The Evolving Professional Relationship between Canadian Physicians and our Health Care System: Where do we stand?

OVERVIEW

This paper discusses the current state of the professional relationship between physicians and the health care system. A review of the concept of medical professionalism, and the tensions that can arise between the care of individual patients and a consideration of the broader needs of society, provides some basic groundwork. Our understanding of what it means to be a physician has evolved significantly over the years, and the medical profession is now being challenged to clarify the role it is willing to play in order to achieve transformation of our health care system.

We have arrived at this point due to a convergence of several factors. Regionalization of health care has led to a change in the leadership roles played by practising physicians and to the opportunities they have for meaningful input into system change. Physicians are now also less likely to be involved in hospital-based care, which has resulted in a loss of collegiality and interactions with peers. Changing models of physician engagement status and changing physician demographics have also presented new and unique issues and challenges over the past few years.

The Canadian medical association (CMA) suggests that its physician members and other stakeholders employ a "AAA" lens to examine the challenges and opportunities currently facing Canadian physicians as they attempt to engage with the health care system: autonomy, advocacy and accountability. These important concepts are all underpinned by strong physician leadership. Leadership skills are fundamentally necessary to allow physicians to be able to participate actively in conversations aimed at meaningful system transformation.

KEY CMA RECOMMENDATIONS ARE AS FOLLOWS:

Physicians should be provided with the leadership tools they need, and the support required, to enable them to participate individually and collectively in discussions on the transformation of Canada's health care system.

Physicians need to be provided with meaningful opportunities for input at all levels of decision-making, with committed and reliable partners, and must be included as valued collaborators in the decision-making process.

Physicians have to recognize and acknowledge their individual and collective obligations (as one member of the health care team and as members of a profession) and accountabilities to their patients, to their colleagues and to the health care system and society.

Physicians must be able to freely advocate when necessary on behalf of their patients in a way that respects the views of others and is likely to bring about meaningful change that will benefit their patients and the health care system.

Physicians should participate on a regular and ongoing basis in well-designed and validated quality improvement initiatives that are educational in nature and will provide them with the feedback and skills they need to optimize patient care and outcomes.

Patient care should be team based and interdisciplinary with smooth transition from one care setting to the next and funding and other models need to be in place to allow physicians and other health care providers to practise within the full scope of their professional activities.

INTRODUCTION

The concept of medical professionalism, at its core, has always been defined by the nature and primacy of the individual doctor-patient relationship, and the fiduciary obligation of physicians within this relationship. The central obligation of the physician is succinctly stated in the first tenet of the CMA *Code of Ethics:*

> *Consider first the well-being of the patient.*[1]

Since the latter half of the 20th century, however, there has been a growing emphasis on the need for physicians to also consider the collective needs of society, in addition to those of their individual patients. As stated in the CMA *Code of Ethics*:

> *Consider the well-being of society in matters affecting health.*

This shift in thinking has happened for at least two reasons. First, there have been tremendous advances in medical science that now enable physicians to do much more to extend the length and quality of life of their patients, but these advances inevitably come at a cost which is ultimately borne by society as a whole. Second, since World War II, Canadian governments have been increasingly involved in the financing of health care through taxation revenues. As a result, there have been growing calls for physicians to be prudent in their use of health care resources, and to be increasingly accountable in the way these resources are employed.

The 2002 American Board of Internal Medicine (ABIM) Foundation Charter on Medical Professionalism calls for physician commitment to a just distribution of finite resources: "While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources."[2] This has also been described as *civic professionalism*.

Lesser et al have put forward a systems view of professionalism that radiates out from the patient-physician relationship to broader interactions with members of the health care team, the training environment and to the external environment, dealing with payers and regulators and also addressing the socio-economic determinants of health.[3] Understandably, given that the resources available for health care are finite, tensions will arise between the care of individual patients and the collective needs of society, and these tensions can at times be very difficult to resolve for individual medical practitioners.

