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Professionalism

Super Hero or Human

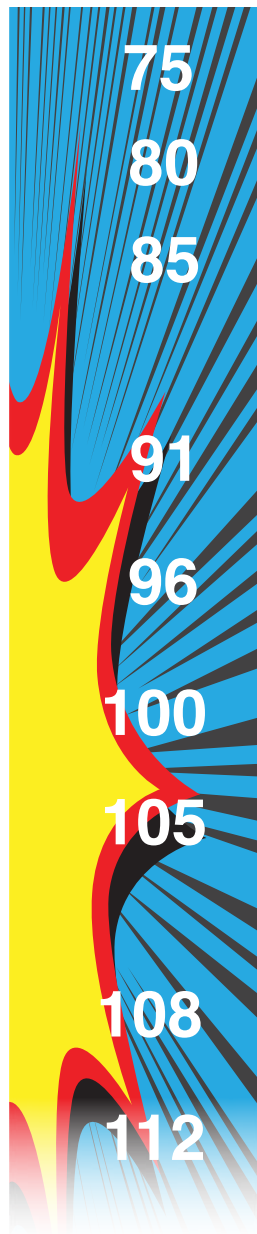
In this Issue EDITORIAL: Causing disease by curing disease?

Hero or human: professionalism for leaders

ADVICE: Transitioning to an executive role? What you should know about your retirement plan



Contents



EDITORIAL: Causing disease by curing disease?

Johny Van Aerde, MD, PhD

Hero or human: professionalism for leaders

Monica Branigan, MD

Medical professionalism and physician leadership: the time for action is now

Jenny Buckley, MA, MSc; André Bernard, MD; Emily Gruenewoldt, MHA; Cécile M. Bensimon, PhD; Jeff Blackmer, MD, MHSc

PERSPECTIVE: The current reality in Quebec's health care system

Ruth Vander Stelt, MD

REFLECTIONS: Leadership lessons from the Rio Paralympic Games

Gaétan Tardif, MD, ICD.D

Physician health as a potential indicator of quality

Laura Calhoun, MD

CSPL WHITE PAPER: A blueprint for improving physician engagement and leadership in the Canadian health care system

Johny Van Aerde, MD, PhD, and Graham Dickson, PhD

ADVICE: Transitioning to an executive role? What you should know about your retirement plan

Vince Tarantino, MBA, CFP, CIM

Medical registration in Canada: a brief overview

Fleur-Ange Lefebvre

BOOK REVIEW: Better Now Six Big Ideas to Improve Health Care for All Canadians

115

Reviewed by
Johny Van Aerde, MD, PhD

BOOK REVIEW: Leading with Noble Purpose How to Create a Tribe of True Believers

117

Reviewed by



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Contact Information:

Canadian Society of Physician Leaders
875 Carling Avenue, Suite 323
Ottawa ON K1S 5P1
Phone: 613 369-8322
Email: carol@physicianleaders.ca

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EDITORIAL

Causing disease by curing disease?

Johny Van Aerde, MD, PhD



As Canada and other OECD countries spend about 10% of GDP on health care, it is inevitable that the delivery of health care services has consequences for the natural environment.

Stewardship is an ethic that embodies the responsible planning and management of resources and begins with the willingness to be accountable for some larger body than ourselves.¹ The word stewardship has been used in the context of the physician's role in the sustainability of the health care system.^{2,3} It has also been used to describe the responsible use of our natural resources and the sustainability of our planet. The main purpose of this paper is to raise awareness around the sustainability of some of the many



systems in which we live and work, as awareness and knowledge are the first elements of any change initiative. Based on new data, mostly unknown to the physician community, some reflective suggestions are offered to start those changes.

During the CMA's 2016 annual meeting, its president, Dr. Cindy Forbes, vowed to act on climate change. However, she said that the best way to take action against the growing effects of climate change is still to be found.⁴ Dr. Orbinski, founding member of Médecins sans Frontières and keynote speaker at the same event, told the audience that, in Canada, air pollution alone is linked with 21 000 preventable deaths annually, 92 000 visits to family physicians, and 620 000 trips to emergency departments. He said that, therefore, physicians have some professional responsibility to take a more active role in addressing such problems. He added that discussions about climate change tend to miss the human element, "We don't see ourselves in them."⁵ While Orbinski

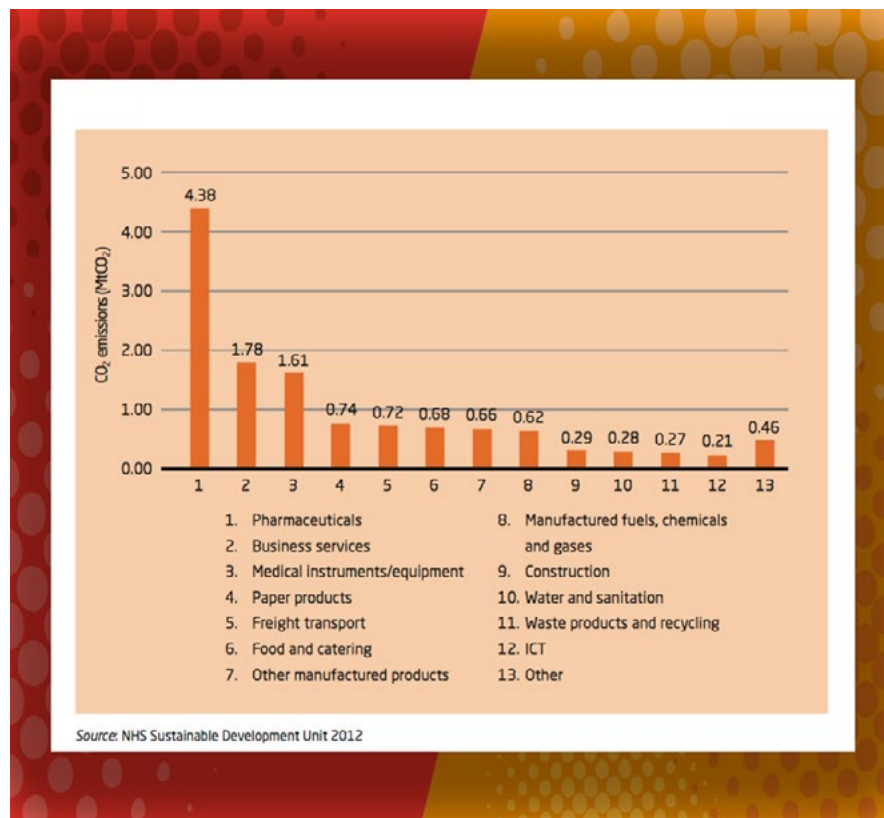
addressed the serious impact of climate change on global health, this paper deals with the reverse by looking at the effect of the health care system on the environment, and how we as physicians can see ourselves in that narrative.

The health care system impacts the ecological system

As Canada and other Organisation for Economic Co-operation and Development countries spend about 10% of GDP on health care, it is inevitable that the delivery of health care services has consequences for the natural environment. In the United States the health care industry accounts for 8% of the nation's greenhouse emissions. In the European Union, it is about 5%, equivalent to that of the international aviation and shipping industries combined.

The National Health Service (NHS) has probably led in studying the effect of the health care industry on the environment and possesses a decade worth of data. For

Figure 1. Procurement-related CO2 emissions in the United Kingdom’s National Health Service, 2010



example, 25% of all public-sector emissions come from the NHS or about 4% of all emissions in England.^{6,7} This is more than all passenger aircrafts departing from Heathrow airport. Five per cent of all vehicle emissions in England come from road traffic related to NHS activities (patients, staff, supplies, food, etc.). Surprisingly, the largest contribution to the NHS’s CO₂ emissions, two-thirds of the total, comes from procurement, mainly pharmaceuticals, medical equipment, and supplies. This exceeds the amount of CO₂ produced by direct energy use (electricity and fuel for buildings) by more than three times (Figure 1).^{6,8}

Translating this data into an understandable narrative,

Tennison¹⁰ estimated that the average admission day produces 380 kg of CO₂ per patient, and each subsequent day produces another 80 kg. This means that the amount of CO₂ produced for five patients, each admitted to hospital for one week, would be the same amount as emitted by an average car driving 18 000 km.

For each patient admitted, the NHS produces 5.5 kg of waste per day, twice as much as in the United States and ten times as much as in Germany.¹¹ Although no overall data on waste production exist for Canada, some hospitals, like Lions Gate Hospital in Vancouver, have monitored the weight of certain supplies that were turned into waste. Per inpatient day, 718 g

of paper was used (print, towels, toilet paper, cups/plates), 268 g of diapers (adults and children), and 165 g of gloves (synthetics and paper).¹² A mix of 80 hospitals in Ontario used, on average, 1230 L of water per bed,¹³ which is four times the amount used by the average citizen in Canada. Annual energy consumption per square meter of floor space, or energy intensity, of hospitals and other health facilities is remarkably consistent across geography, ranging roughly from 230 to 330 kWh/m².¹⁴ That means that each 4 m x 4 m surface area consumes about as much energy as the average Canadian does each year.

Overall, the ecological footprint of health care institutions is 400–700 times their actual surface area. Thus, for every hectare of land a health institute occupies, 400–700 hectares are needed to sustain its functioning and services.^{12,15}

Economic, health, and quality co-benefits of reducing the ecological footprint of our health care system

Physicians may ignore these statistics and hide behind their responsibility to serve each patient and the health system in general. However, the health care system, the financial system, and the ecological system are closely intertwined, and their sustainability is inseparable from their interdependence. It seems logical then that, besides climate change and environmental sustainability, there are potential synergies and co-benefits between the core objective of health care and

efforts to minimize environmental impacts.^{6,7}

First, there are *financial* co-benefits to developing environmentally sustainable approaches to the delivery of health care. For example, promoting efficiency of resource use reduces direct costs. Using peer-reviewed data from the US's Environmental Protection Agency, the organization Practice Greenhealth has created an energy impact calculator that allows hospitals to estimate some of their health impacts, such as premature deaths, chronic bronchitis, asthma attacks, and ER visits.¹⁶ It also estimates the financial cost to society. For instance, a typical 200-bed hospital in the coal-powered US midwest, using 7 million kWh/year is responsible for over \$1 million/year in negative societal



public health impacts (\$0.14/kWh), and \$107 000/year (\$0.01532/kWh) in direct health care costs.¹⁶

Efficiency measures at the Mayo Clinic have reduced its energy consumption by 36% in the decade since they started in 2006.¹⁷ Even countries with fewer financial resources than Canada have proved that this co-benefit can

be accomplished and is lucrative. In Brazil, one efficiency project reduced the demand for electricity of a group of 101 hospitals by 5769 MWh/year and the cost by 25%.⁷ These savings can be reinvested for enhanced patient care elsewhere.

Second, there are the obvious health co-benefits from reducing the health care industry's impacts on the environment. However, while we try to cure disease, the delivery of the services also contributes to some of those diseases. For instance, air pollution causes 369 000 premature deaths in Europe each year,⁷ and the release of toxins related to health care activities, such as sulfur dioxide, nitrogen oxide, and mercury, adds to the disease burden.^{7,18} Further details of the effect of climate change on disease burden have been well reported by the WHO.¹⁹

Finally, there are co-benefits when changes to health and social care services simultaneously improve quality of care and reduce environmental impacts. For example, minimizing duplication and redundancy in care paths, delivering the right care in the right place at the right time, and optimizing a smooth, continuous flow of care throughout the entire health care system would meet the objectives of both quality-of-care and ecological agendas.

Innovation

Innovative delivery of health care services can decrease the environmental and financial burden and improve quality of care in three areas: where, what, and how.

Changing WHERE care is delivered

The buildings where care is provided and patients and staff traveling to and from those buildings produce 35% of health care carbon emissions. Making facilities more sustainable and minimizing distance traveled for care can influence this component. For example, mobile breast screening can reduce carbon emissions by two-thirds, compared with women traveling to a central clinic.⁶ Less obvious initiatives linked indirectly with where care is delivered include low-carbon food menus, software to automatically turn off office computers over weekends, and re-use of redundant office furniture in hospitals or regions.⁶ On a small scale for each of us, simple measures like managing the use of paper, using reusable supplies and energy efficient lighting, minimizing the use of toxins, recycling, turning off computers at night, and using greener transportation all make a difference when multiplied by more than 100 000 physicians.^{20,21}

Changing WHAT care is delivered

Prevention measures can reduce subsequent resource demands and lifetime use of health care services. Investing in self-management can also reduce unplanned hospital admissions among people with long-term conditions.⁶ The relevance of these findings to sustainability is that reduced demand can be a proxy for avoided environmental damage, provided that reduced resource use in one part of the system does not create increased demand for other forms of care in another part of the system.



Evidence-based and personalized care at all levels, ensuring treatment and support that is of maximum value to patients for a given investment of resources also minimizes wastage. More evidence is needed to establish which care pathways have the greatest environmental impact and find clinically appropriate alternatives. Although no large scale studies exist, there are some interesting small examples. Gatenby estimated that carbon emissions from reflux surgery were seven times those from medical treatment, but that annual emissions from ongoing medical treatment made the surgical approach more carbon efficient by the ninth year after surgery.²² Another example demonstrates that the anesthetic desflurane has a greenhouse gas effect that is 10 times that of other anesthetic gases.²³ Other examples can be found in the systematic review of the environmental impact of health services by Brown et al.¹⁴

Changing HOW care is delivered

Delivering well-coordinated and integrated care and improving communication and information sharing reduces waste of financial and environmental resources. Appropriate, accountable, and professional use of telehealth and telecare intervention can reduce emissions.^{24,25} Each telemedicine consultation saves an estimated 39 kg of CO₂. This can add up, as North Yorkshire County in the UK found when it saved \$1.5 million a year by using a telecare support package.⁶

The use of wearable technology for monitoring health parameters might further change the way health is monitored and, perhaps, how care is provided. Pharmaceuticals account for about 22% of the NHS carbon footprint and 13% of its cost.⁶ Reducing the large volumes of wasted medicines can be accomplished by optimizing stock management and reducing

inappropriate prescribing or over-medication. Combined purchasing power can also be used to influence, not only cost, but also the manufacturing processes. Some suppliers are attempting to “green” the production of pharmaceuticals by investing in hydroelectric and wind-powered factories and by creating enzyme technology that allows chemical reactions needed for production to take place at lower temperatures. Novo Nordisk was able to lower its energy use well below European energy targets with such initiatives.¹⁷

What should physicians and physician leaders do?

As medical experts, we zoom in on the immediate details and problems of today’s patients in front of us. As a result, we rarely back off far enough to see the large and long-term systemic effects of our day-to-day activities. As the development of an organizational culture of learning is the essence of successful changes, how can we support a sustainability agenda for our institutions and be engaged in sustainability initiatives, together with other frontline workers, executives, patients, and citizens? How can we ensure that our health system adopts sustainable procurement and commissioning practices? As part of an overarching governance structure, how can we, as physician leaders, use our influence to ensure that environmental issues are incorporated into supportive policy frameworks? As in the NHS, environmental sustainability and

savings must find a place on the agenda at board meetings, just as we review patient-related quality topics regularly.

