023)
- Interviewed on KevinMD podcast about my article (released June 2023)
- Diet Culture is BS - With Trina Dorrah (released)
- The Other Human in the Room - with Joan Chan MD (released)
- Labyrinth - Amanda Knox
- Close the Chapter - with Kristen D. Boice released
- Becoming Trauma-Informed - with Lee Cordell released
- Habits on Purpose - with Kristi Angevine released
- It's not Just You - with Kara Popper
- Arash's World - with Arash released
- The Spoonie Podcast - with Emily Fraser
- Beyond Well - with Sheila Hamilton

SUPPLEMENTARY EDUCATION

We Will Dance With Mountains - Báyò Akómoláfé	2023 (ongoing)
Foundations of Lifestyle Medicine - ACLM	2023 (ongoing)
Mindfulness for Health and Social Care Professionals - Canadian Mindfulness Institute	2023 (ongoing)
Mindful Facilitation - Stirfry Consulting	2023
The Science of Happiness at Work - Berkeley via EdX	2023 (ongoing)
Protoself to Reach the Injured Self with Deep Brain Reorienting - Dr. Frank Corrigan through EEG Learn	2023
2SLGBTQ Foundations Course via Rainbow Health ON	2023
Shame and Self-Loathing in the Treatment of Trauma - Dr. Janina Fisher through Therapy Wisdom	2023
Community & Workplace Traumatologist through Traumatology Institute, Toronto	2023
The Integrated Trauma Therapist: incorporating IFS work with EMDR, SP, CPT, AEDP, DBT, and psychedelic medicines for treating complex trauma and PTSD via PESI	2023
Matrix Reimprinting - EFT Tapping Training Institute (certified)	2023
Integrative Somatic Trauma Therapy Certificate - The Embody Lab	2022
Assessing and Managing Suicide Risk - via Psychwire	2022
The Health Effects of Climate Change - Harvard via EdX	2022
NeuroAffective Relational Model Level 2 - NARM Training Institute (certification completed 2023)	2022
Brainspotting Level 3 with David Grand	2022
Power and Influence for Positive Impact - Harvard Business School	2022
Brainspotting From Freeze to Thaw (1 and 2)	2022
Brainspotting for Addiction - Abeles Consulting	2022
NARM and Cultural Misattunement (3 parts)	2022
Instinctual Trauma Response Trauma Effective Professional for Educators - ITR Training Institute	2022
Advanced TRE Interventions - Dr. David Berceli	2022
Certified Clinical Trauma Professional Intensive Training - PESI with Arizona Trauma Institute	2022
Leading From the Future - Findhorn Foundation, Scotland	2022
Level 3 Qigong for Healing - Spring Forest Qigong	2022
Integrating IFS - How to Unblend Your Own Parts When Working - IFSCA	2022

CHRISTINE GIBSON MD

W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
T | @tiktoktraumadoc

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MEDIA PUBLICATIONS

- Oprah Daily
  Habits for Post-traumatic Growth
  May 2023
- Authority Magazine:
  How to trust your intuition
  Becoming pain-free
  Self-Care and Mental Wellness
- November 2021
  On Climate Change, We're Just Playing Dead and Hoping the Predator Goes Away
  in CBC news
- August 2021
  What's Alberta's long game on COVID?
  in CBC news
- March 2021
  The Pandemic shows how far women have come and how far they have to go
  With 3 AB physicians in the Calgary Herald
- February 2021
  We must pass the COVID-19 marshmallow test
  With AB Mask Advocacy in the National Post
- November 2020
  The Freest Province in Canada
  Featured on the Sprawlcast episode
- November 2020
  The Third Wave: the shortage of health care workers because they are too burnt out or sick themselves
  Interviewed in The National Post
- April 2020
  We urgently need to start making masks in Canada – and wearing them
  With Masks4Canada AB "for CBC news
- July 2016
  To improve a child's health, follow Alberta's lead and give parents a raise
  With Ryan Meile of Upstream in The Globe and Mail

