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# Physician Leadership

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## Finding the Balance

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## EDITORIAL

# Finding the balance



Colleen Galasso  
Executive Director, CSPL

It has been a while since our last journal issue and, in that time, much has happened at CSPL. We are excited to bring you up to speed about our ongoing endeavours.

### Canadian Journal of Physician Leadership

After two years of leading CJPL, our editor-in-chief, Sharron Spicer, has made the difficult decision to step down from this role. CSPL would like to acknowledge and thank Dr. Spicer for the invaluable contributions she has made to our publication. CSPL is currently looking to fill this position. **If you are interested or would like more information on what this position entails, please contact us ([colleen@physicianleaders.ca](mailto:colleen@physicianleaders.ca)).**

With Dr. Spicer's departure, we felt this was an opportune time to review and assess the future direction of our journal. At the end of March, we sent a short survey to our members, and we thank those who responded with valuable feedback. In "Room for improvement, say CSPL members," we share the key findings from the survey. Of course, we welcome your feedback on *CJPL* at any time.

### Canadian Conference on Physician Leadership

We are delighted to provide you with a recap of

CCPL2023, which took place in Vancouver on 26–27 May. This year's conference centred around the theme **Healing our Health System: Leadership for Renewal** and included thought-provoking presentations and insightful discussions. To get the essence of the conference, read the article "Harnessing hope and optimism at CCPL2023."

**Save the date: CCPL2024 will be held 24–25 May in Montréal.** We look forward to seeing you there!

### Annual general meeting

At the time of the conference, CSPL holds its Annual Meeting of Members. One of the key decisions coming out of the meeting was to increase membership dues. After holding dues steady for the past three years, there was overwhelming approval to increase them by 10% for the next two years. The membership fee for 2024 will be \$215 – a small increase considering the value received.

### Also in this issue

This issue's articles are all about finding balance. One weighs the impact that medical questions on licensure applications may have on patient safety and physician well-being. Another navigates the challenges and opportunities that arise when AI is placed alongside physicians. One article examines the impact COVID has had on hospitalists and what is needed to reverse the staff shortages in this specialty.

The CSPL, in partnership with LEADS Global, the Canadian Association of Physicians for the Environment, Sanokondou, and EqHS (Equity in Health Systems lab) hosted a post-conference summit, *Thriving People and Flourishing Planet: Leadership in Action*, which was well attended by an enthusiastic and committed group of industry leaders and physicians. Dr. Johnny Van Aerde's review of *The Climate Book* details how close we are to the tipping point of irreversible harm to our planet. It also ties into the concerns raised at the post-conference summit.

We hope you enjoy this issue!



OPINION

# Artificial intelligence in health care: should it replace physicians?



Abi Sriharan, DPhil, and Savithiri Ratnapalan, PhD

Sriharan A, Ratnapalan S. Artificial intelligence in health care: should it replace physicians? *Can J Physician Leadersh* 9(2): 32-35  
<https://doi.org/10.37964/cr24768>

The global Artificial Intelligence (AI) in health care market was worth \$7.4 billion in 2021 and is expected to reach \$48.77 billion by 2027.<sup>1</sup> Although theoretical, recent reports estimate that AI has the potential to improve up to 40% of patient care, diagnostics, research, and administrative tasks.<sup>2</sup> Are current AI solutions ready to replace physicians?

From task automation to decision support, from remote monitoring, imaging, and diagnostics to workflow optimization, AI systems are being deployed and tested to improve the daily functions of health care organizations. However, the current AI systems have yet to mature into the level of super intelligence needed to understand patients' emotional and social contexts and provide patient-centred care.

## What are the limitations of current AI systems?

Current AI solutions are skilled at performing specific tasks only within a particular setting. Consider Google Health's AI solution (Google, Mountain View, CA, USA), which uses a deep-learning model to identify signs of diabetic retinopathy through high-quality eye scans, accurately diagnosing patients at a level comparable to human specialists in laboratory settings. However, when deployed in real-world environments in Thailand, where nurses conducted eye scans in variable lighting conditions, the AI rejected images that did not meet a certain quality threshold. This led to misdiagnoses and an increased workload for nurses to retake images and wasted patient time for follow-up appointments.<sup>3</sup>



Current AI solutions face data challenges. Differences in patient demographics and biases in data limit the generalizability of the performance of predictive models in health care. For example, in a 2022 study, DeepMind's (London, UK) model for predicting acute kidney injury (AKI) performed well in male patients but poorly in female patients because of its original training context – United States Veterans' Affairs – where patients are predominantly male.<sup>4</sup>

Similarly, current AI solutions have limited ability to learn from past experiences in dynamic contexts such as health care. A recent study of the ability of

machine-learning models to diagnose or prognose COVID-19 from chest radiography or computed tomography scans found that none of the 400 AI models examined could accurately diagnose COVID-19 because of flaws in the development of the models or biases in the training data sets.<sup>5</sup>

Most important, AI implementation in health care is limited by lack of organizational readiness to adopt innovative technology. Take for instance IBM Watson for Oncology (IBM Watson Health, Cambridge, MA, USA), an AI tool designed to aid oncologists with treatment recommendations for cancer patients. The University of Texas MD Anderson Cancer Center in Houston invested \$62 million during the first five years of partnership with Watson, but the project was not fully implemented because of difficulties in integrating Watson into the hospital setting.<sup>6</sup>

## What is the role of AI in health care then?

Regardless of these limitations, AI is an expensive health care experiment that is rapidly advancing and is expected to become a crucial part of health professional teams. AI is already supporting physicians in three important tasks.

**AI as an assistant** to perform routine tasks, like capturing patient interactions, scheduling appointments, and synthesising records to reduce administrative burden. Here, technology has some intelligence and agency but still relies on the human user for the final decision and action. For example, Suki Assistant (Suki, Redwood, CA, USA) is an AI-powered, voice-enabled digital tool for doctors to dictate notes during patient encounters, rather than typing or manually entering data into electronic health records. It has been shown to decrease documentation time per patient by 62% and reduce after-hours charting time by 70%.<sup>7</sup>

**AI as a partner** to collaborate with the human user on a shared goal to improve the quality and efficiency of care delivery. At this level, technology has more intelligence and agency and can communicate, negotiate, and coordinate with the human user. For example, the da Vinci Surgical System (Intuitive Surgical, Sunnyvale, CA, USA) uses robotic arms

and an AI algorithm to help stabilize a surgeon's hand movements and filter out tremors, resulting in steadier and more controlled surgical actions.<sup>8</sup>

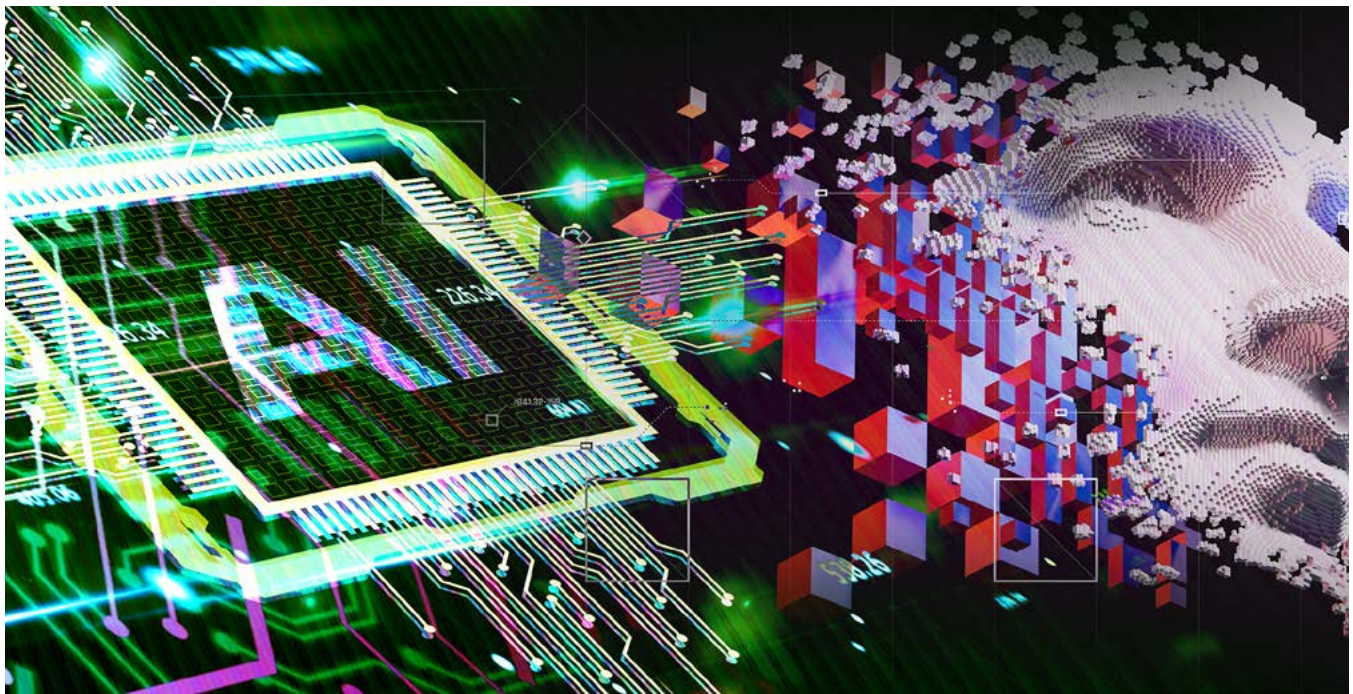
**AI as a task leader** in achieving a goal, like remote monitoring of patients or virtual assistants providing personalized support to patients. At this level, technology has high intelligence and agency and can direct, motivate, and inspire the human user. Technology is responsible for the outcome and quality of the task. For example, Woebot (Woebot Health, San Francisco, CA, USA) is an AI-powered chatbot that uses natural language processing and learned responses to mimic conversation, remember past sessions, and provide mental health support and cognitive behavioural therapy to patients from the comfort of their smartphones.<sup>9</sup>

## Will AI eventually replace physicians?

AI systems have demonstrated their ability to analyze extensive patient data proficiently, identifying trends and enabling early disease detection. They offer tailored options and interventions, enhancing the precision of medical care. In patient assessments, AI proves invaluable, particularly in time-sensitive situations, like emergency rooms and walk-in clinics, where efficient triaging reduces wait times. In addition, AI-powered solutions extend beyond the traditional hospital setting, enabling continuous patient monitoring that promptly alerts physicians to potential concerns. This approach minimizes infrastructure costs and fosters a patient-centric, value-based approach to care. AI's prowess in data analysis and pattern recognition significantly enhances the accuracy of diagnostic processes, especially in medical imaging. Furthermore, the growing capability of AI to process natural language commands holds remarkable potential, ranging from providing preliminary medical guidance to managing patient reminders and streamlining administrative tasks.