Economics, quality improvement, and environmental sustainability are all affected by the services we deliver, simply because they are interconnected with the ultimate system we call planet Earth. The NHS is probably the most advanced health care system on this topic; for the last decade, it has been monitoring its performance against 29 measures every year.⁸

Limited, voluntary initiatives also exist in Canada: for example, the Greening Health Care Sector of the Ontario Hospital Association¹³ and Green Healthcare Canada.²⁶ At the national level, HealthCareCan recently released a report on the economic and environmental impact, resilience, and sustainability of Canada's hospitals and recommended, "Scale and spread best practices nationally that will help to reduce the significant ... demands on the environment in accordance with the 'Comprehensive environmental health agenda for hospital and health systems around the world'.^{15,27} How can this recommendation also find a place in the new Canadian health accord(s)?

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Author

Johny Van Aerde, MD, MA, PhD, FRCPC, is editor-in-chief of the Canadian Journal of Physician Leadership and past president of the Canadian Society of Physician Leaders.

Correspondence to:
johny.vanaerde@gmail.com

Hero or human: professionalism for leaders



Monica Branigan, MD

Dealing with problems related to professionalism shouldn't require a superhero. Making professionalism a shared responsibility moves it to a more human level. This article offers three tools to do that by "harnessing the power of the community."

KEY WORDS: professionalism, definition, decision-making, collegiality, disruptive behaviour, compassion

The burden on individual physician leaders to "fix problems" can be immense. You need to be a superhero, or at least it feels like it. "Fixing" professionalism issues is no exception. The discourse is most often negative — a compendium of stories about disruptive physicians. Leaders are expected to step in and solve egregious behavioural issues often with little support from their colleagues. Although

institutional supports for leaders do exist (see appendix) the support of the profession is necessary. What we need is a different approach to professionalism, one that doesn't rely on non-existent super power. We need a "human" vision of professionalism.

Making professionalism a shared responsibility — and not simply a problem for leaders to fix — is a way to move from superhero to human. Three tools are key to harnessing the power of the community:

1. A definition of professionalism that is attainable and desirable
2. A shared way of discerning right professional behaviour
3. A commitment to compassionate collegial conversations

With these three tools, physician leaders can begin to create environments where professionalism is likely to flourish. A human vision of professionalism acknowledges that our professionalism is both an individual and a community responsibility.¹ Without this shared responsibility and accountability, the burden on individual leaders to be superheroes can be immense.

A human definition of professionalism

How do we currently "see" professionalism? An agreed on definition does not exist. Perhaps the most common and widely referenced definition is described in the Physician Charter:

Professionalism is the basis of medicine's contract with society. It

demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health.²

In addition, the charter goes on to list commitments: to professional competence, honesty with patients, patient confidentiality, maintaining appropriate relations with patients, improving quality of care, just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest, and professional responsibilities of self-regulation.

As physicians, we need and want to express our sincere desire to be of service. If we set the bar too high, it becomes unattainable and, therefore, demotivating. It may also make our lapses too threatening to our self-image as a "good doctor."³ As Parker Palmer, renowned educator, points out: "If we approach it as a problem to be solved by 'raising the ethical bar' — exhorting each other to jump higher and meting out tougher penalties to those who fall short — we may feel more virtuous for a while, but we will not address the problem at its source."⁴ The "problem" of course is that we are human beings and not superheroes.

The other challenge with this definition is that it gives no guidance for right action. Perhaps, if we simply make rules and regulations and policies for every conceivable situation, we can agree on right action. Although agreed-on norms of behaviour are very important, they do not account for context or how we do things.

The Royal College of Physicians of London uses a definition that points toward how we might judge actions. Professionalism is “a set of values, behaviours and relationships that underpin the trust the public has in doctors.”⁵ So perhaps an action can be judged on the basis of the trust it engenders in the public. Is this enough clarity?

I propose that a human vision of professionalism include a definition that is attainable and moves beyond individual ideas about right action. We can view professionalism as a dynamic and responsive process.⁶ Professionalism is the ability to aspire to ideal professional values, to identify when reality does not conform to this ideal, and to actively commit to narrowing the gap.

The heart of this definition is “to actively commit to narrowing the gap.” This is not about perfection but rather moving toward continuous quality improvement. It also normalizes the gap between real and ideal. As Mary Gentile, author of *Giving Voices to Values*, explains: “Instead of normalizing the loss of our values, we can normalize the fact that we will be called upon to preserve them in the face of predictable challenge.... [and] then those who present these conflicts don’t have to be seen as villains.”⁷

Without such honesty about the predictable challenges of being a physician, our learners and colleagues believe that those of us who speak about professionalism are naïve at best, ignorant at worst. I also suspect that without this normalization, we become jaded

and lose our initial enthusiasm about our work if it doesn’t live up to our ideals.

Professionalism decision-making

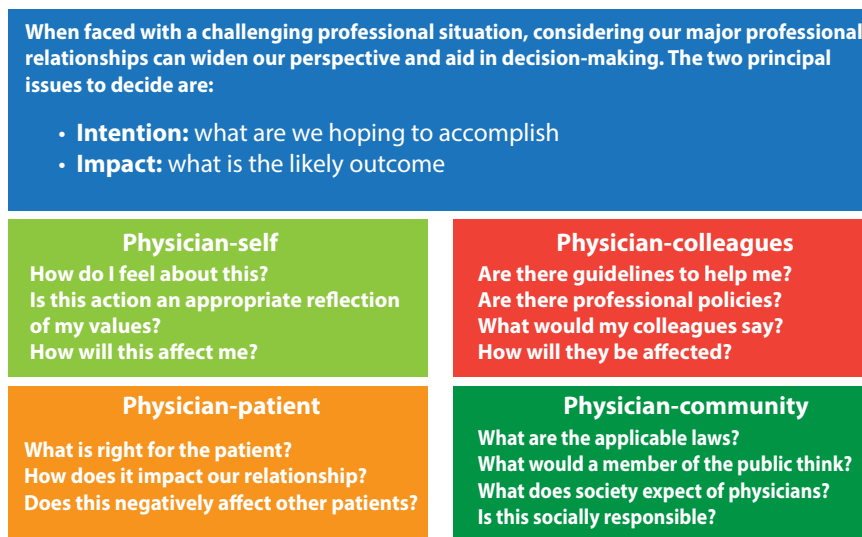
A human vision of professionalism also needs to support clarity about right professional behaviour. Ideas about appropriate professional behaviour change over time. Consider how we now approach truth-telling about a terminal illness, disclosure of medical error, right relationship with industry, and the concept of privilege — and our approach 20 years ago. Do individual physicians have their own “opinions” about right behaviour? Should leaders simply impose their idea of right action? If, however, leaders can offer a reproducible method of discerning why an action in a given context is “professional,” it is more likely that consensus can be reached.

A method of discerning professional action is using the concepts of intention and impact (Figure 1). Intention refers to what we

hope to accomplish in a given situation and impact refers to the expected outcome. These two broad concepts map easily to rules-based and outcome-based ethical decision-making. The clarity comes from considering our responsibilities in important professional relationships: with ourselves and our values, with our patients, with our colleagues, with our community.

As a current example, the intention and impact tool can be used in deciding on and justifying our anticipated involvement with medical assistance in dying (MAiD). Our own personal values must be considered first. If, for example, those values do not allow us to be actively involved in MAiD, we still need to consider our patients, who may make a request for information or more assistance, and not abandon them. How we do this will depend on our colleagues and how we support each other’s conscience — our colleagues who consciously object and our colleagues who consciously participate. We need also to consider our particular

Figure 1. Intention and impact tool



community of practice, as options and expectations may vary if one is working in a faith-based institution or rural community, for example. We cannot make these decisions in isolation. This is a shared responsibility, as are all such decisions.

Using this process moves professionalism from individual opinion to justifiable course of action. Often, serious lapses in professionalism are associated with an inability to appreciate the impact of our actions on others. Deliberately widening our perspective to include patients, colleagues, and our community offers the possibility of moving beyond personal impact and personal opinion. As leaders, we can begin to articulate our reasoning process and engage others in discussions about right behaviour.

Committing to “collegial conversations”

This concept of shared responsibility is key to effective and sustainable professionalism. It manifests when we observe behaviours of concern in our colleagues and we decide whether to get involved. Using intention and impact helps to guide our choice. Imagine observing a physician shouting in a threatening way to a nurse. If we begin with ourselves, we could imagine that we would prefer to deal with a colleague rather than have the issue escalated or we could be a learner and feel vulnerable. We do know that such conflict interferes with patient care and safety. The particular relationship we have

with our colleague may influence our decision, or we may have an understanding in our group that support in the moment is the ideal.

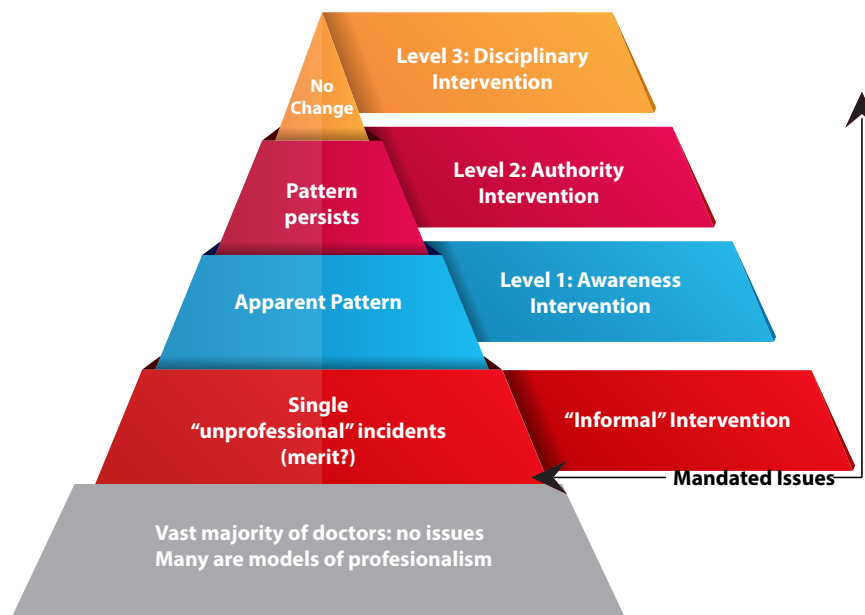
Without a doubt, a member of the public would expect that this less than ideal situation be dealt with in an effective way. If we choose not to engage, we need to justify why. We also need to share in the responsibility for a pattern of behaviour that may develop in our colleague and, in time, become disruptive. If a community of practice chooses to commit to collegial conversations, many unhealthy behaviours will never develop into patterns and the burden does not rest solely on leaders to correct behaviour.

If we do choose to engage — with our colleague or with another professional — how do we do that if we have a human vision of professionalism? We have a collegial conversation. Collegial means in a spirit of friendliness

Often the decision is made not to engage in a collegial conversation. Alternatives include silence, talking about the situation/person to others, blaming people higher in authority for not “fixing the problem” without being willing to come forward, pretending it isn’t a problem and “working around it,” or even aggressively “confronting” someone. None of these alternatives is effective. All of these choices have consequences that leaders are often left to “fix” with little sense of shared responsibility. However, as a leader, you are in a position to initiate discussions about the preferred way to deal with these situations and move toward group agreement.

Why is the decision to engage with a colleague so difficult? At an individual level, many barriers exist: fear of upsetting a colleague, lack of communications skills, belief that someone else will deal with the issue, belief that behaviour will not

Figure 2. Hickson triangle for identifying, assessing, and dealing with unprofessional behaviour



Source: Hickson et al.⁸



change, or even feeling sorry for the colleague.¹⁰ At a systems level, there is a basic confusion over our responsibilities and relationship to our colleagues. Are our colleagues simply co-workers, competitors, peers, friends, or something different? If professionalism is a shared responsibility, do we have a responsibility for the behaviour and well-being of a colleague?

Compassionate accountability

A human vision of professionalism includes a sense of compassion toward our colleagues. Compassion includes an affective component — trying to understand empathetically and generously where a colleague may be coming from — and a cognitive component — what skillful action is called for.

Often a collegial conversation can be a compassionate response. Daniel Goleman, author of

Emotional Intelligence, points out that compassion is not so easy. One of the biggest barriers to feeling compassion is fear.¹¹ When we are feeling rushed, when we have not taken care of our own needs, when we are unclear about our responsibilities, and when we do not feel that our colleagues “have our back,” it is difficult to feel compassion for others. A leader who exhibits good self-care, who talks about our responsibilities to each other, and who shares our personal struggles models this compassion.

If we, as individual physicians and a profession, embrace a human vision of professionalism, we see things in a different light. With a human vision, professionalism lapses are seen as errors. We are seen as humans and not villains. Just culture principles apply, and a root cause analysis is explored. The intention is to understand,

mitigate harm, and prevent further lapses. A learning and supportive response makes sense, and a clear line exists where a more formal remediation or punitive response is indicated. In a root cause analysis, individual factors as well as institutional factors are explored.

So as a physician leader are you expected to be a superhero or a real human being? You can add three new tools to your practice:

- An operational definition of professionalism to actively work to narrow the gap between ideal and real behaviour
- A process to clarify and justify professional behaviour that is grounded in intention and impact on our professional relationships
- An agreement among colleagues to engage compassionately in collegial conversations

These tools can help to engage our communities of practice in shifting professionalism from an individual responsibility to a shared one. As Edmund Pellegrino reminds us, the “burden is too heavy without the support of the whole profession.”¹²

Appendix: Institutional supports for promoting professionalism

As a leader, I use following institutional tools, allies and resources, or opportunities for improvement:

Institutional vision

- mission, vision, values
- supportive vision/definition of professionalism

Clarity about desirable behaviour

- codes of conduct
- institutional policies that are prominent and understood, e.g., conflict of interest, confidentiality, disclosure of error, do not resuscitate

Ethics supports visible and known

- ethical and professionalism decision-making tool(s) available and consistently used
- ethics committee or ethics consultation services available
- ethics and professionalism education and resources available at all levels

Inclusive decision-making

- involving employees, patients, and appropriate stakeholders in institutional decisions
- processes for expressing opinions, including dissent: confidential lines, town halls, walk around, rounds

Openness

- rationales for decisions are shared
- rationales and decisions are connected to values/ethics
- expressions of concern, disagreement are welcomed without blame
- diversity of members in senior management

Consistency

- appreciating and rewarding ethical/professional behaviour is part of performance review for all
- leadership role-modeling of respectful behaviour

Monitoring

- process in place to monitor

and track professionalism and ethical learning issues and successes

- ability to identify trends in behaviour or frequent ethical challenges from multiple sources
- faculty and learner assessment of professionalism
- miscommunication/professionalism component of medical error/near miss identified

Enforcement

- individual professionals accept responsibility for their colleagues' behaviour and are involved in accountability/conversations
- leaders have a step-wise approach to disruptive behaviour
- sanctioning undesirable behaviour occurs when appropriate

Preventive ethics/continuous quality improvement implemented

- formal relationship between ethics and quality/safety to identify trends in challenging behaviour/safety issues
- process for responding to patterns of unprofessional behaviour or frequent ethical challenges with education or other interventions
- health professional health and wellness a quality indicator

Source: Adapted from Kaptein.¹³

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Author

Monica Branigan, MD, MHS (Bioethics) is an associate professor at the University of Toronto and practises palliative care. She is on the faculty of the Physician Leadership Institute of the Joule inc., a CMA company, where she teaches "Professionalism and Ethics" and "Crucial Conversations."