As stated in the CMA policy Medical Professionalism (Update 2005):

> *Medical professionalism includes both the relationship between a physician and a patient and a social contract between physicians and society. Society grants the profession privileges, including exclusive or primary responsibility for the provision of certain services and a high degree of self-regulation. In return, the profession agrees to use these privileges primarily for the benefit of others and only secondarily for its own benefit.* [4]

Over time the delivery, management and governance of health care have become more complex, and as a result the health care sector now accounts for roughly one in 10 jobs in Canada. There are more than two dozen regulated health professions across Canada, as well as numerous professional managers employed in various capacities, many of whom have had little or no exposure to the everyday realities of the practice of clinical medicine. Notwithstanding the acknowledgement of the very real and important need for inter-professional collaboration and teamwork, inevitably this creates competition for influence in the health care system.

The CMA 2005 update of its policy on medical professionalism acknowledges the need for change.

> *While maintaining responsibility for care of the patient as a whole, physicians must be able to interact constructively with other health care providers within an interdisciplinary team setting. The relationship of physicians with their colleagues must be strengthened and reinforced. Patient care benefits when all health care practitioners work together towards a common goal, in an atmosphere of support and collegiality.*

Now, physicians are being challenged to clarify exactly what it is that they are prepared to do in order to advance the much-needed transformation of our health care system, and how they will partner with patients, other care providers and the system in order to achieve this common goal. This provides a significant opportunity for physicians to continue their leadership role in the health care transformation initiative in the interests of their patients, while at the same time redefining their relationship with the system (understood in this context as health care administrators, governments and their representatives, health districts, health care facilities and similar organizations) in order to ensure that they have a meaningful and valued seat at the decision-making table, now and in the future.

BACKGROUND

The common refrain among health administrators, health ministry officials and health policy analysts for the past decade and longer has been that physicians are "not part of the health care system", that they are independent contractors and not employees, and that they are too often part of the problem and not the solution.

Over this period of time, several developments have resulted in a diminished role of physicians in clinical governance in Canada and have, to varying degrees, transformed the professional and collegial relationship between physicians and their health regions, health care facilities and communities to one that is increasingly governed by legislative fiat or regulation.

REGIONALIZATION

Beginning with New Brunswick in 1992, all jurisdictions except Ontario, the Yukon Territory and Nunavut have adopted a regional governance model. This change has eliminated all hospital and community services boards within a geographic region and replaced them with a single regional board. Clinical governance is now administered through a regional medical advisory committee (MAC). Some provinces such as Saskatchewan recognize the role of the district (regional) medical staff association. This has had a profound impact in reducing the number of physicians engaged in the clinical governance of health care institutions.

Another by-product of regionalization is that in virtually all jurisdictions, physicians no longer sit on governing boards. While physicians continue to serve as department heads and section chiefs within regions and/or individual hospital facilities, the level of support and financial compensation to do so varies greatly, particularly outside major regions and institutions, and there has been a lack of physician interest in such positions in some places.

Evolution: Factors playing a role in the current relationship:

- **Regionalization**: most provinces and territories have adopted a regional governance model, thereby reducing the number of physicians engaged in the clinical governance of health care institutions
- **Practice environment**: there are challenges to physician participation in meaningful decision-making in both the hospital and community settings
- **Engagement status**: changing models of physician engagement have led to uncertainty with respect to the degree of job protection that physicians may have
- **Changing demographics and practice patterns**: changes may result in practices having smaller numbers of patients and being open shorter hours

PRACTICE ENVIRONMENT

In addition to a diminished presence in clinical governance, physicians are less likely to be actively involved in hospitals than they were previously. Anecdotally, many physicians, particularly in larger urban communities, describe having been "pushed out" of the hospital setting, and of feeling increasingly marginalized from the decision-making process in these institutions. Another result of the diminished engagement with hospitals has been the loss of the professional collegiality that used to be fostered through interaction in the medical staff lounge or through informal corridor consultations.

In the community setting, there have been some positive developments in terms of physician leadership and clinical governance. Ontario and Alberta have implemented new primary care funding and delivery models that promote physician leadership of multidisciplinary teams, and at least two-thirds of the family physicians in each of these jurisdictions have signed on. British Columbia has established Divisions of Family Practice, an initiative of the General Practice Services Committee (a joint committee of the BC Ministry of Health and the BC Medical Association), in which groups of family physicians organize at the local and regional levels and work in partnership with the Health Authority and the Ministry of Health to address common health care goals.