Although AI's impact on health care is undeniable, a complete replacement of doctors remains improbable because of the intricacies of medicine.<sup>10</sup> Health care interactions between clinicians and patients are complex and often require cognitive





skills to deconstruct patients' narratives of their experience with illness and identify objective facts. Qualities like empathy and nuanced decision-making, crucial for intricate patient interactions, transcend AI's capabilities. Nevertheless, when effectively designed and integrated, AI can empower physicians by handling tasks that don't require human judgement. It will augment physicians' capabilities and allow them to prioritize complex decision-making and patient-centred care. This synergy between AI and medical expertise heralds an exciting future for health care.

### How can health care organizations create symbiotic relationships between physicians and AI?

Creating a symbiotic relationship between a physician and AI requires a strategic approach that combines organizational support, education, transparency, and a focus on patient well-being. Here's how health care organizations can achieve this.

**Bottom-up solutions:** Encourage physicians to actively engage in the development of AI solutions that address real-world patient care challenges. Foster an environment where they can contribute their insights and experiences to create innovative AI-driven approaches.

**Collaborative problem-solving:** Promote collaboration between physicians and AI experts within the organization. This collaboration ensures that AI solutions align with the practical needs of health care providers, resulting in more relevant and valuable tools.

**Transparency:** Promote transparency in the use of AI systems. Ensure that physicians understand how AI-generated recommendations are reached and encourage AI systems to explain their decisions clearly. Transparent AI enhances trust and enables physicians to communicate treatment plans to patients confidently.

**Patient-centric focus:** Emphasize patient-centred care in AI implementation. Communicate to patients how AI supports their health care journey and its role in improving diagnostic accuracy, treatment options, and overall outcomes. This transparency reduces concerns about depersonalization and reinforces the human aspect of care.

**Ethical guidelines:** Establish and enforce clear ethical guidelines for AI use. Ensure that AI technologies are used responsibly and align with the organization's values, strongly emphasizing patient safety, privacy, and well-being.

**Accountability:** Implement a robust AI governance framework that defines responsibility for AI-related decisions and errors. Prioritize patients' welfare and families' needs, and ensure that any issues arising from AI use are addressed promptly and transparently.

**Upskilling and support:** Create avenues for ongoing upskilling and support for physicians as AI technologies evolve. Ensure that physicians feel confident and equipped to collaborate with AI tools in complex clinical contexts.

By upholding these principles, organizations can successfully navigate the integration of AI while preserving the human-centric nature that defines the essence of medicine.

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# Health questions on medical licensure applications: effective or counterproductive? A systematic review



Quyen K. Lam, MD, and Jeremy Beach, MBBS, MD

**Objectives:** Many medical regulatory authorities (MRAs) require their members and applicants to report information about their health on their medical licensure application and renewal forms. We wanted to determine whether this practice is effective in identifying physicians who have a health concern impacting their professional capacity and whether it influences members to seek treatment for their health concerns. **Methods:** A literature search was conducted in accordance with PRISMA publications standards. **Results:** From 7998 references found in all databases, after removal of duplicates and screening, five studies were included in this systematic review. None

addressed the question of how effective health questions on licensure application forms are in identifying relevant health concerns. Stigma and fear of perceived ramifications of reporting mental health illness to MRAs were common reasons for physicians and medical students not seeking professional mental health care. **Significance:** MRAs who include health questions on their medical licensure applications should consider their effectiveness in identifying members who have health concerns that may impact their fitness to practise. Contrarily, these questions may deter members from seeking professional treatment for their own mental health. This is an important consideration, especially as burnout is prevalent among practising physicians and medical trainees.

**KEY WORDS:** health questions, medical licensure, physician health, medical regulatory authorities, stigma

Lam QK, Beach J. Health questions on medical licensure applications: effective or counterproductive? A systematic review. *Can J Physician Leadersh* 2023;9(2):36-44 <https://doi.org/10.37964/cr24769>

Medical regulatory authorities (MRAs) have a mandate to protect patients; this includes ensuring that their active regulated members are fit to practise medicine. As part of the process, some MRAs require



reporting of information about certain aspects of physician health on licensure application forms. In the United States, concerns have been raised that asking these health questions might breach the *Americans with Disabilities Act (ADA)*, as well as acting as a barrier to regulated members seeking treatment for their own health conditions.<sup>1,2</sup> Similar concerns have been raised in other countries.<sup>3,4</sup>

Medicine is often considered a career with high expectations, attracting individuals who tend to be perfectionist, compulsive, and have a high drive.<sup>5</sup> Occupational distress, including burnout and overwhelming exhaustion, is thought to be prevalent among practising physicians and medical trainees.<sup>6-9</sup> Further, burnout, which comprises the core dimensions of exhaustion, depersonalization, and diminished professional efficacy,<sup>10</sup> has been associated with self-reported medical errors<sup>11,12</sup> and lower-quality patient care.<sup>13,14</sup>

Although several interventions have been suggested to reduce risk,<sup>15-17</sup> it remains important for MRAs to identify physicians who have a health condition impacting their fitness to practise. However, it does not help protect the public if regulatory processes deter a regulated member from obtaining care for their own health conditions.

This paper aims to build on the work of a recent non-systematic review.<sup>4</sup> We undertook a comprehensive systematic review to identify evidence about two issues: whether including health questions on licensure applications is effective in identifying physicians who may have a relevant health concern; and whether including such questions influences their decision to seek treatment for their own health concerns.

## Methods

A literature search was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.<sup>18</sup>

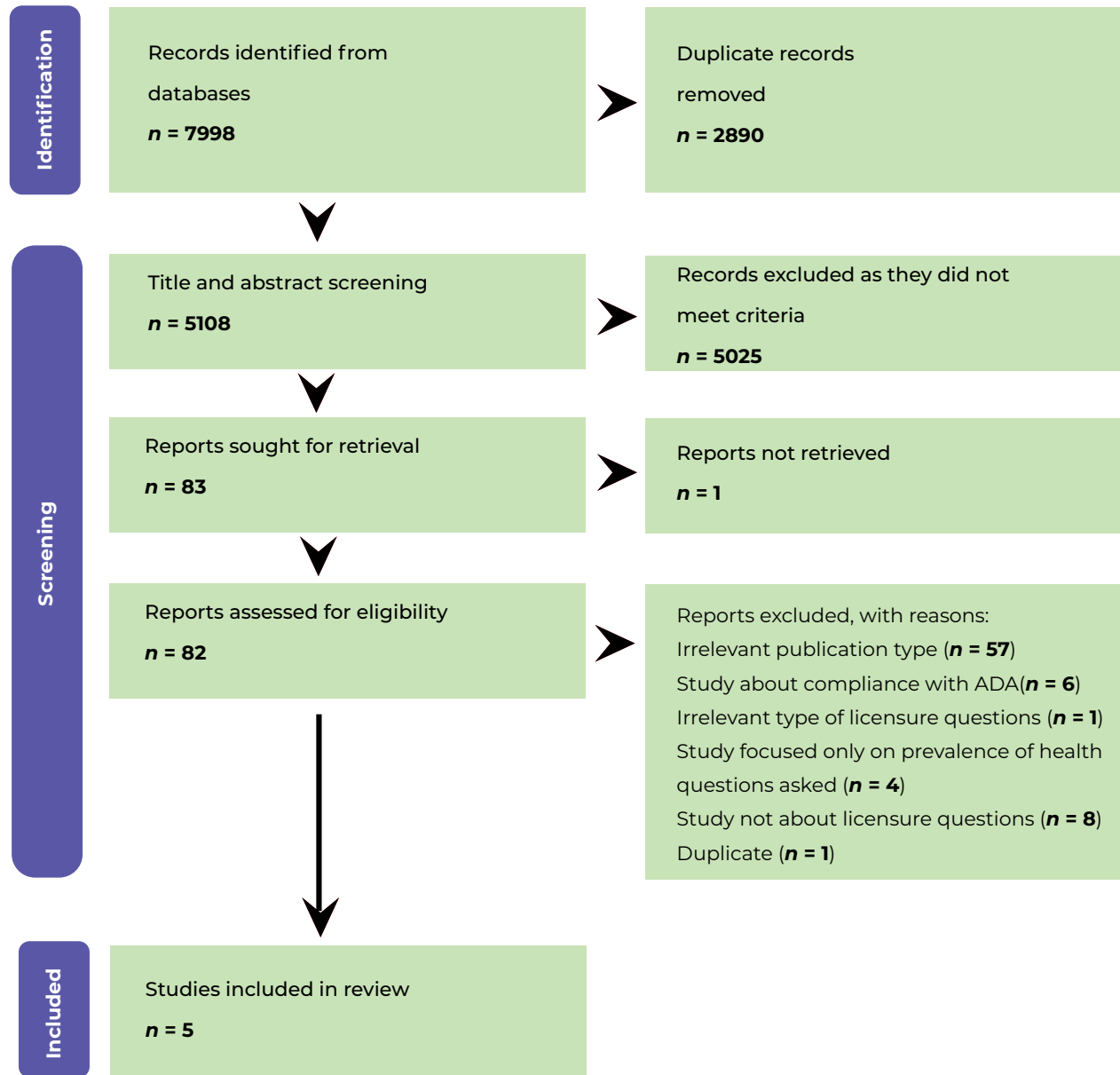
**Search strategy and study selection:** A research librarian developed search strategies through an iterative process in consultation with the review team; it was then peer reviewed using the PRESS Checklist.<sup>19</sup> Ovid MEDLINE ALL (including Epub Ahead of Print, In-Process and other non-indexed citations), Embase, APA PsycINFO, Web of Science (WoS) Core Collection, and Scopus were searched. The Ovid searches were performed on 22 Sept. 2021, and the WoS and Scopus searches on 23 Sept. 2021.

The search strategy used a combination of controlled vocabulary (e.g., "licensure, medical," "physicians/lj [legislation and jurisprudence]," "disclosure"), and keywords (e.g., "medical permit," "confidential," "stigma"). Vocabulary and syntax were adjusted across the databases as needed. No search restrictions by time or language were applied. Results were downloaded and de-duplicated using EndNote version 9.3.3 (Clarivate Analytics, Chandler, AZ). An additional potentially relevant article was identified by reviewing the bibliographies of papers identified in the literature search. An update was performed on 26 April 2023, to ensure that no recent publications were omitted.

Publications were screened for relevance based on title and abstract (stage I) by two independent reviewers (QL, JB). The full text of retained articles was then reviewed (stage II) by the same two reviewers before selecting those for extraction. A third reviewer was available when required to resolve a tied outcome.