Correspondence to: Monica.branigan@utoronto.ca

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Medical professionalism and physician leadership: the time for action is now

Jenny Buckley, MA, MSc; André Bernard, MD; Emily Gruenwoltdt, MHA; Cécile M. Bensimon, PhD; Jeff Blackmer, MD, MHSc

Expectations of physicians and of the medical profession are undergoing significant change. Some of these changes call into question the unwritten compact between physicians and society known as the social contract of medicine. Although, in some ways, these changes represent threats to the profession, they are also a unique opportunity. Physician leaders can play a role in addressing issues at the system level: by unifying the profession, improving relations between physicians, and ensuring greater focus on patient-centred care. None of

these solutions is easy. However, determined action can ensure that physicians reclaim their role as health system leaders and contribute to a system that provides high-quality care for patients and a rewarding career for physicians.

KEY WORDS: medical professionalism, physician leadership, accountability, quality, profession-led regulation, intra-professionalism, unity, patient-centred care

The concept of professionalism is not unique to medicine. However, medical professionalism has endured in its centrality to the identity of physicians. From the Hippocratic oath to more recent codes of ethics, medical professionalism is rooted in the well-being of the patient. Beyond this, physicians are expected to consider their actions vis-à-vis society and the systems in which they practise. These expectations are often referred to as the “social contract of medicine,” whereby physicians act in the best interests of their patients and society in exchange for privileges, such as professionally led regulation. Changes in practice and expectations of the public, of governments, and within the profession have begun to call into question the nature and scope of the social contract. Increasingly, there are suggestions that physicians may not always be holding up their end of the bargain.

Recent evidence shows that patients no longer trust physicians the way they once did. An Ipsos poll commissioned by the Canadian Medical Association in 2013 found that less than half (46%) of Canadians view their physicians as trustworthy — a decrease of 24% in 10 years.¹ The same poll found a decrease in the proportion of physicians perceived as up to date on current developments (from 60% to 36%) and compassionate (from 61% to 35%). Physicians themselves agree, with 85% reporting a threat to their reputation and role in Canada.¹

Physicians have not necessarily failed to uphold their side of the agreement. Rather, changing expectations are beginning to redefine the social contract. There is a need to ensure that the professional values and roles that physicians have always adhered to still reflect the realities of 21st century medicine. These new realities offer both a threat and an opportunity. If physicians and their representative organizations do not rise to the challenge, then other parties, such as governments and regulatory bodies, will step in and make changes that may not benefit patients or the health care system. On the flip side, physicians have a unique opportunity to reclaim their role as health system leaders.

In this article, we present some of the challenges facing the medical profession. We examine issues at the system level, the impact of strained relations between physicians, and the need to increase care that is truly patient-centred. This analysis is intended to provide physician leaders with

an impetus for change. We believe that changes will ultimately lead to better patient outcomes as well as a more rewarding practice for physicians.

Leadership for health system improvement

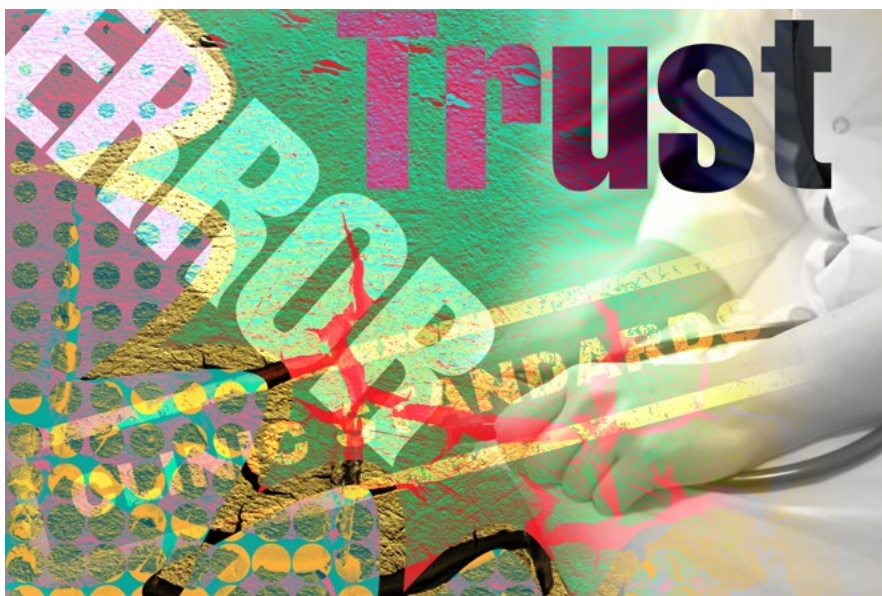
As the Ipsos data¹ show, the reputation of physicians collectively in society has decreased in recent years. Research on medical investigations/interventions has demonstrated gaps in knowledge as well as practices that have little benefit and are even sometimes harmful.² A recent study in the *British Medical Journal* found that medical errors are now the third leading cause of death in the United States.³ Although there are questions about the reliability of these data, and many errors are due to systemic issues, patients are more likely to question medical decisions as the number of serious injuries and deaths increases. This can challenge the trust relationship between physicians and their patients.

Patients are not the only ones questioning medical professionals. The public is increasingly calling on governments to be accountable for taxpayer dollars. As a result, governments are looking at spending as a way to demonstrate accountability to taxpayers. In 2014, the British Columbia auditor general's report, "Oversight of Physician Services,"⁴ included three main findings. First, government is not ensuring that physician services achieve value for money. Second, government is unable to demonstrate whether physician services are high quality and compensation is best value. Third, systemic barriers limit the government's ability to achieve value for money.

Further, at least three provinces have questioned the system of professionally led regulatory oversight of medical practice. From 2010 to 2011, a series of problems with the quality of diagnostic imaging reports was identified in health authorities in British Columbia. A resulting report recommended improvements in

licensing, credentialing, privileging, and performance management.⁵ In October 2014, Ontario Health Minister Eric Hoskins issued a letter to all college presidents and registrars/executive directors calling for increased public reporting and transparency.⁶ He cited his responsibility under the *Regulated Health Professions Act, 1991*⁷ to regulate in the public interest, including ensuring relevant, timely, useful, and accurate public access to information. Finally, in November 2015, the Quebec National Assembly passed Bill 208 to address the province's concerns about access by establishing minimum requirements for general practitioners and specialists for the provision of patient care. Before its passage, Quebec Health Minister Gaëtan Barrette reached an agreement with physicians to delay implementation until December 2017 in exchange for a commitment to ensure that 85% of the province's population would have a family physician.⁹ This conversation is ongoing, and the challenge to physician autonomy remains.

Physician accountability in Canada is currently governed primarily by the profession. Legislative authority over health professionals is the purview of provincial and territorial governments, which have delegated authority to the provincial medical regulatory colleges. Regulators are responsible for public protection through the licensure of physicians and the development and enforcement of regulations, standards of practice, policies, and guidelines governing medical practice.¹⁰ Concern is growing that colleges may not be sufficiently protecting the public



from incompetent or even criminal physicians.¹¹

Professionally led regulation is a privilege, not a right, and one that can be removed. Regulatory failings in the United Kingdom led to the removal of professionally led regulation through the creation of the Professional Standards Authority for Health and Social Care, an umbrella regulatory body governing the activities of regulatory bodies.¹¹ Composition of the General Medical Council is no longer determined by physicians. In addition, all UK physicians are required to renew their license every five years through a process of revalidation.¹¹

Further, the alignment of incentives/ payments for performance and quality of medical care is an issue of concern. In Canada, fee-for-service (FFS) remains the second most popular payment method, accounting for 37.2% of physician payments.¹² FFS is a volume-based system that rewards physicians for providing services regardless of whether they are necessary or delivered with high quality. This is not to say that a FFS system cannot be successful in achieving desired outcomes, but, as the Canadian system is currently designed, it may limit opportunities to promote quality of care and practitioner accountability.¹³

A number of issues face physicians at the system level: (1) calls for increasing accountability to patients and the system; (2) a need to demonstrate value and quality; (3) the need for a regulatory system that does a better job of protecting the public; and (4) a need to

examine the systems of incentives that have made health care improvements difficult for many years. None of these challenges has an easy solution; they require a reconsideration of the way physicians interact with the system. However, they also represent an opportunity for physician leaders to work with stakeholders to ensure a health system that meets the needs of Canadians.

Unifying the profession

At a recent gathering of Canadian physician thought leaders, participants noted a lack of unity among physicians.¹⁴ They noted divides between family physicians and specialists, between students/ residents and practising physicians, and between medical leaders/ administrators and front-line physicians.

There are many systemic challenges to effective intra-professional relationships in Canadian health care.¹⁵ One of these is the hidden curriculum in medical education; the peer and educator influences that function within the organizational and cultural structure of the institution. It is these unwritten rules and behaviours that work alongside formal training to determine how physicians will practise.¹⁵

Perhaps one of the more difficult realities is the denigration of colleagues that sometimes occurs between specialties.¹⁶ This can be especially true for trainees considering family medicine or psychiatry. Research in Canada and internationally has demonstrated that many specialties

see family physicians as less skilled and not as worthy of respect.¹⁷ Medical students also report the negative attitudes of colleagues and family as a deterrent to choosing psychiatry as a specialty.¹⁸

In his 2014 book, *The Secret Language of Doctors*, Dr. Brian Goldman devotes an entire chapter to the terminology that doctors use to refer to other specialties.¹⁶ Goldman suggests that much of the slang is merely a way to deal with the stresses of medicine; language such as this, however, has the potential to reinforce negative stereotypes and could result in significant strains on intra-professional relationships.

Another potential barrier is the issue of pay relativity. Specialists with similar education, training, and responsibility are sometimes paid vastly different amounts depending on whether they provide procedures or rely on direct patient encounters with no procedures.¹⁹ Annual compensation can differ by hundreds of thousands of dollars between specialties.¹⁶ These pay differentials may lead to conflict, with greater pay being seen as synonymous with greater respect.¹⁶ Although there are no easy answers to this issue, some provinces have begun the difficult process of revising and modernizing their fee codes to address such inequities. This is a good example of the challenging but ultimately necessary conversations that lie ahead for physician leaders in Canada.

There are also serious issues in the relationship between practising physicians and medical

learners. Studies conducted with medical students and residents have found that intimidation and harassment are still issues of concern in Canadian medical training. According to a 2012 survey, 72.9% of respondents reported experiencing inappropriate behaviour from others during residency.²⁰ Of these, half came from attending physicians or nursing staff. Further, 45–93% of residents or junior doctors experienced some form of negative encounter at least once during residency. Verbal abuse was the most common form. Sexual harassment was also documented by 25–60% of residents.

During summer 2016, physician contract negotiations in Ontario presented a stark example of this difficult challenge. Although there was disagreement among physicians at all levels, medical learners seemed to face particularly harsh criticism for their views. Although thankfully small in number, threats to end careers as well as threats of actual physical violence were reported by medical students and residents and were in clear public view in many cases on social media.²¹ The medical profession has an obligation to denounce this sort of behaviour in clear and unmistakable terms.

This treatment of learners is problematic for a number of reasons. Harassment and intimidation can lead to burnout and cynicism.²² Affected learners face isolation, self-blame, and loss of confidence, all of which can lead to deteriorating physical and mental health.²⁰ Witnessing unprofessional behaviour has been



shown to have negative effects on the learner's own personal code of ethics and can become part of the hidden curriculum as outlined above.²³ Finally, witnessing this type of behaviour threatens to work at cross purposes with the values of professionalism being taught in the formal curriculum.

Increasing unity within the profession presents the biggest opportunity for physician leaders. Although burnout and stress from larger system issues can cause negative and disruptive behaviour, physicians are the only ones who can address and improve these relationships. Leaders must be proactive in bridging the divide with front-line physicians. Further, physician leadership should be developed at the clinical level. Finally, efforts should be made to connect system leaders and academics, clinical leaders, and front-line practitioners in addressing the important challenges facing health care in Canada.

Increasing patient-centred care

Another important challenge rests with improving the overall health care experience for our patients.

Research demonstrates that achieving patient-centred care leads to greater patient satisfaction, improved patient outcomes, and a reduction in both underuse and overuse of health care services.²⁴ Research has also demonstrated associated reductions in mortality, hospital acquired infections, and improved patient functional status.²⁵ These results make it clear that increasing patient-centred care will have benefits for physicians as well. Despite this evidence, very few health systems are managing to achieve this objective.

There are a number of challenges to integrating the principles of patient-centred care into medical practice. One is the lack of effective communication between physicians and their patients. Patients are often unsatisfied with communication, even when physicians think they have done a good job.²⁶ Surveys have shown that better communication from physicians is a key desire for patients.²⁶ Researchers have linked poor communication with misdiagnoses, ordering unnecessary tests, and low patient compliance. Poor communication is the root cause of 40% of malpractice suits due to medical errors.²⁷ Conversely,

effective communication increases self-management of chronic disease.²⁸

Another barrier is the way that systems are currently designed: putting providers rather than patients at the centre of system planning and delivery. According to data from a 2013 Commonwealth Fund survey, 62% of Canadians find it difficult to access medical care in the evenings, on weekends, or during holidays.²⁹ Nearly half of respondents (47%) said they had recently used an emergency department for a problem that could have been treated by their family doctor. Fewer than half (41%) can get same-day or next-day access to their family physician.

The relationship between physicians and their patients is fundamental to the practice of high-quality medicine. Bolstering trust should be a primary goal for physician leaders. Improvements will lead to patients who are more engaged in managing their own care. These activated patients often use resources more effectively, take more preventative health steps, and may in fact reduce pressures on the system.³⁰ Reducing pressures on the system, in turn, could translate into reductions in demand for all members of the system, including physicians.

Conclusion: a vision for medicine in the 21st century

The practice of medicine in Canada is facing challenges that are different from those at any other time in recent history. Pressure from patients and society, from governments and from within the

profession is contributing to an era of change and uncertainty.

These challenges also represent tremendous opportunities. The delivery of high-quality patient-centred care and enhanced accountability for clinical outcomes should be promoted by all physician leaders.

Further, there is a need to take action to help unify the medical profession. Leaders should demonstrate to their colleagues that there is much more that unites the profession than divides it and create safe spaces for colleagues to interact with civility.