Looking ahead, regionalization is also likely to affect physicians in community-based practice. There is a clear trend across Canada to require all physicians within a region to have an appointment with the health region if they want to access public resources such as laboratory and radiology services. In the future this may also result in actions such as mandated quality improvement activities which may be of variable effectiveness and will not necessarily be aligned with the learning needs of physicians.

PHYSICIAN ENGAGEMENT STATUS

Traditionally physicians have interfaced with hospitals through a *privileges model*. This model, which has generally worked well, aims to provide the physician with the freedom to reasonably advocate for the interests of the patient.[5] In this model, legislation and regulations also require that there are minimum procedures in place for renewing, restricting, and terminating privileges, and that procedures are set out to ensure that this takes place within a fair and structured framework. The hospital's MAC generally reviews physician privileges applications and recommends appointment and reappointment. The MAC thus plays an integral role in ensuring the safety of care within the region or hospital.[5]

There has been increasing attention recently on engaging in other types of

physician-hospital relationships, including *employment or contractual arrangements*. This type of arrangement can vary from an employment contract, similar to that used by other professional staff such as nurses and therapists, to a services agreement whereby the physician provides medical services to the hospital as an independent contractor.[5] However, there are concerns, expressed by the Canadian Medical Protective Association (CMPA) and others, that many of the procedural frameworks and safeguards found in hospital bylaws pertaining to the privileges model may not necessarily extend to other arrangements, and that physicians entering into these contractual agreements may, in some cases, find their appointment at the hospital or facility terminated without recourse. Under such arrangements the procedural fairness and the right of appeal available under the privilege model may not be available to physicians.

One relatively new approach is the *appointment model*, which aims to combine many of the protections associated with the privileges model with the advantages of predictability and specificity of the employment model. It generally applies the processes used to grant or renew privileges to the resolution of physician performance-related issues.[5]

It has been argued that changes in appointment status and relationship models can have a detrimental impact on the relationship between practitioners and health care facilities.[6] While this has been reported specifically within the context of Diagnostic Imaging, the same may hold true for other specialties as well.

It should also be noted that the issues raised in this paper are applicable to all members of the profession, regardless of their current or future practice arrangements or locations.

CHANGING PHYSICIAN DEMOGRAPHICS AND PRACTICE PATTERNS

It is well recognized that physician demographics and practice patterns have changed significantly over the past several years. Much has been written about the potential impact of these changes on medicine, and their impact on patient care, on waiting lists and on the ability of patients to access clinical services.[7] It is also acknowledged that "lifestyle factors," that is to say the attempt by many physicians to achieve a healthier work-life balance, may play a role in determining the type and nature of clinical practice chosen by new medical graduates, the hours they will work and the number of patients they will see.

All of these changes mean that clinical practices may have smaller numbers of patients and may be open shorter hours than in the past. Physicians are being increasingly challenged to outline their understanding of their commitment to

ensuring that all patients have timely access to high quality health care within the Canadian public system, while balancing this with their ability to make personal choices that are in their best interests.

Put another way, how can we assist physicians in adjusting their clinical practices, at least to some extent, based on the needs of the population?

DISCUSSION

While there are clearly challenges and barriers to physician participation in meaningful transformation of the health care system, there are also opportunities for engagement and dialogue, particularly when the doctors of Canada show themselves to be willing and committed partners in the process. Health care transformation cannot be deferred just because it involves difficult decisions and changes to the status quo. Regardless of how we have reached the current situation, relationships between physicians and other parties must evolve to meet future needs. Physicians need to be assisted in their efforts in this regard, both by local health boards and facilities, and by organizations such as the CMA and its provincial and territorial counterparts.

Physicians, individually and collectively, need to demonstrate what they are willing to do to assist in the process and what they are willing to contribute as we move forward, and they need to commit to having the medical profession be an important part of the solution to the challenges currently facing the Canadian system.

We examine some of these challenges through the "AAA" lens of Autonomy, Advocacy and Accountability, which are underpinned by the concept of Physician Leadership.