SUPPLEMENTARY EDUCATION

Facing Human Wrongs: Navigating paradoxes and complexities of social and global change, University of British Columbia collaboration with Gesturing Towards Decolonial Futures, Social Innovation cohort	2022
Brainspotting and Demystifying Dissociation	2022
Brainspotting and Dorsal Vagal collapse	2022
Pathways to Improvement for Environmental Sensitivities and Chronic Fatigue Syndrome with Dr. Eleanor Stein	2021-2
Brainspotting - Levels 1 and 2 complete, certification attained	2022
The Flash Technique and Advanced Flash - Flash and Four Blinks	2022
Deep Brain Reorienting - Centre for Trauma and Stress	2022
Protocols to Empower Outcome Havening with Neuroplasticity - Dr Kate Truitt	2022
Freedom from Chronic Pain Practitioner Training - Mind Body Medicine Centre with Dr Howard Schubinar	2021
Introduction to Integrative Mental Health via The University of Arizona's Andrew Weil School of Integrated Medicine	2021
Developmental Needs Meeting Strategy - DNMS Institute	2021
Expert Strategies to Help Clients Develop Tolerance for Emotional Distress - NICABM	2021
Ancestral Medicine (Parts 1 and 2) – Dr. Daniel Foor	2021
Integrating CBT and the Havening Techniques - Dr Kate Truitt	2021
Mind-Body Syndrome (TMS) Practitioner Certification Course - MindBodyFoodInstitute	2021
Think Resilience Self Directed Course - Think Resilience	2021
Cultural Somatics - Resmaa Menakem	2021
Non-pharmacologic interventions for chronic non-cancer pain: Physical Activity - CADTH	2021
Foundations of Polyvagal Informed Practice Part 1 - Deb Dana via the Polyvagal Theory Institute	2021
Peer Counseling for Healing Social Identity Based Trauma - Barbara Love through Trauma Research Foundation	2021
EFT Advanced (Level 3) - Susan Bushell	2021
Havening Techniques in the Treatment of Suicide - Dr Kate Truitt	2021
Immigrant and Refugee Mental Health - CAMH	2021
Environmental Health: An Integrated Approach via The University of Arizona's Andrew Weil School of Integrated Medicine	2021
Overcoming Addictions: Certified Addictions-Informed Mental Health Professional (CAIMHP) Training Course - Psychotherapy Networker	2021
How to Decolonize your Syllabus - Pam Roach via Cumming School of Medicine Faculty Development	2021
The Brain, Inflammation, and Recovery in the Time of COVID - Donna Jackson Nakazawa via EEG Learn	2021
In Her Words with Joanna Macy - Music as Medicine Project	2021

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W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
T | @tiktoktraumadoc

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MEDIA APPEARANCES

- Global News: ecoanxiety
  August 2023
- Global News: ecoanxiety effects on youth
  May 2023
- CTV News: the physician shortage in AB
  March 2023
- Integrative Practitioner: Approaching Substance Use Disorder with Integrative Therapies
  January 2023
- Forbes: The 10 Biggest Risks And Threats For Businesses In 2023
  January 2023
- USA Today: Trauma isn't just psychological, it can impact your body too
  January 20, 2022
- Washington Post: How to vet mental health advice on TikTok and Instagram
  October 3, 2022
- Global News: vaccine uptake
  May 2022
- Calgary Herald and Global News: Ukrainians evacuees
  April 2022
- USA Today: how trauma presents
  Jan 2022
- CBC News: Mental Health grant for music and breathwork for newcomers
  Aug 2021
- CTV News: AB COVID cases print and news
  April 2021
- CTV News: vaccination promotion
  April 2021
- CTV News: third pandemic wave in Alberta
  April 2021
- Global News: public health restrictions in Alberta
  Dec 2020
- National Post: Burnout in Health Care
  Nov 2020
- CBC News: vulnerable populations in COVID
  Mar 2020
- Global News: Nepal earthquake
  April 2015
- CBC News: Nepal earthquake
  April 2015

SUPPLEMENTARY EDUCATION

Foundations of Community Engagement - Tamarack Institute	2021
Advanced TRE - Drs. David Bercelli and Stephen Porges	2021
Embodying Polyvagal Theory - Deb Grant	2021
Trauma, Development, and Neuroplasticity - Ruth Lanius EEG	2021
Ketamine Assisted Psychotherapy - Polaris Insight Centre Modules 1 and 2 (Introduction, Intermediate for Clinicians)	2021
Design Space Camp - The Decade Ahead - Buckminster Fuller Institute	2021
A Future Free of Historical Trauma - Arizona Trauma Institute	2021
Turn Your World Around - Pema Chodron	2021
TraumAddiction - Dr. Eric Gentry via Udemy	2021
Seeking Safety for Trauma and Addictions - Treatment Innovations	2021
International Social Justice Summit - Trauma Research Foundation	2021
Learning Essential Approaches to Palliative Care - LEAP by Pallium	2021
Mindfulness Certificate Levels I, II, III, Master – Achology Academy of Modern Applied Psychology	2020
Safe and Sound Protocol / Remote SSP Associate - Dr Stephen Porges via Unyte Learning Systems	2020
Working with Developmental Trauma through Havening Techniques, Reparenting Protocols - Dr. Kate Truitt	2020
TRE Level 3 - Dr. David Bercelli and Lynea Gillen	2020
Self-Havening with Dr. Steven Rudin - Havening Techniques	2020
ADHD and Epigenetics - PsychedUp	2020
Self-Havening: growing the neural garden - Harry Pickens	2020
Understanding Psilocybin: Effects, Neurobiology, and Therapeutic Approaches - Psychedelic Support	2020
Learning From The Raven (Parts 1, 2, 3) Indigenous Culture and Trauma by Dr. Martin Brokenleg Jack Hirose & Associates	2020
Tapping for Trauma 2.0 - Dr. Craig Weiner - Trauma Training	2020
Psychedelics 101/102 (Integration: Promise and Premise) - Fluence	2020
GI Motility and Brain-Gut Disorders: Evidence and Consensus - Continuing Education, Harvard Medical School	2020
NLP and NLP Master Practitioner Certification - via Udemy	2020
Mind-Body Connection and the Microbiome - PsychedUp	2020
The Future of Mental Health - Complexity U with Zaid Hassan (Social Lab Revolution)	2020
Resilience Workshop - Sensorimotor Psychotherapy Institute	2020