Finally, leaders need to work together to help restore the trust that is so necessary for effective patient–physician relationships. By demonstrating leadership in health system improvements, physician leaders can ensure a health system that works for their patients, for funders, and for all health care providers.

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Authors

Jenny Buckley, MA, MSc, was senior advisor, Medical Professionalism, at the Canadian Medical Association and is a PhD candidate at Carleton University, Ottawa.

André Bernard, MD, MSc, FRCPC, is chair of the Board of Directors of

Doctors Nova Scotia and an assistant professor in the Department of Anesthesia, Pain Management & Perioperative Medicine, Dalhousie University, Halifax.

Emily Gruenwoltd, MHA, was director of Professional Affairs at the Canadian Medical Association, Ottawa.

Cécile M. Bensimon, MA, PhD, is director of Ethics and Professional Affairs at the Canadian Medical Association, Ottawa.

Jeff Blackmer, MD, MHSc, FRCPC, is vice-president, Medical Professionalism, at the Canadian Medical Association, Ottawa.

Correspondence to:
cecile.bensimon@cma.ca

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PERSPECTIVE

The current reality in Quebec's health care system—Auscultation of an ailing system: the symptoms and their causes



Ruth Vander Stelt, MD

In this turbulent time for health care in Quebec, it is crucial that we establish a clear vision of the steps we need to take to make our health care system a model of quality, accessibility, and safety, and one that we can count on for the long term. As part of the search for solutions, I offer a series of three articles. This first one sketches a portrait of the current situation and

describes the symptoms of profound affliction within our system. The second will conceptualize an ideal future situation, i.e., a system in continuous equilibrium. The third will draw on evidence to support a potential avenue to achieve the desired result.

KEY WORDS: health care system, Quebec, accessibility, costs, clinicians, managers, common goals, co-management

Patients using Quebec's health care system can't help but notice an abundance of undesirable traits: wait lists, inefficiencies, incidents, accidents, lack of communication, and more. However, by attempting to treat these symptoms in isolation, without bringing to light their underlying causes, we risk taking a firefighter's approach, continually trying to put out fires and living in a state of perpetual frustration as new situations crop up here and there.

Maintaining this management style is very much a choice; we also have the option of adopting a more scientific, more reasonable, and much calmer approach, similar to the diagnostic method of clinicians. By treating the undesirable effects of the system like the symptoms of a disease, we will be able to explain them with a single deep etiology. Only then will we be able to prescribe a cure and apply it appropriately.

Society's expectations

When our fellow citizens fall sick, they want to know that they can rely on a high-quality health care system that is not only accessible and safe, but also sustainable. Not only do they want a system that evolves with their values, but they also want to be proud to call that system their own.

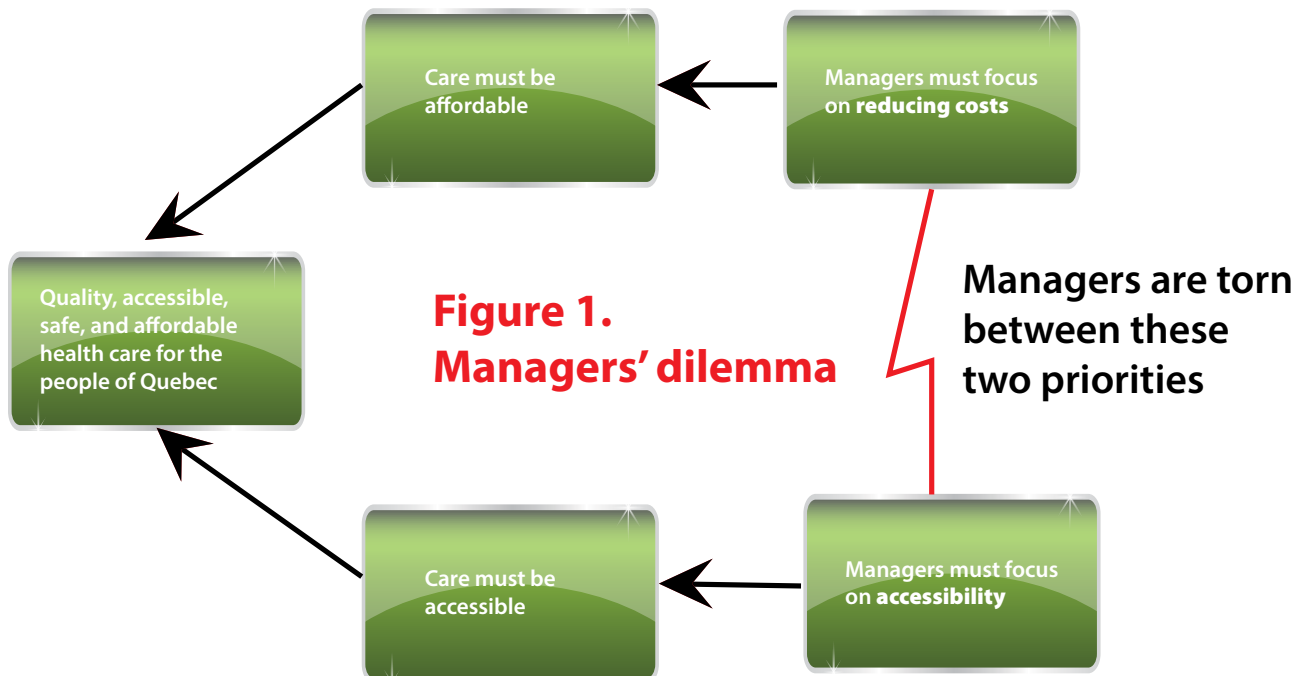
This is why they charge decision-makers with the double task of both treating and preventing disease. It also explains why they are shocked when results are lacking. In fact, any patient entering the system anywhere in the province can easily observe that Tim Horton's restaurants across Quebec have a better mastery of the ABCs of management than publicly funded health care facilities. And since they are funding those services with their taxes, they feel that they are not getting their money's worth. Until very recently, physicians were held

The gulf separating physicians and managers is still extremely wide.

in high esteem by the citizens of Quebec; indeed, it was thought that our doctors played a key role in the organization of care. Moreover, our population was under the illusion that physicians and managers had a certain control over spending. The reality, however, is quite different. In fact, the gulf separating physicians and managers is extremely wide.

Two parallel worlds

We, the doctors and managers of the health care network, essentially share a common goal. We all



work “for the patient” to the best of our abilities and knowledge. However, the dilemmas we face and the perceptions we have of our obligations with respect to the health care system often diverge.

Managers’ duties and the scope of their work are effectively defined by the Ministry of Health and Social Services, which must consider both access to care and the budgetary framework. Managers, thus, endeavour to achieve accessibility while optimizing costs. They regularly update their employer by submitting structured reports, and they offer recommendations for their boards of directors according to allocated budgets. These workers are intimately aware that the needs of each individual patient must harmonize with those of the population at large. In fact, consideration for the health of the population is a part of the continuous discourse of health care administrators across the province.

For their part, physicians naturally concentrate on the patient who

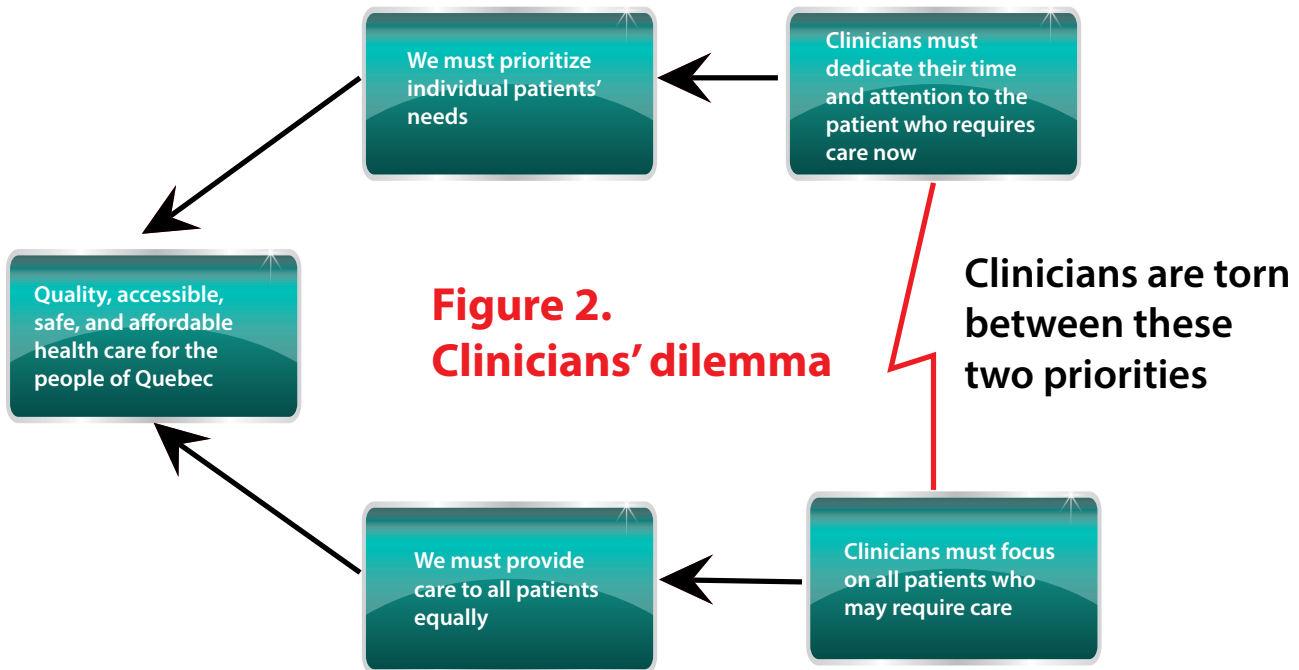
requires immediate attention. As the physician–patient relationship is at the heart of the practice of medicine, it is natural that clinical physicians prioritize the patient they are currently treating. All the more so when we remember that, by taking the Hippocratic oath, the physician pledges allegiance to the patient and the profession, and not to the cost of clinical activities.

In medical school, future physicians learn to recommend the best that science has to offer to their patients. Because advances in medicine and pharmacology have been much more rapid over the last few decades, physicians hasten to treat the diseases they encounter by applying increasingly precise and specialized science. Moreover, given that they are generally not trained in finance or health economics, physicians dedicate their time and attention to the patient in front of them, who needs treatment right then and there. The

patient, thus, receives appropriate medical care.

The concept of population-based responsibility has recently made headway in Quebec. It is not yet well ingrained across the health system, but it appears that the impact physicians could have on the health care system, as well as their involvement in management, may well increasingly extend beyond their relationship with their patients. In fact, it will become more and more obvious that the needs of any one patient must be weighed against a vision that privileges the health of populations. Therein lies the dilemma for clinicians.

As clinicians feel much more responsible for their patients than for the population in general, they take for granted that managers will ensure that patients are sent to them at the right time. However, in Quebec’s current health care



system, it is not at all unusual to hear statements like: “I made my diagnosis and I submitted your request for admission, but the institution did not provide the operating time necessary for your surgery to take place as soon as possible,” or “If I had a nursing/IT/administrative assistant, the system would run more smoothly and you would receive better care.”

Moreover, clinicians generally have relatively little knowledge of the administrative aspects of care and feel more responsible for the quality of the medical procedure than for the management or cost of care. They offer recommendations to their Board of Directors through their establishment's Council of Physicians, Dentists and Pharmacists. These recommendations are based on quality of care and do not take into consideration either financial impact or subsequent waitlists for the population. From their perspective,

this is a completely normal state of affairs. In fact, for them, the worst case scenario would be that their patients are unable to benefit from the latest scientific advances because of budgetary constraints.

Furthermore, physicians have no responsibility to the institutions themselves, but are instead responsible to the province through their union affiliation and professional organization. This means that their responsibilities are more of an ethical and moral nature than specifically territorial or administrative.

Clinicians' expectations of managers, i.e., that they will ensure that the right patient is at the right place at the right time, are simply not officially formulated. Managers attend to their work while making recommendations to their Board of Directors. They are accustomed to the fact that clinicians prioritize their patients over budgetary

constraints. Thus, managers fulfill their mandate as best they can while under no perceived obligation to either consult clinicians about their decisions or even keep them informed.

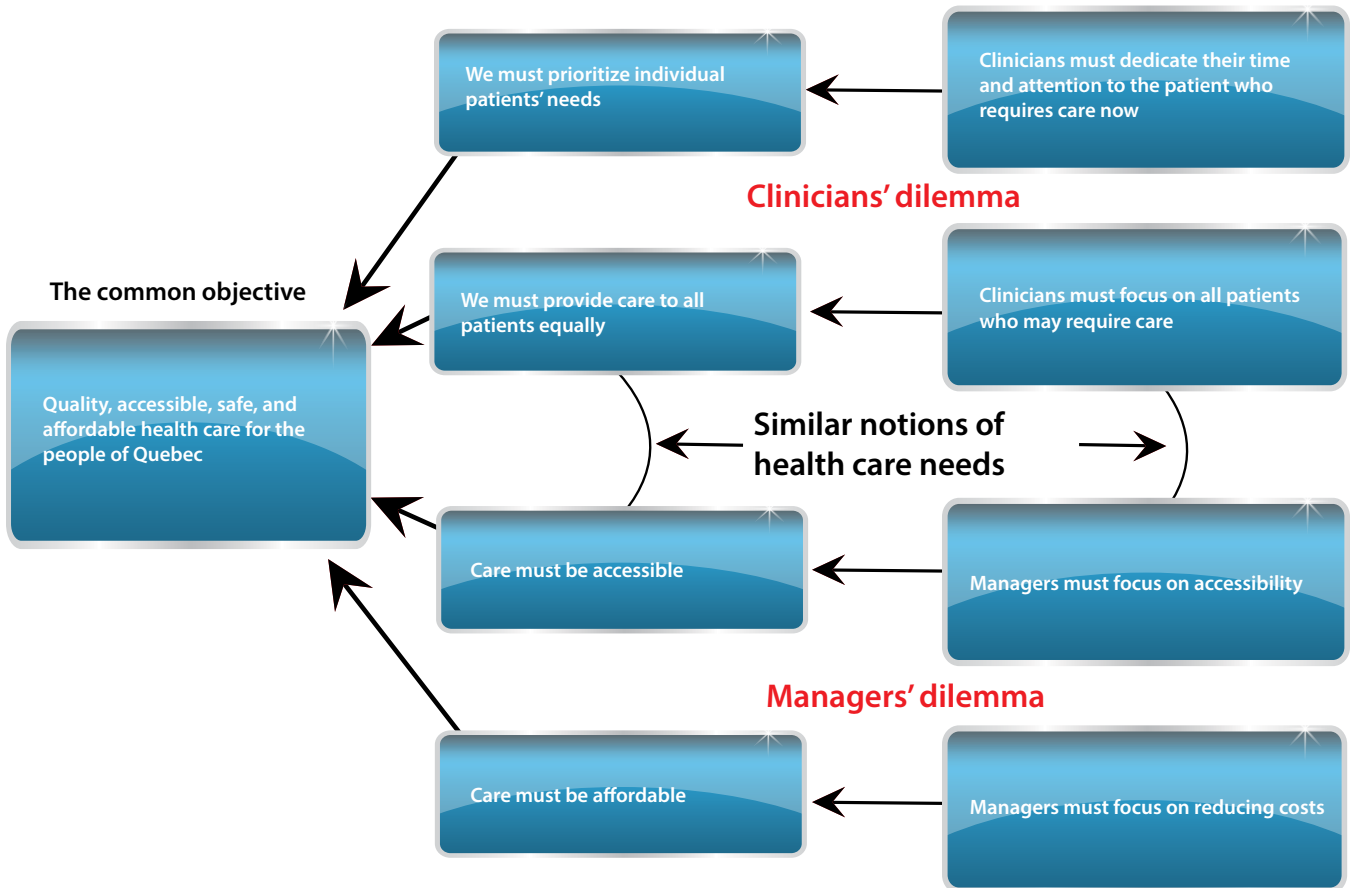
Thus, health care managers and clinicians are on completely different wavelengths. Worse still, they work in parallel structures under conflicting priorities. It follows that even if board members want patients at their particular institution to have access to better care, they must often choose between clinical recommendations and budgetary constraints.