Inclusion criteria comprised: study population consisting of physicians, resident physician trainees, or medical students; considered initial or renewal MRA licensure forms; and included original data. Exclusion criteria comprised: non-medical professions; non-relevant focus of study (e.g., study not licensure-related, licensure questions not health-related); full text not available; or included no relevant original data (e.g., review articles, opinion statements, and editorials).

Figure 1. PRISMA flow diagram



**Ethical considerations:** Because of the nature of the work undertaken, ethical approval was deemed not necessary.

## Results

Figure 1 illustrates the search process. The initial search resulted in 7998 references comprising 2422 from MEDLINE, 1579 from Embase, 135 from PsychINFO, 1399 from WoS, and 2463 from Scopus. After removal of duplicates, 5108 papers remained with titles suggesting they were potentially relevant.

Of these, 5025 were excluded after initial screening of titles and abstracts resulting in 83 full text articles for review. The full text of all but one of these was retrieved and reviewed. The reference for the article that could not be retrieved appeared to be incorrect and no links could be found to it elsewhere. Of the full-text articles reviewed, 77 were omitted as they did not meet the inclusion criteria or met the exclusion criteria, leaving five studies<sup>20-24</sup> to be included in this systematic review (Table 1). Two articles were retrieved from the update completed in April 2023,

**Table 1. Summary of findings from reviewed studies**

Study	Type	Objective	Setting	Dates of data collection	Study design	Population	No. participants	Outcomes	Authors' relevant conclusions
Fletcher et al, 2020 <sup>20</sup>	Cross-sectional	To determine whether students would be willing to disclose a mental health diagnosis on a medical licensing application if prompted to do so and, if not, to identify the reasons.	University of New Mexico School of Medicine (UNM SOM)	Unspecified dates, over one month	Anonymous electronic survey; initial email invitation + three reminder emails	UNM SOM classes of 2019, 2020, 2021, and 2022; (349 invited students)	175 students completed survey (50.1% response rate)	47% noted overall worsening of their mental health through their medical training ( $p < 0.001$ ); 34% were likely to seek treatment for a mental health condition while enrolled in medical school.  51% would not disclose mental health conditions to NM medical board (49.7% feared stigmatization); 63% would not disclose on electronic residency application system (65.7% feared stigmatization).	Medical students are reluctant to use mental health services and disclose a history of mental health diagnoses.  Decreasing the stigma associated with using mental health resources is necessary to build a healthier physician workforce. In part, this includes modifying the language in common professional applications to inquire only about current impairment.
Tamminga and Tomescu 2021 <sup>21</sup>	Cross-sectional	To determine medical students' knowledge of state medical licensure application disclosure questions and how that knowledge is related to treatment-seeking for mental health conditions.	Survey emailed to 617 current medical students at a single private, allopathic American medical school in Pennsylvania.	9–22 Dec. 2019		Students from all 4 class years plus MD/PhD students and "yearout" students	327 surveys: 53% completed, 62% female	Female students (49%) were more likely to have ever sought mental health care vs. male (36%).  Of 327, 44% endorsed seeking some kind of mental health care before or during medical school.  75% of respondents (243) disagreed or strongly disagreed that it is appropriate for licensing agencies to require disclosure history of mental health treatment or diagnosis.  Those who reported mental health treatment were much less likely to support mandatory disclosure of current mental health treatment (29% vs. 49%; $p < 0.001$ ).	Disclosure requirements discourage students from seeking mental health care.  Medical students have limited knowledge of the existence or consequences of mental health disclosure questions.  Most medical students who have sought mental health care do not intend to report care-seeking during future medical licensing.
Gold et al, 2016 <sup>22</sup>	Cross-sectional	To identify self-reported history of mental illness in a group of female physicians; attitudes about mental illness, treatment, and reporting; and impact of state board requirements on help-seeking.	Facebook group of physician mothers, ~ 57000 members at time of survey	8 weeks (February to April 2016)	Four invitations to participate posted on the group's main Facebook page.	Physician mothers, representing all 50 states + District of Columbia; broad range of specialties; active US medical license within the last five years	2109, all female	959 (46%) reported that they had been treated for a mental health condition; 1009 (48%) reported either diagnosis or treatment; of these, 6% reported disclosing their mental health condition to state medical board.  1574 (75%) of respondents agreed or strongly agreed that medical board questions about mental health diagnosis or treatment impacts decisions about seeking treatment.  Top reasons for not seeking treatment included: the belief that they could get through this without help (68%); lack of time (52%); belief that having a diagnosis would be embarrassing or shameful (45%); and never wanting to report diagnosis to a medical board or hospital (44%).	Stigma plays a significant role in deterring disclosure and treatment for female physicians affected by mental illness.  Licensing questions, particularly those asking about a diagnosis or treatment rather than functional impairment, may contribute to treatment reluctance.
Dyrbye et al, 2017 <sup>23</sup>	Cross-sectional	To determine whether questions about mental health on state medical licensure applications are related to physicians' reluctance to seek help for a mental health condition.	United States (national)	28 Aug. 2014 to 6 Oct. 2014 (collected in a previously reported national survey)	National study	Convenience sample of nonretired US physicians who participated in a previously reported national survey.	5829 (66.3% male)	39.9% reported reluctance to seek treatment for a mental health condition for fear of repercussions on their licensure.  Independent factors for being more reluctant: younger age, male, private practice.	Changing medical license application questions so that they inquire about current functional impairment may be a meaningful step to decrease barriers to physicians seeking help for mental health conditions.
Arnhart et al. 2019 <sup>24</sup>	Cross-sectional	To determine whether physicians experiencing symptoms of burnout are likely to perceive requirement to report mental health status to state medical boards, malpractice carriers, and hospitals as a barrier to receiving care.	27 700 invited to participate	Fall 2016	Online survey	Physician members of the Medical Society of the State of New York	Final sample of 1058 respondents (37% female); physicians-in-training were excluded.	57% were identified as having symptoms of burnout; 67% thought it would definitely be a barrier for physicians to receive mental health care if this had to be reported on license applications and renewals.	Physicians tend to perceive the requirement to report mental health care on professional applications as a barrier to seeking such care and this perception is greater among physicians who are experiencing symptoms of burnout.



but neither met the inclusion criteria.

All five identified studies<sup>20-24</sup> were cross-sectional, based on research performed in the United States, and published between 2016 and 2021. Populations included medical students, physician mothers with an active medical licence within the last five years, and non-retired physicians who participated in a previously reported national survey. The overarching theme of all the studies was to determine what impact mandatory reporting of health conditions had on physicians' or medical students' self-reported reluctance to seek medical care. No studies attempted to address the question of how effective health questions were in identifying relevant health concerns.

Fletcher et al.<sup>20</sup> invited 349 medical students enrolled in classes of 2019, 2020, 2021, and 2022 at the University of New Mexico to participate in a confidential electronic survey about their mental health throughout and before starting medical school; their willingness to seek mental health care; and whether they would disclose a mental health diagnosis on a licensing application to the New Mexico Medical Board (NMMB) or on the electronic residency application system. Half the students completed the survey and, of these, 36% reported a mental health condition before medical school. Of the respondents, 51% reported that they would not disclose a mental health condition on the NMMB licensure application, 21% said they would (28% were unsure). The top three reasons given for not disclosing to the NMMB were: fear of stigma (49.7%), belief that their condition was not applicable to performance or ability (46.3%), and fear of repercussions or inconvenience (45.7%).

Tamminga and Tomescu<sup>21</sup> sent an anonymous survey to medical students at a private American medical school in Pennsylvania. Among other questions, they asked whether students had accessed mental health treatment before or during medical school, whether they believed that disclosing mental health care could

affect their licence, and the degree to which concerns about medical licensing discouraged them from seeking health care. They received 327 completed surveys, and the results are as outlined in Table 1. Of note, respondents with a mental health history were less likely to believe that disclosing a mental health condition would not affect licensing (13% vs. 25%,  $p = 0.03$ ).

Gold et al.<sup>22</sup> surveyed physician mothers through the Facebook platform, and of the 2109 who completed responses, 33% indicated that they had been given a mental health diagnosis since medical school and nearly half reported receiving treatment for a mental health condition. Of the 1009 women who said they had received a diagnosis of, or treatment for, a mental health condition, 6% had disclosed this information on their licensure application. The most common reasons for not disclosing were "the respondent believed that: the condition did not pose any potential safety risk to patients" (75%); "the condition was not relevant to clinical care" (70%); and "it was not the business of the medical board" (63%). Qualitative responses with representative quotes about mental health stigma, treatment-seeking, and disclosure were also provided.

Dyrbye et al.<sup>23</sup> surveyed a "convenience" sample of 5829 physicians, asking, "If you were to need medical help for treatment of depression, alcohol/substance use, or other mental health problem, would concerns about the repercussions on your medical licensure make you reluctant to seek formal medical care?" Nearly 40% replied yes. The authors also examined the initial and renewal medical licensure applications of 48 states and classified them as "consistent" with the *ADA* if they asked only about current (within 12 months or less) impairment or did not ask about mental health conditions. Physicians working in a state in which either the initial or renewal application form was not "consistent" indicated more self-reported reluctance to seek treatment for a mental health condition compared with those who worked

in states where both applications were consistent (odds ratio [OR] = 1.21, 95% confidence interval [CI] 1.07–1.37,  $p = 0.002$ ). Increased reluctance was also noted in states in which only the renewal application was consistent (OR 1.22, 95% CI 1.05–1.43,  $p = 0.011$  vs. both applications consistent). Similar findings were found in the study by Roman et al.,<sup>25</sup> which surveyed physician assistants, demonstrating that health professionals other than physicians also sometimes display a reluctance to seek medical care because of concerns about repercussions on their licensure.

### **This review reveals the paucity of studies assessing the effectiveness of health questions on a licensure application or renewal form and the impact of such questions on health-seeking treatment by physicians and medical trainees.**

Arnhart et al.<sup>24</sup> compared New York state physicians with and without symptoms of burnout and asked whether they thought mandatory reporting of their health condition on their medical licence, malpractice, and hospital privilege credentialing applications and renewals would be a barrier to seeking mental health care. Their analyses showed that compared to physicians without symptoms of burnout ( $n = 456$ , 43% of respondents), those experiencing symptoms ( $n = 602$ , 57%) were significantly more likely to think that such mandatory disclosure for medical licensing ( $X^2 = 7.9$ ,  $p < 0.05$ ), malpractice insurance ( $X^2 = 16.3$ ,  $p < 0.001$ ), and hospital practice credentialing ( $X^2 = 23.2$ ,  $p < 0.001$ ) would be a barrier to them seeking treatment. The authors noted that the New York State Board for Medicine does not have questions about mental health on its medical licensing application.

## **Discussion**

This review reveals the paucity of studies assessing the effectiveness of health questions on a licensure application or renewal form and the impact of such

questions on health-seeking treatment by physicians and medical trainees. None of the identified studies included medical residents as part of their analyses. All studies used data that were self-reported by participants. Nonetheless, some trends are worthy of further discussion.