AUTONOMY

To a large extent, physicians continue to enjoy a significant degree of what is commonly termed *clinical or professional autonomy*, meaning that they are able to make decisions for their individual patients based on the specific facts of the clinical encounter. In order to ensure that this autonomy is maintained, physicians need to continue to embrace the concept of clinical standards and minimization of inter-practice variations, where appropriate, while also recognizing the absolute need to allow for individual differences in care based on the requirements of specific patients. Professional autonomy plays a vital role in clinical decision-making, and it is at the heart of the physician-patient relationship. Patients need to feel that physicians are making decisions that are in the best interest of the patient, and that physicians are not unduly limited by external or system constraints. As part of this decision-making, physicians may

also need to consider carefully the appropriate balance between individual patient needs and the broader societal good.

Key messages - Autonomy:

- Physicians need to be mindful of their personal and professional autonomy as different entities
- With respect to professional autonomy, it is important that physicians consider the appropriate balance between individual patient needs and the broader societal good.
- Physicians may need to consider what they are willing to concede in terms of personal autonomy in order to contribute to societal goals
- By working collectively and collaboratively amongst themselves, with government and other partners, physicians can find this appropriate balance in creative ways

In recent years, governments have sometimes made use of the "legislative hammer" to force physicians to conform to the needs of the health system, thus undermining physicians' *individual or personal autonomy*. Historically, physicians have organized themselves to provide 24-hour coverage of the emergency room and other critical hospital services. This has proven increasingly challenging in recent years, particularly in the case of small hospitals that serve sparsely populated areas where there are few physicians.

Physicians need to continue to make sure that they do not confuse personal with professional autonomy and that they continue to ensure that health care is truly patient-centred. Physicians have rights but also obligations in this regard and they need to make sure that they continue to use a collaborative approach to leadership and decision-making. This includes an ongoing commitment to the concept of professionally-led regulation and meaningful physician engagement and participation in this system.

While physicians will continue to value and protect their clinical and professional autonomy, and rightly so as it is also in the best interests of their patients, they may need to consider which aspects of personal and individual autonomy they may be willing to concede for the greater good.

For example, physicians may need to work together and collaboratively with administrators and with the system to ensure that call coverage is arranged and maintained so that it need not be legislatively mandated, or imposed by regions or institutions. They may need to consider changing the way they practice in order to serve a larger patient population so that patients in need of a primary care physician do not go wanting, and so that the overall patient care load is more evenly balanced amongst colleagues. New primary care models established in Ontario and Alberta over the past decade that provide greater

out-of-hours coverage are one example of such an initiative.

By working collaboratively, both individually and collectively, physicians are finding creative ways to balance their very important personal autonomy with the needs of the system and of their patients. These efforts provide a solid foundation upon which to build as the profession demonstrates its willingness to substantively engage with others to transform the system.

To paraphrase from the discussion at the CMA's General Council meeting in August 2011: *Physicians need to carefully examine their individual and collective consciences and show governments and other partners that we are willing to play our part in system reform and that we are credible partners in the process*.

All parties in the discussion, not only physicians, must be able to agree upon an appropriate understanding of professional autonomy if the health care system is to meet the current and future needs of Canadians.

ADVOCACY

Physician advocacy has been defined as follows:

> *Action by a physician to promote those social, economic, educational and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise*.[8]

This can consist of advocacy for a single patient to assist them in accessing needed funding for medications, or lobbying the government for changes at a system level. How and when individual physicians choose to undertake advocacy initiatives depends entirely on that individual practitioner, but physicians as a collective have long recognized their obligation to advocate on behalf of their individual patients, on behalf of groups of patients, and at a societal level for changes such as fairer distribution of resources and adequate pandemic planning.

Traditionally, physicians have served as advocates for their patients in a number of arenas; however, various factors such as provincial/territorial legislation, regulatory authorities, and hospital contracts have combined to make them more reluctant to take on this important role and as a result overall patient care may suffer and the patient-physician relationship may be threatened. Increasingly, hospital bylaws urge or require physicians to consult with their institution or health region before going public with any advocacy statements, and in at least one health region physicians are required to sign a confidentiality agreement. Because of this, many physicians fear reprisal when they decide to act as an advocate.