Common ground

Resolving the dilemmas of managers and clinicians requires careful comparison of their underlying nature. After all, experts working in the same field very likely face similar problems.

First, let us note that clinicians and

Figure 3. Possible common ground



managers are faced with rather distinct realities. Clinicians spend most of their practice time with individual patients. Managers, on the other hand, have to deal with questions about system costs, for which they are accountable.

However, when we examine the accessibility side of the problem more closely, we find that managers and physicians share similar concerns: on the one hand, clinicians feel more and more responsible for the needs of the community, while on the other, managers are responsible for waitlists.

It is, thus, on the issue of accessibility that managers and physicians are now beginning to draw closer together. Even if we have a long way to go, there

is a glimmer of hope for the physician–health care manager comanagement approach currently catching on here and there across the province.

Principles of the solution

Many dilemmas confront all players in the system, whether we are clinicians, managers, or users of the system.

As we will see in the next article in our series, a solution to our current predicament must take a direction based on four principles:

- The approach must be patient centred and clinically based. To achieve this, we must base care objectives on the needs

of individual patients by setting our priorities on a clinical basis.

- The main objective is to improve the flow of patients through all trajectories of care simultaneously. By identifying which task or resource creates the longest wait times for the most patients in the system and by improving the synchronization of resources, we can quickly reduce wait times without using additional resources.
- Continuous improvement of the system to balance the flow of patients is of vital importance. Balancing the flow of the system is very different from balancing its capacity. We often make the mistake of confusing these two factors when we try to improve the health care

system. We need to identify the most frequent causes of interruption in patient flow to eliminate them as rapidly as possible.

- The elimination of local optimization measures is essential when improving many interacting chains of activity. Otherwise, local optimization will continue to interrupt the flow of patients through the system and stall the continuous improvement process.

Any and all solutions must simultaneously:

- Create an ever flourishing health and social care system
- Rapidly improve the quality, safety, and timeliness of patient care
- Rapidly improve the affordability of care
- Not create more complexity for staff

Furthermore, for comanagement teams to understand each other and work in a coherent fashion, clinicians must accept the responsibility of making care more affordable and managers must agree to help improve the

quality of care. Together, these two professional bodies must work to improve the accessibility of care. The common goal of all these objectives is to encourage the free circulation of patients through the system.

It is on the issue of accessibility that managers and physicians are beginning to draw closer together. Even if we have a long way to go, there is a glimmer of hope in physician-health care manager co-management.

Conclusion

The primary objective of health care is to have fewer and fewer people using the system for the simple reason that they have less and less need for it. In fact, in Quebec, citizens have been loud and clear in their call for policymakers to focus on prevention to decrease the number of sick people. These efforts must necessarily come from the government as a whole and not just the Ministry of Health and

Social Services.

And, yet, Quebec's health care system is in an unprecedented state of turmoil.

When they venture into the system, people do not always find the high-quality, accessible, safe, and sustainable system they expect. Clinicians and managers often have parallel perspectives and modus operandi that barely enter into dialogue with each other. The time has come to put forward a solution that is patient-centred and clinically based, a solution that will facilitate patient flow through all care trajectories within a continuously improving environment. This solution must simultaneously eliminate local measures of optimization which impede system fluidity and cloud focus. We will be able to assess the success of this solution by measuring the improvement of care, the capacity to pay, and the creation of a sustainable environment that does not create more complexity for health care workers.

Author

Ruth Vander Stelt, BA, MD, CMFC, MM, is a family physician practising in the Pontiac region of western Quebec. She has also served as president of the Association médicale du Québec.

Correspondence to:

ruthvanderstelt@gmail.com

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REFLECTIONS

Leadership lessons from the Rio Paralympic Games



Gaétan Tardif, MD, ICD.D

The Rio Paralympic Games experience can be seen as a condensed leadership lab that allows for reflection and learning that can be applied to physician leadership. Starting with good governance is essential, including clarity of message and proper stakeholder engagement. Preparation is key and involves scenario-based planning for expected as well as less-expected but risk-laden situations. Leadership presence and leveraging team skills are paramount.

KEY WORDS: leadership experience, Paralympic Games, governance, key messages,

stakeholder engagement, communication, preparation, scenario-based planning, leadership presence

My involvement in the Paralympic Games makes me a better health care leader. The paralympic experience, it turns out, is a condensed leadership lab conducted in a fishbowl. With a set beginning and end, the event allows for rapid reflection and learning that will be applied to the next games.

The basic premise for success in a large sporting event can be equally applied to many other endeavours, including the running of a large health care organization. With everything magnified — the successes and failures are indeed very public — and so compressed in time, the lessons that emerge cannot be easily ignored.

Here are a few key points I learned from my participation at the last nine Paralympic and Winter Paralympic Games, most recently in Rio de Janeiro. I've grouped them around three themes: good governance, practice, and leadership presence.

Start with good governance

Success comes to the well prepared, and preparation starts



with good governance. Private businesses are keenly aware of the importance of a high-functioning board of directors, and these people are selected carefully to ensure a wide variety of skills around the table.



The Canadian Paralympic Committee's Board of Directors is chosen through an open election, a common occurrence in the world of sport. For the chair, this represents a challenge, as he or she is given a team of people chosen by the member sports organizations rather than people specifically picked for their balance of skills.

Although this is a departure from best practices for most business people, it will feel familiar to the health care leader. Who among us was able to choose the physician leaders on the Medical Advisory Committee? We are generally given a mandate and a group of smart people to work with, but must find all the skills we need in that group, occasionally with a bit of outside help.

The successful leader will spend time learning something about the members of the team, what they really care about, and what skills they have that may help further

the goals of the group as a whole. It takes time, and there can be no shortcuts. Email is not a particularly good tool for this; instead, the effective leader will “cross the floor,” meet colleagues on their own turf, create time for listening, and invite comment from those who care about the organization.

Seek a variety of opinions



Looking at an issue from all angles minimizes the risk of preventable failure. Some of the most useful advice I was given was, ask “what else?” and count to seven before moving on. This practice gives team or group members permission to think and raise an issue rather than simply react. Too often, I’ve heard the ubiquitous, “anything else?” with the unspoken message “please don’t.” If some lower items on the agenda have to be deferred, so be it. A well-constructed agenda places the important items up front for this very reason.

Be mindful that, in complex environments, discussions are often as political as they are business-related. People around the table may have different motives, often directed by their peer groups. An effective board eventually rises above these constraints, but it takes time, and trust must be built among the group.

Don’t get into the weeds



Pay attention, but don’t try to run someone else’s business. “Noses in, fingers out” is the golden rule of governance. For instance, at the Canadian Paralympic Committee, we have talented staff, who are experts in their field. We also have board members who have similar responsibilities in other organizations and great operational skills. They may want to focus on minutiae to the detriment of the big picture. Blind spots can easily emerge when one gets too close to the ground.

In fact, one of the most difficult tasks of the chair may be developing an effective way to say, “We have more important things to discuss right now,” but this is crucial to board functioning. As it’s likely that the person focusing on details has an emotional attachment to the issue, redirecting without disengaging is an important skill for the leader to develop.

Engage all partners



Is the paralympics all about the athletes? Is health care all about patients? Yes, to a certain extent, but in reality both involve many other stakeholders, all of whom have a significant interest in a positive outcome. Coaches, national sports organizations, sponsors, and government all have a real stake in the success of the games. However, how they measure success may vary significantly. As a leader you may not necessarily agree, but failure to engage is akin to operating with one’s head in the sand.

Know your key messages



Blaise Pascal once said, “I would have written a shorter letter, but I did not have the time.” Make sure you are clear and concise about what your group is trying to say. Those who disagree with you, or have other personal motives, will undoubtedly try to take you in a different direction. Spending time agreeing on the important messages — and communicating them clearly to all stakeholders — is a crucial component of success.

Knowing your key messages can also make decision-making easier. Shortly before the Rio Paralympics, the International Paralympic Committee announced a total ban on Russia’s participation. Despite

numerous requests, I refused to go on live television to discuss the issue, as it was clear from the pre-interviews that journalists' preferred story was criticism of the Olympic movement rather than highlighting the work of the paralympics. Criticizing our partners was definitely not a top message for us; thus, we passed up the opportunity for media coverage that was not congruent with our aspirations.

Practice makes perfect



Practising in the operating room is not a good idea, and neither is trying to run a complex games operation without proper practice. Our challenge is compounded by the fact that a large proportion of the mission team on site is composed of volunteers and staff of other organizations, such as national sports bodies. Yet they have to operate as one unit during the games in support of the athletes.

Groups within the mission team each have clear leadership (e.g., media, medical, security), but, even at that sub-team level, new relationships have to be forged very rapidly. This is best done before the stress of the games begins and the inevitable tensions occur when the needs of one team clash with those of another.

A few months before the games, the entire mission team meets for several days to rehearse and, more important, to work and solve problems together in a controlled environment. In fact, the inability to attend this orientation session is a disqualifying factor for participation at the games.

Communication is the key



If safety huddles are new to Canadian hospitals, they are not to running games operations and are deemed essential to team success. They last a bit longer, and a “look back, look ahead” format is used to ensure that mistakes are not repeated or compounded and that one team’s plans will not compromise the success of another. Despite the high stress and time constraints, these regular meetings take place twice a day and take precedence over other activities, even sleep, which unfortunately comes in short supply to our volunteers.

Plan for the expected

It's fairly easy to be motivated to prepare for an event that has a high probability of occurring. That at least one athlete will be significantly injured or become sick during the games is almost a certainty. It's also not difficult to dedicate time to

incidents that often occur and can have significant negative outcomes, particularly if a non-event would be welcome news; a Norwalk virus outbreak would be one such instance.



In Rio, the main issues highlighted by the press were possible violent crime, demonstrations related to political instability, and, most of all, the Zika virus.

As well-informed professionals, our concerns were 180 degrees from those conveyed by the Canadian press. Spontaneous demonstration and political turmoil were the least predictable and controllable, crime was worrisome but manageable, and Zika was really a non-issue based on the scientific evidence we had received. Most of us never saw a mosquito during our entire stay, although several ankles were feasted on by “no-see-ems.”

The lesson for health care leaders here is that emotion trumps knowledge. As tempting as it may have been to be dismissive about Zika, this would have been seen as not caring about the team, and who would follow a leader who doesn't care? We prepared for Zika, even though the chances of having to implement any on-site plan was remote.

Plan for the unexpected



It is more difficult to find motivation to spend time on events that have little chance of occurring. However, building scenarios for practice around the same issues can be counterproductive; practice becomes repetitive, less engaging, and the response less creative. The answer can be to create credible scenarios around events with some level of probability rather than the truly rare and unexpected.

For the Vancouver Winter Olympics and Paralympic Games, a course was developed to train, not only the Canadian team, but also the host Vancouver-based medical volunteers who would provide assistance to athletes from all nations at the various sport venues.

The course leader, Dr. Julia Alleyne, who later became the chief medical officer for the Toronto Pan-Am and Parapan-Am Games, used this approach in developing a two-day course, and she was eerily accurate in her predictions. The two anchor cases were a crash on the bobsled track and a medal contender seriously shaken by the death of a close relative.

Anchoring the course kept the participants engaged and their

minds open to “what ifs.” This type of approach can be very useful in a difficult project implementation, or even introducing a new patient population or procedure to your health care organization.

Leadership presence



Leaders must be visible and easy to follow. I have already alluded to clarity of message as a prerequisite to good leadership; equally critical is being present at important moments.

Visibility has always been difficult for me, and jumping on a podium is not within my comfort zone. In reality, how you are received has more to do with the receptors and filters of your audience than how you think you are communicating. Symbols are important and we all use them, whether we are aware of it or not. Knowing your own biases, and factoring them in, is a must for an effective leader.

This was demonstrated near the end of the games, when our wheelchair basketball teams held an event to thank their families and friends for their support. Our men's team, the defending paralympic gold medalists, although in a renewal phase, had not expected to lose so many games. Our

women's team, the defending world champions, had just lost a tough quarter final and would not even make the medal rounds.

I was asked to say a few words and declined. Who wants to hear from a guy in a suit when in pain? However, the basketball team manager, whom I had gotten to know well during our training seminar, ignored my wishes and called me to the stage. I don't really recall what I said. I just recall athletes and parents coming by through the evening to thank me for coming and making a few comments. The women's team captain even sent me an email the next morning. Having a relationship with a colleague who understood the power of being visible proved invaluable to me.

One cannot rush success. Medical professionals are often frustrated by what they perceive as suboptimal results from their teams. My experience is that this is almost always a result of deficits in governance, preparation, or leadership presence. Having the paralympic fishbowl as a laboratory has proven extremely helpful in making these lessons clear to me.

Author

Gaétan Tardif, MD, FRCPC, ICD.D, is president of the Canadian Paralympic Committee. He is also physiatrist in chief at the Toronto Rehabilitation Institute, University Health Network, and a professor of medicine at the University of Toronto.

Correspondence to: gaetan.tardif@uhn.ca

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Physician health as a potential indicator of quality



Laura Calhoun, MD

Physicians have the right and the responsibility to be physically and emotionally healthy, and patients deserve healthy physicians. Physicians who are unwell are less likely to provide quality patient care. To achieve better health for themselves and their patients, physicians must overcome the stigma attached to their own illnesses and allow themselves to be patients when appropriate. At a systems level, national stakeholders are demonstrating a commitment to physician health and wellness.

KEY WORDS: physician health, resiliency, burnout, patient safety,

mental illness, stigma, quality of patient care, quality indicator

Physicians have long been interested in the quality of patient care, sometimes to the exclusion of other factors, such as cost, which can lead to tension between physicians and administrative health care leaders. The desire of physicians to do the best for patients to the exclusion of other considerations can also mean that they neglect their own health and well-being. This selflessness can have the unintended consequence of physician burnout.