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W | www.christinegibson.net
E | contact@christinegibson.net
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WORKSHOPS AND FACILITATIONS

- August 2023
  Workshop Leader
  How to Write About Trauma Without Causing Trauma
  To 60 attendees of When Words Collide
  Calgary, Canada
- 2019-2020
  Facilitating Mosaic PCN AGM and Town Halls towards enhancing member physician engagement
  Calgary, Canada
- 2016
  Workshop on sensitizing specialty faculty towards Family Medicine
  Gondar, Ethiopia
- 2014
  East Africa Family Medicine Initiative meeting
  Nairobi, Kenya
- 2013
  East Africa Family Medicine Initiative meeting
  Kampala, Uganda
- 2012
  East Africa Family Medicine Initiative meeting
  Victoria Falls, Zimbabwe
- 2011
  East Africa Family Medicine Initiative meeting
  Mwanza, Tanzania

SUPPLEMENTARY EDUCATION

ACT for Trauma - Dr. Russ Harris via Psychwire	2020
ART - Advanced / Enhanced - Lainey Rosenzweig	2020
Self-Havening for Resilience - Dr. Kate Truitt PhD	2020
Inner Engineering - Sadhguru Isha Foundation	2020
Treating Complex Trauma with Internal Family Systems - Psychotherapy Networker	2020
New World Leader Facilitator training - Processwork Institute	2020
Sex and Gender in Data Collection and Analysis - CIHR	2020
Forward-Facing Trauma Therapy - Arizona Trauma Institute	2020
CBT Narrative Exposure Therapy for Trauma Memory - Arizona Trauma Institute	2020
Community Resilience Skills for Health Care Providers - Trauma Resource Institute	2020
Making Good Use of Suffering: Intrarelational AEDP Work with Overwhelming Emotional Experience - via Accelerated Experiential Dynamic Psychotherapy Institute	2020
Certificate in Psychoneuroimmunology - PNI Australia	2020
Emergent Healing - Lydia Harutoonian and Adrienne Maree Brown	2020
The Treatment of Trauma in the Internal Family Systems Model with Dr. Richard Schwartz	2020
Tapping out of Trauma 1.0 - Dr. Craig Weiner Trauma Training	2020
Making Sense of Systems - Eric Garza	2020
CBT for COVID-19 response, for Depression - 10 minute CBT	2020
Humanitarian Clowning in Mexico City with Dr. Patch Adams	2020
Acceptance and Commitment Therapy (ACT) - Dr. Russ Harris MD via Psychwire	2020
Writing the Other - Deep Dive into Diverse Characters // Deep Dive into Description // Deep Dive into Inclusive Worlds // Building Inclusive Worlds	2020
Psych K Basic Certification - Psych K	2020
Trauma Memory and the Restoration of One's Self - Dr. Bessel van der Kolk at The Esalen Institute	2020
Aboriginal Narrative Practice Course – Dulwich Centre, Australia	2020
Advanced Training for Trauma Treatment of complex PTSD – Arizona Trauma Institute via Udemy	2020
How to Work with Shame - NICABM	2019
Collective Trauma and Healing – Thomas Hübl	2019

CHRISTINE GIBSON MD

W | www.christinegibson.net
E | contact@christinegibson.net
P | 001-403-710-0226
T | @tiktoktraumadoc

My career goal is to promote individual and community well-being through promotion of agency, connection, and nourishing of post-traumatic growth. Focusing on social innovation allows examination of complex challenges from a system-level perspective, in order to build adaptive resilience.