Health questions on medical licensure forms are intended to identify regulated members with health conditions that may affect their fitness to practise medicine to help ensure safe health care provision to the public. None of the reviewed papers reported simple measures of effectiveness of this practice in identifying relevant health concerns among physicians and trainee physicians. Thus, it appears that it is assumed to be effective.

A large proportion of participants responded that they would not disclose their mental health condition on medical licensure forms or they believed that it was inappropriate for MRAs to mandate such disclosure. In the study by Fletcher et al.,<sup>20</sup> half the survey respondents reported they would not disclose a mental health condition to their medical board, while, in the Gold et al.<sup>22</sup> study, only 6% of women who reported having had a mental health condition said they had disclosed that to their state medical board.

Including questions about health on licensure applications appears to increase self-reported reluctance of a physician or medical trainee to seek treatment for their own health. In Gold et al.,<sup>22</sup> three-quarters of the respondents agreed or strongly agreed that questions about mental health diagnosis or treatment impacted their decisions about seeking treatment. Similarly, in Arnhart et al.,<sup>24</sup> 69% of participants believed that it would be a barrier for physicians to receive mental health treatment if reporting such treatment on licensing applications and renewals was mandatory. In Dyrbye et al.,<sup>23</sup> reluctance to seek treatment for mental health conditions was more apparent when health questions

were not considered compliant with the *ADA*.<sup>26</sup>

The main reasons why physicians and medical students are reluctant to seek treatment for their mental illness or report a mental health disorder to MRAs appear to be related to the stigma of having a mental health disorder and fear of ramifications regarding their licences. Weiss and Ramakrishna<sup>27</sup> have defined health-related stigma as, “a social process or related personal experience characterized by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group identified with a particular health problem.” Coupling the stigma surrounding mental health issues with the fear of perceived consequences of reporting a mental health condition to an MRA potentially magnifies the issue of physicians not seeking treatment for their mental health.

It is important to distinguish between an illness and a work impairment. Impairment is defined by the American Medical Association as “any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities.”<sup>28</sup> Not all illnesses have that effect, especially when appropriate care is provided and accepted.

Although the culture of medicine is deep-rooted, regulatory organizations can take actions to mitigate the stigmatizing effects of asking health questions on their licensing applications. It would be legally and ethically sound to adhere to the principles of the *ADA*, anti-discrimination legislation in other jurisdictions, and the guidelines provided by the Federation of State Medical Boards, including only asking about current (within one year) health conditions, not dividing physical from mental health disorders, and focusing on any impairment to work function as opposed to diagnosis or treatment.<sup>5</sup> A recent article by Stergiopoulos et al.<sup>29</sup> discussed how policy regarding questioning physicians about their health on medical licensure applications should change in Canada.

There were limitations in our systematic review.

Very few studies met our inclusion criteria. Included studies were all cross-sectional, and most relied on self-reported perceptions. Some of the reported reluctance to report to an MRA likely reflects the respondents’ intentions in a theoretical manner rather than actual outcomes, and the two may differ in some instances. Finally, selected studies were all based in the United States and, thus, caution should be used when extrapolating their findings to other jurisdictions.

## Conclusions

Our systematic review revealed no studies reporting the effectiveness of health questions on medical licensure forms and only a handful of cross-sectional studies examining the effect that health questions have on physicians seeking treatment for their own health. Stigma and fear of perceived ramifications of reporting mental health illness to MRAs were common reasons for physicians and medical students not seeking professional mental health care. Prospective studies involving regulated members in different countries, and with collaboration among MRAs, medical associations, physician health programs, and educational organizations are needed.

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**24** Participants      **40** Average Age

**14** Average Years of Experience

**8** Average Years of Leadership Experience

**52%** Women



# Physician leadership during the pandemic: reflections from hospitalist leaders in British Columbia



Vandad Yousefi, MD, FHM, DRCPSC

**Background:** Hospitalist physician leaders play an important role in how health care organizations deliver acute care services. Understanding the challenges they face can be important in preparing them for future crises. **Methods:** We conducted a mixed-methods evaluation study to explore the challenges faced by hospitalist leaders and the impact of the COVID-19 pandemic on their ability to address them. **Results:** Our findings suggest that staffing issues are a major concern, along with the quality of relations between physicians and health authority managers. Moreover, our findings suggest a need for more leadership

training for hospitalists. **Conclusions:** Hospitalist physician leaders in British Columbia face significant challenges in staffing their programs, as well as difficult relations with administrators. Efforts to improve collaboration and physician engagement should be a high priority for health system leaders in the province.

**KEY WORDS:** hospitalist medicine, relationships, leadership training, staffing

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The impact of the COVID-19 pandemic on Canada's health care system is well described.<sup>1,2</sup> Facing this unprecedented challenge, organizations had to rapidly adapt to manage increasing demands. This required many sectors of the health care industry to pivot to address pressing challenges, such as large-scale testing, procurement, and deployment of personal protective equipment; development of effective therapeutics; and implementation of treatment and triage protocols.

Such a massive transformation in health care delivery services requires strong leadership across the board. In particular, during the early stages of the pandemic, physician leadership proved crucial, as the expertise of physicians was required to develop triage protocols and infection control practices. As the pandemic response evolved to incorporate treatment guidelines, physician leadership was again needed to ensure that such therapeutics could be deployed rapidly to the front lines of the fight against COVID-19.<sup>3-6</sup>

One group of physicians who were particularly affected by the pandemic were hospitalists.<sup>7,8</sup> Hospitalists are physicians with generalist training who specialize in the care of patients in hospital.<sup>9</sup>

In Canada, hospitalists care for a large percentage of general medicine inpatients.<sup>10,11</sup> As most hospital patients with COVID-19 did not require critical care in an intensive care unit,<sup>12</sup> but instead were cared for on the general medicine wards, Canadian hospitalists were on the forefront of fighting COVID-19 in the hospital setting.<sup>13-15</sup>

Hospitalist physician leaders faced particular challenges as the pandemic evolved. Like their counterparts in other jurisdictions,<sup>16</sup> they had to rapidly reorganize their teams to accommodate the constantly changing state of the COVID-19 response.<sup>17</sup> From creating dedicated COVID-19 physician teams, building contingencies into schedules, and training staff, to protecting vulnerable group members from getting ill and providing peer support, the pandemic highlighted the important role of hospitalist leaders in facilitating a robust response to COVID-19 in hospitals.

In British Columbia (BC), hospitalist programs exist at 21 (out of 84) acute care hospitals that are operated by four of the province's seven regional health authorities. In early 2022, physicians in the Doctors of BC Section of Hospital Medicine embarked on an evaluation project to better understand the demographic breakdown, workload concerns, and job satisfaction of the hospitalist workforce in the province. We also aimed to identify specific challenges faced by hospitalist physician leaders, as well as the impact of the pandemic on their ability to perform their operational responsibilities and promote relations with other stakeholders. In this paper, we focus on the findings that relate to hospitalist physician leadership. Other aspects of the evaluation will be reported separately.

## Methods

The evaluation included an online survey of all individuals practising hospitalist services in the province, with a subset of questions specifically addressed to hospitalists in leadership positions. We also conducted a series of semi-structured interviews with physician leaders from various hospitalist programs across BC. The interviews aimed to supplement the survey findings by focusing on

the current state of partnerships between hospitalists and other stakeholders (both within and beyond their health care institutions).

The online survey was created and distributed to potential respondents over a two-month period from 17 January to 14 March 2022. Survey questions were designed in collaboration with the members of the executive of Doctors of BC's Section of Hospital Medicine, the professional organization that represents hospitalists provincially. We pilot tested the survey with a subset of respondents and used their feedback to revise the questions before launching to the broader target audience.

The survey contained a set of questions targeted only to those in leadership roles. These included exploration of the volume of services provided by each hospitalist group; workload capacity; recruitment and orientation of new hospitalists; models for shift coverage; and connections to hospital medicine groups across regional health authorities and more broadly. They also explored the main challenges that hospitalist physician leaders faced in overseeing their programs.

Hospitalists were invited to participate in the survey through customized SurveyMonkey (San Mateo, CA, USA) email invitations. All respondents were required to give informed consent before commencing. Participation was voluntary and respondents could withdraw at any time. All respondents were automatically entered into a prize draw to win one of three \$100 Visa gift cards.

Thirty hospitalists were also invited to participate in semi-structured telephone interviews. These physicians were current or recent leaders of their programs. They were identified through members of the Section of Hospital Medicine, the online survey, and recommendations by other leaders. We purposefully attempted to identify people from across the province and across a range of hospital sizes and communities. A total of 11 interviews were completed (response rate 37%), at which time we reached thematic saturation. The interviews were 20-30 minutes in length. All individual responses were kept anonymous.

**Table 1. Involvement of survey respondents in leadership activities and roles**

Variable	No.	%
<b>Involvement in leadership activities (n = 277)</b>		
Sitting on a hospital committee	169	61
Participating in quality improvement or innovation projects	160	58
Sitting on a non-hospital committee or working group	143	52
Participating in leadership training	87	31
Other (residency coordination, site leadership, supporting contract negotiations, etc.)	143	52
<b>Held formal leadership position (n = 366)</b>		
Yes	80	22
No	286	78
<b>Types of formal leadership roles (n = 80)</b>		
Program lead	19	24
Division head	14	18
Local department head	25	31
Regional department head	3	4
Medical director	7	9
Other (chief of staff, chair of committee, etc.)	25	31

De-identified survey data were exported to SPSS (v. 14.0) for analysis. General descriptive statistics and frequencies were run. Cross-tabulations were also prepared to examine various factors associated with key variables of interest. Chi-squared tests and corresponding p values were calculated to test for independence between two categorical variables. Fisher's exact test was used with small cell counts and when contingency tables were larger than 2 × 2, p values were computed by Monte Carlo simulation. Measures and directions of association were calculated using odds ratios (OR) and 95% confidence intervals (CI). Thematic analysis of qualitative data

from interviews was completed in NVivo 12 (QSR, Burlington, MA, USA) to identify key themes emerging from open-ended responses.

Because this was an operational evaluation project of the members of the Section of Hospital Medicine of a physician association, we did not seek ethics approval.

## Results

### Survey insights

The survey was sent to 609 hospitalists; 374



completed the survey for a 61% response rate.

A subset of survey questions explored the involvement of respondents in leadership activities, either currently or in the previous five years. Roughly three-quarters of survey respondents ( $n = 277$ ) indicated that they had participated in non-clinical leadership activities, including sitting on hospital committees (61%); participating in quality improvement or innovation projects (58%); sitting on a committee or working group not related to the hospital (52%); and participating in leadership training (31%) (Table 1).