Several studies point to this concern and the subsequent risk of mental illness, as well as the increased risk of death by suicide, in the medical profession.^{1,2,3} At the same time, the stigma around mental illness is high in health care and researchers posit that stigma may be one of the factors involved in physicians' reluctance to seek psychological treatment.^{4,5} Add to this a third body of knowledge that has emerged in recent years indicating that physicians who are unwell, fatigued, or even poorly fed are less likely to provide quality patient care, and an opportunity to improve quality of care emerges.^{6,7}

This paper explores this equation: physician over-dedication to patient care leads to fatigue and burnout. Because of the stigma around mental illness, physicians tend to keep working and not ask for help. When many physicians are unwell, the quality of care they provide decreases.

Physician wellness has been suggested as a quality indicator

in the past.⁶ This paper describes some of the emergent changes at the macro-level of health care in Canada in this regard and points to an opportunity at the meso-level where quality indicators are decided and at the micro-level, among physicians themselves.

Scope of the problem

In November 2016, West et al.⁸ noted that burnout has reached “epidemic levels” for physicians in the United States. The latest American Physician’s survey⁹ states that “The majority of physicians surveyed, describe their morale as somewhat or very negative.”

Although Canada-wide data are outdated — the last Canadian Medical Association (CMA) survey was in 2008³ — they are generally similar to those of the United States. The 2008 survey revealed that workload, coupled with incongruence between personal and workplace values, explained the increased risk of burnout in physicians. The survey revealed that 46% of respondents were at an advanced stage of burnout.

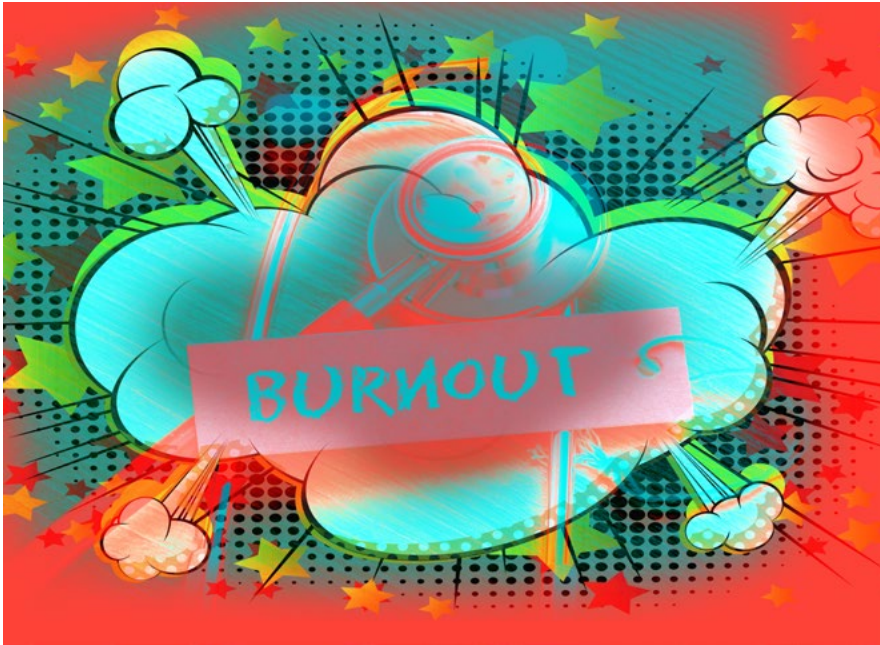
A recent review of physician health literature states: “Because of methodological differences, it is difficult to accurately determine the actual prevalence of mental health problems among physicians, but there is a higher frequency of burnout and death by suicide compared to the population as a whole.”¹

Paradoxically, the public generally perceive physicians as a healthy group. As they are mostly self-employed, they have control over

their time, ostensibly allowing them to attend to their self-care. Further, their workplace affords them access to knowledgeable colleagues, so they can quickly get an educated opinion on how to manage their own health.¹

Not all physicians will experience burnout at the same rate even with the same experiences.¹ The causal factors thought to underlie burnout are multiple and interdependencies between the factors create individual physician risk profiles.

dismemberment, and other suffering; making an error that results in patient harm or death; and always being held accountable for poor outcomes despite not having full control of a care team.^{1,3,11} In a Canadian study of physician stress, 28% of respondents identified intrinsic factors as major contributors to their stress levels.¹¹



What is burnout?

Burnout is most frequently described and measured using the Maslach definition and inventory. The Maslach Burnout Inventory (MBI) scale measures the three components of burnout: emotional exhaustion, depersonalization, and a low sense of personal accomplishment.¹⁰

Depersonalization is experienced as a detachment, especially from emotions and thoughts, such that the person is aware they have emotions but cannot feel them, and their thinking can feel slowed and cloudy. Depersonalization is a defense mechanism also used by survivors of trauma to protect themselves from their experiences.

Roman and Prevost¹ have divided these factors into three groups: factors intrinsic to the physician work place; factors extrinsic to the physician work place; and internal factors, i.e., intrapersonal characteristics that each physician brings with them into their work world.

Intrinsic factors

Intrinsic factors are those resulting from the physician's workplace. They include: constantly working in an emotionally charged environment that involves suffering and/or death; dealing with patients who have chronic disease and unrealistic expectations; conveying bad news to patients and families; dealing with difficult patients and colleagues; the vicarious trauma of repeatedly witnessing death,

Extrinsic factors

Extrinsic factors, as a source of burnout, refer, "not to medical practice itself, but rather to how it is organized."¹¹ Examples include: the ever-increasing workload, rising expectations to be more than a medical expert, shortage of time required to do all things well, long duty hours and resulting fatigue, rapid changes in medicine as well as governance and structure, decreasing professional autonomy, lack of work-life balance, increasingly being called to take on management and leadership roles, and media reports on the low value for money of Canadian health care combined with the knowledge that physicians are one of the main drivers of health care costs.^{1,11}

Lemaire and Wallace¹¹ discovered that physicians identified extrinsic factors as the number one source of their stress. "Approximately one-half (43%) of the physicians indicated that the most stressful aspect of their work was related to feeling overwhelmed with their workload."

Individual factors

Many authors have identified individual factors that put physicians at increased risk of burnout.^{1,12,13} Personality traits, such as perfectionism, are known to increase the risk of

major depression in the general population, and physicians are no different. Myers and Gabbard¹³ describe a triad of personality traits, common to physicians that increase the risk of burnout and mental illnesses: self-doubt, guilt, and an exaggerated sense of responsibility.

Lemaire and Wallace¹² found that 36% of the physicians in their sample self-identified as “control freaks.” Physicians with a high need for control can have a detrimental impact on their care team when something goes awry, such that others on the team are walking on eggshells trying to avoid the ire of the physician. This type of interpersonal dynamic can lead to poor communication between team members and a decrease in care quality.

Barriers to self-care

Barriers to care occur at the individual, organizational, and system level; however, individual barriers offer the biggest opportunity for change.

Dike Drummond (commonly known as The Happy MD) astutely observes that the medical education that physicians endure and require to be successful also sets them up for burnout.¹⁴ Physicians are trained to be “perfectionistic, superheroes, lone rangers and workaholics” and these ways of behaving and thinking can be adaptive — when they are used in the right place and at the right time. However, when these unconscious structures become automatic and generalized, they can lead to burnout, lost relationships, and ill health.



The stigma surrounding mental illness is an individual barrier to care. Stigma is an overarching term that includes labeling, separation, prejudice, and discrimination.¹⁵ Stigma against the mentally ill is widely identified as one of the biggest barriers to care.

Self-stigma comes about as an internalization of others’ beliefs. Self-stigma is understandably a major barrier for physicians who have signs and symptoms of burnout or mental illness. Doctors are well aware what a “formal diagnosis” might mean — scaling back workload, losing privileges, or being uninsurable.¹ “Stigma is reinforced by teaching and encouraging physicians to place a low priority on their own health, to deny they have any health problems, to keep any concerns about themselves or their colleagues to themselves, and to deal with it on their own.”¹⁵

Stigma is highest inside health care itself.^{4,5} The Mental Health

Commission of Canada (MHCC) has a project aimed at decreasing stigma inside health care for the very reason that they identified health care providers as highly stigmatizing.¹⁶

Physicians’ addictions and mental illnesses can come to light during the investigation phase of a patient complaint or an adverse event. When the adverse event is related to physician illness, the physician has traditionally been disciplined, which sends the message that “to be ill is to be bad,” further increasing stigma.⁵ Furthermore, among physicians with perfectionistic personality traits, this type of investigation can be traumatic and lead to increased risk of death by suicide.¹³

“Self-treatment becomes a strategy that is accepted and even encouraged by colleagues, since it allows physicians to stay on the job and avoid the discomfort of having to assume the role of patient.”¹

Drilled into physicians during their extensive and intensive training is the identity of caregiver or healer

and the idea that physicians care for and heal “the other,” i.e., patients. This binary division sets up a false dichotomy between physicians and patients, which is adaptive when used appropriately and maladaptive when taken to the extreme. When physicians internalize the idea that needing help means being one of “them,” that coming forward with emotional concerns means losing your social identity as a healer, they use defense mechanisms like denial to defend against the resulting anxiety.¹⁷

Quality of patient care

Systemic quality of care indicators are listed by the Canadian Institute of Health Information (CIHI) as: appropriate (evidence-based), patient centred, safe, and timely.¹⁸

These indicators are at the macro level, and it is up to individual provinces to model what they measure inside their own systems to align with them. In Alberta Health Services, for example, at the meso-level, the quality indicators are: appropriateness, acceptability, accessibility, effectiveness, efficiency, and safety.¹⁹ For each of these indicators, a set of measurements is taken on a regular basis. As an example, one of the safety indicators measured is adverse events.

In a Lancet article titled, “Physician wellness, a missing quality indicator,”²⁰ the authors argue that, should physician wellness be a priority for individual physicians as well as for health care systems, improvements would be seen in productivity and efficiency, quality of care, patient satisfaction and

adherence to treatment, medical errors, and recruitment and retention of physicians. They state that “measurement of provider wellness as a health-system quality indicator could be highly beneficial.”

Other authors have made the link between physician burnout and quality of patient care.²⁰ A Canadian study revealed a connection between proper nutrition of physicians and the quality of patient care delivered.⁷ In an exploratory study, the authors found that physicians themselves do not recognize the relation between their own self-care and the quality of the care they provide.² Some research reveals that physicians who have experienced the beneficial effects of a healthy lifestyle are better at promoting these benefits to patients.^{21,22}

On the flip side of this coin, many studies have shown the effect of physician burnout: reduced efficiency and safety, especially medical errors. At the time this article was written, the Resident Doctors of Canada website included a link to multiple articles on physician burnout and its effect on quality of care.²³ Wallace et al.⁶ also cite numerous studies.

Moving physician wellness forward

At an organizational level, most provincial medical associations offer a range of health and wellness services to physicians. These services rely on self-identification and are anonymous, so few data are available. Some health authorities, such as Alberta Health Services, are beginning to incorporate physician wellness into

their human resources strategy, recognizing that without healthy physicians, the goal of “patient first” health care is impossible to achieve.

When physicians internalize the idea that needing help means being one of “them,” that coming forward with emotional concerns means losing your social identity as a healer, they use defense mechanisms like denial to defend against the resulting anxiety

At a systems level, national stakeholders have demonstrated their commitment to physician health and wellness. For instance, within the Royal College of Physicians and Surgeons of Canada’s “professional” CanMEDS role, residents must demonstrate a commitment to maintaining their own health as well as that of their colleagues. The Canadian Medical Association (CMA) is revising its 1998 policy on physician health²⁴ and creating a forum that will bring together provincial and territorial health programs in Canada. Major initiatives have also been taken by other national organizations, including those representing students and residents. The Canadian Federation of Medical Students recently completed the first national survey of medical student health and wellness and the Resident Doctors of Canada is developing a resiliency curriculum, among other initiatives.²³

The Mental Health Commission of Canada (MHCC) has been

working in the area of stigma in the workplace for many years and provides hope for physician leaders. In the past five years the MHCC has developed, offered, and evaluated programs that help reduce stigma in the military and in first responders. Two programs — Opening Minds and Road to Mental Readiness (R2MR) — have been shown to decrease stigma and increase mental wellness in these two populations. Currently, the MHCC is working on implementing this training in Nova Scotia's health authority (Dr. Laura Smith, Nova Scotia Health Authority, 15 Nov. 2016, personal communication). The Resident Doctors of Canada resiliency curriculum is based on the R2MR program.²³

Although the work of these regulatory and supporting bodies in physician health is important, physicians themselves have the biggest opportunity to effect change. The future will require physicians who value their own health and the quality of patient care at the same time. It will require physicians to let go of the binary, “us and them,” and tolerate the uncertainty of a continuum of identity. Empowering physicians to put their own health on an equal footing with patient's health is but the first step.

Conclusion

Physicians have the right and the responsibility to be physically and emotionally healthy. Patients deserve healthy physicians. Health organizations must invest in this valuable human resource and consider measuring their investment as one of the indicators

of quality patient care. The evidence surrounding the need for healthy physicians is mounting. How long can we afford to wait to take action?

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Author

Laura Calhoun, MD, FRCPC, MAL(H), CEC, is a psychiatrist and senior medical leader for Alberta Health Services. She currently works in human resources with a focus on physicians.

Correspondence to: Laura.Calhoun@ahs.ca

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CSPL WHITE PAPER

A blueprint for improving physician engagement and leadership in the Canadian health care system



Johny Van Aerde, MD, PhD, and Graham Dickson, PhD



Efficient and effective reform of Canada's health care system cannot occur without the active and willing participation and leadership of physicians. Physicians must work

If you would like more information about this issue and the white paper, want to develop an immediate action plan for your sphere of influence, or be a spokesperson for the white paper, please join us for an Interactive Workshop directly following the Canadian Conference on Physician Leadership on Saturday, April 29 at 3:30 pm, Hyatt Regency Hotel, Plaza C, Vancouver.

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with others to change the structural, cultural, and political environment if we are to accomplish that goal. In addition, physicians' own views of leadership must change, along with the mindsets of system managers, members of other professions, and providers in pursuit of this aim. A number of challenges exist: capacity challenges, mindset challenges, collaborative leadership challenges, educational challenges, and alignment challenges. However, none of these is insurmountable.

The purpose of the CSPL's white paper¹ is to stimulate dialogue and action: to help develop an environment that will create the energy and commitment needed for physicians to take charge of their own future — on their own and in collaboration with their partners in the health care system. For transformation of the Canadian health care system to be successful, physicians must play a central role in planning and implementing change. This necessitates collaborative and distributive leadership in cooperation with other groups — citizens, administrators, politicians, and allied health care professionals — particularly because of the current fragmentation of the system at many levels.