Key messages - Advocacy:

- The ability to undertake advocacy initiatives is a fundamental concept and principle for Canadian physicians.
- In addition to advocating for issues related directly to patient care, physicians, as community leaders, may also be called upon to advocate for other issues of societal importance, such as protection of the environment or social determinants of health
- There can be a fine line between advocacy that is appropriate and is likely to affect important and meaningful change, and advocacy that others will perceive as being obstructive or counterproductive in nature
- CMA has outlined factors for physicians to consider when deciding whether or not to undertake advocacy initiatives, and how to do so

The ability to undertake advocacy initiatives is a fundamental concept and principle for Canadian physicians. Indeed, the CMA *Code of Ethics* encourages physicians to advocate on behalf of the profession and the public. Patients need to feel that their concerns are heard, and physicians need to feel safe from retribution in bringing those concerns forward.

A well-functioning and respectful advocacy environment is essential to health care planning. Health care is about making choices every day. Governments struggling to balance budgets should be aware that the public can accept that hard choices must and will get made – but they are less likely to be supportive if physicians and their patients do not feel that their opinions are sought and considered as part of the process.

Frontline health care providers, many of whom work in relative isolation in an office or community setting, also need to feel that they have a voice. The CMA supports the need for a forum where primary care physicians can speak with one voice (and make sure that this voice is heard and respected) in a community setting.

In addition to advocating for issues related directly to patient care, physicians, as community leaders, may also be called upon to advocate for other issues of societal importance, such as protection of the environment or social determinants of health. These advocacy undertakings can also be of great importance.

There can be a fine line between advocacy that is appropriate and is likely to affect important and meaningful change, and advocacy that others will perceive as being obstructive or counterproductive in nature. To further complicate matters, what might be seen as appropriate advocacy in one circumstance might not be in a different setting. Physicians should be clear on whose behalf they are speaking and whether they have been authorized to do so. If they have any questions about the possible medicolegal implications of

their advocacy activities, they may also wish to contact their professional liability protection provider (e.g., CMPA) for advice in these instances.

Depending on the facts of the individual circumstances, physicians may need to consider other factors as well when deciding if, when and how to undertake advocacy activities. They should also be aware that their representative medical organizations, such as national specialty societies, provincial and territorial medical associations and the CMA, may be able to assist them with their initiatives in certain situations.

Physicians should not feel alone when advocating for their patients, particularly when this is done in a reasonable manner and in a way that is likely to effect meaningful and important change.

Factors for physicians to consider when deciding whether or not to undertake advocacy initiatives, and how to do so:

- Is this an area or issue that impacts patient care, either directly or indirectly?
- If the advocacy activity is successful, will the anticipated change or outcome improve the situation and have a beneficial impact on patient care or access to care?
- Are there other partners, such as physician colleagues, other health care providers or organizations, who might want to be involved, or who will be directly impacted? Should they be consulted prior to undertaking the activity?
- Prior to making concerns publicly known, are there internal communications that should occur first?
- Can the issue be resolved satisfactorily in a private versus a public manner? Is there a specific benefit to the public being made aware of the issue?
- Am I fully confident that I know all the relevant and salient facts about the situation? Do I need to gather more information before undertaking the activity?
- Am I at risk of divulging any private or confidential information without first seeking the consent of the patients or parties involved?
- How will the activity impact those with whom I work and the facility where I practice? If there is likely to be a negative impact, is there anything that can be done to mitigate this prior to undertaking the activity?
- If speaking on behalf of a group or organization, do I have the necessary authority to speak on behalf of others? If not, have I adequately communicated that my comments are not being made on behalf of others?

Accountability

Physician accountability can be seen to occur at three levels: accountability to the patients they serve, to society and the health care system and to colleagues and peers.

Accountability to patients

The physician-patient relationship is a unique one. Based on, optimally, absolute trust and openness, this relationship allows for a free exchange of information from patient to physician and back again. Physicians often see patients at their most vulnerable, when they are struggling with illness and disease. While other health care providers make essential contributions to patient care, none maintain the unique fiduciary relationships that are at the heart of the physician's role and which are recognized by law.

Physicians are accountable to their individual patients in a number of important ways. They provide clinical services to their patients and optimize their availability so that patients can be seen and their needs addressed in a timely fashion. They follow up on test results. They facilitate consultations with other physicians and care providers and follow up on the results of these consultations when needed. They ensure that patients have access to after hours and emergency care when they are not personally available.