Almost a quarter of respondents ( $n = 80$ ) also indicated that they held or had held formal leadership roles, which ranged from site-level program or departmental leadership, to regional administrative positions. These respondents were asked additional questions related to their formalized leadership responsibilities.

### Hospitalist physician leader challenges

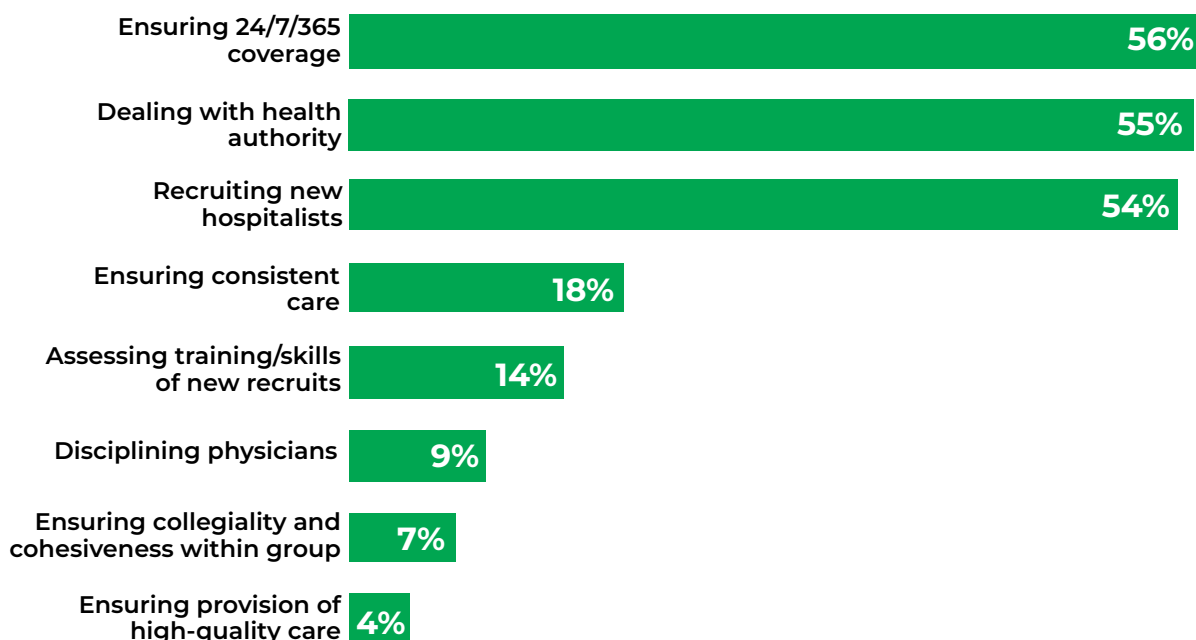
Hospitalist leaders identified continuous staffing of their programs, relations with their health authorities, and recruiting new hospitalists as their top challenges (Figure 1).

Half reported significant challenges in ensuring adequate staffing. Most indicated that evening/overnight and weekend shifts were more challenging to cover (77% and 61%, respectively), compared with daytime shifts (33%). They most frequently identified insufficient workforce of hospitalist physicians, excessive workload, and burnout associated with the COVID-19 pandemic as key factors. Other common challenges identified were hospitalists experiencing illnesses, funding uncertainties, and retirement of senior physicians.

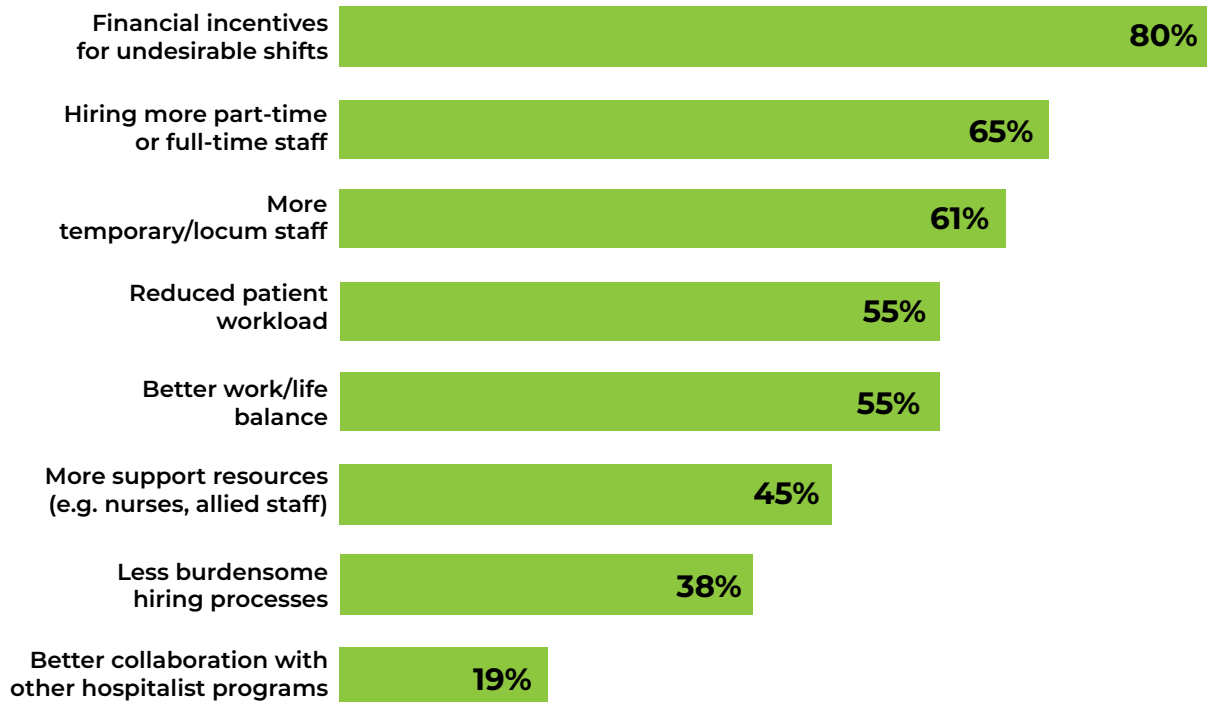
According to survey respondents, the top three factors that could help facilitate hospitalist shift coverage included financial incentives for undesirable shifts, hiring more part-time or full-time staff, and using more temporary/locum providers (Figure 2).

Over half the hospitalist physician leaders also identified recruitment as a significant challenge. On average, respondents estimated that 82% of new hospitalists for their programs were recruited from BC, 15% from elsewhere in Canada, and 5% from other countries. When all respondents were surveyed, they speculated that the top three factors deterring physicians from choosing to practise as a hospitalist were high patient complexity/acuity, heavy workload, and the burden of after-hours work (Figure 3).

**Figure 1. Challenges reported by hospitalists in leadership roles ( $n = 71$ )**



**Figure 2. Factors that could facilitate hospitalist shift coverage (n = 69)**



**COVID-19 and hospitalist leadership**

Of hospitalist physician leaders in the survey, 59% reported that they had been involved in planning activities related to COVID at their hospitals and/or health authorities. These leaders described various responsibilities, such as developing COVID protocols, procedures, and workflow modifications, sitting on hospital COVID planning/response committees, and advising on vaccine rollout plans. Most reported that COVID made it somewhat more challenging (46%) or much more challenging (37%) to ensure shifts were covered.

**Interview insights**

We conducted semi-structured interviews with a sample of hospitalist physician leaders in the province. Most interviewees (9 out of 11) did not have formal leadership training to prepare them for their roles. A few explained that they had been informally mentored by senior hospitalist leaders. Others noted that their health authorities offered various leadership training opportunities, but they had not been able to find the time required to participate. One hospitalist participated in negotiations training offered by the

Doctors of BC, which validated their on-the-ground experience supporting regional contract negotiations.

**Connection and partnerships with decision-makers**

We asked hospitalist physician leaders a series of questions about their connections to decision- or policymakers at various levels: within their local hospitals, with their regional health authorities, with decision-makers at the provincial level, and with other physician groups.

Most described strong partnerships with administrators and medical leaders at their local site. Interviewees often indicated that they had direct communication and standing meetings with site-level administrators, medical directors, and other physician leaders to manage hospital operations and administrative issues, discuss challenges and potential solutions, and make progress toward common goals. Relations appeared stronger in smaller community hospitals that tended to foster more collaboration.

“We have these dyad partnerships within the hospital. We’re connected with the administrative facility managers, with the chief

of staff and the site medical director. They are hospitalists as well. We have direct access to communicate with them.”

“I feel pretty connected with local admin and leadership here. So, I have good a relationship with the site medical director. Every week I meet with the clinical director whose responsibility is the inpatient side of things. All of that is good in terms of the relationships.”

“We are quite integrated with the daily events around the hospital, such as managing overcapacity and things like that. Generally, we have good to quite good relationships. Although, that hasn’t always been the case here. Now we have a strong program and we are collaborative. We built those relationships.”

“In my experience, smaller community hospitals tend to have more collaborative relationships. More intimate environments lead to better relationships with site medical directors and administration. There are just better dynamics with hospitalist groups. We take care of 90% of inpatients in the hospital. We have a good dynamic with the site medical director.”

**Of hospitalist physician leaders in the survey, 59% reported that they had been involved in planning activities related to COVID-19 at their hospitals and/or health authorities.**

A more mixed picture emerged when we explored relations between hospitalists and administrators at the regional health authority level. Although some interviewees described somewhat positive relations, others noted challenges or a complete lack of connection. Interviewees explained that relations with health authorities had been strained because of a variety of factors, such as frequent turnover among administrators, misunderstanding of motives and priorities, lack of appreciation for services provided,

disrespectful behaviour during negotiations, and toxic relations.

“I don’t have any meaningful connections to the health authority. We get a lot of information and communication pushed on us. They aren’t working with us and the relationships are now quite toxic.”

“One challenge is the turnover in the health authority roles. You get people put in who don’t know about our program. You develop those relationships with the health authority leaders, but then they leave the roles.”