The content of this paper is fueled by commitment, energy, and passion; guided by a clear goal; and accompanied by concrete suggestions for action drawn from the CSPL community. The paper is based on the results of a study² conducted by the CSPL, with financial and personnel support from the Canadian Medical Association (CMA) and the Centre for Health Innovation (CHI) at the University of Manitoba; on data from Canadian and international studies on the physician leadership needed for effective reform of the health care system; and on conversations with CSPL members in a workshop setting. Yet, it is only a start. Those writing the paper, and the physicians who contributed to it, are fully aware that a systemic, coordinated effort across the whole health care system is needed to ensure that the contribution physicians can make to reform is realized. The paper is intended to stimulate a next step: dialogue and action crafted together by all agents of the Canadian health care system in support of physician engagement and physician leadership.

As a profession, physicians have a unique and central role to play in service delivery, and, in most instances, they are paid directly by government rather than health

care service delivery organizations. Currently, the processes and methods dedicated to creating and supporting physician leaders, i.e., education, mentorship, and professional leadership development, are disorganized, episodic, and limited in scope, if they exist at all. When changes in service delivery are expected, physicians must develop a critical mass of knowledgeable and effective leaders to ensure they are partners in the process.

Governments, administrators, and physicians themselves at all levels must formally recognize the role of physicians as leaders. Steps must be taken by all groups to ensure that the scope and breadth of physician leadership needed to effectively transform the health care system exist. To that end, a philosophy and infrastructure supporting the creation of meaningful physician engagement and leadership must be built.

The white paper is the first step toward systematically and strategically improving physician engagement and leadership in the Canadian health care system. The process begins with an argument for and articulation of the goal. However, that in itself is not enough. Such a change requires broader systemic engagement of partners who agree on the challenges and the solutions. We recommend actions to stimulate structural, cultural, political, and personal change. Those actions must be informed by a broader dialogue about whether they are appropriate and, more important, how to make them work. The goal is to generate energy to improve

physician leadership at all levels and make physicians true partners in efforts to achieve meaningful large-scale change.

Recommendations from the white paper

What physicians should do

We recommend that physicians, individually and collectively:

1. Explore and challenge their personal mental models and the world views that restrict them from (a) engaging in the health care system and (b) realizing their potential as leaders.
2. Be willing personally to participate in and champion efforts by colleagues to understand the reform agenda within their provincial health care system and the implications for their own area of responsibility.
3. Take advantage of opportunities provided by colleagues, fellow professionals, health organizations, regions, and governments to participate in reform initiatives, especially patient-safety and quality-improvement initiatives.
4. Take steps to negotiate appropriate working conditions for physicians in a reformed health care system.
5. Become active champions for, and partners in, physician engagement and physician leadership development.

What health care service organizations should do

We recommend that health care organizations, including hospitals, primary care agencies, health regions, and long-term care organizations, either individually or collectively:

6. Measure the current level of engagement of their physician population, both those working in house and those working

in partnership as independent contractors.

7. Gather data and information about the current state of physician leadership in their organization to understand roles, responsibilities, remuneration, time allocation, and contracts and determine a base line for improvement.
8. Make changes in organizational structure and design, jointly advocated by the organization and physician representatives, to alter policies and practices toward involving physicians in informal and formal leadership roles.
9. Engage in projects to ensure that the organizational culture is conducive to facilitating and supporting the engagement and leadership of physicians.
10. Use informal and formal communications approaches to ensure that physicians are aware of organizational issues and priorities and are able to respond and provide feedback on such issues.
11. Identify potential future physician leaders and ensure their mentorship and development.

What provinces and medical associations should do

We recommend that provincial ministries and medical associations take steps to:

12. Initiate negotiations to develop an enabling policy framework that formalizes and supports regional and organizational efforts to realize effective physician leadership and engagement.
13. In the absence of an appetite in both parties to enter into such negotiations, build trust as a first step toward an increased willingness to negotiate.
14. Work with universities and health research agencies, both provincially and nationally, to identify best practices; either conduct or gather research on the impact of various models of physician leadership and engagement; and share that

- knowledge widely with potential partners.
15. Publicize the benefits of meaningful physician engagement and leadership by explicitly recognizing those benefits.
 16. Provide financial support for physician leadership development and remuneration for physicians in leadership roles.

What Canada should do

We recommend the following actions at the national level:

17. The Government of Canada and Health Canada are encouraged to endorse the recommendations of the Advisory Panel on Healthcare Innovation and, in the spirit of human resource development, instill in the national innovation hub strong support for physician leadership development and engagement.
18. The Canadian Society of Physician Leaders is encouraged to develop a national strategy, in partnership with other national physician organizations, such as the Canadian Medical Association and others, to coordinate their existing resources and new efforts to help provinces and regions increase physician engagement and leadership capabilities across Canada.
19. The Canadian Medical Association should develop a policy statement that recognizes the importance of physician leadership in health care reform and, through its subsidiary, Joule, reform and expand its existing efforts to increase physician leadership.
20. The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, provincial colleges, and medical schools across the country should expand their efforts to embed leadership development in formal medical education and professional development curricula and explore options, such as the Royal Australasian College of Medical Administrators, to

recognize physicians who move permanently into formal leadership roles.

We hope the white paper will stimulate national, provincial, regional, and local conversations to identify and implement actions that will generate greater physician leadership in the area of health care reform.

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Authors

Johny Van Aerde, MD, PhD, is editor-in-chief of the Canadian Journal of Physician Leadership and a past president of the CSPL.

Graham Dickson, PhD, is senior research advisor to the Canadian Society of Physician Leaders.

Correspondence to:
johny.vanaerde@gmail.com



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ADVICE

Transitioning to an executive role? What you should know about your retirement plan



Vince Tarantino, MBA, CFP, CIM

For many physicians, the decision to move into an executive role is driven by a desire to improve the health care system. Their unique knowledge of the health care system, combined with practical experience, often translates well into a role as a health care steward. However, although the personal rewards are obvious, one important consideration is the potential impact on retirement plans.

KEY WORDS: retirement plan, leadership role

Supplemental retirement plans

In my practice as a financial consultant, I work exclusively with physician clients, some of whom have decided to transition into an executive role. For many physicians at the higher end of the pay scale, a common question is how to set up a supplemental retirement plan to compensate for the fact that they have maximized their registered retirement savings plan (RRSP) contributions.

Many hospitals will supplement their executive compensation packages with long-term incentive payouts.

A hospital or health care facility may offer a supplemental retirement plan, such as a retirement compensation arrangement (RCA) as an additional incentive to enhance retirement income benefits. These structures help physician executives retain more money in registered savings than they could in a regular RRSP. In turn, the hospital can avoid the administrative burden and risks associated with operating a retirement pension plan for such a relatively small pool of senior employees.

Many hospitals will supplement their executive compensation packages with long-term incentive payouts. Unfortunately, when these payouts are received by the executive they will be treated as income and taxed at the top marginal rate, which could amount to more than half of the incentive compensation. In some cases,

restructuring an RCA agreement can reduce the tax impact on these payouts and improve the client's longer-term retirement outlook.

Fraser Lang, senior vice-president at Gordon B. Lang & Associates Inc., specializes in retirement, health and welfare, and taxation solutions. He and his team have done extensive work with MD Management over the years, and he believes that supplemental retirement plans may become increasingly valuable to physicians, particularly given the federal tax changes to certain complex corporate and partnership structures. The new rules may affect some physicians' eligibility for the small business tax deduction.

"Because the options for corporate savings strategies are continually changing, it's essential for executive physicians to focus on registered plans to help them defer taxes as they accumulate assets," says Fraser. "For many hospital executives, the RCA is one of the few tax-efficient vehicles available that does not place undue burden on the hospital's finances."

A closer look at retirement plan options

Here's how these supplemental retirement plans work.

An individual pension plan (IPP) is a defined plan funded by an employer on behalf of an employee. Like an RRSP, assets accumulate in an investment account over time as retirement benefits.

However, an IPP allows up to 65% more in asset accumulation than



an RRSP and sets your monthly income at retirement. Your locked-in pension savings benefit from tax-deferred growth and are paid out and adjusted for inflation on retirement. Contributions are tax deductible for the company.

A retirement compensation arrangement (RCA) allows an employer to make tax-deductible retirement contributions on behalf of an employee, to the maximum amount allowable. An RCA is flexible (especially during retirement), creditor proof, and allows access to funds (not locked-in).

On retirement, you may draw from the assets of the RCA without any restrictions on maximum or minimums, potentially at a lower tax rate. Ultimately, an RCA allows a hospital to specifically tailor the funding that they and the physician executive have agreed on.

What about incorporation?

In most cases, if an incorporated physician is transitioning into a fully

salaried role, the corporation would drop the “Medicine Professional Corporation” portion of its name (by filing Articles of Amendment) unless a continuing stream of earnings from medical services remains. If the accumulated funds in the corporation are not significant, it might make sense to wind up the corporation rather than continue to incur professional fees. In all other cases, the corporation would continue with corporate funds paid out to shareholders, as appropriate, or conserved and used as supplementary retirement income.

Hybrid situations

There are also situations in which a physician accepts a salaried role but continues to have an opportunity to earn income from medical services. In these cases, the salaried position is often less than full-time and the remuneration is usually less than \$200 000 a year. Directing clinical income to a corporation could allow a physician to shelter it from the additional 4% increase in the top federal tax rate applicable to incomes over

\$200 000 (introduced in the March 2016 federal budget). A physician might also have the opportunity to split the corporate income with a spouse, adult children, or even parents. Alternatively, the physician could pay the corporate income to him- or herself at a later time, when personal income from other sources is lower.

Part-time executive appointments

Part-time appointments are similar to hybrid situations in that compensation is usually in the form of salary and benefits. However, in the absence of other income, there may be implications for projected savings, taxation on retirement income, and a physician’s ability to achieve retirement/estate plan goals.

Let’s look at an example. Dr. G a full-time physician, transitions into a part-time executive arrangement and experiences a significant decrease in compensation. She does not adjust her lifestyle expenses accordingly, resulting in a reduction in annual non-registered savings toward her projected retirement income goals. Dr. G also has several estate objectives she has not yet acted on, including leaving a bequest to a specific charity using permanent life insurance. However, her new cash flow budget is making it more challenging to afford the annual premiums associated with this type of policy. This is especially the case if a policy is owned personally rather than by a medical professional corporation, where the premiums would be more affordable



on an after-tax basis.

Here's another example. Dr. J has accumulated substantial registered savings and, as a result, will have to draw on these funds in retirement as regular income — potentially at a high average tax rate. Depending on Dr. J's projected tax rate in retirement, it may make sense to forego sheltering his part-time salary in an RRSP and, instead, pay tax on these funds now, as long as his current average tax rate is lower by comparison. Before making a final decision, Dr. J will also need to consider the tax deferral advantage that the RRSP provides over the period leading up to retirement.

Finally, a part-time physician should understand the employer's benefits package and how it may change leading up to and during retirement. Often, a physician may have to make changes to his or her current personal benefits coverage as a result.

Unfortunately, not all situations with split income streams lend themselves to the benefits of incorporation. Each situation must be evaluated based on the specific circumstances.

I recently worked with a client who is the director of a large Canadian hospital and whose compensation was equally divided between salary and self-employed income. His retirement plan had to account for both types of income, and we had to consider whether it made sense for him to incorporate his self-employed earnings. After carefully considering opportunities for tax deferral and income splitting, the benefits did not merit the cost and complexity of introducing a professional corporation into the plan.

A comprehensive financial plan is the first step

If you're considering moving into an executive role, it's crucial to plan ahead to ensure that your retirement plan is on track. The

process should begin by meeting with a financial consultant who understands physicians and their unique needs, to develop a complete financial plan with special focus on your current retirement scenario.

Most people don't realize the importance of having a thorough and integrated financial plan. Without one, a consultant will not have a complete picture of a client's situation and might overlook key factors that will help improve the quality of the retirement plan.

For example, a simple cash flow statement can help the consultant understand the various components that make up a client's lifestyle expenses and project how they may change leading up to and during retirement over a 5-, 10-, or 20-year period. An accurate net worth statement can also help the consultant assess the client's capacity versus appetite for risk. Depending on the risk profile of each asset, various growth rates might be assumed, which can significantly alter a client's projected long-term aggregated net worth.

Your compensation structure will help to shape your retirement plan

Once you have transitioned into your new role, it's important that both you and your financial consultant understand the impact of your new compensation structure on your retirement plan. Some questions to consider:

- Does the hospital plan to

compensate you with salary or will you be self-employed or both?

- What form of pension will you receive, if any?
- If you are incorporated, what role should the corporation play leading into retirement and beyond?
- Should your investment plan be changed?

Working with an integrated team of qualified financial planning professionals can help you find the answers to these questions and create a solid retirement plan that provides guidance, clarity, and peace of mind.

Author

Vince Tarantino is a senior financial consultant with MD Management Ltd in Toronto. To learn more, please visit mdm.ca

Correspondence to: Vince.Tarantino@cma.ca

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The screenshot shows the CSPE e-newsletter layout. At the top is a header with the CSPE and SCMG logos and the tagline 'Developing Physician Leaders'. Below the header is a navigation bar with '30 November 2015', 'Join the CSPE', and 'Contact'. The main content area features several articles with images and text. Ad placements are indicated by letters A through F: A (top leaderboard), B (top banner), C (body banner), D (top skyscraper), E (lower skyscraper), and F (product spotlight). The footer contains copyright information and a mailing address.

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Medical registration in Canada: a brief overview

Fleur-Ange Lefebvre

Although physician leaders may be familiar with provincial and territorial medical regulation when recruiting Canadian-trained physicians, registration and licensure may seem more complicated for physicians who cross provincial or territorial boundaries or for physicians trained outside Canada. This paper provides information for physician leaders to better understand the basics of medical regulation, its standards, and the regulatory authorities in Canada.

KEY WORDS: medical regulation, registration, licensure, standards, regulatory authorities, complaints, Canada

Medical regulation

Professional regulation aims to provide public assurance and



protection. Several professions are regulated in Canada, including medicine, usually by a process that relies heavily on the involvement of peers. Originally self-regulation, medical regulation now involves more and more public representation on various councils or boards across the country.

The three main mandates of medical regulation are:

- Registration and licensure — the processes by which a physician applies for, and may be granted, a license to practise in a chosen jurisdiction.
- Complaints and resolution — the processes by which public complaints and concerns about a physician’s practice or conduct are managed and adjudicated, including disciplinary action where necessary.
- Quality assurance of practice — the processes through which a physician is expected

to demonstrate ongoing competence in the scope of their medical practice.

In addition, several (but not all) medical regulatory authorities in Canada are also involved in reviewing and accrediting out-of-hospital diagnostic and surgical facilities.

Medical regulatory authorities

Professional regulation occurs at the provincial or territorial level in Canada. There are 13 medical regulatory authorities, one in each province and territory. In the ten provinces, the “colleges” exercise the authority delegated to them through legislation. In the three territories, government departments carry out the licensing functions of a regulatory authority.