Key Messages - Accountability:

- Physicians must recognize their individual and collective accountabilities (as one member of the health care team and as members of a profession) to their patients, to their colleagues and to the health care system and society
- CMA has specific recommendations to help ensure that physicians are able to meet their obligation to be accountable to the health care system for high quality care

Physicians can also fulfill their obligation to be accountable to patients in other ways. They can participate in accreditation undertakings to ensure that their practices meet accepted standards. They can ensure, through lifelong learning and maintenance of competency activities, that they are making clinical decisions based on the best available evidence. They can undertake reviews of their prescribing profiles to ensure that they are consistent with best current standards. All of these activities can also be used to maximize consistencies within and between practices and minimize inter-practice variability where appropriate.

Accountability to society and the health care system

Physician accountability at this level is understandably more complex. In general, society and the health care system in Canada provide physicians with financial compensation, with a significant degree of clinical autonomy as reflected by professionally-led regulation, and with a high level of trust. In some cases, physicians are also provided with a facility in which to practice and with access to necessary resources such as MRIs and operating rooms.

In return, physicians agree to make their own individual interests secondary in order to focus on those of their patients, and they agree to provide necessary medical services. Accountability then can be examined based on *the extent* that these necessary services are provided (i.e. patients have reasonable access to these services) and also *the level of quality* of those services. Clearly, neither access nor quality can be considered in isolation of the system as a whole, but for the purposes of this paper the focus will be on the role of the physician.

The issue of level and comprehensiveness of service provision has been considered to some extent above under the concept of physician autonomy. Physicians as individuals and as a collective need to ensure that patients have access to timely medical care and follow up. They also need to make sure that the transition from one type of care to another (for example, from the hospital to the community setting) is as seamless as possible, within the current limitations of the system.

Collectively and individually, physicians also have an obligation to make sure that the *quality of the care* they provide is of the highest standard possible. They should strive for a "just culture of safety", which encourages learning from adverse events and close calls to strengthen the system, and where appropriate, supports and educates health care providers and patients to help prevent similar events in the future.[9]

Thousands of articles and hundreds of books have been published on the subjects of quality assurance and quality improvement. From a physician perspective, we want to be able to have access to processes and resources that will provide us with timely feedback on the level of quality of our clinical care in a way that will help us optimize patient outcomes and will be seen as educational in nature rather than punitive. As a self-regulated profession, medicine already has strong accountability mechanisms in place to ensure the appropriate standards of care are maintained.

To ensure that physicians are able to meet their obligation to be accountable to the health care system for high quality care, the CMA has developed a series of recommendations for Continuous Quality Improvement (CQI) activities (see box below).

Physicians need to take ownership of the quality agenda. New medical graduates are entering practice having come from training systems where they have access to constant feedback on their performance, only to find themselves in a situation where feedback is non-existent or of insufficient quality to assist them in caring for their patients. While regulators and health care facilities have a legitimate interest in measuring and improving physician performance, ultimately physicians themselves must take responsibility for ensuring that they are providing their patients with the highest possible standard of care, and that mechanisms are in place to ensure that this is in fact the case.

CMA Recommendations for Continuous Quality Improvement (CQI):

- That the ultimate goal of CQI activities should be to improve patient outcomes.
- That all physicians have access to voluntary CQI initiatives in their area of clinical activity and expertise.
- That in order to help build capacity in CQI there should be an increased focus on quality improvement education at all levels of physician training as well as increased research funding made available to study the quality and impact of CQI initiatives.
- That physicians agree to participate actively and voluntarily in these activities.
- That the results of these assessments and the information provided during CQI processes be kept strictly confidential unless otherwise mandated by a professional regulatory body or by legislation.
- That physicians should benefit from their participation in these activities, both through optimization of patient outcomes and through having these initiatives accredited for maintenance of competence certification.
- That any comparisons made be based on updated and best available objective scientific evidence.
- That the objective of such activities be educational rather than punitive.
- That all patient information be kept confidential, but that it be anonymized and aggregated to support CQI research and analytical activities.
- That funding be made available for these initiatives and that costs be shared in a reasonable manner. Where relevant and appropriate, that funding that has been diverted from such activities be reinvested in CQI initiatives.
- That physicians have a stake in how any savings resulting from CQI activities are reinvested for the public good.
- That any collection of extra data or information should be done in a way that minimizes the impact on the time physicians are able to spend in direct patient care activities.
- That such activities should be primarily driven by practising physicians in groups such as primary and specialty care divisions in both institutional and community settings. Regulatory bodies and regional health authorities may also have a role to play in these activities.
- That every duplication of these activities at multiple levels must be avoided.
- That community practitioners have equal access to these initiatives.
- That the CQI instruments chosen will provide valid and meaningful feedback to the physician participants. While no instrument is perfect, the CMA notes that the relatively recent implementation of "360^0 evaluations" as learning tools for physicians has met with support in places like the United Kingdom.