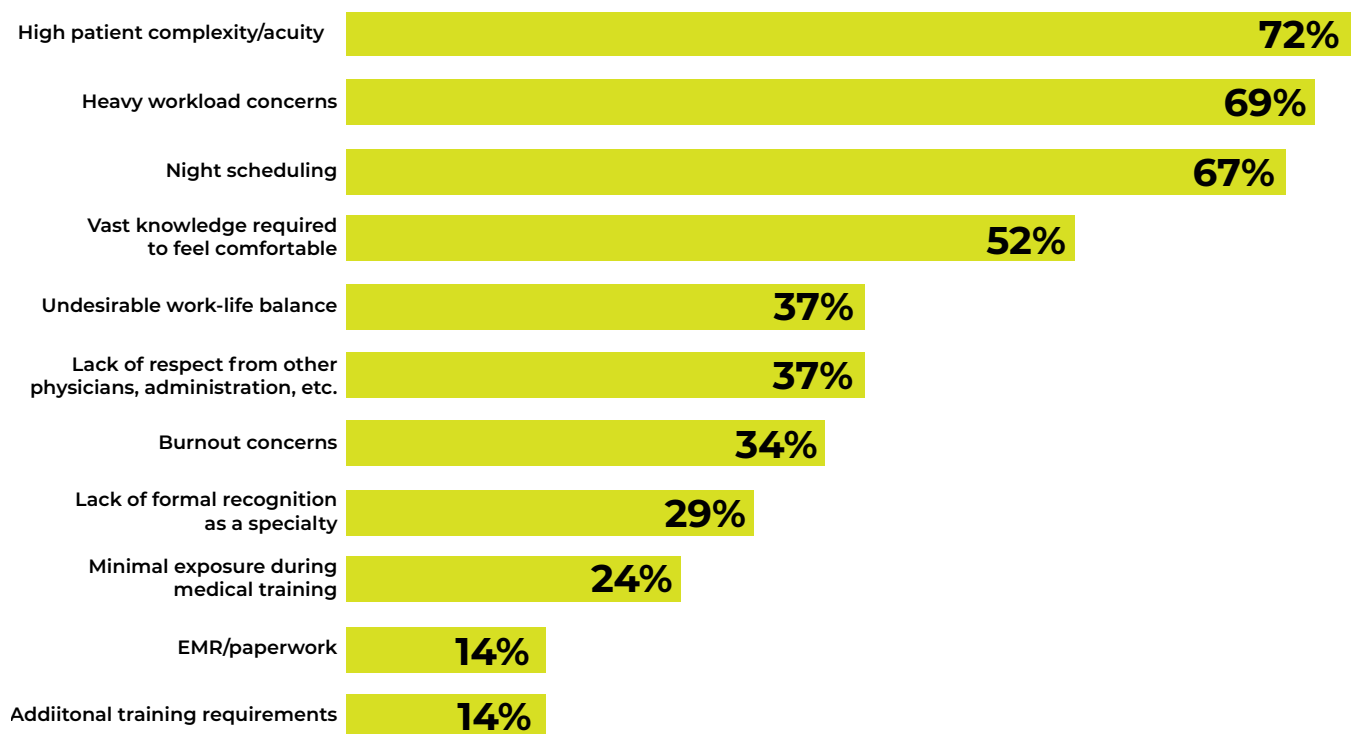
At the macrosystem level, unifying and amplifying the voice of hospitalists at provincial tables, with direct lines of communication to provincial decision-makers was identified as a gap.

“I think the major concern is that we have become a substantial part of medicine in BC, we are approaching almost 40% of inpatient beds in the province. But the fact is, we don’t really have an avenue to have a voice at a higher, provincial level. Our communication is through the HA at best. Nothing beyond that at a meaningful level. Since we are not a formal specialty, our voices get lost in the GP dynamic.”

“Connections to the provincial level need to be strengthened, otherwise we’re completely in the dark.”

“Thinking about provincial relationships, it’s a difficult thing to consider. It’s always someone else’s problem. With the family practice crisis, the ministry doesn’t have money. Everyone has siloed themselves into their own stressful circumstances. Others are adding to their burden. There needs to be some way to be brought together. We have the same goal here. Let’s work towards that. The system is overloaded already.”

**Figure 3. Factors deterring physicians from choosing to practise as a hospitalist (n = 107)**



On the other hand, most interviewees indicated that current relations between their hospitalists and other physician groups were positive, collegial, and collaborative. They explained that such partnerships were fostered through advocacy and support for other physician groups when they needed it and translating the goodwill generated through this to support for hospitalists.

“Relationships with FPs have gotten better over time. During the time of transition in inpatient care models, the relationships were wounded. We have built strong relationships with them since.”

“Our relationships with other physician groups are also very collegial, like emergency doctors. We have lots of physician leaders that we work with here.”

“We need to not just advocate for ourselves. We need to help emergency work better, and other subspecialties. That attitude to help others helps our reputation in the

hospital. There are still GPs who talk about how we’re the reason there are no GPs in the community. More and more, that is going away, but still there.”

We asked interviewees to identify mechanisms to strengthen relations with decision- and policymakers. Some interviewees indicated that standing meetings between administrators and hospitalist physicians were necessary to discuss how both sides could make progress toward common goals. When fostering relations between hospitalists and health authority administration, in-person events rather than virtual communications were identified as preferable, with conversations focused on collaboration and cooperation.

Interviewees also highlighted the importance of hospitalist involvement with non-clinical activities (e.g., quality improvement and access initiatives) and assumption of leadership/administrative roles as a way to gain exposure and build relations to enhance opportunities for collaboration.



Finally, some respondents identified a need for formal training on how to build relations with administrative leaders. Although interviewees were also asked if they would benefit from media training or support from public relations specialists to strengthen stakeholder partnerships, a large majority did not see value in this type of support.

**We believe that this study is a first attempt to understand the perspectives of a group of hospitalist physician leaders in Canada on the roles and challenges they faced operationally, as well as in establishing relations with other decision-makers and health care system managers during the pandemic.**

#### Impact of COVID-19

The interviews also explored whether hospitalist physician leaders experienced any changes during the COVID-19 pandemic. Many interviewees explained that, as the pandemic unfolded, the demands on hospitalist leaders increased. They were more involved in virtual meetings and communications related to determining new protocols and procedures, optimizing patient access and flow, and general clinical operations. Others indicated that their clinical workloads increased and included direct care of COVID-19 patients, while non-clinical activities were largely paused. Some interviewees expressed concerns that high patient volumes negatively impacted patient safety and quality of care. Two years into the pandemic, interviewees highlighted that hospitalists were experiencing high levels of burnout and stress, resulting in staffing issues at their sites.

“COVID created more solidarity. The early pandemic helped with that. Now we have lots of burnout, not enough doctors, beds.”

Some interviewees explained that, while COVID-19 dramatically increased hospitalists’ clinical workloads, their commitment to “step up to the plate” demonstrated their value in their hospitals and placed

them at the forefront of decision-making. Others indicated that the pandemic resulted in enhanced relations and solidarity with other physician groups, site administration, and health authority leadership. On the other hand, some explained that COVID-19 negatively impacted relations with their local health authorities given workload issues experienced by hospitalists.

“Any time you have a crisis, whoever is willing to do work gets the prize of having more influence at the end. Our CTU didn’t want to be involved with COVID, FPs didn’t want to see COVID, we took it on instead... we are a more integral part of the hospital now.”

“[COVID] certainly forced us into spending significant amounts of time in meetings as leaders. Lots of crisis management that, in a way, brought us closer with leadership. It allowed us, as hospitalists, another opportunity to demonstrate value.”

“I am quite disengaged from my [health authority] because of COVID and workload issues.... It lasted a few weeks with extreme congestion. I had to save myself. I reduced my work time. Workload is getting worse. COVID soured our relationship with [the health authority].”

Some interviewees explained that they could have benefited from crisis management and leadership training to better support them in their leadership roles during the initial onset of COVID-19.

## Discussion

We believe that this study is a first attempt to understand the perspectives of a group of hospitalist physician leaders in Canada on the roles and challenges they faced operationally, as well as in establishing relations with other decision-makers and health care system managers during the pandemic. Because it was conducted at a time when the COVID-19 pandemic was still at its height, it allows for a timely assessment of its impact on hospitalist leaders across BC.

Although staffing issues are common to many physician groups, they are a significant challenge for hospitalist physician leaders. The burden of ensuring evening, overnight, and weekend coverage is a major barrier in recruiting new staff. Hospitalist staffing levels have been associated with overall hospital outcomes.<sup>18</sup> Moreover, lower staffing levels result in higher individual physician census, which has been associated with longer length of stay and lower efficiency of work.<sup>19,20</sup> As a result, there is a clinical imperative to ensure that staffing of hospital medicine programs is sufficient to meet clinical workload demands and patient volumes, and that all shifts are adequately and consistently covered to achieve that goal.

Inadequate staffing levels also result in higher individual workloads. Work overload has been associated with higher burnout rates and greater intention to leave practice for a range of health care workers during the COVID-19 pandemic.<sup>21</sup> Prior studies have suggested that high rates of physician staffing turnover result in significant recruitment costs to their organizations.<sup>22,23</sup> As such, it is important for hospitalist physician leaders to retain their existing staff, as well as recruit new members to their programs.<sup>24</sup> Given the impact of COVID-19 on frontline physician burnout levels,<sup>25</sup> organizations must develop strategies to empower hospitalist physician leaders to address staffing shortfalls before it is too late.

A bigger challenge that was identified in the survey, and further explored in interviews, revolved around the importance of developing relations with various key stakeholders (particularly the regional health authorities that are responsible for the delivery of services). Historically, relations between hospitalist physicians and health authorities in BC have been characterized by periods of stability punctuated by episodes of strife and mutual distrust, mainly revolving around difficult contract negotiations.<sup>26,27</sup> Given that health authorities fund and operate hospitalist services, the quality of relations between

health authority administrators and hospitalist physicians can have a direct impact on work satisfaction and burnout among frontline providers. It can also affect the ability of hospitalist physician leaders to fulfill their responsibilities as they sit in a potentially uncomfortable position that straddles the divide between the two sides.

### **Although more than half the physician leaders in our survey identified relations with health authorities as an area of challenge, a more nuanced picture emerged during the interviews.**

Although more than half the physician leaders in our survey identified relations with health authorities as an area of challenge, a more nuanced picture emerged during the interviews. The degree of challenge varied based on the level of bureaucracy in the health authority: hospitalist leaders described generally effective and collaborative relations with their health authority counterparts locally, but progressive erosion of the quality of the working relationship with higher levels of authority. Lack of access to health system leaders at the provincial level (e.g., the ministry of health, which ultimately oversees and operates the health authorities as its service delivery agencies) may explain the headline-making staffing challenges for some hospitalist programs in recent months.<sup>28,29</sup>

In this context, leadership training that focuses on developing skills and competencies around establishing and improving relations can be very important for hospitalist leaders. Such training could allow them to adopt strategies that would improve collaboration with their hospital administration counterparts locally and identify an approach to reach out to higher levels of health care leadership in a highly bureaucratic management system. In fact, a number of interviewees in our study highlighted leadership training for that purpose.

The LEADS in a caring environment capability framework<sup>30</sup> has been widely adopted in Canada as

the basis for various leadership training programs for physicians and other health care leaders. It emphasizes the importance of building and managing relations, with a number of domains focusing on various aspects of relationship development (engagement, developing coalitions, and spreading changes).<sup>31,32</sup> It has also been shown to effectively address the capabilities required by health care leaders to address overarching challenges, such as the COVID-19 pandemic response.<sup>33</sup> Leadership development programs based on the LEADS framework can address the competency requirements of hospitalist physician leaders in addressing the challenges we uncovered in our evaluation study.

