# The view from the North

Only rarely does the incoming president of an association hope to make an imprimatur by serving as the voice of the disadvantaged and the stressed.

But if Dr. Anna Reid has her way, by the time she steps off the stage as the Canadian Medical Association president in August 2013, the nation's physicians will have initiated the development of a national strategy to reduce health inequities among Aboriginal peoples, as well as put in place a mechanism to help burned-out physicians, particularly from smaller provinces and territories, get the help they need to remain on the job.

Roger Collier/CMAJ

Physicians must become stronger advocates for health equity, says incoming CMA President Dr. Anna Reid, an emergency physician in Yellowknife, Northwest Territories.

As an emergency physician in Yellowknife, Northwest Territories, it's impossible to overlook health inequities, Reid says. "We have a very large homeless, addictive population, many of them Aboriginal, and every day, I see the devastation from loss of culture, homelessness, inability to access adequate food, no education. These are things that hit me in the face every day, every night, when I go to work."

Physicians must become stronger advocates for health equity, Reid adds. "We're starting to look at health in a broader sense and I think we need to do so as a profession. We can very much advocate for that, on a local level, on a community level, as well as on a provincial and federal level."

Reid argues that physicians have become increasingly aware in recent years of the links between the social determinants of health and the level of health within population groups, and will therefore be more inclined to advocacy on behalf of the disadvantaged.

"But I'd like to stress that it's not just a northern and Aboriginal issue, health equity, and so when I talk about Aboriginal health as being a big passion of mine, it's because it's a reflection of the larger thing I'm passionate about, which is health equity. I've worked in both urban and rural remote areas around the country and it's an issue that crosses all those areas, all the provinces, all the territories. Every family doctor comes face to face with these issues every day."

Reid says there's also a need for increased advocacy on behalf of physicians themselves, and particularly, on behalf of physician health. "We know that physicians are humans and that we struggle with the same issues that many people do," she says. "We have our illnesses. We have our mental health. We have our addictions issues."

But physicians have added burdens, Reid adds. "We work in highly stressful environments, many demands and many physicians have become demoralized over time by their increasing loss of autonomy, and how they practise medicine, and there's many reasons why we're seeing more problems with, particularly, physician's mental health and addictive issues."

"It's actually vital to the sustainability of our health care system that we (physicians) have a healthy core," says Reid, who's intimately aware of the consequences of such stress. "After being in practice for a number of years [in British Columbia] and doing everything as a solo family physician and not being able to find locums and working day in, day out, and never taking a day off, working every weekend in the hospital, never getting holiday time, I had a burnout. I had to make a decision either to reinvent myself or to quit medicine because it was not sustainable going on in how I was doing things." She undertook retraining as an emergency room physician, which eventually led to her current posting at Stanton Territorial Hospital in Yellowknife (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-3981).

Medical associations and governments in larger, wealthier provinces such as British Columbia and Ontario typically have treatment programs to assist physicians in need but that's generally not true in smaller provinces or the territories, Reid says. "There's nothing more distressing than watching a colleague in need and having nowhere to turn for help. … So for me, it's very important that we be able to get these services on a pan-Canadian level in place."

But some form of national program isn't the answer, Reid adds. "I don't think that we need to reinvent the

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wheel. We have several programs working very well in several of the larger provinces. I think we need to find some mechanism where those provinces and territories that are so small, who can't have their own programs, need to have some central agency, institute that they can go through to get linked in ,hopefully in some manner, to use the services of another province. I don't think we need to make a whole new Canadian program but we need to develop linkages so that everyone in the country has access to some already very strong programs."

Reid expects that developing such comprehensive approaches to health equity and physician health over the course of her tenure will be as challenging as shepherding CMA's ongoing initiative to promote transformation of the Canadian health care system (www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/HCT/HCT-2010report_en.pdf).

When it comes to health care transformation, the challenge will be to convince the federal government and physicians to take a "strong leadership role" in implementation of the initiative, Reid says.

Both may prove tricky, as the federal government has repeatedly indicated it is essentially vacating the field having indefinitely fixed a formula for future cash transfer payments to the provinces (www.fin.gc.ca/n11/data/11-141_1-eng.asp), while physicians have long been publicly tagged with the voice of self-interest, a public perception that has hardly abated in the light of the Ontario government's making hay in its spat with its doctors over the fact that 407 physicians received more than $1 million in Ontario Health Insurance Programs in 2010, including 27 who topped $2 million, five who topped $3 million and one who topped $6.4 million.

Within that context, to help achieve health care transformation, Reid believes physicians must do a better job of communicating the notion that they're not the primary drivers of higher health costs.

"Health costs are rising and physician payouts are rising for a number of reasons and one of the reasons they are going up is the population is growing. And more importantly, the population is getting older, and so they're using money, per capita, on health care costs and these are things that the government does not wish to discuss in general with the public. And perhaps as a profession, we haven't done a good enough job communicating those issues," Reid says. "Also, we haven't communicated the fact that technology is changing, diagnostic imaging fees, all these things that the public actually demands, in terms of wanting what they call the best in health care, we haven't done a good job in communicating that these diagnostics and technologies and new drugs often cost a lot more money than previously. So, I think the strategy I would like to do is see us do better communication about what our health care system costs to the public, and why it costs that. Then, ultimately, the taxpayers are going to have to decide what kind of system they would like and what they would like to see funded." — Wayne Kondro, *CMAJ*

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