Accountability to colleagues

Physicians are also accountable to their physician peers and to other health care providers. While much of this accountability is captured by the concept of "collegiality," or the cooperative relationship of colleagues, there are other aspects as well.

Anecdotal evidence suggests strongly that many physician leaders find themselves marginalized by their peers. They describe being seen as having "gone over to the other side" when they decide to curtail or forego their clinical practices in order to participate in administrative and leadership activities. Physicians should instead value, encourage and support their peers who are dedicating their time to important undertakings such as these. As well, physicians should actively engage with their administrative colleagues when they have concerns or suggestions for improvement. Collaboration is absolutely vital to the delivery of safe and quality care.

Physicians also need to make sure that they do everything they can to contribute to a "safe" environment where advocacy and CQI activities can be undertaken. This can mean encouraging physician colleagues to participate in these initiatives, as well as serving as a role model to peers by participating voluntarily in CQI undertakings.

Physicians are also accountable to ensure that transition of care from one physician to another occurs in as seamless a manner as possible. This includes participating in initiatives to improve the quality and timeliness of both consultation requests and results, as well as ensuring professional and collegial communications with other physicians and with all team members.

Finally, physicians need to support each other in matters of individual health and well-being. This can include support and care for colleagues suffering from physical or psychological illness, as well as assisting with accommodation and coverage for duty hours and professional responsibilities for physicians who are no longer able to meet the demands of full-time practice for whatever reason.

PHYSICIAN LEADERSHIP

> *"You will not find a high performing health system anywhere in the world that does not have strong physician leadership."*
> Dan Florizone, Deputy Minister of Saskatchewan Health

As we can see from the discussion above, having strong physician leaders is absolutely critical to ensuring that the relationship between physicians and the health care system is one of mutual benefit. Physicians as a collective have an obligation to make sure that they support both the training required to produce strong physician leaders, as well as providing support for their colleagues who

elect to undertake this increasingly important role.

Physicians are well-positioned to assume leadership positions within the health care system. They have a unique expertise and experience with both the individual care of patients, as well as with the system as a whole. As a profession, they have committed to placing the needs of their patients above those of their own, and this enhances the credibility of physicians at the leadership level as long as they stay committed to this important value. Leadership is not just about enhancing the working life of physicians, but is about helping to ensure the highest possible standard of patient care within an efficient and well-functioning system.

As part of their leadership activities, physicians need to ensure that they are consistently engaged with high quality and reliable partners, who will deliver on their promises and commitments, and that their input is carefully considered and used in the decision-making process. These partners can include those at the highest level of government, and must also include others such as medical regulators and senior managers. Without ensuring that they are speaking with the right people, physicians cannot optimize their leadership initiatives.

Physician leadership activities must be properly supported and encouraged. Many physicians feel increasingly marginalized when important meetings or training opportunities are scheduled when they are engaged in direct patient care activities. Non-clinician administrators have time set aside for these activities and are paid to participate, but physicians must either miss these discussions in order to attend to the needs of their patients, or cancel clinics or operating room times. This means that patient care is negatively impacted, and it presents a (sometimes significant) financial disincentive for physicians to participate. Some jurisdictions have recognized this as a concern and are ensuring that physicians are compensated for their participation.

Patients want their physicians to be more involved in policy-making decisions and this must be enabled through the use of proper funding mechanisms, reflective learning activities, continuing professional development credits for administrative training and participation, assisting in the appropriate selection of spokespersons including guidelines on how to select them, and guidelines for spokespersons on how to provide meaningful representation of the profession's views.

Physician leadership training must take place throughout the continuum of medical education, from the early days of medical school through to continuing professional development activities for those in clinical practice. Physicians with an interest in and aptitude for leadership positions should ideally be identified early on in their careers and encouraged to pursue leadership activities and training through means such as mentorship programs and support from their

institutions to attend training courses and meetings where they will be able to enhance and refine their leadership skills.