Jurisdictional regulation means that there is no pan-Canadian license to practise medicine. If a physician wishes to practise in more than

one province or territory, he or she must apply for and be granted a license in each jurisdiction. The exception to this is in the provision of telemedicine services, which may not require jurisdictional licensure in the province or territory in which the patient receives care. However, some jurisdictions do require licensure for telemedicine services.

Federation of Medical Regulatory Authorities of Canada

The Federation of Provincial Medical Licensing Authorities of Canada was created in 1968 to provide a forum for information exchange among the provincial colleges, called “licensing authorities” at that time. It later expanded to include the territories, and, in 2004, its current name was adopted to reflect the fact that professional regulation is broader than licensure.

Today, FMRAC’s mission is to advance medical regulation on behalf of the public through collaboration, common standards, and best practices. Its four objects are to:

- Provide an effective forum for the exchange of information and collaborate with its members and others on issues that involve medical regulation
- Develop and maintain programs, services, and benefits for its members
- Develop and promote pan-Canadian policies, standards, statements, and perspectives on aspects of medical regulation
- Interact with and inform key

stakeholders (including the federal government, the public, and media) on medical regulatory matters of national or international importance

Evolution of registration classes and the Agreement on Internal Trade

The Federal–Provincial–Territorial Agreement on Internal Trade (AIT)¹ was first implemented in 1995, and significant changes in labour mobility came into effect on 1 April 2009. Summarized, the changes dictate that full licensure in one jurisdiction should result in full licensure in another jurisdiction in Canada, without any further requirements.

There is one exclusion: language proficiency in English or French. In addition, this recognition does not preclude the need for a certificate of professional conduct. In addition to recognition of full licensure, provisional licenses are also included in the labour mobility part of the agreement, provided the receiving jurisdiction can meet the same restrictions and supervision requirements.

In 2008, the pending changes on labour mobility mobilized FMRAC and the medical regulatory authorities to streamline the categories of medical registration and licensure, agree on common language, and foster common standards and approaches. The intent was to facilitate the mobility of physicians across the country. As many aspects of regulation rely on legislation, it took several years for some of the changes to come into

effect in each province or territory; indeed, some of them remain aspirational today.

The Canadian Standard sets out the academic qualifications that automatically make an applicant eligible for full licensure in every Canadian province and territory.

Physicians applying for the first time to become licensed to practise medicine in a Canadian jurisdiction may achieve full licensure only if they:

- have a medical degree [from a medical school that, at the time the candidate completed the program, was listed in the World Directory of Medical Schools (WDMS)], or a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation; **and**
- are a Licentiate of the Medical Council of Canada; **and**
- have satisfactorily completed a discipline-appropriate postgraduate training program in allopathic medicine and an evaluation by a recognized authority; **and**
- have achieved certification from the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada or the Collège des médecins du Québec.

Model Standards for Medical Registration in Canada

In addition to the Canadian Standard above, FMRAC’s Model

Figure 1. The physician practice improvement system



Standards for Medical Registration in Canada² set out the requirements for provisional licensure (including pre-screening requirements) for family physicians and general practitioners, as well as other medical and surgical specialties. They include a standard for the route from provisional to full licensure.

Physician practice improvement

FMRAC also developed the physician practice improvement system³ with the following vision: that Canadians are assured of the competence of physicians and that physicians are supported in their continuous commitment to improve.

This multi-year endeavour involved seven other stakeholder organizations: the Association of Faculties of Medicine of Canada, the Canadian Medical Association, the Canadian Medical Protective Association, the College of Family Physicians of Canada, HealthCareCAN, the Medical

Council of Canada, and the Royal College of Physicians and Surgeons of Canada. The system aims to be transparent, relevant, inclusive, transferable, formative, efficient, and integrated. It comprises a five-step cycle (Figure 1).

By moving through these five steps, physicians will be able to demonstrate how their continuing education choices align with their learning needs and measure whether what they learn leads to improved care. This cyclical process is ongoing during the entire career of physicians, to ensure their practice is meeting the needs of the patients and the requirements of the CanMEDS 2015 and CanMEDS-FM 2015 frameworks.

Pan-Canadian consistency and rigour

FMRAC and its 13 members agree:

- That protection of the public is the primary statutory responsibility of the medical

regulatory authorities

- To the Model Standards for Medical Registration in Canada²
- On consistent and sufficiently rigorous registration and licensure processes for physicians across all Canadian jurisdictions
- To support the mobility of qualified physicians across Canadian jurisdictions
- To notify other each other of changes to registration standards in advance of implementation

The websites referred to in this article offer additional and detailed information that may be of interest for physician leaders.

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Author

Fleur-Ange Lefebvre is executive director and CEO of the Federation of Medical Regulatory Authorities of Canada.

Correspondence to: falefebvre@fmrac.ca

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BOOK REVIEW

Better Now Six Big Ideas to Improve Health Care for All Canadians

Dr. Danielle Martin
Allen Lane, 2017

Reviewed by Johny Van Aerde,
MD, PhD

In her book, *Better Now*, Danielle Martin proves to be a great storyteller. She integrates elements from many respected evidence-based publications on health care systems,¹⁻⁷ adds her perspective as a system physician, and interweaves superb narratives about patients throughout the book. The result is an absolute page-turner — a must-read for anyone who knows little about the Canadian health system and would like to understand some of its underlying limitations and read about some suggestions for improvement.

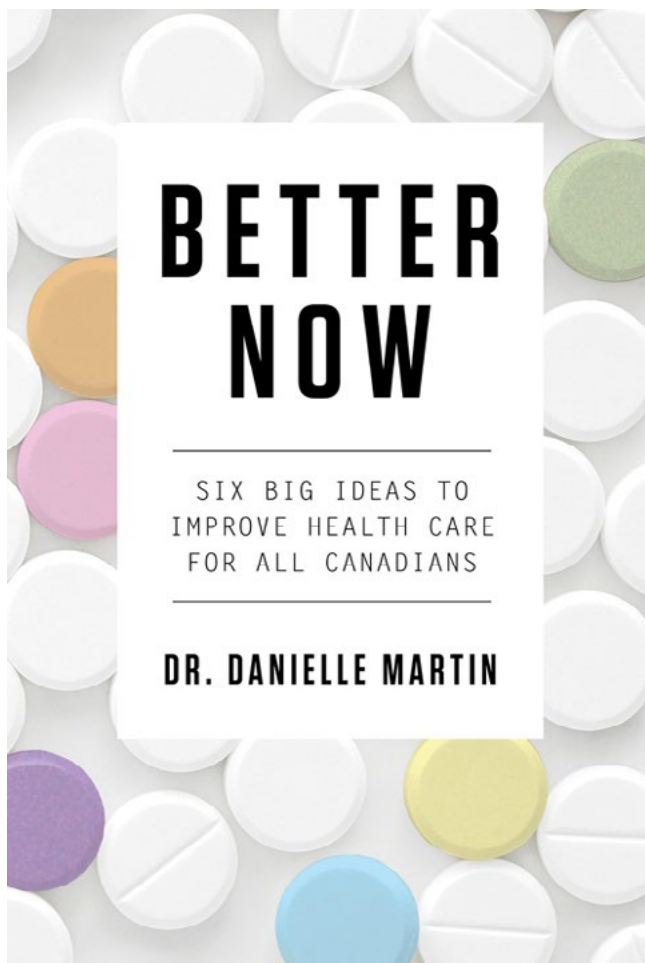
Two dominant threads run through the book. First, whatever ideas, big or small, one pursues, they have to comply with the principles of triple aim, i.e., better health, better care, better value, and with our Canadian value of equity. Second, all stakeholders — physicians,

patients, and government — have to accept their part of the responsibility to keep our health care system sustainable. Without that commitment, no innovation, no matter how big, has a chance of surviving.

Martin offers six “big ideas” to improve health for Canadians. The first, “the return of relationships,” is perhaps the most important one in terms of how primary care physicians can contribute to health care transformation. In primary care, everything is about relationships and connections. Someone either has to make

someone is the general practitioner or the family doctor, who sees the patient as a whole, in her or his own setting and socioeconomic context. Where the specialist zooms in to look at an organ or body part, the GP zooms out to see the overall picture and form the relationships that are needed.

Big idea 5 is closely related to idea 1, in that it looks at socioeconomic and the influence of poverty on the health gap. Although Michael Marmot⁵ wrote extensively about the topic, Martin places it within a Canadian context, with two specific solutions for basic income that seem logical and worthy of pilot studies.



Big idea 2 — universal pharmacare — also becomes part of the poverty conversation, when those who need medication cannot pay for it. Pharmacare seems feasible in Canada, according to a study by Morgan et al.⁸ (of which Martin was a co-author) and would create an overall annual tax burden of 1 billion dollars or \$28 per person. To work well, the pharmacare system would have to include an extensive and integrated database, a change in some of our prescribing habits, and prices negotiated between government and the pharmaceutical industry.

those connections to the benefit of the patient or develop new types of connections by changing the way services are delivered. That

The numbers Martin quotes for the cost of drugs in Canada are

staggering and about the highest in the world. In New Zealand, for example, some drugs cost 2% of what we pay in Canada. The biggest resistance to universal pharmacare is expected to come from those who have the most to lose financially: the pharmaceutical industry, private insurance companies, and pharmacy chains. Perhaps that helps explain why a similar recommendation on drug affordability in the report from the Advisory Panel on Healthcare Innovation² hasn't gone anywhere. Indeed, many of Martin's big ideas, including this one, require what she calls real "political courage."

Big idea 3 — reducing the number of unnecessary interventions and tests by practising evidence-based medicine, minimizing variation in treatment, and having conversations with patients about "choosing wisely" — is already gaining more and more traction in the context of triple aim.

Big idea 4, doing more with less, is a synthesis of the Advisory Panel on Healthcare Innovation's recommendations on integration of services, value for money, and empowering patients.² Martin explains how we can do more and different things with the same amount of money by managing wait lists creatively, redesigning care closer to home, incorporating disruptive technology, and, most important, engaging and empowering patients. She makes a strong argument for accepting innovation failures as part of organizational and systems learning and for having the political courage to accept this type of failure. So far, that courage has been lacking

in Canada, as evidenced by the research of Lazar et al.⁴ Perhaps such innovations have to be found in partnership with private industry, which can serve as an economic driver and innovation catalyst, as suggested by the Advisory Panel.² It is surprising that Martin did not make that link with her fifth big idea.

The sixth big idea, "the anatomy of change," tries to describe what large-scale change looks like. Although this big idea is crucial to accomplishment of the other five, the topic is explored only rather superficially.

Understandably, as a founding member of Canadian Doctors for Medicare, Martin wrote this book from the sole perspective of a publicly funded health care system. If we accept that this is the only premise, then two fundamental questions must be asked. First, what is the purpose of our health care system? Because that question has never been asked, let alone answered, in Canadian history, the future demands on the system will continue to expand into areas that it was not intended to fund. Second, while keeping the Canadian health care system equitable for all, what are the many possible meanings of the word "private" that could benefit each and all of us?

In short, this is a book that belongs in the library of most politicians, who must find the courage to support what needs to be done. It belongs on the coffee tables of patients and Canadian citizens, who want to become knowledgeable and responsibly involved in health care system transformation. And it

belongs on the desk of physicians, who must find out what leadership skills they need to lead health system reform.

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Author

Johny Van Aerde, MD, MA, PhD, FRCPC, is editor-in-chief of the Canadian Journal of Physician Leadership and past president of the Canadian Society of Physician Leaders.

Correspondence to:
johny.vanaerde@gmail.com

Note: Dr. Danielle Martin will be a keynote speaker at the 2017 Canadian Conference on Physician Leadership. Each conference participant will receive a free copy of her book, compliments of the Canadian Medical Association

BOOK REVIEW

Leading with Noble Purpose How to Create a Tribe of True Believers

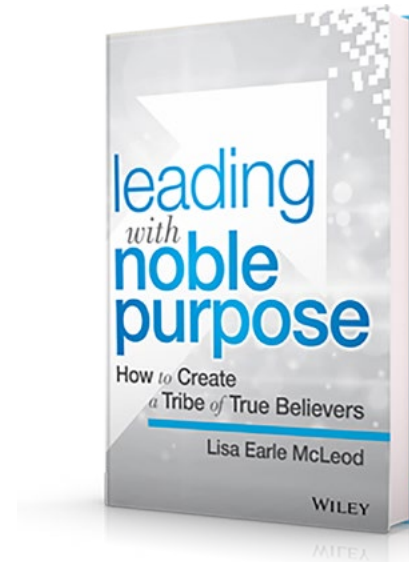
Lisa Earle McLeod
Wiley, 2016

Reviewed by
Gillian Kernaghan, MD

As leaders in health care, we have refocused our vision, mission, and values on why: why do we need to improve quality and safety for those we serve and those who serve? The answer inspires people to greatness, as it captures both the heart and the mind. With that in mind, I was intrigued by the title of this book: *Leading with Noble Purpose*. Noble is defined in the Oxford Living Dictionaries as “Having or showing fine personal qualities or high moral principles” and “Of excellent or superior quality.”

Lisa Earle McLeod is writing more to for-profit businesses, challenging them to find what she calls their “noble purpose,” as it is crucial that every member of an organization understand the services it sells and is living the purpose. She describes noble sales purpose (NSP) as in the service of others (noble), based on what you actually sell (sales), and your end game (purpose).

She says that the NSP answers three big questions: How do



you make a difference to your customers? How do you do it differently from your competition? On your best day, what do you love about your job?

The author cites many examples of businesses that achieved great success by inspiring employees and leaders based on an NSP. She also describes good organizations that floundered when they either lost sight of or did not define their NSP.

According to McLeod, the NSP is your North Star. An effective NSP describes your desired impact on your customers, is a jumping off point for strategy, defines expected behaviour, and provides a lens for decision-making.

She quotes Ralph Waldo Emerson: “The purpose of life is not to be happy. It is to be useful, to be honourable, to be compassionate, to have it make some difference that you have lived and lived well.”

We spend a great deal of time at work, and leaders have an obligation to inspire employees based on the vision and mission of the organization. A noble purpose leader is one whose actions, policies, and culture align around the impact they want to have on customers. The leader must choose who the customers are and how the organization wants to affect them.

Although written for businesses, this book is a good framework to remind us in health care about the importance of anchoring what we do in a noble purpose. Given our mandate and roles, it should not be difficult to find our North Star. The challenge inherent in this book is what we do with that. Does a noble purpose fundamentally inform how we interact with our patients? Does it inform our strategy? Do our values and behaviours align with it and, more important, do we hold people accountable to them?

Given the changing health care systems across the country, this book challenges us to ask such questions and speak about them to ensure that we never lose sight of why we are here and who we serve. We can inspire leaders, staff, and physicians to greatness if we find our noble purpose and then live it.

Author

Gillian Kernaghan, MD, CCFP, FCFP, CCPE, is president and CEO of St. Joseph's Health Care, London, Ontario. She is also a former president of the Canadian Society of Physician Leaders. Correspondence to:
gillian.kernaghan@sjhc.london.on.ca



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