MEMBERSHIPS AND ASSOCIATIONS

- Member - City of Calgary Climate Advisory Committee (2 year term)
- Advocacy Committee Member - Canadian Women in Medicine
- Member - Brainspotting Canada
- Member - Canadian Psychedelic Association
- Member - Canadian Society of Addiction Medicine (CSAM)
- Member - World Health Network
- Member - Medical Psychotherapy Association of Canada (MDPAC)
- Member - EFT international
- Past Board Member – Mosaic PCN
- Faculty – Lissa Rankin's Whole Health Institute
- Mental Health Innovation Network (Grand Challenges Canada)
- The Taos Institute
- LEx – the Leadership Expedition (past member)
- Canadian Association of Physicians for the Environment
- Canadian Association of MAiD Providers
- Bridging Health and Community
- Deepening Community, Tamarack Institute
- TEDxYYC alumni speaker
- WONCA -World Organization of Family Doctors *Working Party on Education* member
- WONCA *Working Party on the Environment* member
- WONCA *Working Party on Indigenous and Minority Health* Issues member
- Besrour Center of the College of Family Physicians of Canada member - Lead of *Narrative Working Group*
- Health in Humanities, Cumming School of Medicine, University of Calgary
- Avenue Top 40 Under 40 Alumni
- Past faculty – Diploma of Tropical Medicine and Hygiene, LSHTM

SUPPLEMENTARY EDUCATION

Fundamentals of Interactive Guided Imagery IGI with Death, Dying, Loss, and Transformation Academy for Guided Imagery	2019
uLab: *Leading from the Emergent Future* via TheoryU/EdX	2019
Social Design – Gaia Education	2019
Design Thinking – Acumen+ and IDEO U	2019
Havening Techniques - Havening Canada (certified)	2019
Warriors for the Human Spirit – Margaret Wheatley	2019
Integral Facilitator – Ten Directions	2019
DBT Skills Training – Psychwire with Marsha Linehan	2019
Insights for Innovation – IDEO U	2019
Alberta Opioid Dependency Treatment Virtual Training Course - University of Calgary Cummings School of Medicine	2019
CBT for Anxiety – CBT Canada	2019
Level 1 Sensorimotor Psychotherapy	2019
Certification in TRE (Tension, Trauma Releasing Exercises) Levels 1 and 2	2019
Sprint School – Design Lab of Alberta Health Services	2019
Certificate Program in Trauma Stress Studies - PESI	2019
Social Construction: Principles and Practices – The Taos Institute	2019
Storytelling for Influence – IDEO U	2019
Systems View of Life - Capra Course	2018-19
uLab: *Leading Change in Times of Disruption* - Theory U/EDx	2019
Roots Deeper than White – White Awake	2019
Inclusion 2.0: Move Beyond Power, Politics, and Political Correctness – Ten Directions	2019
Me and White Supremacy Workbook Layla F Saad	2019
Psychological First Aid – Johns Hopkins via Coursera	2018
The Social Context of Mental Health and Illness – University of Toronto via Coursera	2018
Introduction to Food and Health – Stanford via Coursera	2018
Treating Trauma Master Series - NICABM	2018
Creating a Culture of Respect for Gender and Sexual Diversity Certification – Calgary Centre for Sexuality	2018
Suicide Prevention, Risk Assessment, and Management - AHS	2018
Certificate in Medical Abortion Training - SOGC	2018

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- Reviewer – peer reviews articles for Canadian Family Physician journal
- Advisor – Global Health Pre-Departure Online Training Certificate
- Fellowship in College of Family Physicians of Canada
- College of Physicians and Surgeons of Alberta
- Alberta Medical Association
- International Health Program at University of Calgary
- Global Health Education Consortium
- Canadian Society of International Health
- Alumnus of the London School of Hygiene and Tropical Medicine
- Member of Alpha Omega Alpha Honor Society
- Past Member of MENSA - Canada

Certificate in Accelerated Resolution Therapy (ART)	2018
Nonviolent Crisis Intervention Training - CPI	2018
Compassionate Inquiry with Gabor Maté	2018
Oral History for Social Change - Groundswell	2018
Practical Improvement Science in Health Care – Harvard University and Institute for Healthcare Improvement via EdX	2018
Spring Forest Qigong – Spring Forest Institute. Minnesota Levels 1, 2, and Five Element Healing.Certified Practice Group Leader	2018
Narrative Palliative Medicine – Rita Charon, Columbia University, NYC	2018
Evaluation Masterclass: Principle-focused Evaluation – Michael Quinn Patton and Mark Cabaj, Tamarack Institute	2018
Mindfulness in Health Care - Mark Sherman	2018
Ayurvedic Wellness Counsellor – Kerala Ayurvedic Academy	2015-18
Neighborhoods: the heart of Community Workshop – Tamarack Institute	2017
Indigenous Canada - University of Alberta via Coursera	2017
Community Agency and Health Conference – Bridging Health and Community, Oakland CA	2017
Health across the Gender Spectrum - Stanford University via Coursera	2017
Lean Data course - Acumen	2017
Whole Health Medicine Institute course – Drs. Lissa Rankin and Rachel Naomi Remen	2016