**To our surprise, a large percentage of hospitalist physician leaders in our sample lacked formal leadership training. Only 46% of those who identified as physician leaders had participated in leadership training.**

To our surprise, a large percentage of hospitalist physician leaders in our sample lacked formal leadership training. Only 46% of those who identified as physician leaders had participated in leadership training. This was confirmed during the interviews, when only two of the 11 leaders interviewed had received formal training to enhance their leadership skills. Many interviewees indicated that such leadership opportunities were available to them, but they could not find the time away from clinical work to participate in such programs. Hospitalist physician leaders undertake leadership training for a variety of reasons: improving communication and interpersonal skills, enhancing negotiation skills, refining goals and strategic thinking, and improving self-development.<sup>34</sup> However, lack of protected time and increasing clinical responsibilities can prevent many from taking such training.

## Conclusions

Our evaluation of hospitalist physician leaders in BC during the COVID-19 pandemic has uncovered

a number of operational challenges, particularly related to staffing shortfalls. In addition, it highlights the importance of relations between hospitalists and health care administrators in the BC context and the impact of the pandemic response on these relations. Lack of formal leadership training remains a notable issue. Health care organizations, such as health authorities in BC, should invest in their hospitalist leaders by more than simply offering training programs, but also facilitating their participation through compensation for lost clinical time. They should also support engagement in leadership training, not only by the individuals in formal leadership roles, but also for those who are informally considered to be influential or have the potential to assume leadership positions in the future.

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## Declarations

**Ethics approval** – This evaluation project was conducted by the professional medical association as an evaluation project of its membership, which is deemed exempt from the need for ethics approval in BC.

**Availability of data and materials** – The data that support the findings of this study were used under license for the current study, and so are not publicly available. However, data are available from the author on reasonable request and with permission of Doctors of BC's Section of Hospital Medicine.

**Competing interests** – VY is the CEO and cofounder of Hospitalist Consulting Solutions, Inc., a health care management consultancy. He is also on the executive of the Section of Hospital Medicine of Doctors of BC. He did not receive any payment for his involvement in this project.

**Funding** – This project was supported by Doctors of BC's Section of Hospital Medicine, which provided a grant to hire a professional evaluator to conduct the project. The section was involved in the design and administration of the evaluation study of its membership.

**Informed consent** – All survey and interview participants provided informed consent before participating in the evaluation study.

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*This article has been peer reviewed.*

## CJPL SURVEY RESULTS

# Room for improvement, say CSPL members

Colleen Galasso



In its ninth year of publication, the *Canadian Journal of Physician Leadership* (CJPL) has been the “go to” source of articles on physician leadership in Canada, and we want to continue to build on this. With the departure of our editor-in-chief and the search for

someone to take on this exciting role, the Canadian Society of Physician Leaders (CSPL) felt this was a fitting time to step back and assess the journal, so that it continues to provide the information physicians need and want.

In March/April this year, we surveyed CSPL members. A mix of both closed- and open-ended questions allowed participants to share their perspectives, insights, and feedback.

Despite a low response rate (only **6%** of our **801** members), we consider the feedback valuable and will take it into consideration as we move forward. Here’s what you told us.

- Most respondents (88%) read *CJPL*, with 45% enjoying both the online and PDF versions; 40% preferred the online version, and 15% preferred the PDF version.
- Most respondents (88%) indicated that they read only those articles that are relevant or of interest to them, with just 15% saying they read the entire journal.
- Just under 80% indicated that the articles are relevant to their position or role.
- Respondents (67%) would like *CJPL* to be published

four times a year or three times plus a special conference issue and on a regular schedule.

- *CJPL* needs to expand its scope and include articles from academia, industry, health care services, specialties, leadership level, nongovernmental organizations, and international health organizations (United States and United Kingdom).
- *CJPL* must cast a wider net and bring in more diversity of authorship and opinion to appeal to a broader base of readership. Not everyone is an academic or an institutional leader; most lead at the community, local, or regional level.
- *CJPL* should consider adding features, such as a resident-focused section, health and well-being, advice column, coaching, showcase of a health leader.
- *CJPL* should increase its visual appeal.
- Overall, 67% of respondents rated *CJPL* as excellent or very good, while 21% rated it as average.

We appreciate your feedback and insights. We will use this information to guide us over the coming year to ensure that *CJPL* remains relevant, informative, and inspiring to all physician leaders.

If you did not complete the survey, it’s not too late to share your thoughts and ideas with us. Your feedback is invaluable in helping us understand your needs better.

If you have conducted leadership research, engaged in leadership initiatives that were successful or not, or have a unique perspective on health care leadership, we encourage you to submit an article to *CJPL*. Your insights and experiences can have an impact on physician leadership in Canada.

If you are dedicated to advancing physician leadership, fostering innovation, and driving positive change, we encourage you to apply for the position of editor-in-chief.

To provide feedback or submit an article or if you are interested in the editor-in-chief position, please contact Colleen Galasso at [colleen@physicianleaders.ca](mailto:colleen@physicianleaders.ca).



## 2022-23 CCPE Recipients



**Dr. Amanda Brisebois**

Associate Chief Medical Officer, Covenant Health, AB / Physician Advisor, Edmonton Zone Medical Staff Association  
Edmonton, AB



**Dr. David Carroll**

Senior Medical Officer – Central Zone, Newfoundland and Labrador Health Services  
Gander, NL



**Dr. Lilanie Cooper**

Past Psychiatry Area Lead, South East Saskatchewan Health Authority / Past Chief Psychiatrist and Division Lead Weyburn and Area, SHA  
Weyburn, SK



**Colonel Colleen Forestier, MD**

Director of Health Services Strategic Concepts, Canadian Armed Forces  
Ottawa, ON



**Dr. Carlos Lalonde**

President and Chief of Staff, Homewood Health Centre / Executive Vice President Medical Services, Homewood Health Inc.  
Guelph, ON



**Dr. Eddy Lang**

Professor and Department Head for Emergency Medicine, Cumming School of Medicine, University of Calgary, Alberta Health Services, Calgary Zone / Scientific Director, Emergency Strategic Clinical Network  
Calgary, AB



**Dr. Tanya Munroe**

Senior Medical Director, Access and Flow Network/ Care Coordination Centre NSH / Medical Site Lead, Colchester East Hants Health Centre  
Truro, NS



**Dr. Rakesh Patel**

Chairman, Board of Directors, South Calgary Primary Care Network (SCPCN) / Family Physician  
Calgary, AB



**Dr. Cheryl Pugh**

Medical Executive Director, Western Zone, Nova Scotia Health / Department Head, Women & Children, Western Zone, NSH  
Bridgewater, NS



**Dr. debbie Robinson**

Medical Site Lead, Obstetrics and Gynecology, St. Boniface Hospital / Primary Supervisor, Clinical/Physician Assistants in Obs/Gyn, Winnipeg  
Winnipeg, MB



**Dr. Stephanie Young**

Physician Executive, Integrated Northern Health, Saskatchewan Health Authority / Northern Palliative Care Physician, Far Northeastern Saskatchewan  
La Ronge, SK

## CANADIAN CONFERENCE ON PHYSICIAN LEADERSHIP

# Harnessing hope and optimism at CCPL2023



Shannon Fraser, MD, Colleen Galasso, and Deirdre McKennirey

With the COVID pandemic a little further away in our rearview mirror, physician leaders from coast to coast gathered in Vancouver on 26 - 27 May for the Canadian Conference on Physician Leadership. Under the theme “Healing our Health System: Leadership for Renewal,” we came

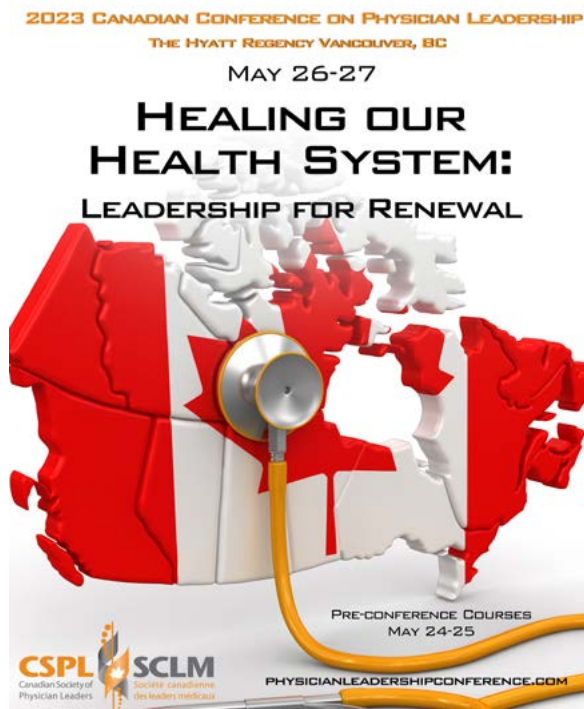
together with a shared spirit and commitment to revitalize health care.

From the opening blessing by Elder Doris Fox, who inspired and challenged attendees, to the last keynote, a renewed sense of hope and optimism infused the conference.

The opening speaker, Dr. Thomas Homer-Dixon, executive director of Cascades Institute at Royal Roads University, literally talked about hope and how it must be a key leadership competency in a time of crisis. In his book *Commanding Hope: The Power We Have to Renew a World in Peril*, he stresses that hope is essential for leadership – if we can’t inspire hope, we can’t lead. However, our traditional perception of hope needs to be reimagined; instead of seeing it as false, naïve, and passive, we must view hope as honest, astute, and powerful. To leverage hope in leadership, we must shift from the position of “hope THAT...” to “hope TO....” This shift in mindset pushes us to create our vision of a desirable future and to be active participants in making that vision a reality.

Dr. Bonnie Henry, reflecting on her own experience leading in a time of crisis, delivered an emotional address on remaining resilient during very challenging times. She talked about how the pandemic tested both her spirit and her leadership. She did not lose hope, but instead held fast to the power that kindness, compassion, and integrity hold in times of crisis, imploring participants to “respond to unrelenting uncertainty with unrelenting kindness” and to “always take the high road; it’s peaceful up there because there aren’t many people.”

Dr. Alika Lafontaine, CMA’s president, opened day 2 of the conference with an insightful presentation on mobilizing change. To lead change, we need to go beyond the repeated cycles of denial, resistance, and status quo. According to Dr. Lafontaine, the reason systems stay the same is because the mental models on which they are built – the information, beliefs, and ideas we form from our experiences – remain the same. However, there is hope for change because people can change. The role of leadership, he insisted, is to motivate and move people to new mental models, which will translate into a new system and a new status quo.