There has been action on several fronts to support the organized professional development of physicians in leadership roles. Since the 1990s the Royal College of Physicians and Surgeons of Canada (RCPSC) has been implementing its CanMEDs framework of roles and competencies in the postgraduate medical training programs across Canada, and this has also been adopted by the College of Family Physicians of Canada (CFPC). The CanMEDs framework sets out seven core roles for physicians. Two that are most pertinent to the relationship between physicians and the health care system are those of manager and health advocate.[10] These roles highlight the importance of physician involvement in leadership and system engagement activities, and are relevant for physicians in training as well as those in practice.

> *As managers, physicians are integral participants in health care organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the health care system.*
>
> *As health advocates, physicians responsibly use their expertise and influence to advance the health of individual patients, communities and populations.*

A number of key enabling competencies have been identified for each role, and the RCPSC has developed a variety of resource materials to support the framework.

For almost 30 years, the CMA has been offering the Physician Manager Institute (PMI) program in order to provide training for physicians pursuing leadership and management positions. PMI is offered in "open enrolment" format in major cities across Canada, and also "in house" through longstanding associations with hospitals and health regions (e.g., Calgary zone of Alberta Health Services [AHS]). In 2010 the CMA and the Canadian Society of Physician Executives introduced the Canadian Certified Physician Executive (CCPE) Program. The CCPE is a peer-assessed credential that can be attained either through an academic route that is based on completion of PMI courses or through a practice-eligibility route based on formal leadership experience.[11]

The CMA also partners with several provincial and territorial medical associations to provide leadership training. Currently CMA has agreements with the Saskatchewan, Ontario and Quebec medical associations and this will extend to the four Atlantic medical associations and the Alberta Medical Association/AHS in 2012.

In addition, a number of university business schools have developed executive

program offerings for health leaders. During the past decade, a number of physicians have taken up CEO positions in Canada's major academic health organizations.

Internationally, it has been recognized that physician leadership is critical to the success of efforts to improve health services.[12, 13]

Having well trained and qualified physicians in leadership roles is critical in making sure that physicians continue to play a central role in the transformation of the Canadian health care system. The CMA and its membership unreservedly support our physician colleagues who dedicate their time and energies to these leadership activities and the CMA will continue to play an integral part in supporting and training the physician leaders of the future.

CONCLUSION: THE CMA'S VISION OF THE NEW PROFESSIONAL RELATIONSHIP BETWEEN CANADIAN PHYSICIANS AND OUR HEALTH CARE SYSTEM

We have explored the factors that have brought us to this point, as well as the issues that must be examined and addressed to enable us to move forward. It is now time for the physicians of Canada to commit to meaningful participation in the process of transforming our health care system. This can only be achieved through the concerted efforts of all parties, including governments, health authorities, health care facilities, physicians and other health care providers. It will not be easy, and it is not likely that this transformation will take place without commitment and sacrifice on our part.

However, now is the time for physicians to demonstrate to their patients, to their colleagues and to society that they are willing to do their share and play their role in this critically important process, at this critically important time. Doing so will help them to achieve the CMA's vision of the new professional relationship between Canadian physicians and the health care system.

In this vision:

> **Physicians are provided with the leadership tools they need, and the support required, to enable them to participate individually and collectively in discussions on the transformation of Canada's health care system.**
>
> **Physicians are provided with meaningful opportunities for input at all levels of decision-making, with committed and reliable partners, and are included as valued collaborators in the decision-making process.**
>
> **Physicians recognize and acknowledge their individual and collective obligations (as one member of the health care team and as members of a**

profession) and accountabilities to their patients, to their colleagues and to the health care system and society.

Physicians are able to freely advocate when necessary on behalf of their patients in a way that respects the views of others and is likely to bring about meaningful change that will benefit their patients and the health care system.

Physicians participate on a regular and ongoing basis in well-designed and validated quality improvement initiatives that are educational in nature and will provide them with the feedback and skills they need to optimize patient care and outcomes.

Patient care is team based and interdisciplinary with seamless transition from one care setting to the next and funding and other models are in place to allow physicians and other health care providers to practise within the full scope of their professional activities.

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