Dr. Victoria Sweet, author of the book *Slow Medicine: The Way to Healing*, gave a provocative presentation on how to make modern medicine better. The health care pendulum has swung from the personal to the efficient (EMRs, electronic forms) to the inefficient (more administration, less time interacting with patients). She contends that medicine needs to return to the personal where physicians are given more time to spend with their patients so that they can identify and remove any barriers impeding the patient's healing or, as she terms it, provide "slow medicine." Dr. Sweet does not dismiss the fact that we need fast medicine (treatments that fix, repair, or replace), but it must be complemented with slow medicine to return it to the personal and effective profession it is at heart.

Of course, any discussion on healing and renewing our health system must address politics, which is involved in all aspects of health care from jurisdictions to institutions, funding, systems, and service delivery. Moderated by Dr. Kathleen Ross, four passionate and astute physician leaders (Drs. Eric Cadesky, Ramneek Dosanjh, Gigi Osler, and Dietrich Furstenburg) debated whether politics is a barrier that constrains change or a bridge that facilitates it. At the conclusion of the debate, participants felt that it was neither purely bridge nor barrier, but both. Irrespective of this outcome, a conference participant commented on Twitter: "Listening to the panelists makes me optimistic for the future."

Each year on day 1, the conference celebrates recipients of the Canadian Certified Physician Executive (CCPE) credential in an award ceremony, with family and friends on hand to support their loved

ones. This credential, which is based on the LEADS framework, recognizes and advances physician leadership and excellence through a national, peer-generated, standards-based assessment process. Notably, for the first time since the CCPE's inception, more female than male applicants qualified. Congratulations to our 11 deserving recipients!

Rounding out the conference program were 22 unique workshops offered in four concurrent sessions. Facilitated by expert instructors, these interactive workshops provided participants with the opportunity to learn about system-enhancing initiatives as well as improve their leadership skills.

Although registration was down from pre-pandemic levels, that did not mute the excitement or buzz of conversations. You could see that people were longing to reconnect, share, and learn from each other. In fact, several people asked that we find ways to add more networking opportunities in future.

Using the valuable feedback received, the conference Planning Committee is hard at work developing the program for CCPL2024 under the theme "Shifting the Paradigm." Join us 24-25 May 2024 in Montréal and get inspired and empowered to make a real impact in transforming Canada's health care system.

Dr. Shannon Fraser is CSPL President and Chair, CCPL Planning Committee, as well as Chief General Surgery and Medical Director, C4 Command Centre, Jewish General Hospital, CIUSSS CODIM.

**2024 Canadian Conference on Physician Leadership**  
**May 24-25, 2024**  
 Le Centre Sheraton, Montreal

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**SAVE THE DATE**

Contact: [colleen@physicianleaders.ca](mailto:colleen@physicianleaders.ca)  
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**CSPL** Canadian Society of Physician Leaders  
**SCLM** Société canadienne des leaders médicaux

The Canadian Society of Physician Leaders is proud to announce

# Dr. Preston Smith

Dean, College of Medicine, University of Saskatchewan

as the 2023 recipient of the  
Chris Carruthers Excellence in Medical Leadership Award



Dr. Preston Smith's leadership career can be described as one person starting a cascade of culture change and system transformation.

Under his leadership, the dyad leader model was adopted at Moncton Hospital and the number of family physicians involved in hospital leadership increased; Provincial Department Head positions were created to establish joint leadership appointments between the College of Medicine academic departments and Saskatchewan Health Authority clinical departments; family medicine residency sites were established in Prince Edward Island and Nova Scotia; the College of Medicine at the University of Saskatchewan achieved its best accreditation status in the past 20 years and the new role of Vice Dean of Indigenous Health and the Department of Indigenous Health and Wellness, the first of its kind in Canada, is being developed.

In every role that Dr. Smith held over his distinguished career he actively mentored and coached the next generation of physician leaders.

*"Dr. Smith is an artful leader, demonstrating the ability to listen deeply, acknowledge differences, seek consensus and advocate for those with less powerful voices. He is also an artful mentor, recognized locally, nationally (and internationally) for his own skills as a mentor, and also for his recognition of the importance of mentorship as a vital tool for personal and leadership growth."*

- Dr. Anna Karwowska







CSPL President Dr. Shannon Fraser, Dr. Debbie Robinson, Dr. Colleen Forestier, Dr. Stephanie Young, Dr. Lilanie Cooper, Dr. Cheryl Pugh, Dr. David Carroll, Dr. Amanda Brisebois and CSPL Past President Dr. Rollie Nichol. Missing: Dr. Carlos Lalonde, Dr. Eddy Lang, Dr. Tanya Munroe and Dr. Rakesh Patel.







*See you Next Year*



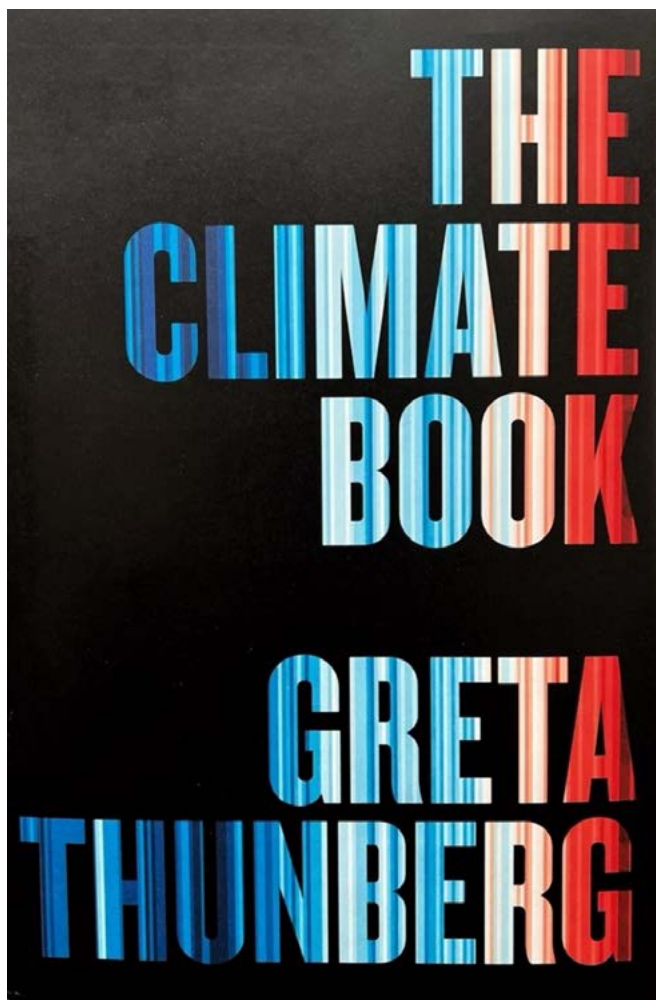
## BOOK REVIEW

# The Climate Book

Greta Thunberg

Penguin Press, 2023

Reviewed by John(y) Van Aerde, MD, PhD



Greta Thunberg's *The Climate Book* co-written by more than 100 scientists, economists, mathematicians, historians, philosophers, indigenous leaders, journalists, and social activists – is one of the most comprehensive books on the enormity of the planetary and social crisis. Although I started to read this book to better understand the impact of climate change on health and how the health care system itself contributes to the climate crisis, the book offered a much wider view. In the language of complex adaptive systems, the book explains how very close we are to or have already reached irreversible tipping points in all aspects of our

biosphere. The clear language and simple graphical representation of numerous data make this an easy, but also a painful read.

Five sections, connected by wise reflections from Greta Thunberg, take us through the causes, integrated consequences, and possible solutions to the impending disaster. In “How climate works,” the basic historical, evolutionary, and systemic facts are explained. The section, “How our planet is changing” is filled with an enormous amount of scientific data on weather, oceans and water, icesheets and permafrost, soil and forests, and related environmental issues. In “How it affects us,” we learn how all the changes are affecting water shortages, health and disease, environmental oppression and injustice, climate refugees, and geopolitical conflicts.

The fourth section, “What we have done about it,” is eye-opening. It not only reveals that we haven't even scratched the surface of what should be done, but it also shows that much of the data provided by governments and past agreements have been manipulated to their advantage, obscuring what they are really doing. Whether you are politically oriented right or left, after reading this section you must admit that we continue to live in a world of environmental colonialism and oppression. The Northern Hemisphere produces the most pollution, extracts non-renewable resources from the South, which, in turn, is also the greatest victim of those actions.

The final section explains “What we must do now”: first educate ourselves as world citizens and societies, and then take very difficult but not impossible action based on honesty, solidarity, integrity, and climate justice. To do this, the Northern Hemisphere as an entity must accept that globalization in the sense of economic growth has become a malignancy. As individual world citizens of the Northern Hemisphere, it means that we must wean ourselves off addictive consumerism.

As individuals, for example, we can eat meatless twice a week and buy less “stuff.” That makes a difference, but only when we all do these things at the same time. Reducing the use of fossil fuels and managing water consumption responsibly cannot be handled

alone, but require collaboration of all societies, national and international.

Nationalism, military power, and geopolitical disparities are fundamental to the dynamics that repeatedly have stymied and continue to frustrate efforts to reach a global agreement on rapid decarbonization. Conflict and national rivalries are fundamental drivers of climate change and environmental degeneration. Attention is deflected from those real issues toward technocratic and economic “solutions,” many of which are driven by our addiction to consuming and wasting.


Naomi Klein summarizes this well in her chapter, “The bottomless quest for profits that forces so many to work upward of 50 hours a week with no security, fuelling an epidemic of isolation and despair, is the same quest for bottomless profits that has pushed our planet to peril.” Cultural and structural systemic changes require fundamental paradigm shifts in our assumptions, beliefs, values, and expectations. To accomplish those changes and their related actions, real distributed leadership will be needed.

**Addendum:** On May 27, after CCPL2023 in Vancouver, a summit, Thriving People and Flourishing Planet – Leadership in Action, was attended by over 50 leaders from various organizations, most of them related to health. After an inspiring opening speech by Dr. Melissa Lem, president of the Canadian Association of Physicians for the Environment (CAPE), participants identified eight items to explore deeply in a setup that allowed cross-pollinated conversations. Those conversations led to actionable initiatives that each attendee will implement in their own environment, with planned follow-up. The event was sponsored by LEADS Global, the Canadian Society of Physician Leaders, CAPE, Sanokundu, and Eq HS (Equity in Health Systems lab). More news will follow in future *CJPL* issues.

### Author

Johny Van Aerde, MD, PhD, FRCPC, is former executive medical director of the Canadian Society of Physician Leaders and founding editor of the *Canadian Journal of Physician Leadership*.

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